



Home Visiting Programs Are Vital for Maternal and Infant Health

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When 19-year-old Rosa went into labor three months early, she had to be taken 60 miles to the nearest hospital, according to a 2013 video interview with the organization Save the Children. Her baby, Sirena, was born premature and needed immediate and constant medical attention. Days after giving birth, Rosa was discharged to the home she shared with seven other family members in her small, economically challenged California community. Sirena stayed in the hospital's intensive care unit to continue receiving treatment, miles away from her mother.

Even in the best circumstances, parents' joy at greeting a new baby is tempered by stress and worry during a child's first months. But mothers like Rosa face many additional stressors, including preterm birth, inadequate housing, economic uncertainty, and being young themselves. Fortunately, Rosa did not have to navigate these challenges alone. Diana, a dedicated home visitor—someone specially trained to provide support to new or expectant parents—immediately arranged Rosa's transportation to and from the hospital to visit Sirena. This helped Rosa and her daughter bond during a crucial period and soothed Rosa's heartache over their separation. Once Sirena was healthy enough to go home with her mother, Diana continued to visit them regularly, bringing books and educational tools to help Rosa support her baby's development.¹

Home visitors like Diana are support professionals, such as nurses or social workers, who are well-versed in child development, parenting, and family functioning. Local agencies—such as tribal organizations and departments of health, human services, or education—match home visitors with new or expectant parents interested in receiving services.² Home visiting is a voluntary, home-based service-delivery strategy that provides services to parents and children that help the whole family.³ Parents often learn about home visiting through their children's pediatricians, social workers, and other support professionals. Although home visiting can benefit any family, it can be especially helpful for families who need additional support during stressful periods of economic insecurity or health concerns. Decades of research prove that home visiting can promote healthy child development and academic success, improve health outcomes, and support families' economic security in both the short and long terms.⁴

This issue brief explores how home visiting programs—specifically, evidence-based programs funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program—address three key maternal risk factors that directly influence maternal and child health and disproportionately affect mothers who participate in home visiting: postpartum depression, domestic violence, and tobacco use. Each of these risk factors negatively affects a mother’s physical and emotional health, which in turn can produce worse outcomes for children, including low birth weight, prematurity, and even death. Although families face many more challenges, these health indicators highlight the diverse ways home visiting can benefit mothers and children. The brief also demonstrates how home visiting programs contribute to women’s economic security and, therefore, to the economy as a whole. Finally, it examines continued challenges to funding these programs, as well as potential solutions.

Maternal, Infant, and Early Childhood Home Visiting program

The Maternal, Infant, and Early Childhood Home Visiting program, a partnership between the Maternal and Child Health Bureau (MCHB) and the Administration for Children and Families (ACF), is the largest source of federal dollars for home visiting programs.⁵ In addition to MIECHV dollars, states use money from state and local funds, as well as other federal sources such as Medicaid, to pay for developing, implementing, and expanding home visiting services.⁶ The MIECHV program specifically provides federal funding to states to expand evidence-based home visiting programs that meet rigorous evidence thresholds.⁷ These programs serve families in need, often reaching socially or geographically isolated communities.⁸ Thus, MIECHV funds specifically enhance the reach of the most effective home visiting programs and increase access to professional guidance and support when families need it most. Currently, there are 20 different evidence-based models—programs that have undergone rigorous evaluation to prove their effectiveness—that are eligible to receive funding. In 2015, more than 3,200 local agencies, operated by state and local government offices, delivered evidence-based home visiting services across the country.⁹

Home visiting works by supporting and empowering parents so that they in turn provide a positive environment during a child’s critical early years. These programs, then, influence the well-being of two generations. Of the 20 MIECHV-approved models, for example, there is evidence that 11 models support improved maternal health among participating mothers.¹⁰

Who does the MIECHV program serve?

To receive MIECHV funding, states must prioritize services for families who may benefit most from additional support. These include young mothers, single mothers, first-time mothers, families with a history of child maltreatment and substance abuse, and families with low incomes.

Due largely to a lack of social and institutional supports, many families struggle in numerous ways, particularly financially, after children are born. Home visiting can provide critical supports at this pivotal moment. In 2015, 77 percent of families served by MIECHV-funded programs had incomes at or below the federal poverty level, and 46 percent of families were living in extreme poverty—at or below 50 percent of that guideline.¹¹ The majority of those served by home visiting were young mothers, 39 percent were single mothers, and 43 percent were women of color.¹² Through this targeting, home visiting programs aim to help families meet basic living standards when existing supports or income from work is falling short.

Maternal health risk factors

Postpartum depression

Maternal depression encompasses a range of symptoms that can affect mothers during their pregnancy and up to a year after delivery. These can include feelings of sadness, anxiety, or hopelessness; loss of energy or interest; problems concentrating; and physical symptoms such as aches, pains, and sleeplessness.¹³ Not surprisingly, these psychological and physical symptoms interfere with mothers' day-to-day lives, sometimes to disastrous extremes. Indeed, suicide accounts for about 20 percent of postpartum deaths and is the second-most common cause of mortality in postpartum women.¹⁴

Not only does depression influence mothers' quality of life and subjective well-being, it inhibits mothers' ability to respond appropriately to their children. If untreated, it can lead to a variety of negative health and developmental consequences for children,¹⁵ including childhood behavior problems, cognitive delays, and physical health problems.¹⁶ Untreated maternal depression has also been associated with negative outcomes in employment and income for mothers, suggesting that the costs of maternal depression extend beyond the individual family to the broader economy.¹⁷

Despite the significant impact of maternal depression on mothers and children alike, maternal mental health needs are often neglected or undiagnosed.¹⁸ Prevalence rates of maternal depression are high among low-income women due to the greater challenges they may face related to financial hardships, low levels of community or familial support, and societal prejudice.¹⁹ In fact, the prevalence of maternal depression among low-income women in the United States is double the prevalence rate for all U.S. women.²⁰ At the same time, these women are less likely to receive treatment or be screened for postpartum depression.²¹ Studies show there are clear racial and ethnic disparities in who accesses treatment in the United States, even among women of the same general socio-economic status: In a multiethnic cohort of lower-income Medicaid recipients, 9 percent of white women sought treatment, compared with 4 percent of African American women and 5 percent of Latinas.²²

Interventions that identify this health risk early and help women access adequate treatment can help alleviate the harmful impacts of postpartum depression.²³ In Rosa's case, her home visitor Diana quickly recognized the young mother's feelings of helplessness at being separated from her vulnerable premature daughter and provided the resources Rosa needed to take care of her own emotional needs. While Rosa did not talk specifically in the Save the Children video about postpartum depression, research shows that stressful life events, including premature birth, are risk factors for maternal depression.²⁴ Evaluation studies confirm that women who participated in home visiting programs were less likely to demonstrate symptoms of depression and reported improved mental outlook when compared with control groups of women who did not participate in home visiting.²⁵ For example, parents participating in the Child First model—one of the 20 evidence-based models eligible to receive funds from the Maternal, Infant, and Early Childhood Home Visiting program—experienced lower levels of stress and depression at the end of the program compared with parents who did not participate.²⁶

Recognizing the opportunity to use the MIECHV program to help improve new mothers' mental health, many states are building on promising approaches to address postpartum depression directly through home visiting programs in effective, innovative ways.²⁷ In 2014, 68 percent of state MIECHV-funded programs increased screenings for maternal depressive symptoms and improved referral rates among pregnant women or women enrolled in home visiting programs.²⁸ Additionally, 70 percent of state programs reported improvements to parents' emotional well-being by successfully lowering reported parental stress and reducing rates of depressive symptoms among participating families.²⁹ For example, Moving Beyond Depression is a program that uses in-home cognitive behavioral therapy to ameliorate, not just screen for, maternal depression. This approach, which is used to augment MIECHV-funded home visiting, allows therapists to observe and address elements of the home environment that may affect mothers' mental health.³⁰

Domestic violence

Domestic violence is a public health problem that affects millions of Americans. The term "domestic violence" is used to describe physical, sexual, or psychological abuse.³¹ In addition to immediate health concerns due to injuries and emotional distress, survivors can experience a wide variety of longer-term cardiovascular, gastrointestinal, endocrine, and immune system problems stemming from abuse.³² These health problems may contribute to victims' higher annual health care costs up to 15 years after the abuse ends.³³

Perpetrators of domestic violence inflict lifelong harm on children, even if they are not the target of abuse. At birth, children of abused parents are more likely to be born at low birth weight and experience stunted growth.³⁴ As they grow, children raised in homes where they witness domestic violence are 50 percent more likely to misuse alcohol and drugs and 6 times more likely to take their lives, compared with children living in homes free of domestic violence.³⁵ As adults, they are more likely to become abusers themselves.³⁶

Home visiting helps mitigate the negative impacts of domestic violence by screening for risk factors and providing guidance and support to parents. Domestic violence screenings and reducing domestic violence rates are specific benchmarks for success under the MIECHV program, and recent evaluations suggest states are making important progress toward reaching those goals. In 2014, 39 states increased the number of women screened for domestic violence, and safety plans were completed for 63 percent of families identified as experiencing domestic violence.³⁷

As a result, many home visiting programs are prioritizing domestic violence prevention in their models.³⁸ Notably, Missouri trains all professionals who are part of the state's MIECHV program to screen for domestic violence and help ensure children are living in safe homes.³⁹ Other states have enhanced their home visiting programs by integrating the Domestic Violence Enhanced Home Visitation Program (DOVE) into their state home visiting program. DOVE is an evidence-based intervention that trains home visitors to screen for partner violence among participating families and intervene to support victims using research-tested processes and protocols.⁴⁰ In states participating in an evaluation of DOVE, reported partner violence among participating families decreased at a statistically significant rate over the course of the program.⁴¹

Evaluations of home visiting programs show that MIECHV-funded services are associated with lower rates of domestic violence in a variety of contexts.⁴² For example, several evaluations of the Nurse-Family Partnership (NFP), an MIECHV-funded home visiting model operating in 42 states, showed that families who participate in the program across different locations were less likely to report domestic violence.⁴³ In one study, about 7 percent of participating families in NFP reported experiencing domestic violence, compared with nearly 14 percent of nonparticipating families.⁴⁴

Tobacco use

Women who smoke during pregnancy are at a higher risk for miscarriage and complications during pregnancy and delivery.⁴⁵ According to the Centers for Disease Control and Prevention (CDC), smoking during pregnancy leads to more than 1,000 infant deaths each year.⁴⁶ After giving birth, health risks continue through infancy, childhood, and adolescence. Studies link tobacco use to reductions in breastfeeding initiation and duration, meaning that infants of mothers who smoke are less likely to enjoy the health benefits of being breastfed.⁴⁷ Relatedly, exposure to secondhand smoke increases children's risk of sudden infant death syndrome (SIDS) during the first 12 months of life. Throughout childhood, exposure to secondhand smoke increases the risk of asthma, respiratory infections, and ear infections.⁴⁸ During adolescence, children whose parents smoked are twice as likely as children of nonsmokers to begin smoking between ages 13 and 21.⁴⁹

But while tobacco use takes years off a smoker's life, quitting quickly mitigates its impact. Within a few years after quitting smoking, a former smoker's risk of stroke falls to about the same level as that observed in people who have never smoked.⁵⁰ Quitting also benefits children, especially if a parent quits while their child is still young. One study found that parents who quit smoking before their child was in third grade reduced their child's risk of taking up the habit by 30 percent.⁵¹

Home visiting teaches parents about the unique health risks associated with smoking for adults and children, and research demonstrates that it can successfully decrease smoking among expectant and new mothers who participate in the programs.⁵² For example, one recent study from Pennsylvania confirms that women who participated in one of four different MIECHV-funded home visiting models—NFP, Parents as Teachers, Healthy Families America, or Early Head Start—were more likely to quit or reduce their amount of smoking during pregnancy than women who did not participate in the programs.⁵³

Long-term economic benefits

Through improving maternal and child health, home visiting can also improve economic conditions for participating families. Addressing critical health risk factors such as maternal depression, domestic violence, and tobacco use during pregnancy and infancy reduces health care costs in the long term and can improve families' economic security.

Beyond the physical and emotional costs of maternal depression, domestic violence, and tobacco use, these risk factors have negative impacts on mothers' ability to work and support their families. If left untreated, maternal depression can lead to decreases in income and employment as the condition worsens.⁵⁴ Similarly, relationship violence leads to a collective loss of 8 million days of paid work per year.⁵⁵ As discussed above, many poor maternal and child health outcomes are associated with tobacco use during pregnancy. Long-term tobacco use following pregnancy also results in poorer maternal health, which an extensive body of research shows is intricately linked with economic trends, educational opportunities, and productivity.⁵⁶ Women's lower wages, unemployment, and lost productivity resulting from these risk factors add up to high costs that home visiting can help alleviate.⁵⁷ With 42 percent of mothers in the United States being breadwinners, home visiting programs are critically important to support not only their health but also their and their families' economic well-being.⁵⁸

Home visiting programs are proven to reduce these costly health risks among the families that participate in their voluntary services. By working with families to screen for and treat maternal depression, intimate partner violence, and tobacco use, home visiting can lower state and federal Medicaid spending and reduce the need for social services such as special education, food assistance, and income supports.⁵⁹

Similarly, home visiting programs support families' economic security. In 2016, 79 percent of programs funded by the Maternal, Infant, and Early Childhood Home Visiting program saw an increase in household income among participating families.⁶⁰ Furthermore, investments in MIECHV evidence-based home visiting programs produce a return on investment of \$1.89 for every dollar spent on implementing the program, in part through reduced spending on the social services noted above.⁶¹ These results prove that home visiting programs provide economic benefits for everyone—not just the families that participate. Investments in interventions such as home visiting that support parents to be the most effective caregivers they can be are investments in the nation's long-term economic success.

Existing challenges and moving the program forward

The MIECHV program represents the first large-scale federal investment in expanding home visiting services across the country and has demonstrated positive impacts on women and children. Despite the program's successes, it currently faces several challenges that threaten its ability to serve families in need.

First, despite strong bipartisan support in Congress, the most recent reauthorization only extended the program for two years.⁶² This kind of short-term authorization presents significant challenges for state-level administrators, as uncertainty around funding inhibits long-term planning and impedes program effectiveness at the state and local levels. Second, reauthorizations have remained at the original funding level of \$1.5 billion over five years. As a result, states are unable to expand voluntary home visiting services to all families that could benefit. In 2015, MIECHV-funded programs only reached about 145,000 children and parents,⁶³ a small portion of the nearly 4 million families considered to be high-priority for home visiting services.⁶⁴

For those families who voluntarily participate in evidence-based home visiting, the results can be tremendous. Congress should act to ensure that MIECHV funding continues beyond September 2017. In addition to protecting and extending the existing investment in this critical intervention, Congress should increase the funding amount to allow for services to reach more families in need. Policymakers should also allow for a longer-term authorization. To ensure stability and long-term success, Congress should authorize an extension of the MIECHV program for at least five years and consider authorizing MIECHV as a permanent program.

Conclusion

Bipartisan support for the Maternal, Infant, and Early Childhood Home Visiting program is strong. Evidence-based home visiting programs are proven and cost-effective services that improve the health and well-being of mothers, children, and families by ensuring that parents acquire the skills and resources they need. While this brief examined just three ways that home visiting programs support the health and economic security of mothers and their babies, part of the MIECHV program's strength lies in the many innovative ways it allows states to support parents and young children. Congress must act now to preserve and fully fund this vital program for maternal and child health.

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