TexProtects
Champions for Safe Children

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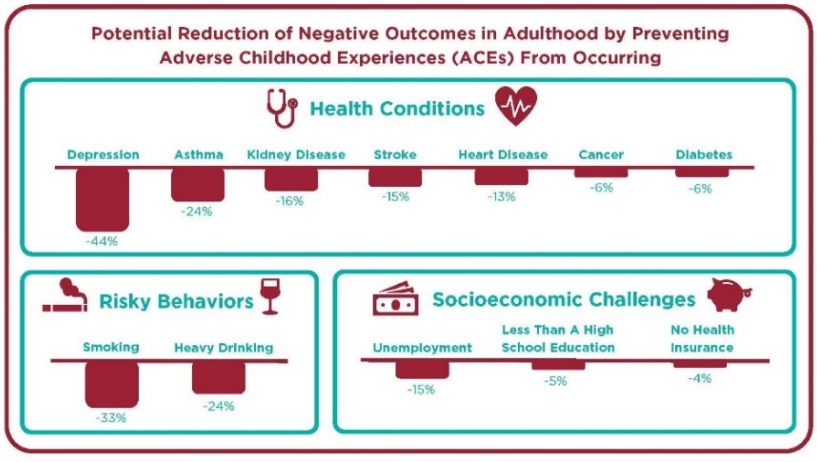
Input to Appropriations/Subcommittee on Article 2 - 2020

Interim Charge #5: Examine state investments in the health and brain development of babies and toddlers, including Early Childhood Intervention and other early childhood programs for children in the first three years. Evaluate opportunities to boost child outcomes and achieve longer-term savings.

Children are born with an amazing capacity to learn and grow. Per second, 700 to 1,000 new neural connections are created in the infant brain. 90% of brain development happens before age 5. However, development does not happen in isolation. It is dependent upon responsive relationships and engagement with a stimulating environment. Like building a house, early experiences will create a strong or unsteady foundation for everything that comes later.

Brain architecture is dependent upon the experiences a child has or does not have. Of primary importance is their connection to a safe, stable, and responsive caregiver. This is the *how* of Early Childhood Brain Development (ECBD). A child learns about the world and how to engage one interaction at a time. When a baby reaches out and does not get a response or gets a negative response, they are learning which skills are important to strengthen and which are not. They may learn that they cannot depend on their caregiver and environment or that they are not safe. Alternatively, when a baby reaches out and is met with a healthy response, they access the safety, security, and connection that is needed to enable higher-level cognitive skills as well as social-emotional development.

Stress is a natural part of life, but chronic and uncontrollable stress is toxic. The biology of stress is intended to be short-term and can be calmed in safe environments and dependable relationships. When children experience chronic adversity and trauma, the neurological and hormonal impacts can alter brain development and biology in ways that have outcomes across the lifespan including mental and physical health.



The immense research done on the health implications of Adverse Childhood Experiences (ACEs)[i]—including abuse, neglect, family violence, or growing up with a caregiver who is incarcerated, mentally ill, or engaging in substance use—makes clear that what happens in early childhood literally lasts a lifetime. The prevention of ACEs holds incredible potential for ensuring healthy development and impacting societal challenges and taxpayer costs across multiple domains.

To create the most effective and efficient systemic change, interventions should occur in early childhood. Nobel Laureate and economist, James Heckman's, work[ii] makes an economic case for early childhood investments that begin before birth. Model early childhood programs offer a return between $3 and $9 per dollar invested and are much cheaper than interventions that work to address problems in our educational, criminal justice, and healthcare systems. Comprehensive supports for children and their families result in better outcomes for children and better economic returns than any one element alone. And in general, the earlier the better.

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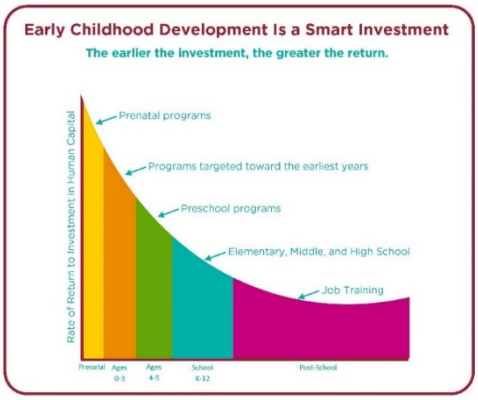


The cost of inaction is clear. ACEs are associated with negative outcomes for individuals across the lifespan including poorer health, lower educational attainment, and higher likelihood of experiencing unemployment. Individuals and governments incur significant costs as a result. Bellis et al. (2019) estimate that annual healthcare costs attributable to ACEs across North America are approximately $748 billion with 82% of costs resulting from individuals who had two or more ACEs.[iii] With one in 10 American children living in Texas we can expect to incur a significant percent of those costs if we aren't better able to prevent ACEs.

Health care costs as a result of ACEs are the most well-documented, but there are also criminal justice, child welfare, education costs, among others. For example, each case of child abuse or neglect causes $830,000 dollars in costs across the victim's lifetime.[iv] This translates to over $55 billion dollars in costs resulting from confirmed abuse and neglect in Texas in 2019 alone. We can continue to pay for the effects of childhood adversity, or we can work to prevent it.

Recent data from the Child and Family Research Partnership at the University of Texas' Prenatal to Three Policy Impact Center suggests that Texas has a long way to go in ensuring that children and families are well supported and healthy.

Outcome measure	Texas Rate	Texas Rank among 51 States
Children < 3 in poverty	22.3%	38
Low income women uninsured	47.4%	51
Children < 3 NOT receiving developmental screening	58.9%	21
Poor maternal mental health	4.9%	29
Low parenting support	22%	47
Children not read to daily	71.1%	48
Children not nurtured daily	52.4%	51
Parents not coping very well	25.4%	10
Children < 3 not fully immunized	27.7%	28
Maltreatment rate per 1000 children < age 3	18.4%	29

Source: Texas Prenatal to Three State Policy Roadmap/Prenatal to 3 Policy Impact Center

As all of these rates were reported before COVID-19, we have reason to believe that on most of these measures we would see dramatic increases with more current numbers. TexProtects worked with Child Trends to look specifically at the potential impact of COVID-19 on child abuse and neglect risks and found reason to believe that increases in unemployment, mental health struggles, family violence, substance use issues, and parental stress may result in increased abuse and neglect. Research during

the last recession found that **for each point the unemployment rate rises, physical and emotional abuse increase by 12-15%.**[v]

However, with the large majority of CPS cases addressing neglect rather than abuse and much abuse/neglect going unreported, we know families need support more often than they need protection. The most cost-efficient and effective approaches offer supports **before a crisis occurs** and during the first years of life when a stable, safe, nurturing caregiver is **the key** to healthy child development.

TexProtects serves as a steering committee member of the Texas Prenatal-to-Three (PN-3) Collaborative, a group of 100+ organizations around the state who have worked together to identify feasible and effective strategies to ensure over 300,000 more infants and toddlers have access to needed supports by 2026. To achieve that mission, the PN-3 Collaborative is focusing on an agenda for Texas that includes legislative, regulatory, and community work that increases access to healthy beginnings, family support, and quality early care and education.

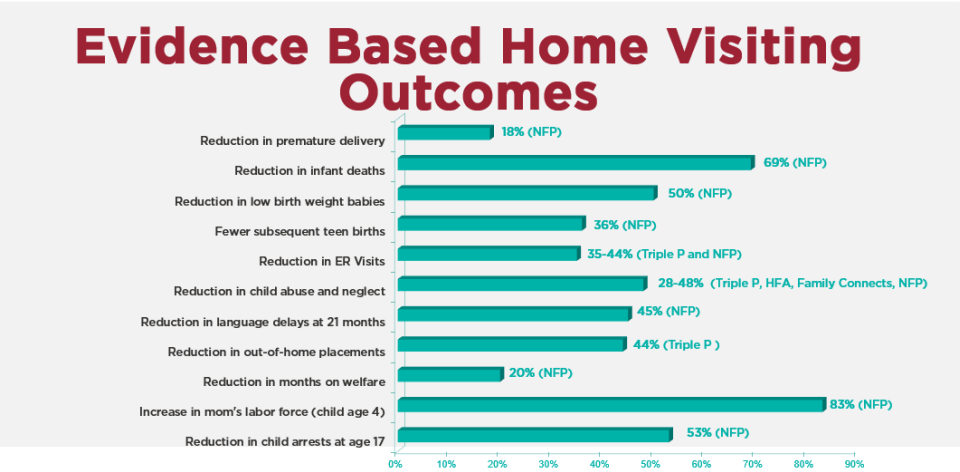
As the statewide leader for the **family support** section of that agenda as well as long time champions for effective and cost-efficient prevention programs that support children and families, TexProtects would forward the following recommendations to the committee:

Recommendations

1. **Fully fund the Prevention and Early Intervention Exceptional Item Request to strengthen community-based, primary child abuse prevention programs for children prenatal to age 5 through Healthy Outcomes Through Prevention and Early Support (Project HOPES) and Texas Nurse-Family Partnership (TNFP).**
   C.1.4 & C.1.5

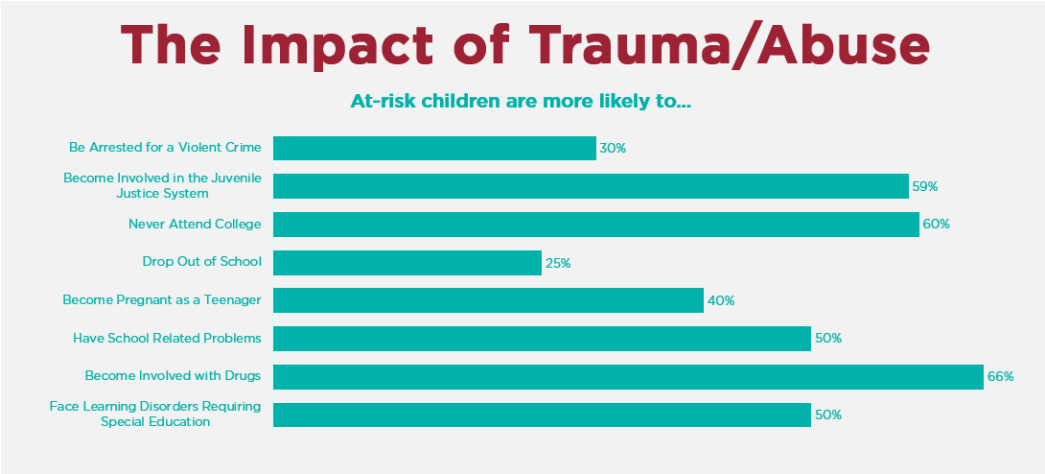
Proven prevention programs administered through the Prevention and Early Intervention Division at DFPS have been critical lifelines for families during COVID-19 and depend on an infrastructure of community providers who work together to support families. Over the past decade, state and federal investments have helped build a prevention infrastructure facilitated through state grants to local communities that is a model for states around the country.

These prevention programs largely provide evidence-based home visiting and wrap-around services to families facing challenges. There are several models; however, they all share an approach in that they are 100% voluntary and provide parenting support, child development information, screenings, and referrals to families. These programs have a proven return on investment of between $1.26 and $8.08 and have impacts across multiple domains and two generations. [vi]



With only 4% of the families in highest need with current access, expansion is critical if Texas desires the statewide impact and cost savings that could result from widespread access to these programs. The current PEI strategic plan indicates that to adequately protect families, a 20% increase in prevention funds is needed every biennium. Currently, DFPS only spends 5% on early prevention efforts compared to CPS costs.

Historically, prevention funding has faced cuts during recession. This is a mistake. Any cut would put children at risk while also negatively impacting local providers and their employees who depend on the state grants to provide services. Ultimately, cuts to prevention would result in increased costs in our education, child welfare, health, and criminal justice systems for years to come.[vii]



As noted by the *DFPS 2018 Prevention Task Force Report,* "Diverting 5% of families from Family Based Safety Services (1786) would save the state more than $9.4 million. Preventing 3% of removals (593) would save upwards of $20.3 million."

2. Expand Universal Prevention Strategies in Public Health Settings

Healthcare settings remain one of the most universal touchpoints for families with young children and provide an opportunity to connect with families during a critical and sensitive period for child development. Innovative programs are working within public health settings to provide more holistic supports to families and create a more efficient mechanism for resource and referral work in communities. One innovative program currently operating in Texas is **Family Connects**. This model begins by offering moms, while they are in the hospital following a birth, a free home visit by a registered nurse three weeks postpartum. Over 85% of those offered the program accept. At the visit, the nurse completes health and mental health screenings on the mom and baby, shares information, and connects the family to other community supports as needed. Follow-up is provided to every family within six weeks to ensure connections were made and to see if additional support is needed. **The program has shown a $3.02 return on every dollar investment in emergency room costs alone. It also impacts maternal mental health, positive parenting behaviors, and has shown a 39% reduction in child abuse investigations even 5 years after services end.** The program is currently operating in five counties around Texas with a mix of federal and state funds administered through the Prevention and Early Intervention Division at DFPS (C.1.4 & C.1.5) as well as local philanthropic and Medicaid Managed Care Organization investments. Innovative funding mechanisms including alternative payment methods for MCOs could further expand these programs around Texas in ways that are cost effective now and later.

3. **Prevent early childhood trauma and entries into foster care by leveraging the opportunities in the Federal First Prevention Services Act to offer families at imminent risk of removal access to evidence-based mental health, substance use, and parenting supports.**

Texas must be proactive and innovative in determining how to maximize the opportunity of the Family First Prevention Services Act to access federal matching funds for prevention funding that can be used to directly address the key drivers of child abuse/neglect: substance use, mental health challenges, and poor parenting skills. 55% of confirmed victims are under age 5, so family supports are critical for families at risk who have young children. Use of these funds should be prioritized for evidence-based programs that will prevent entry into the foster care system as this is the primary way to ensure better outcomes for children, family preservation, and long-term cost savings for the state. The current plan provided by the state invests $33.9 of the $50.4 million federal transition funds toward prevention but does not provide a vision for state investments across the Article 2 budget that could help Texas draw down the federal match and expand access to services. We recommend the 87th legislature ensure there is budgetary infrastructure to support future state investments. We provided more comprehensive comment on FFPSA in separate comments to your committee.

4. **Support additional Prenatal to Three Collaborative Agenda items including strengthening Early Childhood Intervention, enhancing maternal health by extending Medicaid to 12 months postpartum & connecting infants and toddlers to health care through continuous, 12-month coverage in Children's Medicaid.**

Given the social isolation and increasing stress and risks for families due to COVID-19, the work of strengthening families and ensuring child safety must begin before a crisis occurs. While mitigating the health effects of the virus is primary, these longer-term risks will continue to affect our children's and our state's future for years to come. As such, investment in the front end of the system and in our youngest children is needed now more than ever. Thank you for your dedication to this critical issue and for your continued work to ensure healthy beginnings for our state's most important resource, our children.

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[i] *Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998).*
[ii] *www.heckmanequation.org*
[iii] *Bellis et al (2019)*
[iv] *Peterson et al (2018)*
[v] *Schneider, W., Waldfogel, J., & Brooks-Gunn, J. (2017).*
[vi] *: Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009); Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008); Olds, D. L., Kitzman, H. J., Cole, R. E., Hanks, C. A., Arcoleo, K. J., Anson, E. A., . . . Stevenson, A. J. (2010); Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., et al. (2007); Olds, D. L., Robinson, J., Pettitt, L. M., Luckey, D. W., Holmberg, J., Ng, R. K., . . . Henerson, C. R. (2004)*
[vii] *Barnett, W.S., & Masse, L.N. (2002).; Swan, N. (1998).; Campbell, F. A., et al. (2002).; Widom, C., & Maxfield, M. (2001).*