MIGRATION POLICY INSTITUTE
NATIONAL CENTER ON IMMIGRANT INTEGRATION POLICY

Supporting Immigrant and Refugee Families through Home Visiting

Innovative State and Local Approaches

POLICY BRIEF

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Executive Summary

Home visiting programs are an increasingly popular two-generation service model that reaches young children and their caretakers in their homes, providing regular support that promotes well-being and positive long-term outcomes for children and families. Immigrant and refugee families also stand to benefit from the integration-related supports these programs may offer, such as help navigating early childhood, health, and social service systems; supporting a child's home language development; and accessing trauma-informed care. Yet immigrant families are less frequently enrolled in these programs than families in which the parents are U.S. born, despite comprising a significant share of at-risk families that could be targeted for home visiting services.

Immigrant families are less frequently enrolled in these programs than families in which the parents are U.S. born, despite comprising a significant share of at-risk families.

Some states and localities are adopting innovative approaches to address this gap. This brief highlights efforts by policymakers and program administrators in King County, Washington State; San Diego County, California; Illinois; and Massachusetts to boost the enrollment of immigrant and refugee families in home visiting services, and to make these programs responsive to their needs. Working with different populations and in different funding environments, these case studies illustrate important steps actors at the state and local level can take to expand program access and quality for immigrant families, including:

- ensuring that at-risk immigrant families are meaningfully incorporated into state needs assessments and prioritized for home visiting services alongside other at-risk families;
- supporting linguistically and culturally responsive models that can effectively meet the needs of diverse communities;
- incorporating community feedback into program designs;
- designing procurement policies and processes to prioritize support for service provision by organizations deeply rooted in their communities;
- locating home visiting programs within community-based organizations already effectively serving immigrant populations, such as refugee resettlement agencies; and

- facilitating the growth of the research base on models that are effective in meeting immigrant families' needs through program and procurement design choices.

These and other policy and programmatic strategies exemplified by the case studies hold the potential to strengthen and expand home visiting services for immigrant and refugee families. Such approaches can boost equity in service access and quality, and in doing so enable states and localities to leverage home visiting to promote better two-generation outcomes for immigrants and their children in both the short and long term, including children's school readiness and healthy development and their parents' health, education, and employment outcomes.

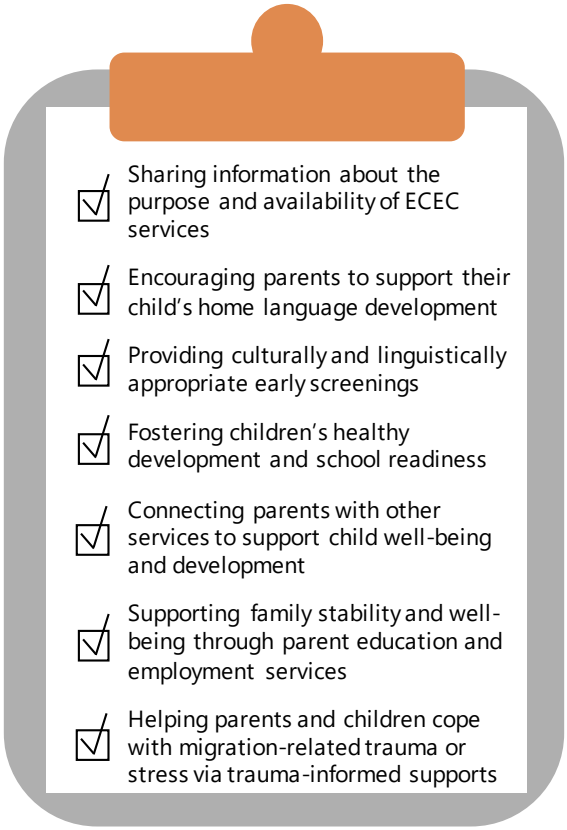
1 Introduction

Home visiting, an important health and social services program model that targets children during their critical first years alongside their caregivers, has seen increased federal, state, and local investment in recent years. With a variety of funding sources, structures, and service delivery methods, home visiting programs can be tailored to the communities they serve, just as home visits themselves can be adapted to the needs of individual families.

Through these programs, individuals who are expecting or caring for young children receive regular in-home visits from trained staff over an extended period, during which they are provided information on a range of topics relevant to the family's needs, as well as training, screenings, and connections to services. This two-generation model has been shown to be effective in promoting children's school readiness and healthy development and parents' education and employment outcomes.[1] Beyond these benefits for families more generally, home visiting programs, if well designed and implemented, can also be an effective tool to support the well-being, inclusion, and success of immigrant and refugee families. These services can therefore play an important role in facilitating their integration, as highlighted in Figure 1.[2]

FIGURE 1

Key Benefits of Home Visiting Programs for Immigrant and Refugee Families



ECEC = early childhood education and care.
Source: Maki Park and Caitlin Katsiaficas, *Leveraging the Potential of Home Visiting Programs to Serve Immigrant and Dual Language Learner Families* (Washington, DC: Migration Policy Institute, 2019).

But despite the potential benefits of home visiting for immigrant and refugee families—and the fact that these groups are disproportionately likely to be experiencing the very risk factors many home visiting programs target, including poverty and low levels of parental education—immigrant families are generally underserved by these programs.[3] This could be because the data used to drive program services often do not identify immigrant families or particular risk factors they may face (for example, language and culture barriers or lack of knowledge

of U.S. systems).[4] And even if immigrants are identified using broader population characteristics, programs may lack the linguistic and cultural expertise or other capacities needed to effectively serve them.[5]

However, recognizing both the benefits of increased investments in home visiting and that programming must better reflect the needs of diverse families to be effective, some states and localities are taking steps to improve their home visiting programs' ability to equitably reach and effectively serve immigrant and refugee families. This includes investing in data collection and evaluation mechanisms to build the research base for linguistically and culturally responsive home visiting programming.

This brief explores four case studies to highlight some of the innovative ways that states and localities are doing this. It also reviews the lessons their efforts hold for policymakers and early childhood stakeholders elsewhere as they work to improve the equitable participation of immigrant families in high-quality home visiting services.

2 Innovative State and Local Home Visiting Strategies

These case studies were selected through research and consultations with home visiting policymakers and program administrators, including at an October 2019 symposium hosted by the Migration Policy Institute's National Center on Immigrant Integration Policy. The efforts described include those of policymakers who are working within the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to improve service access and quality for at-risk immigrant and refugee families, as well as others who are taking advantage of their more flexible state funds to expand services for these populations.

A. King County, WA: Using Funding Processes to Promote Equity and Inclusion

King County in Washington State, home to Seattle, has seen steady growth in its foreign-born population; today, more than one in five residents were born outside the United States.[6] Reflecting the diversity of its population, more than 170 languages and dialects are spoken across the county.[7] The King County government has taken a proactive and holistic approach to building stronger and more equitable communities through its Best Starts for Kids (BSK) initiative, which aims to help children and their families thrive through activities that promote child development. Following voters' approval of the Best Starts for Kids Levy in 2015 (Ordinance 18088), which is projected to provide $400 million in revenue over six years,[8] the initiative has been funded at an average of $65 million per year.[9]

Recognizing the importance of children's early years for their healthy development and well-being, half of this investment is allocated to services for families in need of prenatal care and those with children age 5 or younger.[10] These early years investments, which comprise one of the initiative's four focus areas, include home visiting, universal developmental screening, infant and early childhood mental-health training and endorsement, early childhood workforce development, coaching for child-care providers on trauma-informed care and other health issues, and community-based parenting education. Related systems are linked through a central network known as Help Me Grow. Acknowledging that the creation of the BSK initiative provided an opportunity to design policy and program structures that could be more responsive to the county's diverse population,[11] county staff sought input from a range of

linguistic and cultural communities through focus groups, interviews, and community discussions to inform the initiative's design.[12]

Historically, most research and evaluation of home visiting models have not accounted for the needs and experiences of diverse communities, and the evidence base does not adequately reflect the specific needs and experiences of refugee and immigrant families.[13] BSK takes a multipronged approach that provides funding to a mix of evidence-based programs (those proven effective through rigorous research), evidence-informed programs (those with at least one comparison study showing effectiveness), and community-designed programs, which together ensure that its home visiting investments offer programming tailored to the varied needs of residents.[14] An allocation of $2.7 million marked the first investment in community-designed home-based programs in Washington State and represents a unique effort to support innovative and tailored strategies for reaching underserved populations.[15] These programs focus on specific communities for which evidence-based or evidence-informed programs have not yet been created and draw on local community knowledge to support program design.[16]

Beyond the challenges associated with designing effective programs relevant to immigrant and refugee populations with scarce evidence, funding structures can make it difficult for many organizations with the requisite ties and skills to serve these communities well to receive funding to offer home visiting services. Request for proposal (RFP) processes are often time consuming, resource intensive, and technically demanding, which can render them inaccessible to newer and smaller organizations. Additionally, typical RFP evaluation practices prioritize characteristics such as capacity and infrastructure, which can perpetuate systemic disadvantage for minority-, immigrant-, and refugee-led organizations, as many have historically received less investment from government and philanthropy to develop their infrastructure. At the same time, these processes are generally not designed to reward the strengths and skills of these organizations. As a result, organizations that have high levels of linguistic and cultural competence and strong relationships with at-risk immigrant and refugee families often do not enter or get selected in funding competitions despite their unique ability to provide effective services.

Recognizing these skills and connections as critical elements of organizational capacity helped level the playing field for groups with deep ties to and experience with the communities they serve.

In order to address these challenges and facilitate its community-centered efforts, BSK sought community and service provider feedback when developing its Community-Designed Home-Based Programs and Practices RFP. For instance, after hearing from East African community members and providers that some families were experiencing isolation in current evidence-based and evidence-informed home visiting models, BSK structured the RFP to enable programs to provide up to 40 percent of visits in community-based settings, along with other supports aimed at strengthening social networks, a known protective factor.[17] Input from community members also led BSK to significantly revamp its procurement process. Notably, it changed how "capacity" is defined in all RFP processes, including for community-designed services, by incorporating several indicators to gauge applicants' embeddedness in their community; recognizing these skills and connections as critical elements of organizational capacity helped level the playing field for groups with deep ties to and experience with the communities they serve.[18]

Once the RFP was developed, BSK worked to include diverse community-based organizations in the application process. It advertised the RFP in various community venues across the county, including libraries; recorded all information sessions and posted them online; and provided proposal development technical assistance aimed at removing linguistic and cultural barriers for potential applicants.[19] It also included community members on its RFP review panels and provided reviewer trainings to help raise awareness about racial and cultural norms embedded in typical proposal evaluations and to reduce bias in the evaluation process. As a result of these efforts, organizations that had previously experienced numerous barriers in the application process were more competitive—and many were ultimately funded to provide services.[20] The community-based organizations that were selected for funding under the Community-Designed bucket—the Atlantic Street Center, Centro Rendu, Coalition for Refugees from Burma, East African Community Services, El Centro de la Raza, Iraqi Community Center, Open Arms Perinatal Services, Open Doors for Multicultural Families, Somali Health Board, and United Indians of All Tribes—represent a wide range of King County's cultural communities.[21]

Beyond carving out a space for community-designed programs, in its funding for evidence-informed programs BSK also sought ways to level the playing field for smaller, community-based organizations that have been shown to be highly effective in serving certain cultural and ethnic communities, but that prioritize different metrics than those used by the MIECHV program[22] (the federal program whose approaches and metrics generally predominate in home visiting funding initiatives). For instance, under the BSK initiative, Open Arms Perinatal Services operates the Community-Based Outreach Doula Home Visiting Program, which conducts two home visits per month from the second trimester through the first two years after birth. More than 60 percent of its clients speak languages other than English at home, and more than half are immigrants or refugees. The program works to pair its Somali, American Indian and Alaska Native, and Latina clients with doulas who share their cultural and linguistic backgrounds.[23] An independent evaluation of the program found that it had far higher retention rates than other programs in the state (72 percent after one year, compared to 47 percent for state-funded MIECHV programs).[24] It also produced better health outcomes in comparison to state and county data, demonstrating that this community-based, culturally focused program was effective in serving pregnant and new mothers while boosting the inclusion of those often seen as harder to serve.[25]

The ability of King County to support a program such as Open Arms illustrates the value of BSK's approaches for policymakers seeking to reach a range of diverse, at-risk families through home visiting services. By incorporating community input into all stages of the program cycle, the initiative gathers valuable knowledge from community partners that strengthens the reach and quality of home visiting services in the county. Part of BSK's new approach to partnership is an emphasis on providing intensive support for its community partners. To accomplish this, BSK incorporated capacity-building and evaluation into its implementation plan, providing significant financial and consulting resources to work with grantees to develop racial equity theories of change, gather community input and engage in focused program design, draft budgets and project implementation plans, and access ongoing data-focused and organizational supports throughout program implementation.[26] All programs receive capacity-building support regarding data collection and performance measurement, while community-designed programs are also provided support to build organizational capacity. This focus on capacity-building has enabled BSK to assist smaller organizations and those newer to home visiting with program development and high-quality, culturally responsive program implementation and improvement.

BSK's approach is also allowing the initiative to begin building the research base for home visiting programs that work for diverse families. Indeed, a cross-cutting focus area of BSK is improving data collection and evaluation, with 5 percent of overall funding allocated for this purpose.[27] By building these supports into the initiative alongside programming, BSK is helping its partners strengthen their capacity to provide home visiting services as well as to understand their efficacy. These evaluation efforts are critical if successful programs are to be scaled up, illustrating that this investment can serve these communities well in the short and the long term.

B. *Illinois: Increasing the Focus on Trauma-Informed Care*

As of 2018, nearly 1.8 million immigrants called Illinois home, representing 14 percent of the state's population.[28] Since 1988, the state's Prevention Initiative has worked to promote healthy development and school success among Illinois children considered at risk for negative academic outcomes. This initiative, created under *Public Act 85-1046* and overseen by the Illinois State Board of Education (ISBE), offers intensive, holistic, and evidence-based prevention services for families with young children ages 0 to 3. Supported by Early Childhood Block Grant and General Revenue Funds, the initiative awards funding on a competitive basis, with a range of organizations eligible to apply, including school districts, charter schools, vocational centers, and public and private social service agencies.[29]

The Prevention Initiative funds center- and home-based services using the Baby TALK, Healthy Families Illinois, Nurse-Family Partnership, and Parents as Teachers home visiting models, as well as those that meet Early Head Start and National Association for the Education of Young Children (NAEYC) standards. This combination of eligible models includes both those that fit the MIECHV definition of "evidence based"[30] as well as smaller, emerging models, though all include visits, connections, screenings, and planning as key program components.[31] Of particular significance for immigrant families, the administrative code establishing the initiative includes language and cultural disadvantages in its definition of "at-risk" families, and programs are required to use a screening process that looks at factors including parents' literacy and English proficiency to determine service eligibility.[32] These system elements are critical in encouraging programs to identify at-risk immigrant and refugee young children and families in the state and to provide services that meet their needs.

The early childhood field has become increasingly aware of the potential impacts of early childhood trauma, which has spurred interest in promoting trauma-informed services for young children and their families.[33] But while home visiting programs can be an important vehicle for supporting immigrant and refugee families who have experienced trauma and stress before, during, or after migration,[34] most mainstream models and programs do not capitalize on this opportunity. However, the Prevention Initiative's focus on relationships, including support for families facing stress and trauma,[35] has led it to support RefugeeOne's work at the intersection of trauma, immigrant and refugee services, and home visiting—an approach that is important but rare.

RefugeeOne, the largest refugee resettlement agency in Illinois, provides a range of services aimed at supporting refugees in rebuilding their lives in Chicago. Its Wellness Program was the first mental-health program in Illinois to receive a home visiting grant.[36] Every adult refugee who is resettled by RefugeeOne undergoes an intake process with the Wellness Program, and families who are expecting or have young children are automatically referred to the home visiting program. This has enabled the agency to systematically reach refugee families with young children to offer home visits using the

Baby TALK model.[37] The home visiting program also serves unauthorized immigrant families, who may face challenges that can affect their mental health and well-being. Given the large number of refugee and other immigrant families that experience migration-related trauma,[38] innovating and building evidence in this space is an important opportunity for RefugeeOne and for others looking to provide similar supports.

As a result of this approach, home visitors are able to more effectively identify clients who would benefit from clinical services, and clients are more comfortable taking them up on these referrals.

Home visiting can be a helpful vehicle for supporting family mental health by removing access barriers, identifying needs, and providing connections to outside services (both clinical and nonclinical).[39] RefugeeOne and the Baby TALK model take a relationship-based approach to working with families, with the objective of providing trauma-informed home visiting. To achieve this goal, home visitors are trained on mental-health concepts and terms, trauma-informed practices, identifying symptoms, and providing referrals to meet families' specific needs. As a result of this approach, home visitors are able to more effectively identify clients who would benefit from clinical services, and clients are more comfortable taking them up on these referrals.[40] In addition to five home visitors, the program's team also includes four clinicians, a psychiatrist, and interpreters.[41] Thus, in addition to the other benefits of home visiting, RefugeeOne's home visiting program can provide an important source of trauma-informed support for refugee families. This is in line with the Baby TALK model's emphasis on identifying families that are most at risk in order to provide them with these resources.[42]

To understand and facilitate the replication of successful program elements, RefugeeOne conducted an evaluation of its home visiting program, published in 2018.[43] ISBE, interested in measuring the efficacy of RefugeeOne's work with refugee and immigrant families, provided financial support (alongside Baby TALK, Inc.) for RefugeeOne to conduct this study, a randomized control trial with 200 refugee and unauthorized immigrant parents and their children.[44] The evaluation found that children participating in RefugeeOne's Baby TALK program saw positive language and social-emotional development outcomes.[45] Meanwhile, data suggest that parents experienced decreased stress levels and trauma symptoms, and preliminary information finds that parents utilized a higher number of positive parenting practices.[46]

Already deemed evidence based by ISBE and recognized as a promising practice by the U.S. Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration, RefugeeOne and Baby TALK have submitted their evaluation for review by HHS' Home Visiting Evidence of Effectiveness (HomVEE) initiative, the body that determines which home visiting models will be considered evidence based for federal MIECHV funding. Studies that focus on immigrant and refugee populations are important not only to inform program-level improvement efforts, but also to build the field's understanding of which services are effective—and, ultimately, to expand models found to be successful. RefugeeOne's randomized control trial represents an important step in this direction.

The partnership between RefugeeOne and Baby TALK is helping to fill the research gap broadly and with regard to the value of trauma-informed approaches, and it has the potential to boost the inclusion of immigrant and refugee populations under MIECHV. At the systems level, Illinois' Prevention Initiative illustrates that incorporating characteristics of immigrant and refugee families into needs assess-

ment and program screening processes is critical to including these families in programming and to informing strategies that will effectively serve them. Beyond refugee populations, ISBE and RefugeeOne have worked to explore how home visiting programs can serve mixed-status families,[47] with the evaluation demonstrating that this relationship-based home visiting model can assist unauthorized immigrants as well as refugees. This programming thus stands to play an important role given that some immigrant families are avoiding more formal programs and experiencing heightened stress in the current political climate.[48]

C. San Diego County, CA: Pairing Flexibility and Targeted Investments

California has been ramping up its early childhood and home visiting programming for several decades, fueled in part by voters' approval in 1998 of Proposition 10, also known as the *California Children and Families Act*. This act established a new tax on tobacco products and directed this revenue to early childhood development programs and state- and county-level early childhood commissions, known as the First 5 commissions.[49] The tax revenue is placed in the California Children and Families Trust Fund, and First 5 California distributes funds to local commissions based on county birth rates.[50] First 5 services focus on improving four thematic areas outlined in Proposition 10: family functioning, child development, child health, and systems of care.[51]

County commissions are empowered to determine whether to spend their funding on home visiting, as well as the share of funds to allocate to this and other program areas. They can also choose which home visiting models to use, with many opting to employ locally developed approaches.[52] However, while the Proposition 10 tax has enabled considerable expansion of home visiting and other early childhood services that can be tailored to local needs, the revenue from tobacco products has declined since the law was passed, in parallel with a drop in tobacco sales. Although this decrease in tobacco use demonstrates progress toward one of the law's key aims, it also represents a constraint for First 5 commissions, as their primary funding source is dwindling.[53]

San Diego County ranks third among California counties in its number of immigrant residents, and its immigrant population is the eighth largest among all U.S. counties.[54] The First Steps program run by First 5 San Diego, one of the 58 county commissions in the state, offers home visiting services for pregnant women and children ages 0 to 3 through the Healthy Families America and Parents as Teachers models.[55] Reflecting the fact that San Diego is one of the top immigrant-receiving counties in the country,[56] the program's community needs assessment took into consideration the barriers, gaps, and needs that immigrant and refugee families frequently face.[57] When the First Steps home visiting program was approved in 2012, the commission opted to prioritize services for particular groups deemed to be most at risk: refugees and immigrants, pregnant teens, teen parents, military families, and low-income families.[58]

The trusting relationships developed between families and their home visitors have helped contribute to high program retention and completion rates for immigrant families.

First 5 First Steps home visitors speak Arabic, Chaldean, Portuguese, Spanish, Swahili, and Vietnamese, and many have an immigrant background themselves, which enables them to understand particularly well the experiences of the immigrant families they serve. The trusting relationships developed between families and their home visitors have

helped contribute to high program retention and completion rates for immigrant families—a notable accomplishment, given the challenges many home visiting programs encounter in this regard.[59] Since not all curriculum materials are available in formats that are culturally and linguistically appropriate for the various communities served, First 5 San Diego has contracted with a private firm to translate these tools into several languages spoken by local families and to ensure the content makes sense.[60] Thus, San Diego has decided to use national, evidence-based models and invest in making them accessible to the county's immigrant families by hiring diverse staff and translating curriculum materials.

Just as the state system provides flexibility for counties to identify their local needs and priorities, First 5 San Diego offers flexibility to the programs with which it contracts, so long as these contractors target its priority populations for services. Specifically, First 5 San Diego coordinates a competitive RFP process to select contracted providers, which in turn can subcontract to other organizations providing home visiting services. This allows contractors to collaborate with other organizations to serve certain target communities that they may not have sufficient capacity or reach to serve themselves. For instance, one current contractor has a subcontract with a community-based organization focused on serving families from East Africa.[61]

Mirroring the financial pressures facing First 5 operations at the state level, First 5 San Diego's funding has decreased dramatically in recent years, with expenditures on direct services shrinking from $53 million in 2014–15 to $35 million in 2017–18.[62] Still, the commission's prioritization of refugees and immigrants continues to be reflected in the high number of immigrant families served: of participants in all First 5 San Diego programs in FY 2017–18, 45 percent of children and 39 percent of families spoke a language other than English as their primary language.[63]

First 5 San Diego's experience illustrates that an intentional effort to identify at-risk immigrant families, combined with structural flexibility, has helped immigrant families across the county to access home visiting services—even in a challenging funding environment.

D. Massachusetts: Incorporating Immigrant Families into State MIECHV Needs Assessments

Along with California and Washington State, Massachusetts ranks among the top five states with the largest absolute growth in their immigrant populations between 2000 and 2018.[64] Immigrants have long been a priority service population for Massachusetts Department of Public Health efforts, and this is reflected in their specific inclusion in the state's formative 2010 MIECHV needs assessment, an important policy lever for this program.[65]

Immigrants have long been a priority service population for Massachusetts Department of Public Health efforts.

Needs assessments are central to MIECHV programming at the state level, identifying communities to prioritize for home visiting services based on federally mandated indicators of risk; states may also choose to include other data points. Massachusetts' approach is noteworthy because it was one of the few states—if not the only one—to include any optional immigrant- or refugee-relevant indicators in its initial assessment.[66] At that time, the state incorporated several such indicators under an additional "vulnerable populations" category (referred to in the 2020 needs assessment as "special populations"); these included the percentage of (1) students whose first language is not English; (2) individuals with limited English proficiency; (3) mothers who are foreign

born; and (4) residents who are refugees and asylees. These data points were factored into the Community Risk Ranking used to help identify at-risk communities, which are to be prioritized for MIECHV-funded services.[67]

States were required to submit their MIECHV needs assessment updates by October 1, 2020—the first update mandated since the program's inception in 2010. In preparation, Massachusetts gathered quantitative and qualitative data and sought community input. This included mapping at-risk immigrant families through analysis of different data sources and indicators,[68] such as the:

- share of all residents who are foreign born (using data from the U.S. Census Bureau's American Community Survey);
- share of all live births to mothers who are foreign born (from the Massachusetts Registry of Vital Records and Statistics);
- number of new refugees and individuals with another qualifying immigration status[69] (from the Massachusetts Office for Refugees and Immigrants);
- share of enrolled students who are English Learners (from the Massachusetts Department of Elementary and Secondary Education); and
- share of enrolled students whose first language is not English (from the Massachusetts Department of Elementary and Secondary Education).

The Massachusetts Department of Public Health also held focus groups across the state, part of an effort to reach diverse groups that it sees as central to its emphasis on equity and diversity.[70] One of these groups was comprised exclusively of immigrants (in this case, young immigrant men who have difficulty accessing state health systems); other groups included immigrants among other participants (e.g., Spanish-speaking parents of children with special needs, Somali mothers, and Vietnamese parents of youth with special needs).

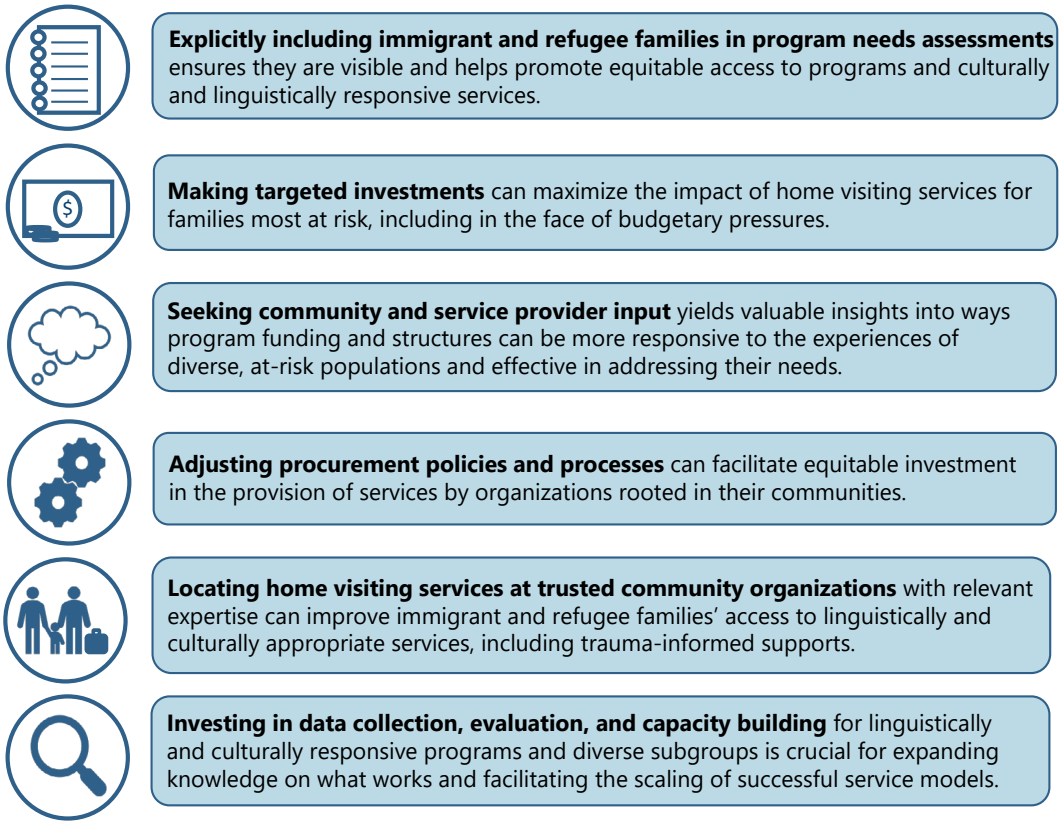
Within the MIECHV program, states have flexibility in how they analyze data in their needs assessments; this includes the option to use additional indicators to assess which communities are considered at risk and should therefore be prioritized for MIECHV-funded services. Making immigrant and refugee families' needs visible through their inclusion in program needs assessments, as Massachusetts has chosen to do, is a key first step in promoting their equitable participation in home visiting services, including by identifying risk factors they may face and the extent to which they are being reached (or not) by current programming. While states were not required to include any immigrant- or refugee-related indicators in their needs assessment updates, doing so enables them to make a richer and more accurate analysis of the needs and service gaps that at-risk families face.

3 Lessons for Expanding the Accessibility and Quality of Home Visiting Programs

With immigrant and refugee families often underserved by home visiting programs, the state and local policy levers and program approaches highlighted in this brief offer helpful lessons for those seeking to strengthen services for these populations (see Figure 2). Notably, the strategies described were implemented in a variety of contexts—some in areas where significant new investments were being made, and others where funding levels were unchanged or even decreasing.

FIGURE 2

Strategies for Strengthening Home Visiting Services for Immigrant and Refugee Families



Source: Compilation by the author.

Making immigrant and refugee families visible in program needs assessments through improved data collection and identifying those at risk as target populations for programming are essential first steps toward ensuring they are served equitably alongside other at-risk families. While strengthening services for immigrants and their children can include tailoring national models to speak to the needs and experiences of diverse families, employing and supporting other, more tailored models that work well with immigrant families is also a useful strategy for states and localities. Although the home visiting models currently considered "evidence based" by MIECHV do not include models studied specifically for their efficacy in working with immigrant and refugee families, there are "evidence-informed" models that have been found to be effective. States and localities stand to play an important role in fostering support for these promising models, not only to be implemented but also to be evaluated so they can develop the rigorous research needed to meet evidence-based standards. This is critical for understanding what approaches are effective in working with different populations and in scaling them up to meet specific subpopulation needs.

In undertaking these efforts, incorporating community input and providing a degree of program flexibility are important to ensure that approaches and models will reach families and communities in ways that are relevant to their experiences and needs. In a similar vein, providing home visiting services through or in partnership with community-based organizations is a helpful strategy for

effectively reaching and serving immigrant and refugee families. Indeed, home visiting programs run by local organizations with deep knowledge of and trusting relationships with their communities, and expertise in providing culturally and linguistically responsive services, possess particularly important competencies due to the centrality of relationships to home visiting and the intimate nature of in-home visits. Meanwhile, given the high need for trauma-informed services among refugee families (and many other immigrant families), home visiting services can be an extremely beneficial component of mental-health or other programming provided by immigrant- and refugee-focused organizations.

As policymakers ramp up their investments in home visiting, procurement processes that use an equity lens and take steps to level the playing field for community-based organizations seeking to participate in service provision hold promise for expanding linguistically and culturally responsive programs. This approach can also help compensate for current blind spots in research on effective program design as well as a lack of rich subpopulation data on immigrant and other minority groups, which can put programs that are successfully serving these families at a disadvantage in funding competitions.

4 Conclusion

A considerable and growing share of the nation's young children live in immigrant families. Because they disproportionately face risk factors that home visiting programs are intended to mitigate, they constitute a significant share of these programs' target population. As this brief demonstrates, numerous tools are available to policymakers, program administrators, community and early childhood stakeholders, and funders who seek to improve the reach and effectiveness of home visiting services for at-risk immigrant and refugee families. Given their track record of serving high-need families and improving child and family outcomes, seizing opportunities like those highlighted in this brief to expand access to home visiting programs and offer culturally and linguistically responsive services can improve the system's overall equity and effectiveness and lift immigrant and refugee families' integration trajectories now and into the future.

Numerous tools are available to policymakers, program administrators, community and early childhood stakeholders, and funders who seek to improve the reach and effectiveness of home visiting services for at-risk immigrant and refugee families.

Endnotes

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5 Park and Katsiaficas, *Leveraging the Potential of Home Visiting Programs.*
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