Robert Wood Johnson Foundation

Published: February 5, 2013
Progress Report
Grant ID: 69466, 66121, 60068, 53605

Child FIRST Develops an Evidence-Based Early Childhood Intervention

Started in one Connecticut city, the intervention is scaling to other cities and is ready to do so in other states

INTRODUCTION

Child FIRST (Family Interagency, Resource, Support, and Training) is a home-based early childhood intervention, located in Connecticut, that works with very young (prenatal through 5 years of age) vulnerable children, and their families to reduce serious emotional disturbance, developmental and learning problems, and to prevent abuse and neglect.

Child FIRST was founded in 2001 under the leadership of Darcy Lowell, MD, a developmental and behavioral pediatrician who continues as the program's executive director. In 2005, Child FIRST received its first grant[1] from the Robert Wood Johnson Foundation (RWJF) as part of the Foundation's Local Funding Partnerships *program. Subsequently RWJF has awarded three additional grants[2] in support of Child FIRST. The most recent grant runs through December 2013. RWJF funding for Child FIRST from July 2005 through December 2013 totals $6,119,580.*

WHAT IS CHILD FIRST ABOUT?

Children growing up in poverty, living in substandard housing in rough neighborhoods, with a mother or other parent figure overwhelmed by life demands, or with significant health issues, experience high levels of stress on a daily basis. Research has found that environmental stress of this kind can damage a child's developing brain, leading to growing difficulties in school and in life as the child gets older.

Fortunately, research also shows that early intervention can lessen, even reverse, the damage. Child FIRST is an early intervention, based on the science of brain development that works with vulnerable families to ameliorate the most devastating effects of stress on young children.

---

[1] ID# 53605

[2] ID#s 60068, 66121, and 69466

A Two-Pronged Strategy

Child FIRST intervenes with families in two ways. First, it works to connect families with appropriate services and resources to reduce stress in the child's environment. These services may include health care, financial aid, social services, and other government or community supports.

Then it works with parents to help them develop high quality or "secure" relationships with their children. Research has shown that a secure parent-child relationship helps to increase a child's self-reliance, adaptation to novel and challenging situations, empathy, curiosity, emotional regulation, and social competence.[3]

> *"Working with one child at a time wasn't enough. These were multiple-problem families with many other challenges. If we didn't address those other challenges we weren't going to make progress with the child."*
>
> *—Darcy Lowell, MD, Executive Director, Child FIRST*

Addressing the needs of the entire family is key to helping vulnerable children, said Lowell, the creator and now executive director of Child FIRST. Her years of work with children and families in Bridgeport—a community of about 145,000 with child poverty rates twice that of the statewide average—confirmed as much. "Working with one child at a time wasn't enough," she recalled. "These were multiple-problem families with many other challenges. If we didn't address those other challenges we weren't going to make progress with the child."

In 1995 Lowell began a collaboration with Bridgeport health, education, and social service providers to address the needs of the most vulnerable young children and their families. The group, called the FIRST (Family Interagency, Resource, Support, and Training) Team, received its initial grant from the Connecticut Department of Social Services in 1998 to hire a FIRST Team coordinator. By 2001 the collaborative had changed its name to Child FIRST and, with a grant from the Connecticut Health Foundation, added a mental health/developmental clinician and a care coordinator—two full-time positions that became the backbone of the comprehensive services that Child FIRST would provide.

---

[3] Lowell DI, Carter AS, Godoy L, Paulicin B and Briggs-Gowan MJ. "A Randomized Controlled Trial of Child FIRST: A Comprehensive Home-Based Intervention Translating Research into Early Childhood Practice." *Child Development*, 82(1): 193–208, 2011. Available online.

A Promising Practice

Child FIRST fits well in the portfolio of RWJF's Vulnerable Populations Team, which has among its goals to identify promising programs or models that have the capacity to make a significant change in service delivery for very vulnerable families and children.

Child FIRST "reaches an underserved population of kids and parents that typical home visiting or day care programs don't serve well because of the complexity of their emotional needs," said Jane Isaacs Lowe, PhD, senior adviser for program development in the Health Group.[4] It is not just another home visiting program, Lowe added. "It is an intensive, psychotherapeutic, intervention—a mental health intervention—that takes on the most vulnerable kids who are exhibiting serious developmental and emotional problems."

HOW DOES CHILD FIRST WORK?

Child FIRST identifies vulnerable children very early, sometimes even before birth, where multiple risk factors, such as the mother struggling with depression or substance abuse or domestic violence, may already be present. Child FIRST staff has cultivated relationships with community-based service providers such as health staff at clinics and early education settings who refer children and families to Child FIRST. Families can also refer themselves. "We want to get them as soon as we can and then we want to make the intervention as useful as possible. So we go into homes," says Lowell. "We don't ask them to come to us."

Engaging Families

Engagement and building trust are fundamental goals of the intervention. A clinical team, consisting of a master's-level mental health/developmental clinician and a bachelor's-level care coordinator,[5] meets with the family and assures them that they are there as partners and advocates. Without judgment or agenda, they ask, "How would you like us to help you and your family?" By listening to and beginning to meet some of the family's concrete needs, the clinical team strives to create a "holding environment" and to give many parents a new experience of relationships.

The family is the target of the intervention. In addition to the mother or other primary parent/guardian, all individuals important to the child are invited to participate in order to strengthen relationships and build a supportive network for the primary parent. These

[4] At the time of the interview for this report, Lowe was a senior program officer and team director of Vulnerable Populations.

[5] Team members are generally of the family's ethnic background and speak the family's preferred language.

may include the father (even if not living with the child), siblings, grandparents, the partner of the primary parent/guardian, and other caregivers.

The clinical team partners with the parent to create a comprehensive assessment of the child and family. The resulting Child and Family Plan of Care—which reflects family priorities, strengths, culture, and needs—identifies treatment, supports, and services. This plan also serves as the Medicaid treatment plan.

Juan and His Toy

One cold November night, while Juan, a bubbly three-year old, was reading a book with his mom and his dad was watching football, armed FBI agents broke down the door and took Juan's dad away in handcuffs, charging him with selling illegal drugs. Juan's life was shattered.

Feeling sick with guilt and stupidity at her failure to recognize her husband's criminal activity, Juan's mom became severely depressed, providing only the most minimal care to Juan and his baby sister. Juan began to act out at day care, hitting and kicking and crying incessantly. He was expelled from day care and placed in a special school for children with problems. Even the trained teachers there could not handle this scared, lonely, and very angry child and recommended outpatient mental health services for Juan and depression treatment for his mom. But Juan's mom was frozen, with no energy, unable to take action.

The teachers called Child FIRST, which immediately assigned a bilingual team of Sylvia, a mental health/developmental clinician and Adriana, a care coordinator. After a month and a half of Sylvia's phone calls and letters, Juan's mom allowed the team to visit her home.

The family's story unfolded as Juan's mom told about Juan becoming emotionally overwhelmed—vomiting and becoming febrile—after each weekly visit with his father in prison. Sylvia gave Juan a toy to help him understand his emotional response: a fat man with a big mouth in his belly. It became his favorite toy.

Through careful, patient, and consistent treatment Sylvia gave voice to Juan's hurt and anger and to the shame and fear inside his mom. Things started to change. Mom was able to articulate appropriate ways for Juan to behave and began to enliven the apartment with a picture here, a plant there, and her good Puerto Rican cooking. Adriana helped her find a part-time job. Juan's anger with his father began to subside and a smart and playful little boy, who could be comforted by a loving and energetic mother, slowly emerged. He returned the toy to Sylvia, saying, "Other kids may need him. I do not need him anymore."

Making Connections

The care coordinator, who is knowledgeable about community resources, connects the family to comprehensive, coordinated, and individualized services tailored to the family's needs, while minimizing barriers to access. The program works to address the needs of the entire family—not just the young child. For example, staff will often make

connections to needed services for an older sibling or other family member. "I accomplished a lot of goals with these ladies [the clinician and care coordinator] and got a lot of programs I didn't know about before," said a mother served by Child FIRST.

Turnaround for Tanya and Her Mom

When 4-year old Tanya visited the Bridgeport Hospital Pediatric Clinic for her well child visit, her mother was asked to complete a new questionnaire. Her responses indicated that the mother was depressed and overwhelmed. A Child FIRST child development specialist approached her and offered help. Two months earlier, Tanya's mom had taken her four children and run away from her abusive husband. Now she was working two full-time jobs to put food on the table and rarely saw her children. She had no money for furniture and her children were sleeping on the floor. Tanya's preschool had just called to say that she would be expelled if she didn't stop kicking and hitting other children. Mom was at the end of her rope.

Four weeks later—after six phone calls, two letters, and two missed appointments—the Child FIRST team met with Tanya's mom at her home. She had used the rent money to fix her car after an accident and the landlord was threatening eviction. The team knew that the first priority was to stabilize the financial situation. Gloria, the care coordinator, filed paperwork to redirect state payments, which the father had been getting, to the mother, who could then quit one of her jobs. Gloria also helped her obtain much-needed furniture (couch, table, and beds) and household items.

Elizabeth, the mental health/developmental clinician, observed Tanya at her preschool and worked with the teacher to use Tanya's very significant cognitive strengths to get the attention she craved. Designated the "teacher's helper," she began to thrive. Elizabeth worked with mom and Tanya together, so Tanya could feel safe once more. She helped mom, with her renewed sense of hope, to approach her landlord and work out a payment schedule for the back rent.

Best of all, Tanya's mother no longer worked on Sundays and was able to return to church. On her first Sunday back, Tanya was to sing a duet in the choir. When she saw her mother sitting in the third row a broad smile spread over her face. She took a deep breath and belted out *Amazing Grace*. The whole congregation broke into applause and Mom beamed. Life was good again.

"We work within a system of care," Lowell said. "We can only work well if we have relationships with all of the providers in the community who are working with young children and families. We talk about this as a community model, not an agency model."

As needed by the family, team members (together or separately) conduct one or more 45- to 90-minute visits per week, over six to 12 months. The team brings toys, books, and other resources to the home visits, which helps with communications and enriches the family's environment.

The mental health/developmental clinician handles therapeutic assessment and intervention for both child and parent. The mental health intervention involves both

relationship-based child-parent psychotherapy ("dyadic psychotherapy") as well as parent guidance. The intervention is designed to help parents understand normal developmental challenges and expectations and the unique characteristics of their own child, develop strategies to tackle problems, and recognize the motivations underlying a child's behavior and their own responses to it. "They really understand the challenges my son's emotional issues raise when parenting him, and the help they offer actually helps," said a mother in New Britain. The skills parents learn are also generalizable. What works in relation to their young child can also be applied to their relationship with other children in the family.

For example, a child's "hitting" the mother might be reframed as a bid for attention from a child who needed his mother, with the therapist speaking for the child. The goal is to help parents internalize a process for future responses to child communications rather than teaching specific strategies for specific problem behaviors.

Through the Child FIRST intervention, the parent comes to understand the child more clearly and develop a different sort of relationship that "they will carry with them always," Lowell said. "When the child is older and has different problems and issues developmentally, this understanding and sense of being with your child—the relationship—goes on. In fact, it goes on for the lifespan."

HOW IS CHILD FIRST PROGRESSING TO DATE?

Results of a Randomized Controlled Trial

In 2003, with funding from the Center for Substance Abuse Prevention at the Substance Abuse and Mental Health Services Administration (SAMHSA), Child FIRST researchers conducted a randomized controlled trial of Child FIRST.[6] In 2007 and 2008, with funding from RWJF, researchers from the University of Connecticut Health Center and the University of Massachusetts Boston analyzed data from the trial. Researchers reported findings in a 2011 article in *Child Development.*[7]

Margaret Briggs-Gowan, PhD, assistant professor of psychiatry, University of Connecticut Health Center, co-investigator on the data analysis, noted several strengths of the trial. First, Lowell selected developmentally appropriate measures for the trial designed to capture children's emotional and behavioral problems, their language functioning, and parenting stress, strain, and psychology.

---

[6] The trial included 78 children receiving the Child FIRST intervention and 79 children receiving usual care. Children were ages 6 to 36 months at baseline assessment. Follow-up assessments were at six and 12 months. Data analysis focused on 12-month results in comparison to baseline.

[7] Lowell et al. op. cit.

Also, a good percentage[8] of the sample that completed the baseline assessment continued through the study—another strength. "Given the high-risk nature of the sample, it's pretty remarkable that as many were retained as there were," Briggs-Gowan said.

Further, stratification of the sample gave assurance that very young children were equally distributed between the intervention and usual care groups. "With really little kids, that could make a difference," Briggs-Gowan said, "because developmentally they could be at very different places." For example, at 10 months a child is developmentally very different from an 18-month-old child, even though they are less than a year apart in age.

Analysis of data from the randomized controlled trial demonstrated that the Child FIRST intervention was clinically effective in comparison to usual care at a statistically significant level. Researcher Briggs-Gowan is enthusiastic about the findings.

Compared with similar families receiving usual care, families receiving services from Child FIRST were 39 percent less likely to be involved with child protective services.

- Compared with similar children receiving usual care, children receiving services from Child FIRST:
  - Were 68 percent less likely to have language problems. "It's remarkable that there were impacts on language," Briggs-Gowan said, "both in terms of children who came with language problems leaving with improved language, and kids who didn't come with language problems continuing to not develop problems. The comparison group was much more likely to develop language problems.

    "This suggests that Child FIRST is changing the trajectory of those really little kids in terms of their language functioning, which is seen as occurring through strengthening the parent-child relationship and improving the quality of the interactions between the mothers and their children. That's huge."
  - Were 42 percent less likely to have aggressive and defiant behaviors, another outcome that will improve their potential for success when entering school.
- Child FIRST mothers had 64 percent lower levels of depression and/or mental health problems than mothers receiving usual care, a "remarkable" result, Briggs-Gowan said.

[8] Participation at six months was 82 percent for Child FIRST families and 85 percent for usual care families. At 12 months it was 74 percent and 75 percent, respectively.

- Compared with similar families receiving usual care, families receiving services from Child FIRST:
  - Were 39 percent less likely to be involved with child protective services, a "definitely important" finding, according to Briggs-Gowan.
  - Had a 98 percent increase in access to community services and supports. "This speaks to a real change in those families in how they become able to make use of services in their community that they may never have known were available."

Replicating Child FIRST in Connecticut

Child FIRST was chosen in October 2011 as one of nine Evidence-Based Home Visiting Service Delivery Models eligible for replication funding from the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).

As providers elsewhere in Connecticut learned about the work in Bridgeport they approached Child FIRST to help them create a similar program in their communities. With funding from RWJF and matching funds from the Connecticut Department of Children and Families, Child FIRST made plans to replicate the program in four other cities. They chose Hartford and New Haven—"two big and very poor communities"—and, through a competitive process, Norwalk and Waterbury.

"I had been in touch with both Norwalk and Waterbury for at least three years," Lowell said. "I knew all the people. There was such active interest and collaboration that we felt very comfortable with them." In addition, New London County, which was already doing in-home mental health work with families under a SAMSHA grant, asked to be part of Child FIRST while using its own funding. All Child FIRST sites engaged local philanthropy to contribute matching funds. This was an important investment in their community, a lesson learned by Lowell from her early *RWJF Local Funding Partnership*s grant.

A second cohort included four additional sites: Middlesex County, New Britain, Stamford/Greenwich, and Windham County (Northeast Region). In addition to funding from RWJF, the Grossman Family Foundation in Connecticut provided a $1 million grant. Training of staff at these sites started in April 2012. Child FIRST's intensive

training program uses the Learning Collaborative[9] methodology and includes multiple two-day learning sessions, training in metrics and assessment, reflective supervision, and other training techniques. A Child FIRST training manual, toolkit, and training curriculum guide the training process.

Five sites, covering the remaining of the 15 Department of Children and Families Area Offices, will be added in 2013 with federal funding. This is possible because Child FIRST was chosen in October 2011 as one of nine Evidence-Based Home Visiting Service Delivery Models eligible for replication funding from the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). MIECHV grants are part of the Affordable Care Act.

Obtaining Medicaid Reimbursement

From its beginning, Child FIRST tried to get Medicaid reimbursement for its services. In Bridgeport, it took four years to get reimbursement, which started in 2007. The other sites will be required to go through a certification process: the state will first certify Child FIRST as a home-based model, which will in turn certify all of its sites for model fidelity.

> *"You often get a model where somebody's very, very good on child development, or on psychodynamics of the mother, or on poverty reduction. But you rarely see all that combined. This combines it," said Elaine Zimmerman, Executive Director of the Connecticut Commission on Children.*

To receive Medicaid reimbursement, programs must be evidence based. Because the original randomized controlled trial covered children only to age 3, Child FIRST must undertake a second trial in the next four years that includes 3 to 5-year-olds. In the meantime, the program has provisional status so it will be possible to get Medicaid reimbursement during those four years once the certification process is in place.

Ultimately, Lowell said, "We think that 40 to 50 percent of the site budgets can be paid through Medicaid reimbursement. There are stipulations [that will limit reimbursement]. Children who don't have a mental health diagnosis cannot be reimbursed, nor can undocumented children or, of course, non-Medicaid children."

[9] The Learning Collaborative, developed by the Institute for Healthcare Improvement, in Cambridge, Mass., promotes the adoption of best practices through Learning Communities, organizational changes, and continuous improvement.

Creating a Business Plan

RWJF provided funding[10] for Child FIRST to undertake a business planning process with The Bridgespan Group[11] so that they could think through how to effectively replicate the model in other states.

That process required addressing big questions, said Katherine Kaufmann, MBA, the Bridgespan partner heading the business planning effort: "What are our short- and longer-term growth aspirations for Child FIRST? How can we best capitalize on the current environment for home visiting programs? What is our overarching growth strategy: site by site, city by city, or state by state? Which communities should we enter next and why?"

The planning process also required Child FIRST staff to figure out what resources and organizational structure they will need to support their growth and what kind of implementation plan will guide their work in the coming months.

The cost of Child FIRST's home-based intervention and care coordination is about $6,800 per family of four, compared to a cost of $700,000 to $900,000 for a year of psychiatric hospitalization for one child.

Addressing these issues and developing the detailed financial and implementation plans was time consuming for Child FIRST leaders. "The Child FIRST team fully capitalized on the business planning process. Not only did they use it to scope the work ahead but also, they invested in building functional tools to guide their efforts in the coming years. Generating the full set of outputs they desired required deep engagement and considerable investment of their time over the seven month planning project," Kaufmann said. "This was particularly challenging for a small organization."

WHAT ARE THE MOST SIGNIFICANT RESULTS TO DATE?

Child FIRST is Known as a Hard-to-Find Comprehensive Model

As executive director of the Connecticut Commission on Children, Elaine Zimmerman focuses on best practices for vulnerable children and families. She has followed Child FIRST for many years and assisted its leaders in growing the program within Connecticut. Child FIRST has created, she said, a system for working with the most vulnerable families that other models of home visitation do not have.

[10] ID# 69841

[11] The Bridgespan Group is a national consulting firm that advises mission-driven organizations and philanthropists.

"They have figured out how to not just do mental health but to do mental health within the context of a social-economic framework, with depth," she said. "You often get a model where somebody's very, very good on child development, or on psychodynamics of the mother, or on poverty reduction. But you rarely see all that combined. This combines it."

Replicated Sites in Connecticut Are Showing Positive Results

When Child FIRST began to replicate at other sites in Connecticut, program leaders were concerned about whether they would be able to achieve the results of the original Bridgeport program. "This is a complicated model," Lowell explained. "It is a therapeutic intervention and we wondered if we could teach it to others and get the same results."

Lowell has been pleased to see that they are getting "very similar" results to those found in the randomized controlled trial. In the areas where the program has been replicated, the first cohort of data has found that "about 78 percent of the children and families who have problems at baseline improved a significant amount on at least one important measure. And the results are very highly significant statistically."

Feedback from the Department of Children and Families and from other providers has also been very positive, with many comments about the program "making a huge difference for our families."

Child FIRST is Growing in Strength and Recognition in Connecticut and Nationally

Child FIRST has demonstrated cost-effectiveness. The cost of its home-based intervention and care coordination is about $6,800 per family of four, compared to a cost of $700,000 to $900,000 for a year of psychiatric hospitalization for one child.

Child FIRST is the only home-based mental health intervention for young children in Connecticut that receives Medicaid reimbursement. "Being able to secure some Medicaid reimbursement for the services that the programs are delivering, is a big accomplishment," RWJF's Lowe said. "There are Medicaid expansion dollars for several of the communities, but it hasn't yet gone completely statewide to all the different regions that the program is in, but it will."

The Connecticut Department of Children and Families has taken over paying for all of the sites in Cohort 1. According to Lowell, the department intends to fund Cohort 2 after philanthropy funding ends and Cohort 3 after federal MIECHV funding is over. "That is a huge accomplishment from our point of view," she said.

The Coalition for Evidence-Based Policy[12] has designated Child FIRST as "Almost Top Tier" (missing only a second randomized controlled trial).

Child FIRST has become a key voice in the national conversation. "This is an opportunity to impact, in a much broader way, how interventions are working for very high-risk, vulnerable children and families and how one approaches families who have had major trauma in their lives," Lowell said.

The Business Plan Has Resulted in Key Decisions

Bridgespan's Kaufmann noted that the business planning process resulted in several key decisions:

The articulation of a growth strategy, with rationale, for Child FIRST. "Specifically," said Kaufmann, "that their objective is to grow to up to two more states and that reaching scale at a state level is the key to encouraging other states to adopt Child FIRST. Their big decision is that they will only expand to new sites in a limited number of carefully selected states. That was a critically important decision for them to make."

Expansion beyond Connecticut to a new state starting in 2014. Director of National Programming Sandy Lopacki said that "we have to get Connecticut absolutely, solidly right before we move into another state."

The creation of a separate 501(c)(3) organization. Child FIRST is now a nonprofit organization with its own set of bylaws and board of trustees. It is in the process of obtaining a 501(c)(3) charitable organization designation from the Internal Revenue Service.

> *"We need to develop a system so that every family can get their needs met," Darcy Lowell said. "That is very difficult and very political—and is still a challenge."*

The identification of what needs to be in place in order to work with a state. This includes both key selection criteria as well as a detailed outline of the work needed to prepare for launch in a selected state.

[12] The nonpartisan, Washington-based Coalition for Evidence-Based Policy works to increase government effectiveness through use of rigorous evidence.

WHAT CHALLENGES DOES THE PROGRAM FACE?

As Child FIRST has expanded within Connecticut it has met many challenges. These have not lessened as staff handles the multiple demands of program replication and a growing organization. Significant challenges, some of which have already been met, include:

Obtaining designation from the Health Research and Services Administration (HRSA) as an Evidence-Based Home Visiting Service Delivery Model. Analysis of the data from the randomized controlled trial was the first step. Then review by the Health Research and Services Administration in a "highly political" environment in Connecticut was another hurdle. "But we persevered and got it done," Lowell said. "We really pushed and used all of our great champions in Connecticut to actually make it happen."

> *Child FIRST has received 28 individual inquiries from 19 different states about the program. Of these, five look like they are "major possibilities," Darcy Lowell said.*

Replicating in Connecticut. "We needed the money and the state commitment," Lowell said. "It was very hard to make sure that the Department of Children and Families had the funding to sustain it, given the budgetary problems."

Developing a system of care in Connecticut. This is necessary since Child FIRST cannot provide all services itself. "We need to develop a system so that every family can get their needs met," Lowell said. "That is very difficult and very political—and is still a challenge."

Hiring, training, and assimilating new staff—both central office staff and clinical staff (especially bilingual). This has been a very demanding effort.

Developing communications, particularly a website. This has been a big task to accomplish given competing demands for time and energy and the lack of communications expertise on staff. A communications team assembled by RWJF is assisting Child FIRST staff in producing a communications plan and expanding the website. The team includes RWJF staff and staff from three communications firms: Fenton[13] (the lead agency), Burness Communications,[14] and Pritchard Communications.[15]

[13] Fenton creates social change campaigns from offices in New York, Washington, San Francisco, Los Angeles, and London. Staff from the San Francisco office leads the Child FIRST project.

Moving forward, Child FIRST will expand beyond Connecticut as it replicates the program in one or more other states. This effort poses a new set of challenges, which include:

Handling the many unknowns of national replication. While the deep experience of Child FIRST in Connecticut will serve as a good model as they begin in a new state, Kaufmann emphasized that "the team really won't know exactly what and how much there is to do until they get started. For example, each state will have a different landscape of state agencies, implementing partners, and potential funders. There are many unknowns."

Providing effective training outside of Connecticut while keeping costs in line. While training in Connecticut has been conducted face-to-face, staff is investigating ways to use technology to communicate basic knowledge to those needing training in other states.

Training is critical to the successful replication of Child FIRST. "Ultimately this model works because we have good people who are well-trained," Managing Director Mary Peniston said. "We expect a certain background and, since we serve diverse populations, we like to have people who are bi- or multi-lingual. We're going to have challenges to make sure we get sufficiently qualified people to do the work well."

With the new trial, Executive Director Darcy Lowell said, "We want to move beyond the time the children are with us—usually between six and 12 months—and look at one, two, and three years out to see how they're doing."

Dealing with competition and turf issues. This is "a profoundly sophisticated and excellent model," Zimmerman said. "Programs preceding Child FIRST might find this model threatening."

Managing organizational change. The Child FIRST staff is at "an inflection point in its development," Kaufmann noted, "The magnitude of work ahead will require that they distribute effort and decision-making across a team. They are an incredibly strong group and are already working to determine the most effective way to collaborate. Nonetheless, this transition will take time and attention."

---

[14] Burness Communications, based in Bethesda, Md., provides public relations support to nonprofit organizations.

[15] Pritchard Communications is based in Portland, Ore., and specializes in social media.

WHAT DOES THE FUTURE HOLD?

Replicating and Building Capacity

Immediate next steps are to firmly establish Child FIRST in all 15 Department of Children and Families Areas in Connecticut and "to make sure that people keep on doing the work in the right way so they can get the same results," Lowell said. Then the team will turn its focus outside of Connecticut.

Child FIRST has received 28 individual inquiries from 19 different states about the program. Of these, five look like they are "major possibilities," Lowell said. They have developed a rubric to evaluate and choose states that would be a good fit for Child FIRST. The intensive experience in Connecticut has given them a thorough knowledge and understanding of the process of replicating the program, the difficulties of the process, and how to navigate systems.

> *"I consider Child FIRST one of the most impressive interventions for young children that I have ever witnessed in my long lifetime."*
> *—Edward Zigler, PhD, founder and director emeritus, Edward Zigler Center in Child Development and Social Policy, Yale University; founder of Head Start*

"We are thinking about national replication in the same way [we expanded in Connecticut]," Lowell said. "Not doing one agency in one state and another agency in another state, but in the context of systems change and building an early childhood system—a continuum of care."

Conducting a Second Randomized Controlled Trial

To meet the Medicaid reimbursements requirements, Child FIRST will be undertaking a second randomized controlled trial that will address children ages 3 to 5, the age group not covered in the first trial. "It is important to document that it is working in a similar fashion with the older kids," Briggs-Gowan said. The trial might also investigate whether there are "additional forms or models of treatment that we might incorporate that would help Child FIRST even better address the needs of the families," she added.

With the new trial, Lowell said, "We want to move beyond the time the children are with us—usually between six and 12 months—and look at one, two, and three years out to see how they're doing."

Creating a Cross-Site Database

With the assistance of an outside company, Child FIRST is creating a "very sophisticated cross-site database with more comprehensive data than has been collected so far," Lowell said. This will allow staff to provide additional information to the sites about how they are doing so that they can improve their practices.

Having a National Impact

With the upswell of interest in brain science and early childhood programs, Child FIRST is positioned to have a major impact in the field. "We want to change the way people think about working with very high-risk families," Lowell said. "Teaching alone—parent education—is not enough. We want to help not only Connecticut, but to be part of the national conversation about how we can intervene differently so we have much better outcomes and close the achievement gap" between very vulnerable children and their more fortunate peers.

Prepared by: Mary B. Geisz
Reviewed by: Kelsey Menehan and Molly McKaughan
Program Officers: Jamie B. Bussel and Jane Isaacs Lowe
Program Area: Vulnerable Populations
Grant ID#: 69466, 66121, 60068, 53605
Project Director: Darcy Lowell (203) 384-3626; darcylowell@gmail.com

---

APPENDIX

Progress Report Interviewees

Jamie B. Bussel, MPH
Program Officer
Robert Wood Johnson Foundation
Princeton, N.J.

Margaret J. Briggs-Gowan, PhD
Assistant Professor
Department of Psychiatry
University of Connecticut Health Center
Farmington, Conn.

Katherine Kaufmann, MBA
Partner
The Bridgespan Group
Boston, Mass.

Sandy Lopacki, MPH
Director of National Programming
Child FIRST
Bridgeport, Conn.

Jane Isaacs Lowe, PhD
Senior Adviser for Program Development
Health Group
Robert Wood Johnson Foundation
Princeton, N.J.

Darcy Lowell, MD
Executive Director
Child FIRST
Bridgeport, Conn.

Mary Peniston, MPA
Managing Director
Child FIRST
Bridgeport, Conn.

Elaine Zimmerman
Executive Director
Connecticut Commission on Children
Hartford, Conn.

BIBLIOGRAPHY

Article

Lowell DI, Carter AS, Godoy L, Paulicin B, Briggs-Gowan MJ. "A Randomized Controlled Trial of Child FIRST: A Comprehensive Home-Based Intervention Translating Research into Early Childhood Practice." *Child Development*, 82(1): 193–208, 2011. Available online.