CHAPTER 12

Child FIRST: A Program to Help Very Young At-Risk Children

Digby Diehl

Editors’ Introduction

Although never formally denoted a Robert Wood Johnson Foundation priority, improving children’s health has occupied an important place in the Foundation’s grantmaking. Since 1972, the Foundation has allocated more than $2 billion to programs aimed at making children healthier. Many of them have focused on improving the health of infants and young children. Back in 1975, the Foundation launched the Regionalized Perinatal Care Program, which organized hospitals in eight areas of the country into regional networks to make perinatal technology available to more women and their at-risk babies. This led to the Rural Infant Care Program in 1979, which expanded perinatal networks to some of the country’s most isolated communities. It was followed, beginning in 1982, by the largest, at the time, randomized control trial on infants’ health undertaken in the United States. The Nurse Home Visitation program (now known as the Nurse-Family Partnership program), under which nurses visit poor, pregnant women in their homes and counsel them for two years after the baby’s birth,
is one of the Foundation’s signature efforts and stands as a well-documented evidence-based intervention.

Firmly rooted in this history is Child FIRST, a family-based intervention that focuses on preventing mental health problems in high-risk mothers and young children. The brainchild of a dynamic pediatrician named Darcy Lowell, Child FIRST was initially funded by the Foundation through its Local Initiative Funding Partners program (now known as the Robert Wood Johnson Foundation Local Funding Partnerships program). Child FIRST has shown promising results in Bridgeport, Connecticut, and is now being replicated throughout the state and beyond. Despite the difficult economic times, which can threaten the viability of resource-intensive programs such as Child FIRST, the State of Connecticut allocated funds to expand the program.

In this chapter, Digby Diehl, a writer whose most recent book, Rather Outspoken, a collaboration with Dan Rather, appeared earlier this year, discusses this innovative program and its replication.
Come and get your child!” the mother was told. “He hits and bites other children. He throws toys. He kicks the teachers. He screams and cries constantly. We are expelling your son from preschool. As of now.”

This was the third school the little boy had attended in less than a year. He’d been a happy three-year-old until the FBI arrived at his home in the middle of the night, lights flashing, sirens blaring. They busted down the door, pushed his mother to the floor, and dragged his father away in handcuffs.

After the father was convicted of drug trafficking, the mother became depressed, but still took her son to visit his father in the high-security prison where he was incarcerated. The setting was so frightening that the boy vomited repeatedly every time he went. Shunned by her own family, the mother spiraled into deep depression. She stopped bathing; she stopped getting dressed. She sat in the darkened apartment all day long. The traumatized boy began showing symptoms of abandonment and rejection. His behavior at preschool was his way of lashing out in rage and confusion at what was happening to his family.

“Behavior Is Meaningful Communication”

What is going on when a very young child’s behavior is so disruptive that he or she gets expelled from preschool or day care? What’s happening in that child’s life that might cause this to happen? Too often, these questions are not being asked.

But they are precisely the questions that Child FIRST asks. Child FIRST is a Connecticut-based intensive, early childhood home-visiting intervention program that works with the state’s most vulnerable young children (up to age six) and their families. Its goal is to “identify young children and families with serious challenges and provide comprehensive assessment, parent–child intervention, and connection to broad, well integrated services
and supports in order to prevent serious emotional disturbance, developmental and learning problems, and abuse and neglect.” Originally based in Bridgeport, the Child FIRST program has expanded to New Haven, Norwalk, Hartford, Waterbury, and New London, and will soon be available throughout Connecticut.

“Behavior is meaningful communication,” says pediatrician Darcy Lowell, the founder and executive director of Child FIRST. “Everything a child does has meaning. In very young children, what we have come to call ‘acting out’ is really a cry for help.” Lowell continues, “We know that in very young children, serious emotional and psychological problems, developmental delays, and learning disabilities are often linked to family stress due to poverty and violence. Nevertheless, these issues are commonly overlooked in the rush to simply ‘fix’ the child’s troublesome behavior and make it go away. At Child FIRST, we do not just respond to a behavior. We identify and respond to the underlying factors that are generating it.”

To do so, Child FIRST works with children and parents in their homes, using a two-pronged approach. One prong fosters a closer and more stable emotional relationship between parent and child. The other is designed to dial down the level of environmental stress by dealing with the family’s concrete needs for basic necessities. Each prong reinforces the other as a clinician and a care coordinator work in tandem to deliver the program. Both must have experience working with young children and their families and have been educated in a field such as social work, family therapy, psychiatric nursing, or psychology—clinicians at the master’s degree level, care coordinators at the bachelor’s degree level. In Child FIRST terms, they “wrap around” the family to address their problems, both large and small.

The Beginnings of Child FIRST

Darcy Lowell has been interested in child health and well-being since her own childhood. “Growing up, I always knew I was going to be involved with children,” she says. “When I was in college,
I became interested in the psychiatric and psychological problems of young children. In medical school I switched to pediatrics, because the pediatricians saw children when they were babies. Psychiatrists rarely saw children before they were five or six years old.”

A summa cum laude graduate of Yale University, Lowell was in its first class of women. She describes herself as a bulldog—and not just because it is the Yale mascot. Lowell is both passionate and tenacious about helping young children, and credits her upbringing with her choice to work with vulnerable and at-risk children and their families. “My father was a lawyer and my mother was a social worker,” she says. “Both were very interested in social justice issues. My father was deputy mayor of New York under Robert Wagner, and then in 1960 became the first chairman of the city’s Commission on Human Rights. My mother gave me great insight into the people side of things—she cared a lot about the families she worked with, especially the children. My parents also encouraged me to believe that I could make things better if I put my mind to it. If I thought something was important and I put my energy into it, I could make it happen. That was the culture I grew up in, and it became part of me—it’s in my blood.”

As a young pediatrician, Lowell became a fellow in a Robert Wood Johnson Foundation program at Yale. “This was a General Academic Pediatrics program that was an appealing combination of a research fellowship, a teaching fellowship, and a clinical fellowship. Eventually I took a position at Bridgeport Hospital, where in 1986 I became the director of the Child Development Clinic and Consultation Service. This job gave me some much-needed flexibility, since by this time I was a new mother, and I understood the importance of spending time with my child. I ran the child development clinic in the hospital, and did one-on-one consultations with local Bridgeport community service providers.”

By this time, Bridgeport was already a city in decline. For more than a century, it had been a prosperous industrial town— circus showman P. T. Barnum is the city’s most famous resident, and was for a time its mayor. One of Bridgeport’s early industries was
the Frisbie Pie Company, whose disc-shaped pie tins gave rise to
the toy we know as the Frisbee. Beginning in the 1970s, however,
Bridgeport’s manufacturing base started to erode, and the city
began a protracted economic skid.

It has yet to really recover. With a population of just under
145,000 people, Bridgeport is still the most populous city in
Connecticut. Although larger than either Hartford or New Haven,
today Bridgeport’s most dubious distinction is that according to
2010 census data, it is the center of a metropolitan area with the
most unequal income distribution in America. In the Bridgeport-
Stamford-Norwalk metropolitan area, the richest 5 percent of the
population earns $49 for each $1 earned by the poorest 5 percent.
Approximately 23 percent of all Bridgeport families fall below
the poverty line, nearly double the state average. Even worse,
more than 30 percent of Bridgeport’s children live in poverty,
compared with a state average of 12 percent.

In her role as director of the child development clinic at
Bridgeport Hospital, Lowell dealt on a daily basis with the
devastating effects that this harsh economic climate was creating
for the city’s poorest children. “I was seeing lots of young
children with developmental delays. Back then, children who
were behind in language development were given speech and
language therapy, but no one was asking why they were behind,”
she recalls. “These children came from families with multiple
challenges in their lives. They were victims of poverty. They had
insufficient access to health care, nutrition, and decent housing.
Beyond that, no one was looking into the broader issues these
families were coping with—domestic violence, substance abuse,
homelessness, mental illness.”

Because she was still consulting individually with a variety
of local educational and social services agencies, Lowell saw an
opportunity to forge the missing connection. “I was dealing with
people from many different organizations that were all working
on aspects of the same problem,” she says, “but no one was
connecting the dots and looking at the larger picture. I knew that
we couldn’t just look at the child in isolation. It was essential to consider the child in the constellation of everything going on in his or her world.”

At Lowell’s instigation, some of the providers she’d been consulting with started meeting informally to discuss the problem. “In the beginning, we had people from the schools, from early care and education, a neurologist, someone from the health department . . . It was a very open group. If you wanted to join us, you were invited. We met weekly, because there were so many children who needed help. Everyone brought their thorniest, most difficult cases to our meetings—these were children and families that had fallen through the cracks.”

In the early 1990s, the kind of interagency effort Lowell put together was uncommon, but in their face-to-face meetings it became clear that each of the participants held a piece of the solution. The group realized that they needed to pool their resources and expertise to put together a case-specific strategy that dealt not only with the problems of the child, but also with the problems of the family.

They began working to fit the pieces together. Within this collaborative environment, individuals and agency representatives stepped up and volunteered to take on whatever piece of the problem was within their purview. The result was an integrated, comprehensive plan for each case. It proved to be effective, even where prior efforts had failed. “With providers coming together for a systems approach, issues of turf dissolved,” says Lowell. “Our task force began as an ad hoc collaborating problem-solving group. We called it ‘The First Team,’ but it was really the genesis of Child FIRST.”

“Darcy Lowell’s approach was collaborative from day one,” says June Malone, who participated in the meetings as a representative of Action for Bridgeport Community Development (ABCD), which encompasses Bridgeport’s Head Start program. “Bridgeport was seeing increasing numbers of children expelled from child care and preschool for behavioral problems that
teachers and daycare providers just couldn’t deal with. Even before the formal establishment of Child FIRST, Darcy brought together representatives from many agencies in Bridgeport that had an interest in child welfare, child development, and early childhood education. As service providers and stakeholders, we identified areas that needed to be addressed as a community, and how we could work in partnership.”

The collaborative officially became Child FIRST in 2001. The “FIRST” in Child FIRST is actually an acronym, standing for Family, Interagency, Resource, Support, and Training, and reflects the program’s ongoing comprehensive, collaborative, and interdisciplinary approach. That same year, Lowell received a grant from the Connecticut Health Foundation to create an “early childhood mental health system of care” for the Bridgeport area.

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The Child FIRST Model: A System of Care

The Child FIRST program that evolved from those early efforts has both community and home intervention components.

- Screening/Early Identification/Referrals
- Work with Schools and Preschools
- Home Intervention
  - Comprehensive Assessment of Child and Family Needs
  - Development of a Child and Family Plan of Care
  - Care Coordination/Case Management
  - Parent–Child Mental Health Intervention

**Screening/Early Identification/Referrals**

Children and families are referred to Child FIRST through a variety of avenues, including pediatricians, neighbors, relatives, schools, and preschools. Because those who need help the most can be the hardest to find, Child FIRST also casts a wide net,
making outreach efforts to high-risk families through homeless shelters; adult mental health, substance abuse, and domestic violence programs; the courts; and the Connecticut Department of Children and Families.

Supported by a Robert Wood Johnson Foundation grant, in 2006 Child FIRST Bridgeport started screening children for emotional and behavioral problems and environmental risks. Screening took place both in local preschools and at the pediatric clinic in the Bridgeport Hospital Primary Care Center. Almost half—47 percent—screened positive for emotional behavioral problems, and 40 percent tested positive for social/environmental risk. Although the hospital screening program remains in place, for doctors and nurses the first indication of a problem often comes from basic observation—looking at the way parents and children interact, or perhaps do not interact. “We might see a child who is very out of control in the examining room, and a mom not even trying to control him,” says Allyson Driggers, the clinic’s medical director. “That makes my antennae go up. If I ask the mom what’s going on, she might say, ‘Oh, this kid is really horrible. He never listens.’ The next question I ask is, ‘How do you handle that situation?’”

Not surprisingly, the mother’s answer often helps to pinpoint the problem. “We have many teenage moms who don’t have good parenting skills because they were not well parented themselves,” explains Driggers. “We refer families to Child FIRST so they can help moms learn a better way to interact with their children. We reap the benefits of the services they provide for our patients, and our families don’t wind up dealing with DCF.”

The DCF is a state agency, Connecticut’s Department of Children and Families, and for many parents the prospect of DCF involvement is seen as a grave threat because it has the legal authority to go to court to remove a child from the home.

Through DCF, Child FIRST began working with three-year-old twin brothers. For their safety and well-being, DCF had taken them from their parents when they were just six months
old. By the time they were three, the twins had already been in two foster homes. Both boys exhibited behavioral difficulties, so neither of the foster placements worked out. After a single mom—a schoolteacher—offered to adopt the boys, Child FIRST was called in to work with her. “We are supporting her in the process of learning how to care for these challenging boys,” says Norka Malberg, a psychotherapist who serves as clinical director at Child FIRST. “It is difficult, but this mother is extremely reflective. She’s strong and has a good social-support network. Our work is to help her advocate for what she needs in terms of being a single mother of twin boys with a traumatic past. We are helping her find the right classroom for them, and helping teachers understand their needs.”

Although these boys were removed as infants from their birth home because both parents were mentally ill, the Department of Children and Families is increasingly reluctant to take this action, except as a last resort. “DCF is moving away from what had been a punitive role—you’re a bad mother and we are going to take your child away—and toward trying to lend families a helping hand,” says Maria Brereton, DCF’s Regional Administrator for Region I (Bridgeport).

Helping parents do better with their children so the family can stay together is one of the primary reasons DCF refers families to Child FIRST. “Research tells us that children do better if they stay with their families in a home environment,” Brereton continues. “I jumped into the deep end with Darcy Lowell and formalized a contract with Child FIRST because they help families avoid having their problems escalate to the point where they need state intervention.”

Brereton talks about the case of a young boy with developmental problems:

He was placed in a group home because his parents didn’t know how to take care of him. He’d been there for about a year. Several of our child welfare staff professionals were recommending that we terminate parental rights, because the mom and dad had been unable
to keep him safe. I asked whether the parents were still visiting their son. They were, like clockwork. That’s when I asked Child FIRST to get involved. They worked with the parents to improve their parenting skills, and they were able to bring their son home. If we had terminated their parental rights, this little boy would have been placed with total strangers at the age of six. That often is a set-up for lifelong repercussions. There was an excellent chance that I’d be dealing with this boy again in ten years, when he was getting arrested, or getting referred to a psychiatric hospital.

Work with Schools and Preschools

Child FIRST clinicians teach skills and strategies to teachers who have at-risk children in their classrooms. In Bridgeport, Child FIRST began providing classroom and mental health coaching in preschools in 2003. “I was in the classroom doing observation and I saw children who were very clearly playing out something traumatic that had happened at home,” says ABCD Head Start’s June Malone. “I knew their play had a serious root cause, and I knew we needed to give our teachers more skills. We asked Child FIRST to help teachers understand the meaning of difficult behaviors, and to coach them on how to deal with it. After that, we saw wonderful gains in our staff skills. We not only stopped kicking kids out for behavior, we also had our teachers volunteering to take the children other teachers wanted to get rid of. We got referral calls from the Board of Education and DCF saying, ‘We’ve got a kid who has failed in three other programs,’ and we’d say, ‘Send him here.’”

Child FIRST clinicians also work with schools and preschools as part of a family home-intervention program (discussed in the following section). For a preschool child, the clinician will meet with teachers and observe the child in the educational setting. As the clinician comes to a fuller understanding of the problems triggering the child’s behavior, he or she works with the teaching staff to find a way to enhance and reinforce the child’s social and emotional development.
The collaboration works in the opposite direction as well—if a school or preschool has a child who is exhibiting disturbing behaviors, it may ask Child FIRST to get involved with the family. One family was referred to Child FIRST after their son had started flipping over desks in preschool. He was also being aggressive with other children. “Like so many of our little guys and girls, he had experienced some things in his life that were hard for him to understand,” says Christine Montgomery, who administers the Child FIRST program at Clifford W. Beers Guidance Clinic in New Haven. “He had witnessed some pretty significant violence between his mom and dad, and his dad had a history of being incarcerated. It was not too hard to track it back.”

**Home Intervention**

Child FIRST tailors its approach to meet the specific needs of each child and family, but in developing that individualized program, clinicians build on the basic components of the Child FIRST model. These components are described in the following sections.

**Comprehensive Assessment of Child and Family Needs**

After a referral has been made, Child FIRST clinicians and care coordinators must establish a relationship with the family. Once the door opens, the clinician focuses on the family’s emotional needs, in particular on the relationship between the parent and the child. The care coordinator focuses on the physical needs of the family—for families facing immediate crisis, this is frequently the beginning point. “We meet the family where it’s at,” says Child FIRST clinical director Malberg. “Heat, light, beds, pest control, winter clothing, diapers, shoes . . . we make every effort to help our families obtain these basic items. This effort reinforces the idea that we are attentive to their needs, and that we are reliable. It reassures them that we are on their side.”
“Going into people’s homes gives us a chance to see what their lives are really like. There could be chaos. There might be strangers coming and going to whom you are not introduced. There could be five children screaming in the other room. It’s important never to judge,” Lowell says. She continues:

I remember going into one house. It was dark. The shades were all ripped, and they were pulled all the way down. The floors were wood, but all around the edges there were sharp tacks that at one time had held a rug in place—sharp edges that would hurt a child. There were broken tiles in the bathroom—more sharp edges. The paint was peeling and there were cockroaches everywhere. This family was obviously living under very difficult circumstances. Yes, there were conditions in the home that were dangerous to small children, but we have to help families, not judge them. We work from the understanding that people are doing the best they can—that they want to be good parents. They just don’t know how.

Patience and persistence are essential. Silvia Juarez, the clinician who worked with the little boy at the beginning of this story, slipped notes under the door of the boy’s home every day for six weeks before his mother would let her in. Even then, the mom was wary. Winning the family’s trust and confidence can become even more challenging once parents realize that the Child FIRST program goes beyond “fixing” the behavioral problems of their son or daughter.

Early on, the Child FIRST team works with the family to complete a detailed written assessment of the family’s needs and psychosocial history. “It’s part of the engagement process,” says Bridgeport clinician Donna Vitulano. “We have a lot of measures that we have families complete—on developmental and behavioral needs, parental mood, as well psychosocial stressors in the home and in the community.”

“We need to make sure that the family understands why we’re here,” says Adriana Lorduy, the care coordinator who is the other half of Donna Vitulano’s team. “We tell families in advance
about the assessment, what it’s for, and how the information is going to be used to help them.”

Once they understand that the assessment will benefit them, most parents cooperate. Some, however, bristle at the intrusion and are troubled by the idea of divulging so much personal information. “Sometimes we can’t do the assessments right away, because there’s too much stuff going on,” says care coordinator Alicia Cruz. “Parents shut down. If it’s too heavy in the home, even taking out a piece of paper can be intimidating. If we start working on the assessment forms before we have really established a relationship of trust, they’ll send us right out the door.”

The team jumps through almost any hoop to create that relationship of trust, and to demonstrate that they are on the side of the family. Assessment occurs primarily in the home, but initial meetings may take place in almost any venue where the family is comfortable. “We meet them wherever and whenever they prefer,” says Lowell. “If they miss an appointment, we’ll schedule another one.”

Development of a Child and Family Plan of Care

Child FIRST develops the plan not for the family, but with the family. “It is essential that we remain respectful of the family’s wishes and desires, and of their culture,” says Lowell. “Change grows out of a relationship of trust—between parent and child, and between parents and Child FIRST. The way we deal with parents helps them understand how to have a different relationship with their children. It’s all about relationships.”

“When families begin working with us, they often don’t know exactly what they’re in for,” says Child FIRST clinical supervisor Christine Montgomery. “We work a lot with the term ‘family vision’: Where do you want your family to be, and how can we help you get there?” For many families, it’s the first time anyone has asked them that question. “We talk with families about their faith and their culture and their extended family,”
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She continues. “We do a lot of building on the family's natural supports, because those are the underpinnings that are going to sustain them after we're gone.”

The plan of care includes not only services for the child, but also services and supports for parents and siblings. Once in place, the plan is reviewed every three months, or more often if the family situation changes.

**Care Coordination/Case Management**

The role of the care coordinator is to help the family gain access to services and assistance. Care coordinators must have community-specific knowledge about resources they can tap into to assist the family with basic needs such as food, clothing, and housing. They must also know how to access health care services for issues such as domestic violence, substance abuse, and maternal depression.

The recent economic downturn and subsequent governmental belt-tightening has made this facet of the Child FIRST program more important but also more challenging. Some families have difficulty getting access to food stamps or federal WIC (Women, Infants and Children) food packages, even if they have been eligible for them before. And this past winter, Connecticut cut back significantly on the amount of money allocated for heating assistance for poor families.

Often lost in what can be a maze of bureaucratic red tape, families who are most in need can be denied services and benefits to which they are entitled—because of their inability to work the system. The care coordinator helps parents fill out forms and serves as a liaison with government agencies. As work with the family continues, the care coordinator teaches the parents how to access services on their own.

It is not uncommon for Child FIRST to enter the scene when the lack of basic necessities is already acute. “Often the first priority is to address the unmet urgent needs,” says Alice Forrester, executive director of the Clifford W. Beers Guidance...
Clinic, Child FIRST’s lead agency in New Haven. “Is there heat? Is there food in the home? Is there a home? Is the family about to lose its home? We start at the crisis, and then get to the work.”

**Parent-Child Mental Health Intervention**

“The work,” as Forrester calls it, is the therapeutic component of the intervention, directed toward establishing a stronger and healthier relationship between parents and child—or more often, between the mother and her child. Although Child FIRST staff is always happy to work with fathers, the majority of cases involve single mothers.

Child FIRST teams work in the home because there they can address issues in their natural setting. In practice, this means that clinicians spend a lot of time on the floor, facilitating play between the mothers and their babies. As they watch the mom and child together, clinicians use open-ended questions to get her to reflect on the meaning of her child’s behavior. “When his eyes turn away like that, what do you imagine he’s thinking?” They also look for “teachable moments” to encourage the mom to see the world from her child’s point of view. “What do you suppose it’s like for him when we can’t quite figure out what he’s trying to tell us?”

The Child FIRST intervention is grounded in attachment theory, which underlies child–parent psychotherapy. Enter the “Ghosts in the Nursery.” These shadowy and potentially formidable adversaries are Selma Fraiberg’s personification of the phenomenon that in parenting, history tends to repeat itself, either for better or for worse. Mothers raise their children in the same way they were raised—even if they had been neglected or abused when they were girls. Without help, these parents often fall into the same pattern they experienced as children, even if that pattern was traumatic or pathological.
For infants to form a secure attachment with the parent, mothers need to really connect with their children by voice, touch, and eye contact, but this may be unfamiliar to them if they never experienced it themselves. “Maybe that mom never had a cuddle as a child,” says Child FIRST’s Norka Malberg. “Maybe her own mother was remote or unresponsive. Maybe she suffered some sort of trauma.”

The Child FIRST intervention breaks the negative cycle by guiding mothers to revisit their own histories and confront their own ghosts. With the youngest preverbal children, this often means that clinicians themselves give voice to the child’s needs. “Mothers may be initially startled,” says Malberg, “to hear their clinician say in a baby-like voice, ‘Mommy, I’m very sad right now. I think you need to pick me up. I need a cuddle.’” Child FIRST teams help mothers understand that even preverbal children have the ability to express their needs, and that these needs are separate from those of the mother.

This may be a difficult concept to get across, especially with traumatized, inexperienced, or immature young mothers. “When we speak for the baby,” says Gail Melanson, the clinical director of the Child FIRST program in Norwalk, “we do it to heighten the mom’s awareness that her child, even as an infant, already has his or her own mind, his or her own capacity to take in the world around them.”

Many parents who are referred to Child FIRST were themselves removed from their families when they were younger. They have a multigenerational history of involvement with Connecticut’s Department of Children and Families. “We’ve been working with a mom who has been in the system forever,” says Malberg. “As a young child, her mother died of AIDS, and she was raised by her paternal grandparents. They did the best they could, but she had a lot of difficulties as an adolescent. She became a teenage mom; she had two children by her first partner, who was a very
violent man. He ended up in jail, and she lost parental rights to those two kids.

“When she was referred to us, she was only twenty years old. She had just had her third baby. The father of this child was also in jail, but not for anything violent—he owed support to his ex-wife. We started working with this mother when her child was just two weeks old. We wanted to give her the parenting tools and the help she needed so she didn’t have to surrender this baby as well.

“We tried to reflect with this mom about what it meant to have this third child, a child she’s hoping to keep. We went every week for an hour and a half. We sat on the floor with the mom and the baby, and we talked. When the baby’s father got out of jail, we invited him into the sessions. He’d never had any contact with his child, and for a while the focus of the work was on integrating the father back into the family, helping the mother get used to having the dad in the relationship. The care coordinator helped the father find a job, and helped the family find a better home. Now this young woman, for the first time in her life, actually has the sense of having her own place, with a partner who is involved with his child and doesn’t hurt her.

“The care coordinator also started working with the young mom on getting into an education program so she can get her GED,” Malberg continues. “Everything was going pretty well until the father of her first two children was released from prison. This added another dimension to our work; we had to work with the parents on the importance of how to stay safe. Part of it entails thinking with the mom about her relationship with this other man, about the pattern of behavior that led her to let this man hurt her—what was there in her history of trauma that was becoming a barrier for her psychologically to be able to stand up and protect herself?”

Above all, of course, the Child FIRST team works on how to prevent the violence from happening again. If necessary, the care coordinator will encourage the mother to file for a restraining order and help her with the paperwork.
The Research Behind Child FIRST

The Child FIRST model is supported by recent groundbreaking research in the field of early childhood mental development, much of it by Jack Shonkoff, a pediatrician and the director of Harvard’s Center on the Developing Child. His research has proven conclusively that a very young child’s experiences and environment profoundly influence brain growth and development, even the architecture of the brain itself.

By the age of just three years, 80 percent of brain development is complete. Infants and toddlers who are happy, sheltered, and stimulated by their environment and by contact with parents and other caregivers develop a robust web of neural networks and interconnections in the brain. In particular it is the loving, secure, playful give-and-take between parent and child that promotes the vigorous growth and expansion of this web, which serves as both springboard and scaffolding for future learning and development. Sadly, what is groundbreaking in Shonkoff’s research is heartbreaking as well. Infants and toddlers who are not happy, not sheltered, and not stimulated do not develop this healthy web of interconnections. On the contrary, sustained exposure to extreme stress, often called toxic stress, produces neural networks that are stunted, frayed, truncated, or miswired.

The underlying physiology behind this breakneck pace in early childhood is the remarkable capacity of the very young brain to take in almost everything around it. But brain plasticity falls off steeply after age six, and the window to effect improvement in at-risk children slams shut rapidly after that. In affection- and stimulation-deprived children, age six is when unused brain cells—cells that would have been part of a healthy neural network—begin to atrophy and die off. By the time a child is in the third or fourth grade, intervention and any needed treatment become more expensive and more prolonged. Worse yet, the chances of success begin to decline markedly, as does the degree of remediation that might be achieved. Early intervention
with at-risk children—while the window is still open—is key if these permanent negative effects are to be avoided or mitigated.

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**The Robert Wood Johnson Foundation’s Initial Support of Child FIRST**

In 2005, through the Local Initiative Funding Partners program (now the Local Funding Partnerships program), the Robert Wood Johnson Foundation made a four-year, $500,000 grant to Child FIRST to support its work in Bridgeport. Then as now, Child FIRST had many funding partners, including the Connecticut Department of Children and Families, The Children’s Fund of Connecticut, the United Way of Eastern Fairfield County, and the Connecticut Health Foundation.

“IT was clear from the grant application that the situation was horrific, not only for the children and their families, but for teachers and day-care workers as well,” says Pauline Seitz, director of the Local Funding Partnerships program. “No one knew how to manage these children. Families were frustrated because they had to take the child into an institutional setting—to the child psychiatrist and the child therapist. The idea that these children could be helped more effectively in their own homes was impressive.”

Anecdotal reports had strongly pointed to the effectiveness of the Child FIRST approach in improving the emotional health of very young children. To confirm the accuracy of those observations, Child FIRST had already secured funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to conduct a rigorous, randomized trial of their model. After the data had been collected, however, there weren’t enough financial resources available to get it analyzed.

In 2007, on the recommendation of the Local Initiative Funding Partners program, the Robert Wood Johnson Foundation made a $125,000 follow-on grant to Child FIRST to
complete the evaluation—as well as to conduct a cost-benefit analysis, to secure expanded Medicaid reimbursement through DCF certification as an “evidence-based program” within Connecticut, and to develop program materials and training for the model’s replication.

The Evaluation of Child FIRST

Once the data was processed, trial results confirmed the positive and statistically significant outcomes for Child FIRST intervention. At the twelve-month follow-up, Child FIRST children were almost five times less likely to display aggressive or deviant behaviors, and more than four times less likely to have language problems. Mothers who had participated with Child FIRST also had significantly reduced levels of depression. The most pronounced change took place not in the first six months of working with Child FIRST, but between six and twelve months of intervention. Care coordinators helped highly stressed Child FIRST families gain three times more access to much-needed social services.6

Program Expansion

In 2009, the Robert Wood Johnson Foundation awarded $3.2 million to Child FIRST to expand into four additional regions of Connecticut: New Haven, Hartford, Norwalk, and Waterbury. Expansion at each site worked through a local lead agency: Clifford W. Beers Guidance Clinic in New Haven, the Village for Families & Children in Hartford, the Child Guidance Center of Mid-Fairfield County in Norwalk, and Wellpath in Waterbury. All sites were up and running by April 2010. An additional Child FIRST venue at New London was funded by SAMHSA, making a total of six Child FIRST sites.
Beyond adding these new sites, however, the grant was used to prepare the groundwork for further expansion. There were eight primary goals of the grant:

- Establish an interagency state-level executive committee to oversee the development and implementation of the initiative.
- Select four Connecticut cities as replication sites, including Hartford and New Haven.
- Establish the Replication Coordination Center to provide intensive training and ensure fidelity to key elements of the model.
- Obtain certification for Medicaid reimbursement for diagnosed children at all Child FIRST sites and advocate for increased reimbursement rates.
- Advocate for the expansion of Medicaid reimbursement to cover preventive services, before a child shows significant symptoms.
- Develop a web-based data system to manage data on process and outcomes across all sites.
- Analyze outcomes data to document effectiveness and disseminate results, including publication in a national peer-reviewed journal.
- Apply to the federal government for certification as an evidence-based model.
- Engage funding partners in a public-private partnership to support replication of Child FIRST and integration of the model with the state’s early childhood system of services.

Replication—with fidelity to the original model—has received special emphasis. The Learning Collaborative of the Connecticut Center for Effective Practice (CCEP) was chosen to replicate the Child FIRST model. The process has included development of a comprehensive training curriculum and publication of a training manual. Beyond that, however,
replication inevitably involves lots of interaction between experienced Child FIRST clinicians and their new colleagues. “Training new staff is intensive and very hands-on,” says Darcy Lowell. “There is lots of role playing, lots of discussion. We find that if we can integrate active participation into the training, it’s much more effective, and a lot more fun. We have a lot of sharing between teams, so that everyone gets to know one another.”

Not surprisingly, clinicians from the various sites describe their work in very similar terms, and the process of sharing among the teams in different cities is ongoing, whether or not training is taking place. Care coordinators also network with one another. In particular they share information about newfound resources they have located. This aspect of the work has become increasingly important and more challenging as state and local budgets have shrunk.

Although the randomized trial has concluded and the study has been published, Child FIRST is continuing to monitor data from all its venues to ensure that outcomes are consistent across the board. Thus far, results achieved at replication sites are similar to those from Bridgeport.

A key goal of the program was met when the federal Health Resources and Services Administration and the Administration for Children and Families designated Child FIRST as one of nine “evidence-based home visiting models” in the country. This designation allows Child FIRST programs to tap into the $1.5 billion in federal funding provided by the Patient Protection and Affordable Care Act. Child FIRST Bridgeport became the first home-based psychotherapeutic intervention for very young children allowed to bill for Medicaid reimbursement in Connecticut.

In January 2012, the Robert Wood Johnson Foundation awarded Child FIRST a grant of $2.3 million for the second phase of its statewide replication. Preparations are under way for the implementation of Child FIRST in New Britain, Middletown, Stamford, and Windham County. As of June 2012, training of clinicians and care coordinators for these venues was complete.
The phase-two grant, which is expected to extend through December 2013, will not only expand Child FIRST operations into these additional venues, but is also expected to facilitate the meshing of the Child FIRST model into the Department of Children and Families. This may happen very quickly. The federal Maternal, Infant, and Early Childhood Home Visiting Program has awarded Connecticut funding that can be used to accelerate establishment of a Child FIRST presence in all fifteen DCF regions in Connecticut.

--- Looking Ahead

Child FIRST is now actively exploring expansion beyond Connecticut. “We are getting many calls from other states,” says Lowell. “There is a lot of interest. I expect that in the next year or two, we will see some replication outside of Connecticut.”

The completion of the business plan will be one key component of this expansion. The availability of mental health professionals qualified to work with very young children and their families is another factor, and Lowell acknowledges that skilled clinicians can be hard to find. “We need clinicians experienced with children and families who have the right kind of heart,” she says. “We look for nurturers—people who care about relationships, and about what goes on inside a parent, and inside a child. We are not looking for people who think they can stop a behavior and solve the problem.”

A third factor will be the change that Child FIRST is likely to bring to the large and cumbersome government bureaucracies currently dealing with very young at-risk children at the state and federal levels. Because Child FIRST is so different from the way government agencies have been coping with the problem, adopting Child FIRST as the preferred approach brings with it the potential need to restructure, transform, and even reinvent child welfare agencies.
Connecticut is in the early stages of dealing with this issue. “Child FIRST really challenges a whole lot about the way child protective services operate across the country,” says Janice Gruendel, deputy commissioner of the Connecticut Department of Children and Families. “It doesn’t just change the world for children—in a positive way; it changes and challenges the way we think about abuse, about neglect, about family-child relationships. Child FIRST pushes us to rethink how we’re doing everything, which is a good thing, but a hard thing. It has the potential to challenge governmental child protective systems to be something that they are not right now.”

Bureaucratic challenges aside, the advantages of adopting the Child FIRST model are compelling. Some of the advantages are financial. The cost-benefit analysis funded by the Robert Wood Johnson Foundation showed that Child FIRST interventions result in significant governmental savings in the fields of special education, child protective services, foster care, and juvenile justice. The cost of a Child FIRST intervention averages about $6,500 per family. The alternatives are far more expensive. Older children with serious psychological and behavioral issues may be referred by the DCF to Level 2 group homes. A Level 2 group home has 24-hour nursing coverage, and has been described as “one step down from a mental hospital.” The cost to the state is just under $100,000 a year per child. DCF places children with violent or criminal tendencies in the state’s juvenile training school (aka reform school) at Middletown. If a Level 2 group home is one step down from a mental hospital, the juvenile training school is one step down from prison. The cost of keeping a child incarcerated there exceeds $450,000 a year. A year of inpatient psychiatric hospitalization costs $920,000.

State legislators, public administrators, and budget analysts can do the math. Even in a time of extreme state budget cutbacks, Connecticut found a way to fund Child FIRST. “The science is irrefutable and everybody knows it,” says Gruendel. “All of
us want every vulnerable child to be competent, capable, and resilient. We want them to be on target with their schooling, their health, and their behaviors in the way they engage with other people. If we truly want all kids to be like our own kids and grandkids, the bottom line is that we don’t have a choice. Every day, these at-risk children get one day older.”

“These are the children that we as a society give up on, the children we throw away,” says Darcy Lowell. “And they end up being the most expensive. These are the kids who have had four pregnancies by the time they’re sixteen, who are not literate, who drop out. They end up in foster care or in residential treatment for psychiatric problems, or in the juvenile justice system.” The ultimate goal of Child FIRST is to segue from remediation into prevention—to identify at-risk children before they display aggressive or disturbed behaviors, language delay, or other psychological problems. “If we can get in there early, we have a good chance of breaking the generational cycle of at-risk kids,” Lowell says. “Those children will eventually be different with their own children. Our goal is to support them now so that they grow up with their brains and bodies strong and healthy. They will be better grown-ups and better parents.”

Epilogue

There is a happy ending to the story of the little boy we started with. Today, he is doing well. His breakthrough came after a Child FIRST team helped his mother deal with her depression, and helped him finally express his hurt and fear—in words rather than through actions. He eventually confronted his father during a prison visit, telling him how angry he was about what he had done. After that, the vomiting stopped. The father was released on parole and reunited with his wife and family. He is supporting his family. The little boy is back in school and thriving. He is also the proud and loving brother to a new baby in the family.
Notes


