

Child FIRST



Child and Family Interagency, Resource, Support, and Training

Introduction

All children need to have the chance to succeed. Yet, today, a baby born to an inner city mother faces multiple barriers to success from the very beginning. Poverty, domestic violence, depression, substance abuse, inadequate health care, poor education, illiteracy, recent immigration, teen and single parenting, unemployment, and crime are common risks in the environments in which these babies live. Although these parents want the very best for their children, they often face multiple challenges which prevent them from nurturing and supporting their children's development. We can change this pattern.

Child FIRST is an innovative, early childhood system of care, which can make a profound difference in the lives of the most vulnerable young children and families. Through early identification, assessment, and intervention, we can prevent serious emotional disturbance, developmental and learning problems, and abuse and neglect. Our goal is to integrate this new model into the Connecticut state system in order to promote change in early childhood policy and practice not only in Connecticut, but nationally as well.

Documentation of Need

Serious emotional disturbance, developmental delay and learning difficulties, and child abuse and neglect have many common roots. Scientific research has made it absolutely clear that the first three to five years of life is one of tremendous brain growth, and that the environment in which a child develops profoundly impacts his cognitive and emotional development. By eight months of age, brain synapses or connections have increased from 50 to 1,000 trillion, and by three years of age, at least 80 per cent of brain growth has occurred. It is early experiences that determine not only which connections are made, but which are hard wired and which are pruned away. Children who are not touched, stimulated, or played with have brains which are 20-30 per cent smaller on Magnetic Resonance Imaging. Approximately 40 per cent of infants of depressed mothers have decreased brain activity. Repetition of traumatic or stressful experiences leads to a hardwiring of neuronal pathways for fear, anxiety, and hyper-vigilance, clear precursors of later emotional disturbance.

Research has clearly associated the number of environmental risks experienced by children with an increased incidence of serious emotional disturbance and school failure.

Less than two risks has been associated with a seven per cent incidence of behavioral problems, while greater than eight risks has been associated with an alarming 40 per cent incidence. A study of 3,800 preschool age children found that 21 per cent met criteria for a psychiatric disorder. (Lavigne et al., 1996) Among children living in poverty with other associated risks, the incidence is much higher. When children ages 12 to 36 months were screened at Bridgeport Hospital Pediatric Primary Care Center and at the Women, Infants, and Children (WIC) program in the Bridgeport Health Department, the incidence of positive screens for emotional and behavioral concerns was over 50 per cent.

According to Jane Knitzer of the National Center for Children in Poverty, “The most powerful effects in reducing long-term negative outcomes...are found in programs that combine a strong child focused program with a strong family component...This suggests a critical need to design and evaluate a new generation of intensive, preventive interventions that are explicitly intended to address the levels of problematic behavior that are almost routinely seen among young children, particularly in programs with concentrations of low-income children.” (Knitzer, 2000) Best practice in developing systems to address these needs is well articulated. Knitzer clearly outlines nine principles of an “early childhood mental health service system.” Child FIRST adheres to every one. However, in the published literature, there is an alarming paucity of sound research evidence upon which to base policy and system change. This is especially critical in the era of results based accountability. Through analysis of the results of a randomized trial to prove the effectiveness of Child FIRST (funded by the Substance Abuse and Mental Health Services Administration – SAMHS) and a cost-benefit analysis, Child FIRST has the opportunity to provide solid evidence which can lead to significant advances in both policy and practice for our youngest children.

History and Development of Child FIRST Model

Child FIRST developed directly as a response to community need. It was clear that many young children and families were “falling through the cracks” and not receiving critically needed services. Many of these families were overwhelmed by the multiple challenges they faced. Although they wanted to do what was “right” for their children, they were not able to access the services and supports which were necessary to promote their children’s development. Some families were isolated and received no supports (e.g., families of depressed mothers, of recent immigrants, or experiencing domestic violence), while others received a single, narrow service (e.g., a child receiving speech and language therapy) which did not begin to address the underlying problems (e.g., disordered parent-child interaction) or the multitude of contributing environmental risks which the family was experiencing. Some families received multiple, fragmented services which worked at cross-purposes, making them both inefficient and costly. Service providers were eager to help, but often found the process of researching and coordinating services extraordinarily challenging, expensive, and time consuming, as they were operating outside their knowledge, expertise, and program mandate. Families’ own priorities and goals were rarely considered, hence families were often not committed to the success of the plans. At other times, well conceived service

recommendations failed when families were left with no supports to facilitate access to and coordination of services or to address the barriers to service access.

The creation of Child FIRST was a direct response to the need for a coordinated, comprehensive, family centered approach to enable high risk families with young children to access necessary services and supports. Over the past eight years, Child FIRST has developed from a multi-agency, collaborative team, working together to provide integrated services to children and families, to a model system of care, which is able to identify young children with emotional problems, developmental delays, and environmental risk within the community and provide comprehensive assessments, family-driven plans, and access to coordinated, comprehensive services and supports.

The core components of Child FIRST include:

Level I: Screening and Early Identification – Formal screening for emotional and behavioral problems occurs in the Pediatric Primary Care Center at Bridgeport Hospital, within fourteen early care and education sites per year, in the Bridgeport domestic violence shelter, and in the family resource centers. Three Masters level clinicians (social workers with both early childhood mental health and developmental expertise) are integrated within these settings to mentor the providers (e.g., pediatric residents, early care teachers, domestic violence staff) so that they are able to respond to positive screens with an understanding of the environmental risks which significantly impact the nurturing relationship, the meaning of challenging behaviors, and strategies for intervention. In addition, any other adult or early childhood community provider serving a family with a young child (e.g., home visitors, adult mental health providers, substance abuse providers, Birth to Three early intervention providers, DCF social workers) may identify children at risk or with emotional difficulties and make a referral to Child FIRST for consultation or intensive services (see below). Approximately 700 families are screened each year.

Level II: Mental Health Consultation – Children and families in need of more in-depth exploration of strengths and needs may receive consultation services. This may involve up to four or five visits with the family either in the home or in a community site (e.g., pediatric, early care, family resource center, workplace) to help with parenting, needs identified by the family, and access to resources. It frequently involves direct work with the service providers to help them understand the child’s relationships (e.g., parent-child, teacher-child) and the challenges faced by the family. While consultation is an intrinsic component of the work in the pediatric and early care settings, it may be requested by any early childhood or adult provider with concerns or seeking a better understanding of how to facilitate the emotional development of a child, (e.g., home visitors, Birth to Three staff, DCF social workers, teachers). Approximately 100 children and their families receive consultation services each year.

Level III: Child FIRST Intensive Services – These services are offered to any family with multiple challenges in need of more in depth assistance. Child FIRST receives referrals from over 70 community providers, and serves approximately 200 families per year. There are four major components:

1) Comprehensive assessment of child and family needs: This is an assessment by the mental health / child development clinician within the home and in any other setting in which the child spends significant time. This is an ecological approach, using both informal and standardized measures, to understand the child's health and development, the relationship between the child and parent (as well as any other important adults in the child's life), and the multiple challenges experienced by the parents which prevent them from being available to nurture and support their child's development.

2) Family plan development: A family-driven plan of comprehensive, integrated supports and services is developed with the family, which reflects the parents' goals, priorities, strengths, culture, and needs. This plan includes services and supports not only for the identified child, but for the parents and siblings as well. It utilizes the broad resources of the community in order to support the family and decrease risk. Referrals to over 70 different agencies have been made, averaging 11 per family.

3) Parent-child, mental health intervention: This intervention starts early in the assessment process for children with emotional and behavioral problems. This is a psycho-educational and psychotherapeutic intervention which uses those "teachable moments" which present within the home environment. This intervention begins "where the parent is" and operates at multiple levels, among them: normal developmental challenges and expectations; parental reflection on the meaning and feelings motivating a child's behavior; reframing the child's behavior; problem solving new strategies; and the relationship between parental feelings and past history and the parental response to the child. Therapeutic intervention within the home provides an opportunity to respond to identified problems as they arise in their natural setting, is much more convenient, and is without the stigma of going to a mental health facility.

4) Care coordination: This is provided by a bachelor's level professional who teams with the mental health clinician and facilitates the family's access to multiple services and resources throughout the community. She provides hands on assistance obtaining information about services; partnering with community providers; researching program appropriateness and availability; and making and facilitating referrals to provider agencies. The care coordinator is responsible for addressing barriers to service access, renewed problem solving, and revision of the family plan in consultation with the Child FIRST team.

Research Evaluating the Effectiveness of the Child FIRST Model

Child FIRST received one of five Starting Early / Starting Smart – Prototype grants from SAMHSA in October, 2001. The grant was to support a randomized trial to evaluate the effectiveness of the Child FIRST model in preventing serious emotional disturbance in very young children, 6 to 36 months. Children were recruited from both the Pediatric Primary Care Center at Bridgeport Hospital and from WIC at the Bridgeport Health Department. Any positive screens for emotional or behavioral problems or for significant environmental risk were eligible for participation. One hundred and fifty families, randomized into the Child FIRST Intervention group or into Usual Care Control group, participated in the study. Follow-

up was conducted by the research staff at six and twelve months. Seventy-five per cent of families participated in the twelve month follow-up.

Partial analysis of the six month results has been conducted by the research team, Alice Carter, Ph.D., Professor of Psychology at University of Massachusetts, Boston, and Margaret Briggs-Gowan, Ph.D., Developmental Psychologist, Assistant Professor of Psychiatry, University of CT Health Center. They have both published with national reputations.

Children and families served by the Child FIRST Intervention showed statistically significant positive change as compared to Usual Care Controls in the following areas:

- Child FIRST parents showed **marked decrease in parenting stress**. (Child FIRST mothers were 4.24 times less likely to have Parenting Stress Index scores above the significant stress cut-points than Usual Care mothers, with similar results with Parent Distress and Difficult Child scales.)
- Child FIRST families had a **decrease in DCF involvement**. (Child FIRST families were 3.5 times less likely to have protective service involvement than Usual Care families.)
- Child FIRST children showed an **increase in language development**. (Child FIRST children were 3.1 times less likely to have language problems than Usual Care children.)
- Child FIRST mothers reported statistically significant improvement in their children's feelings or behavior, their understanding of their children's development, and in feelings of depression and sadness.
- Families served by Child FIRST **accessed 77 per cent of needed services**, as opposed to 30 per cent accessed by Usual Care families.

Within the Child FIRST Intervention there was statistically significant positive change in the following areas:

- Children showed a **marked decrease in behavioral and emotional problems**. (A high emotional/behavioral screen with the Brief Infant-Toddler Social Emotional Assessment was 4.5 times less likely after Child FIRST intervention. There was almost a 50 per cent drop from 71 per cent above the problem behavior cut-point at baseline to 38 per cent post intervention.)
- There was **improvement in parent-child interaction**.
- Parents reported **very high satisfaction** with services received, with a mean score of 4.49 out of a maximum of 5.

The Child FIRST model was also evaluated by the Yale Consultation Center of the Yale Department of Psychiatry, as part of the Bridgeport Safe Start Initiative, funded by the Office of Juvenile Justice and Delinquency Prevention. The intervention was found to be equally effective with young children ages 0-6 years exposed to violence.

The effectiveness of mental health consultation in the early care and education classrooms was evaluated by the Yale Consultation Center, Yale Department of Psychiatry. Among those children identified with emotional and behavioral concerns, **statistically significant improvement was seen in all domains of child protective factors and in behavioral concerns**, as rated by both the teachers and parents (on the Devereux Early

Childhood Assessment). Analysis of baseline and follow-up data shows teachers receiving this consultation reporting a marked, statistically significant increase in feelings of effectiveness in their understanding of emotional and behavioral issues as well as their ability to develop and implement strategies to help the children in their care.

Child FIRST Oversight and Staffing

Child FIRST staff consists of a full time Executive Director, Darcy Lowell, MD, who is Chief of the Section of Developmental and Behavioral Pediatrics at Bridgeport Hospital and an Assistant Clinical Professor in the Yale Department of Pediatrics and the Child Study Center. She was a Robert Wood Johnson Fellow and a Fellow of Zero to Three National Center for Infants, Toddlers, and Families. She was Director of the Children with Special Health Care Needs Program for sixteen years, and has developed multiple programs in the Bridgeport region, with grants totaling over five million dollars. She has served on multiple boards and committees on city, regional, state, and national level, including Clinical Faculty of the Jewish Board of Family and Children's Services, NY, NY; Interdisciplinary Council on Developmental and Learning Disabilities, Bethesda, Maryland; SAMHSA Reviewer for Bright Futures Guidelines, 3rd edition, AAP; CT Birth to Three Medical Advisory Board; CT Child Health and Development Institute's Early Childhood Task Force; CT Early Childhood Partners Core Planning and Steering Committees; CT Birth to Three Autism Task Force; CT Association for Infant Mental Health Board of Directors; CT Behavioral Health and Primary Care Advisory Board; DMHAS Mental Health Transformation Grant; DCF Differential Response Planning Group; CT Infant-Toddler Strategic Plan, Steering Committee (chairing the Workgroup on Health and Mental Health); Bridgeport Success by Six Advisory Board; Department of Children and Families Area Advisory Board; Bridgeport School Readiness Council; Bridgeport Community Resource Collaborative (KidCare), Bridgeport Discovery Initiative Steering Committee; Bridgeport Safe Start Initiative Advisory Board; and Bridgeport Child Advocacy Coalition Early Childhood Task Force and Steering Committee. She has been working in Bridgeport with high risk children birth through age five years for over 20 years.

Staffing consists of a Program/Clinical Director and Associate Director. There are five Masters level clinicians and three care coordinators. All clinical staff members receive a minimum of two hours of group supervision, one hour weekly individual supervision by the Program Director, and frequent peer supervision. Seventy per cent of staff are bilingual.

Program oversight is through a Community Advisory Board which is composed of the leadership of thirty of Child FIRST's community partners with representation from parents, funding partners, business, and legislators. It provides advice and problem solving with regard to program direction and expansion. The Board meets on a monthly basis.

Summary of Unique Aspects of Child FIRST

Child FIRST is an early childhood prevention / intervention system of care. It is unique in a number of ways:

- 1) This **comprehensive, integrated** approach to the needs of young children and families fills a critical gap in the existing array of resources, by integrating existing services across multiple funding streams and service systems.
- 2) Child FIRST targets the children and families at **highest risk** for emotional and behavioral problems, developmental and learning problems, and for abuse and neglect. These are the children most likely to have later school failure.
- 3) Child FIRST **identifies children at the earliest possible point** through strong collaborative relationships with providers throughout Greater Bridgeport.
- 4) **Mental health and developmental consultation** is available to early care and education, pediatric health care, family resource and support centers, early intervention, home visiting, shelters, substance abuse, adult mental health, and other community providers.
- 5) A comprehensive, **ecological approach** is used to fully understand the child and family, focusing on: child health and development, parent/caregiver–child relationships, and parental and environmental challenges.
- 6) **Comprehensive assessment and intervention** is within the **home**, providing natural opportunities to understand and intervene with challenging behaviors.
- 7) A **comprehensive, integrated family-driven plan of wrap-around services** is developed in partnership with the family, reflecting family goals, priorities, culture, and needs.
- 8) **Hands on care coordination/case management** ensures access to comprehensive services for all members of the family.
- 9) Child FIRST flexibly **teams with child and adult community providers** to help them meet the needs of the families that they serve most effectively, without competition or duplication of services.

Child FIRST is an early childhood system of care which reflects the newest efforts by experts throughout the country. This comprehensive, integrated approach to prevention and treatment of high risk children and families can help our youngest children achieve optimal health and development, so they are ready to learn in school and realize their full potential.

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