Child First

An Evidence-Based, Trauma-Informed Model Serving Young Children and Families

Testimony Submitted to the Appropriations Committee

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Response to H.B. No. 5044 AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES FOR THE FISCAL YEAR ENDING JUNE 30, 2017.

Senator Bye, Representative Walker, and members of the Appropriations Committee,

Thank you for the opportunity to submit testimony in response to H.B. 5044. My name is Dr. Darcy Lowell. I am a developmental and behavioral pediatrician and Associate Clinical Professor in the Department of Pediatrics and Child Study Center at the Yale University School of Medicine. I am Founder and CEO of Child First, Inc. I have been working with very vulnerable young children and families in Connecticut for over 30 years. It is because of their tremendous risk for very poor outcomes in mental health and development that I began the Child First model here in Connecticut 15 years ago.

Child First is one of the nine funded, Health and Human Services (HHS) designated, **national, evidence-based home visiting models** that is eligible for national dissemination with funding from the Maternal, Infant, and Early Childhood Home Visiting initiative (MIECHV). Child First currently works with 15 affiliate sites statewide that provide services to very young children and families in all six of the regions of the Department of Children and Families (DCF). DCF directly funds the operating costs of ten Child First sites, and five Child First sites are supported by MIECHV.

The Need

Children who have been abused or neglected in early childhood are at tremendous risk for impairment in language, cognition, mental health, and physical health. These are the children who are served by the DCF system.

Scientific research on early brain development has documented the damaging effects of psychosocial adversity on the formation of brain structure. **Abuse and neglect are among the most significant of the "toxic" stressors that cause major brain impairment.** But in addition, we know that **55% of children under age three years have five or more of the other major risk factors** (extreme poverty, domestic violence, caregiver depression, caregiver substance abuse, homelessness, among many others) which the **Adverse Childhood Experience Study (ACES) has proven lead to major developmental and learning disability** (including executive functioning, language, and cognition), **mental health problems, substance abuse, and physical illness, which last throughout the lifespan.**

The Urgency of Prevention and Intervention that Works

The theory of change underlying the Child First intervention is based upon the most current brain science on the impact of toxic stress and adversity on the developing brains and metabolic function of

very young children. Extreme stress and trauma are able to change the way that DNA is expressed (called "epigenetic modification") and turn on and off critical genes changing the trajectory of a child's life. Very young children are both the most vulnerable and the most frequently exposed to this trauma. It is critical to intervene as early as possible in order to prevent serious, long-term, negative outcomes.

Child First provides both secondary and tertiary prevention/treatment to both the identified child, caregivers, and siblings in the family. The intervention takes a two-pronged approach:

1) Stabilizing the family and decreasing their challenges and stress (so damaging to the young brain) through intensive care coordination, which provides connection to community-based services and supports for all family members (including health providers, housing, early intervention, early care and education, domestic violence shelters, legal/court system, adult mental health/substance abuse services, adult education, job training), while at the same time **building executive functioning skills** in the caregiver. This is the role of the Bachelor's level Care Coordinator.

2) Providing a two-generation psychotherapeutic intervention – trauma-informed Child-Parent Psychotherapy – for both the young child and caregivers, in order to **heal from the devastating impact of violence** and other trauma, and promote a nurturing and secure parent-child relationship, which is able to buffer and protect the young developing brain from damage. This is the role of the licensed, Master's level Mental Health/Developmental Clinician. These professionals work as a Clinical Team in the home.

In 2005 in Connecticut, a SAMHSA funded randomized controlled trial demonstrated that Child First was able to decrease DCF involvement by 39%, sustained at 33% at three years. Child First also decreased child emotional/behavior problems (42%), language delays (68%), and maternal mental health problems (64%) (*Child Development*, 2011). Child First is the only evidence-based MIECHV model that specifically targets this multi-challenged population, often with domestic violence, abuse and neglect, maternal depression, substance abuse, homelessness, and poverty.

Child First National Program Office has tracked our **outcome data** since 2010 to insure that our intervention continues to yield strong positive results, with model fidelity. Over the past year, over all of our DCF families, **82% improved in one area, 69% improved in two areas, and 54% improved in three areas.** Among families with identified areas of concern, we saw a **70% improvement in depression, 69% improvement in parenting stress, 64% improvement in child language, 65% improvement in child behavior, and 74% improvement in child social skills.** When we look at the size of the improvement, we find our "effect sizes" or "Cohen's d" are in the large to very large range (0.7-1.9) with very high levels of statistical significance ($p<.001$ or lower). (See graphs below, where we are specifically showing change in our DCF population.) **We know that Child First really works** for our most vulnerable children and their families!

We believe that **Child First is highly cost effective**, especially in the long term. Cost of serving one family (with an average of four members of the family receiving services) is $7,900. Cost savings will be realized in decreased DCF involvement, foster care, psychiatric residential treatment and hospitalization, maternal depression, special education, ER visits and hospitalization, and incarceration, among others. With increased building of adult capacity, parents can become employed, decrease need for TANF, and pay taxes, supporting our state economy.

Child First serves approximately **1000 families annually in Connecticut**. At the current time, Child First is not available in all geographic areas in our state due to funding limitations. Furthermore, the aggregate

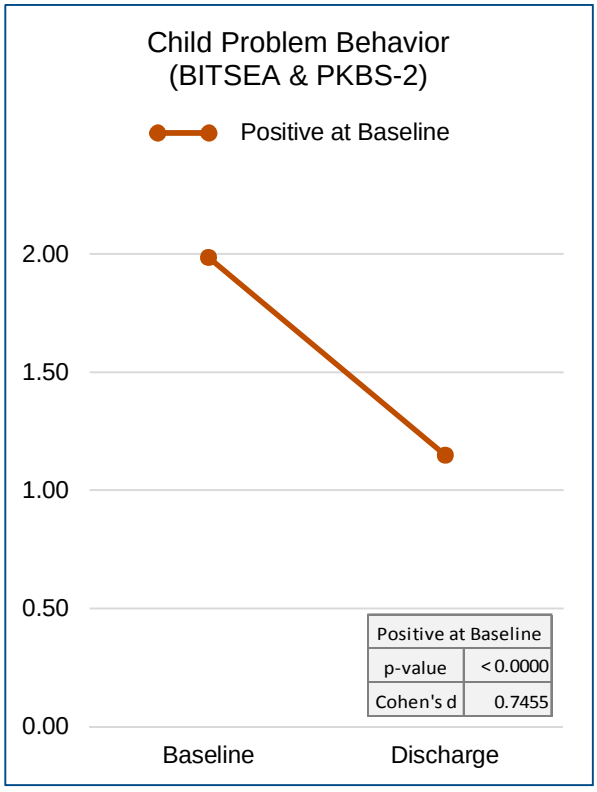
waiting list of our Child First affiliate agencies is about **300 children and families** at any time. All DCF children and families are given priority, due to the severity of the challenges in their lives.

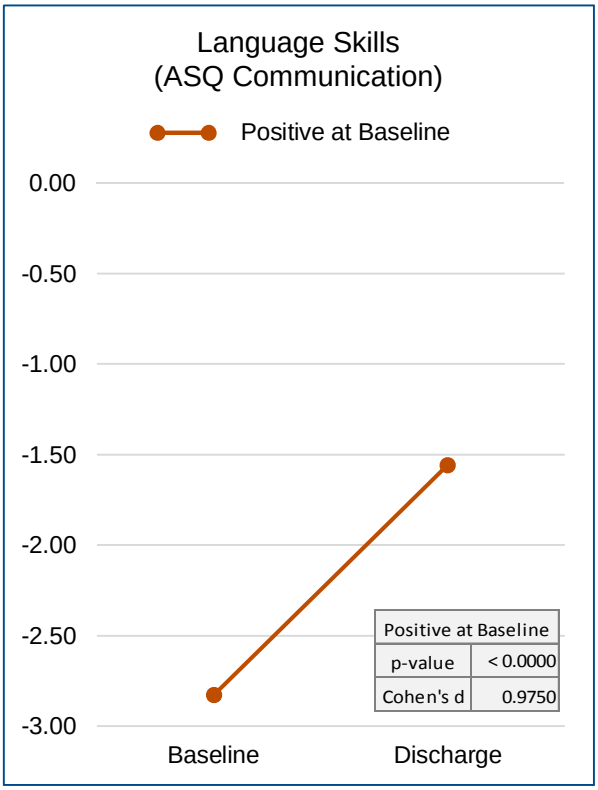
The budget adjustment recommendations to the Department of Children and Families proposed in H.B. 5044 are of grave concern. We cannot afford to allow children who have potential for healthy, successful lives to go unserved. This is both a moral and financial imperative.

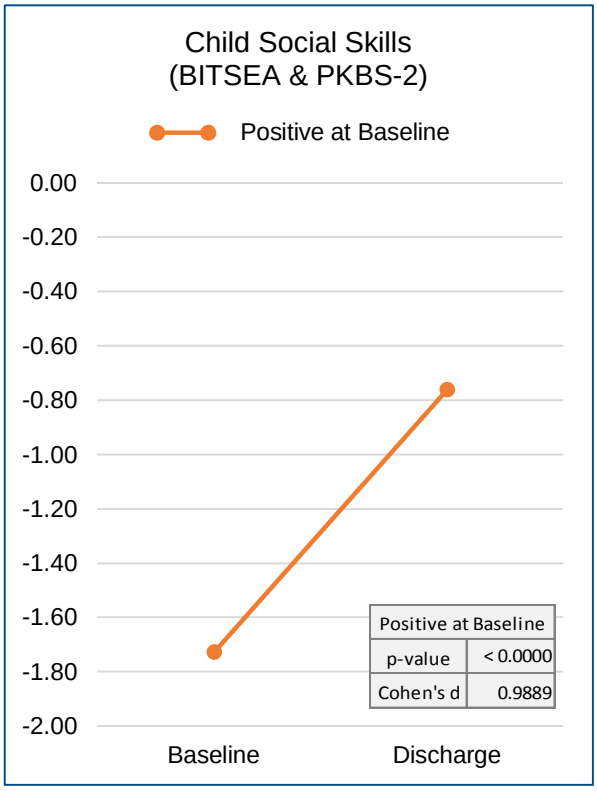
To sustain and expand services that succeed in changing the trajectory of the most vulnerable children and families, Connecticut must adopt a budget that supports those programs that are effective in improving the wellbeing of our most challenged families.

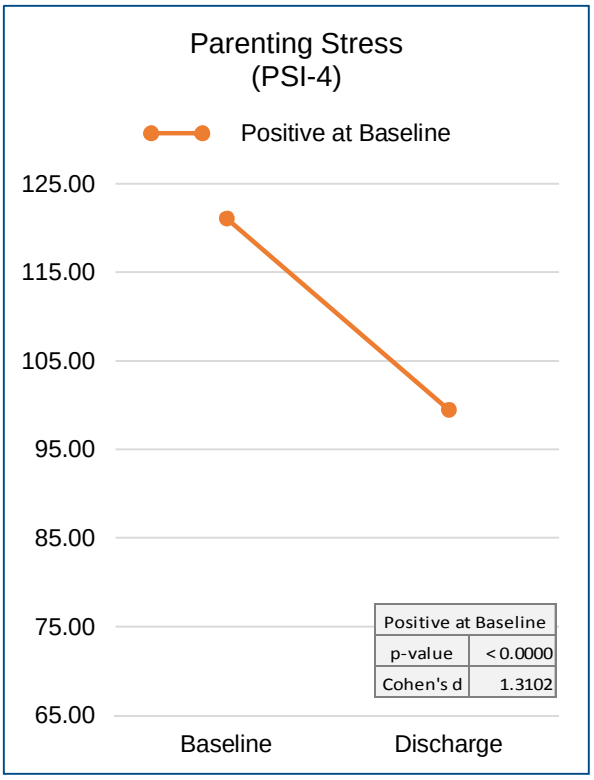
Thank you so much.
Darcy Lowell, MD

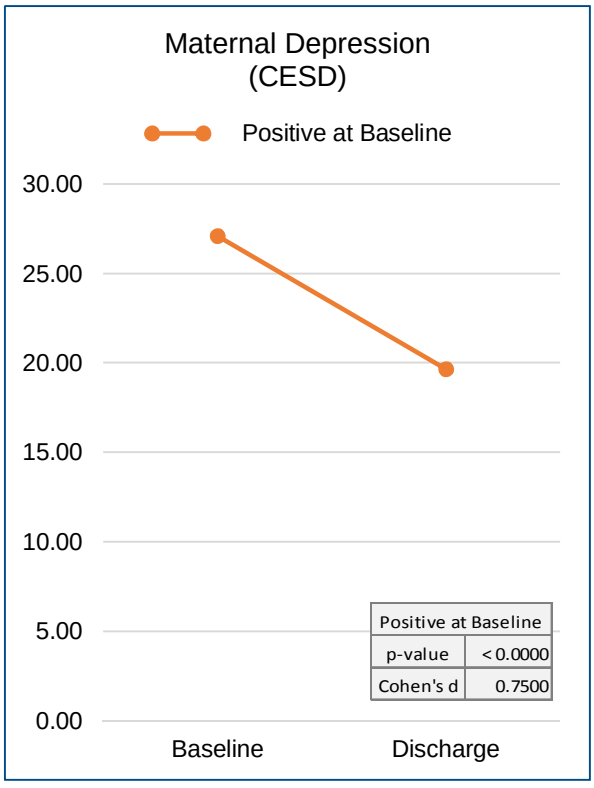
CHILD FIRST ASSESSMENT OUTCOMES - Connecticut











Child First Assessment Measures:

1. ASQ-Communication - Ages and Stages Developmental Questionnaire (ASQ), Communication Domain
2. BITSEA - Brief Infant-Toddler Social & Emotional Assessment
3. PKBS-2 - Preschool and Kindergarten Behavior Scales-Second Edition
4. ASQ-SE - Ages and Stages - Social Emotional
5. CCIS - Caregiver-Child Interaction Scale
6. CESD - Center for Epidemiology Scale-Depression