

Child Welfare Watch

BABY STEPS: Poverty, chronic stress, and New York's youngest children



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OVER THE PAST decade and a half, scientific research has firmly established that early childhood experiences can have a tremendous impact on our lifelong well-being. Giving babies the care and attention they need provides a strong foundation for future development, affecting their ability to process information, regulate their emotions, interact with others and understand their worlds. When infants are exposed to constant stress or trauma, the effect can be toxic, stunting brain growth and changing the trajectories of their lives.

Thankfully, a growing body of evidence points to supportive caregiving as a means to buffer the impact of poverty, trauma and other stressors on young children. Supportive caregiving is a reflective, child-centered approach to parenting that emphasizes sensitivity, warmth and responsiveness. Adult caregivers promote a baby's development by responding to her cues and needs, and by being generally nurturing. A child's emotional well-being is inextricably tied to the parenting she receives.

Of course, a nurturing approach to parenting can be extremely difficult to practice while, say, living in a domestic violence shelter or clocking a 60-hour work week for minimum wage. So helping infants means many things, including investing in strategies

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CENTER FOR NEW YORK CITY AFFAIRS
THE NEW SCHOOL

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Issue Highlights: Facts and Figures

Studies indicate that chronic stress, trauma or neglect in early life can literally change the way a child's brain develops, leading to impairments that can be permanent.

There is also evidence that responsive, nurturing care can prevent or reverse the damage caused by stress. (See "The Science of Trauma," page 17.)

National studies have found that 20 to 60 percent of foster children under age 5 have significant developmental delays, and that 25 to 40 percent display serious behavioral problems.

Foster care agencies do not regularly screen for mental health impairments in very young children. (See "Babies in Foster Care," page 23.)

Putting mental health professionals where parents already are makes services easier for families to use. (See "How to Reach the City's Youngest," page 8.)

Studies have shown that elements common to poverty, such as overcrowding and family turmoil, can cause babies' stress levels to spike precipitously—but only when a baby's mother is not responsive to her child's signals. (See "Baby Watchers," page 5.)

In New York City, only a handful of programs and clinics engage the parent as a partner in a small child's therapy. (See "Baby Watchers," page 5.)

to make the city's most distressed neighborhoods places where children and families can thrive and supporting policies—such as accessible, high-quality child care—to help families better cope with their day-to-day pressures. But helping young children can also involve providing clinical support to their families.

Over the past two decades, professionals devoted to the emotional and social health of babies and toddlers have developed interventions that work with young children and their caretakers. These "dyadic" therapies foster responsive, nurturing parenting and recognize that babies develop in the context of close, consistent relationships.

As these interventions seek to curb social and developmental issues before they become severe, they can be tremendously cost-effective. The Nobel prize-winning economist James Heckman showed that early interventions yield a huge cost savings of about \$8 for every \$1 invested. Waiting to act can be expensive: Heckman found that the potential economic returns decline steeply as early as a child's third year of life.

In New York City, this newfound knowledge regarding developmental strategies for securing a child's earliest years has only begun to shape the fields of mental health and children's services. Just a handful of centers and clinicians are trained and able to offer dyadic therapies for very young children and their parents. Parents needing help for traumatized toddlers have few places to turn, and the dearth of city services and government funding earmarked for young children's social and emotional well-being only exacerbates the problem. The federal- and state-funded Early Intervention program reaches many of the city's most vulnerable babies and toddlers, but its services focus primarily on developmental delays rather than on the effects of trauma and chronic stress.

There are new programs emerging, however, and a few proven ones are winning more attention. Small programs in the Bronx, Brooklyn and Queens are giving parents valuable, hands-on guidance and practice in responsive, playful support for their children. The city's Administration for Children's Services is steering federal dollars to nascent interventions for victims of trauma and their small children.

In this issue, we survey the evidence from research into chronic stress and the interventions that buffer the toxic effects of trauma on babies and toddlers. We look at the city landscape, profiling programs that work with the families of young children living with poverty and other forms of stress. We highlight the need for more expertise, awareness, training and services in a growing field that is increasingly described as "infant mental health."

Researchers have developed a vast store of knowledge regarding what babies require to flourish. The gap between that knowledge and the enduring realities of social policy has persisted so stubbornly, and for so long, that many who work in this field are stumped. Triage typically trumps prevention, they say. A violent teenager is more likely to win policymakers' attention than a toddler who has trouble sleeping after witnessing his father's murder. A mother struggling to care for her small child in an overcrowded apartment is more likely to be the subject of an investigation by government's child protective services than to experience dyadic therapy at a neighborhood clinic.

Promoting small children's mental well-being goes far beyond play therapy. It means finding ways to connect early with parents of young children, help them to lower their stress, and encourage them to provide their families with the love, support and attention they need to flourish. ✕

RECOMMENDATIONS AND SOLUTIONS

This issue of the *Watch* focuses on the city's youngest residents: babies and toddlers. We explore the impact of chronic stress on young children's brain development and present national research around interventions aimed to buffer that effect and to better support the parents of young children. More than 6 percent—or 518,000—of New York City's 8.1 million residents are under 5 years of age. A handful of local programs work with the families of young children who are affected by poverty, chronic stress and trauma, including some innovative programs for the child welfare-involved parents of young children. We highlight the need for more of this type of expertise and illuminate the dearth of government funding and services targeted for caregivers seeking help for young children. **Following are recommendations and solutions proposed by the *Child Welfare Watch* advisory board:**

THE NEW YORK STATE OFFICE OF MENTAL HEALTH (OMH) AND THE CITY'S DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHOULD PROVIDE CONSISTENT, ADEQUATE FUNDING FOR EARLY CHILDHOOD MENTAL HEALTH TREATMENT, AND FOR PROFESSIONAL TRAINING.

Providing early help to infants and toddlers who need it can prevent more costly, intensive and potentially invasive interventions later in life. Nobel prize-winning economist James Heckman has demonstrated that investing in effective early childhood interventions can yield huge cost savings—and that there is a steep decline in the value of these savings as early as the end of a child's third year of life.

However, state and city government funding for treatment is very limited and few professionals are trained to provide treatment to this age group. A 2012 analysis by the Citizens' Committee for Children estimated that state-licensed mental health clinics had treatment spots for only 1 percent of children age 0 to 4 who needed them in three of New York City's boroughs. Slots were most scarce in community districts considered high risk due to factors such as economic poverty and safety. Government and society are missing the opportunity to provide young children with appropriate treatment before their needs and symptoms compound.

Some clinics and organizations providing early mental health treatment are reimbursed a small amount through Medicaid or, in some cases, by their referring foster care agencies. Many

families are not eligible for these funds, or are served outside of clinics. Today, the City Council is one of the few sources of government funding for community-based early mental health treatment, but its support is not solely for treatment or for training clinicians to work with infants and toddlers; it must also cover the cost of screenings and evaluations. What's more, this modest support of \$1.25 million is not "baselined" into the mayor's budget and is therefore at risk of elimination each year. We urge the city and state to recognize the need for more treatment options—including intensive, dyadic therapy, which is most lacking—for this vulnerable group of New Yorkers. There is also a great need to build a viable workforce able to work with children under 5 and their parents.

THE CITY, STATE, AND NONPROFIT ORGANIZATIONS SHOULD CO-LOCATE INFANT AND TODDLER MENTAL HEALTH SERVICES IN THE PLACES WHERE YOUNG CHILDREN AND THEIR PARENTS ALREADY GO: PEDIATRIC CLINICS, FOSTER CARE AND PREVENTIVE AGENCIES, FAMILY COURT, HOMES, COMMUNITY CENTERS AND CHILD CARE PROGRAMS.

Parenting young children while living in poverty or with other sources of chronic stress is taxing. Parents and young children who could benefit from treatment will be far more likely to find help if it is located in the places where parents already go. This makes services easier to access, reduces the stigma frequently associated with mental health treatment and allows infant mental health

specialists to educate other professionals who work with babies—such as child care workers, judges, pediatricians, home visiting nurses and preventive workers—about the social and emotional development of young children.

THE STATE DEPARTMENT OF HEALTH SHOULD PROVIDE PROFESSIONALS IN THE EARLY INTERVENTION PROGRAM WITH COMPREHENSIVE TRAINING IN THE SOCIAL AND EMOTIONAL DEVELOPMENT OF YOUNG CHILDREN.

Early Intervention is the city's largest, most comprehensive program for treating kids under 3. In theory, Early Intervention can work with children under 3 whose only issues are social-emotional. In practice, the program largely focuses on addressing developmental delays and disabilities, making it a missed opportunity to help the families of babies who are struggling with the effects of trauma or chronic stress. To help nudge Early Intervention closer to becoming a system able to address early childhood mental health, Early Intervention professionals should receive comprehensive training around the mental health needs of young children, with a focus on how to address and recognize the effects of trauma in this age group.

THE STATE OMH SHOULD TRACK THE NUMBER OF STATE-LICENSED MENTAL HEALTH CLINICS—ALSO KNOWN AS ARTICLE 31 CLINICS—THAT HAVE THE CAPACITY TO TREAT INFANTS AND TODDLERS.

Few clinics have the capacity to provide mental health treatment to infants and

toddlers. No government agency tracks the number that do serve very young children and their families. This makes it extremely difficult to address the citywide gap between treatment need and capacity.

THE STATE OMH AND THE CITY'S HUMAN RESOURCES ADMINISTRATION AND DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHOULD COLLABORATE WITH PARENTS AND COMMUNITY ORGANIZATIONS TO CREATE AN ADVERTISING CAMPAIGN THAT PROMOTES POSITIVE, SUPPORTIVE PARENTING OF YOUNG CHILDREN.

A growing body of research suggests that "supportive parenting"—a reflective, child-centered approach to parenting that stresses sensitivity, warmth, and responsiveness—is a key to buffering the potentially lifelong toxic effects of a childhood marred by stress, violence and trauma. New York should mount a campaign dedicated to educating parents about the benefits of supportive parenting and provide powerful examples of what it means to be responsive to the developmental needs of infants and toddlers.

THE ADMINISTRATION FOR CHILDREN'S SERVICES (ACS) SHOULD REQUIRE FOSTER CARE AGENCIES TO ENSURE THAT BABIES AND TODDLERS IN FOSTER CARE ARE SCREENED FOR MENTAL HEALTH IMPAIRMENTS, IN ADDITION TO STANDARD DEVELOPMENTAL EVALUATIONS.

Last year, there were more than 3,050 children under age 5 in New York City foster care. Young children often come into care with tumultuous histories that put them at high risk of medical, emotional and developmental problems. Once in the system, many of them continue to experience turbulence, moving from caregiver to caregiver while being separated from their families.

When foster care is necessary, it should be maximized as an opportunity to nurture children's developmental health. In the past decade, ACS has made great progress in the effort to ensure that children receive developmental screenings when they enter care. These screenings focus primarily on cognitive and physical delays, rather than

on the more subtle impacts of disrupted relationships and stressful experiences that threaten babies' emotional wellbeing. Unfortunately, mental health assessments often don't happen until children are older and demonstrate obvious behavioral symptoms of emotional distress.

Some agencies have developmental specialists on staff to ensure that developmental screenings take place, and to follow kids who demonstrate special needs. This systematic approach should be instituted at all agencies, with a similar level of attention paid to mental health screenings for children of all ages.

ACS AND THE STATE OFFICE OF COURT ADMINISTRATION (OCA) SHOULD ROUTINELY TRAIN FRONTLINE STAFF AND CONTRACT EMPLOYEES ON THE DEVELOPMENTAL NEEDS OF INFANTS AND VERY YOUNG CHILDREN.

Removing babies and toddlers from their homes disrupts their attachments to caregivers and can have lifelong negative consequences. Frontline workers at foster care agencies, as well as child protective specialists and key Family Court staff, attorneys and judges, should be regularly trained in the particular developmental, emotional and mental health needs of infants and very young children—including the damage that can be caused by repeated disruptions in care.

In the past, a privately funded court commission ran an initiative that educated court staff about infant development, while also providing guidelines and checklists to help judges and attorneys make sure that babies received appropriate care. In the absence of outside funding, ACS and the courts should continue these practices. OCA should consider designating social workers to follow infants' cases in court, ensuring that they receive developmentally appropriate services. Along with frontline case workers, Family Court judges should consider conducting analyses of babies' existing attachments before making placement decisions. OCA should also consider the feasibility of creating specialized court parts for babies and very young children, staffed by judges with particular training in early childhood mental health, and who are fully informed of resources in the community for infants and their parents.

ACS AND NONPROFIT FAMILY SUPPORT ORGANIZATIONS SHOULD ENSURE THAT PARENTING CLASSES ENGAGE IN ACTIVE SKILL-BUILDING, SUPPORTING PARENTS TO UNDERSTAND AND NURTURE THEIR CHILDREN'S DEVELOPMENT.

Too often, parenting classes are didactic exercises in compliance, instructing parents in basic skills they may already know. These classes—in conjunction with family visits—should be used as an opportunity to support parents' meaningful interaction with their children, building skills that encourage nurturance and children's secure attachments.

With the recent introduction of its ChildSuccessNYC initiative, ACS has taken steps toward incorporating a focus on children's developmental and emotional needs, and on the positive, crucially important role a parent plays in her child's development. Under the initiative, parents participate in facilitated groups that promote both instruction and discussion, including concrete information about strategies to support infant brain development and mitigate the potential harm caused by trauma or neglect.

The implementation of ChildSuccessNYC should not preclude parents and foster care agencies from pursuing alternative approaches, however. Specifically, there ought to be more opportunities for parents to learn about child development in environments where they can interact with their children, supported by facilitators who help them build understanding of real-life issues in real time. The 'Mommy and Me' program at SCO Family of Services is one example of this kind of program. Parents and their children participate in a structured playgroup, in which facilitators discuss elements of development, demonstrate strategies to support that development, and then provide opportunities for parents to interact one-on-one with their children.

Support groups and instruction are both valuable, but they should be closely connected to visitation experiences for parents and their children in foster care—and parents themselves should have both the information they need and the freedom to choose the most appropriate programs.

THE CONTEXT:

Trauma and chronic stress can harm a baby's developing brain, but studies suggest that nurturing, responsive parenting can prevent long-term injury.

THE ISSUE:

With fast-growing knowledge about how to protect babies and toddlers, should government support a systematic mental health response?

Baby Watchers

A small but growing movement in mental health therapy is providing pockets of help for the city's youngest children.

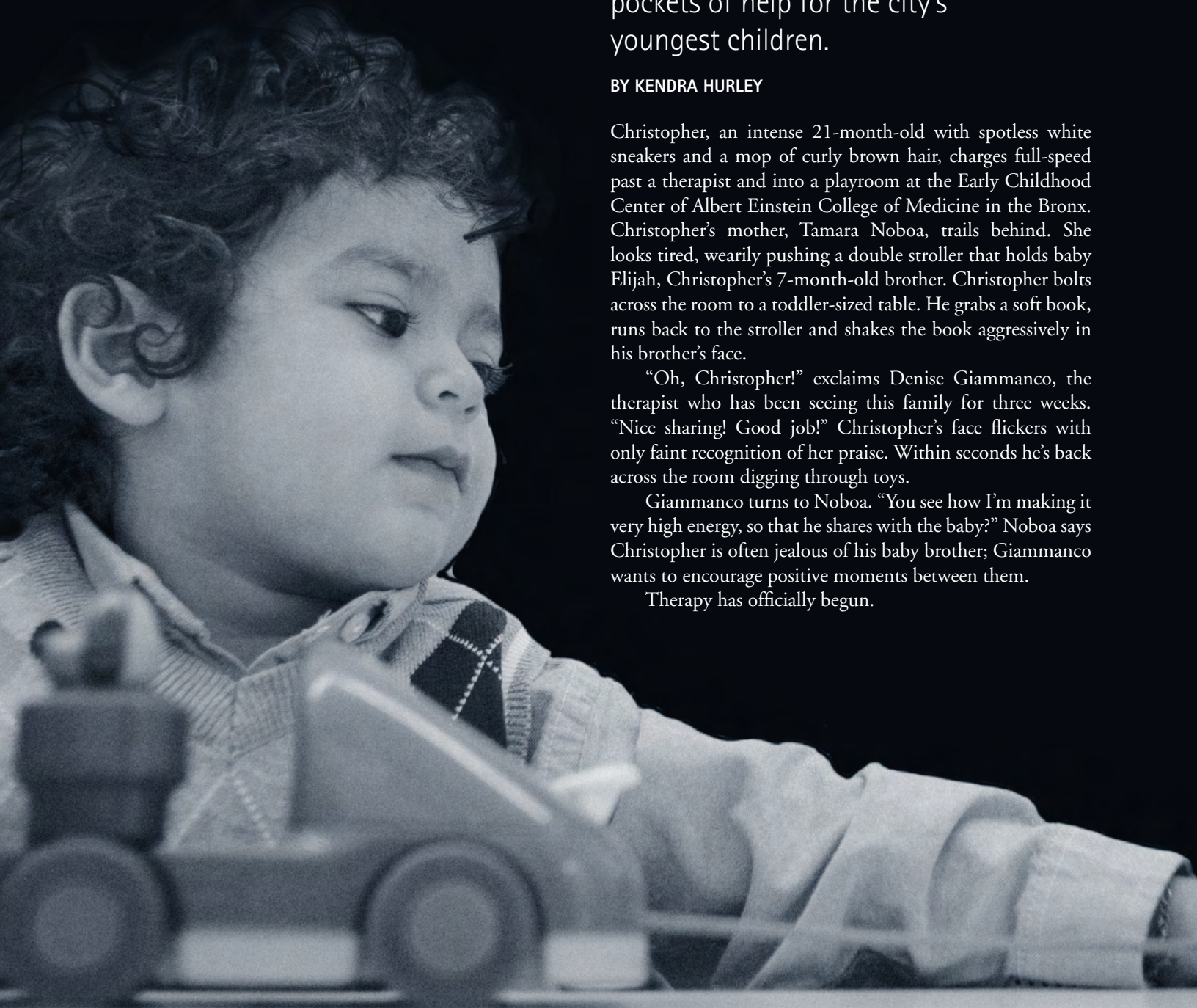
BY KENDRA HURLEY

Christopher, an intense 21-month-old with spotless white sneakers and a mop of curly brown hair, charges full-speed past a therapist and into a playroom at the Early Childhood Center of Albert Einstein College of Medicine in the Bronx. Christopher's mother, Tamara Noboa, trails behind. She looks tired, wearily pushing a double stroller that holds baby Elijah, Christopher's 7-month-old brother. Christopher bolts across the room to a toddler-sized table. He grabs a soft book, runs back to the stroller and shakes the book aggressively in his brother's face.

"Oh, Christopher!" exclaims Denise Giammanco, the therapist who has been seeing this family for three weeks. "Nice sharing! Good job!" Christopher's face flickers with only faint recognition of her praise. Within seconds he's back across the room digging through toys.

Giammanco turns to Noboa. "You see how I'm making it very high energy, so that he shares with the baby?" Noboa says Christopher is often jealous of his baby brother; Giammanco wants to encourage positive moments between them.

Therapy has officially begun.



SEVERAL MONTHS AGO, Christopher was saying “Mommy” and “Daddy.” His parents waited for more words to come, but they haven’t. Now, Christopher doesn’t say much of anything and rarely responds when spoken to. It’s hard to tell how much he understands. He has also started falling a lot. He cries loudly and frequently in the night, waking the baby. And although he didn’t use a pacifier before, he’s begun putting the baby’s pacifier in his mouth. He is easily frustrated, throwing things and hitting. Just this week, he whacked the baby across the face.

Noboa’s teenage daughter also had behavior issues at Christopher’s age. Then she attended a therapeutic day program. It helped a lot. Now she’s on the honor roll. Today, Noboa hints that this is the kind of help she might like for Christopher too.

But the Early Childhood Center, which works primarily with low-income families like Noboa’s, provides a different kind of help, engaging not only the child but the parent as well. Most social work interventions for struggling and poor families view the social worker as the sole therapeutic

“Young children live in the context of their relationships. Any work that is not relational is probably not going to buy much change.”

agent. They strive to change the behavior of either a child or a parent, but not both. In the relationship-based therapy that the Early Childhood Center provides—known as dyadic therapy—the therapist works simultaneously with parent and child, engaging the parent as a partner in the child’s therapy, because in the early years, children are almost entirely dependent on parents to create their world for them.

“There’s very little you can do with a very young child without changing the tenor and context in which they live, and young children live in the context of their relationships,” says Susan Chinitz, director of the Early Childhood Center. “Any work that is not relational is probably not going to buy much change.”

“If the therapist spends an hour a week with the child, that’s one thing,” says Fred Wulczyn of Chapin Hall, a policy

research center at the University of Chicago. “But if you improve the parenting and then the parent knows how to better manage the child, then you get all that exposure to better parenting instead of trying to get the child to be a better child. Caregivers spend so much more time with the child. Delivering the intervention through the parent means you get much higher dose levels.”

In New York City, however, only a handful of programs and clinics provide dyadic therapy for young children and their caregivers, making families like Christopher’s among the very few to stumble across it. What may eventually pass for a movement is beginning to emerge in agencies across the city, rooted in increasingly robust research—and the experiences of therapists like Denise Giammanco and her colleagues.

Giammanco knows that many of Christopher’s changes started around the time his brother was born and his world turned upside down. He went from being the baby of the family to the big brother, no longer the main focus of his mother’s affections.

Not long after Elijah’s birth, both boys and their mother moved into the home of Christopher and Elijah’s father. (Noboa also has a teenage daughter who sometimes lives there, other times with her father.) Christopher’s mother says she, too, is reeling from all the changes—a new relationship, a new home, two children under the age of 2. Some days she wants to close her bedroom door and block out the world. “He makes me crazy sometimes,” she says about Christopher. “I need help for him. Help for me. I don’t want to scold him all the time.”

Christopher will soon receive a full diagnostic evaluation by a pediatrician who will assess his speech development and how well he understands language, among other things. But Giammanco will also consider murkier factors that could be contributing to Christopher’s behavior and delays.

In her hour-long weekly sessions, Giammanco coaches both of Christopher’s parents on how to provide what’s sometimes referred to in the small world of infant mental health as “supportive” or “responsive” parenting—a reflective, child-centered approach to parenting that encourages sensitivity and warmth. Research suggests this kind of parenting is a key to buffering what neurobiologists have documented to be the sometimes brutal and long-term effects of trauma, poverty, and stress in early childhood. (See “The Science of Trauma,” page 17.)

A series of studies of 1,200 infants funded by the National Institutes of Health suggests that elements common to poverty, like overcrowding and family turmoil, caused babies’ stress levels to spike precipitously—but only when a baby’s mother was not responsive to her child’s signals. “When mothers scored high on measures of responsiveness, the impact of those environmental factors on their children seemed almost to disappear,” journalist Paul Tough explains in his recent book, *How Children Succeed*.

Today, in the Early Childhood Center playroom, Giamanco models the supportive parenting approach, interjecting enthusiastic “vroom, vrooms,” as Christopher rolls a truck across the table, and cooing empathetic frustration when he struggles to master a difficult puzzle toy. Eventually, Giamanco will have Christopher play less with her and more with his mother and father as she provides guidance, cheering them on in their parenting in much the same way she cheers Christopher in his play.

A Therapeutic Approach that Treats Parent and Baby, Together

For the first 13 years that Martha Alvarez worked in a high school-based nursery for the babies of teen moms, she had never seen the research around supportive parenting nor heard of dyadic therapy.

Each morning, young mothers dropped off their babies in the school nursery before classes began. Nursery teachers took care of the babies while Alvarez and the other social workers counseled the young mothers, encouraging them to stay in school, speaking with them about college. “It was very academic minded,” Alvarez remembers. “It did touch on issues with their moms and relationships with their babies’ dads, but there was very little to do with the baby.”

Alvarez knew well that many of the young women she worked with were struggling with motherhood. At an age when most young people want nothing more than to forge identities separate from their own families, becoming a parent had tied them inextricably to a very small child—and to their parents and caregivers on whom they depended for support and guidance. While many dressed their infants immaculately in the latest brand-name clothing, they often had trouble seeing their babies as separate from themselves, as little people with their own likes, dislikes, wants and needs.

Young mothers would routinely arrive at school upset, says Alvarez. “She had a fight with her mom or she had a fight with her boyfriend, or her kid threw up on the way.” Typically, staff would take the baby to the nursery and Alvarez would take the mom to her office. “But I realized that this baby was upset too. This baby would be crying.”

One day it became glaringly obvious she needed to try a different approach. A young mom showed up at school with her 2-year-old son, who proudly showed Alvarez a colorful leaf he’d found. He had picked up the leaf near his home and had made it all the way to the nursery with it intact, in his hand.

“I said, ‘Oh my, this is such a great leaf, what beautiful colors!’” Alvarez remembers. “But the mother had been oblivious to the leaf the whole time, not minding what this little boy was doing for the whole ride to the nursery. She was not attuned to him. I knew there was a disconnect.”

When Alvarez pointed out the leaf to her, the mother

said, “Oh, yeah,” and threw it away.

Alvarez remembers the moment as an awakening. “I thought, ‘This kid isn’t getting what he needs.’ I knew that there had to be a way to bring the baby and mother together and work on her parenting skills.... I knew there was something to be done with the moms and babies, but I never had that role explained to me.”

A few years later, through an arrangement with the city’s Department of Education, two social workers arrived at the nursery. Drawing from multiple strategies and interventions developed by researchers and mental health specialists to assist vulnerable parents and their infants, Elizabeth Buckner and Hillary Mayers had created a program called Chances for Children, which gave young mothers a combination of parent education and therapy while working with them and their babies together. The program shifted the focus of Alvarez’s work to helping young mothers take on the vast role of caring for their new families—a role that included pursuing their academic studies, but also a great deal more.

Alvarez’s training was intense. Buckner and Mayers schooled Alvarez and other social workers at the nursery in the research behind the interventions they used. They taught them about attachment theory, which holds that the quality of the attachment an infant has with his caregiver at life’s beginning has lifelong consequences. One University of Minnesota study in the 1970s found that the degree to which young children were securely attached to an adult could predict with high accuracy whether or not they would graduate from high school.

Alvarez and the other nursery social workers also learned about the toxic effects of chronic stress on young children. They read psychoanalyst Selma Fraiberg’s “Ghosts in the Nursery,” a seminal 1975 essay that describes how unresolved issues from a parent’s upbringing can haunt their parenting if left unexplored. And they read about more recent neurological research. Through all their training, they experienced a kind of supervision that Buckner describes as “layers of mothering,” where she and Mayers mothered and supported the nursery staff in their work so that they, in turn, could mother the young moms and help them do the same for their babies.

“It took a while for my thinking to change from just the mom to the dyad,” remembers Alvarez. “It was a cognitive shift of working from one to working with both. But it was rich, rich, rich. You look at the mom, you look at the baby.”

The Chances for Children model begins by videotaping mothers as they play with their babies for 10 minutes. The therapist asks the mom to play with her child just as she might at home. Then the two of them watch the video together, with the practitioner building the mother’s trust by focusing on positive moments.

Alvarez remembers how much the young moms loved this strength-based approach, which could also be described as the “oh, wow” method, where the therapist marvels at all the positive things the mother does. “Nobody had told them,

How to Reach the City's Youngest: Experts Weigh In

INFANT MENTAL HEALTH experts warn that the best way to address the city's stark shortage in mental health services for young children is not simply to create more treatment slots. Rather, attention has to be paid to placing these programs where families can find and use them. "We believe in a co-location model, where you put what we do in other systems," explains Joaniko Kohchi, child development specialist at the Early Childhood Center of the Albert Einstein College of Medicine in the Bronx.

Kohchi and her colleagues would like to see infant mental health services in places where parents with young children already go: pediatric clinics, child care centers, high school-based nurseries, Family Court, foster care agencies, even in home-visiting programs. "If a parent is already stressed, the chances of you getting to a clinic once every week is not realistic," says Susan Chinitz, director of the Early Childhood Center.

As reported in a 2000 report of the Surgeon General's Conference on Children's Mental Health, one study found that only about 41 percent of children referred by a pediatric provider for outside mental health services actually made it to intake. Putting mental health professionals where parents already are makes services easier for families to use while reducing the stigma often associated with mental health treatment, says Bonnie Cohen, director of University Settlement's Butterflies Program. This also allows infant mental health specialists to educate other types of professionals, like child care workers, about the often overlooked social-emotional side of infant and toddler development.

A 2012 Citizens' Committee for Children analysis found that in the Bronx, Staten Island, and Brooklyn, mental health treatment slots exist for only about 1 percent of the children ages 0-to-4 who need them. Once a child turns 5, however, options for receiving help increase. Many more clinics accept children 5 and older, and with kids entering kindergarten at this age, it is far easier for professionals to identify who needs support and to provide help at school. Mental health specialists say that waiting until age 5 wastes valuable time as well as a key opportunity to help children at an age when their brains are developing most rapidly. (See "The Science of Trauma," page 17.)

"In some ways, it's discriminatory to only start services at school age," says Chinitz. "Why wouldn't there be services for every age?" —Kendra Hurley

A few New York City initiatives are already structured this way

- Therapists in the **Butterflies Program at University Settlement** work with the children, teachers, and families enrolled in University Settlement's EarlyLearn program. One full-time therapist and one part-time therapist screen nearly 350 children under age 5 each year for social and emotional issues, support and train EarlyLearn staff, and provide therapy for children and families who need more intensive help. Many of the children they work with are Chinese-American and have recently been reunited with their parents in New York after spending earlier years with grandparents in China. Butterflies therapists help them reconnect with their parents and adjust to their new homes and country.
- The foster care agency **Forestdale's Attachment and Biobehavioral Catch-Up program** works with babies between 6 and 24 months and their caregivers right in their homes. The highly-structured, 10-week program aims to increase attachment between children and caregivers. Forestdale's version of the model typically works with babies in foster care and their foster parents, as well as with parents and children who have recently begun living together again after involvement in foster care. "These mothers have been brought to the attention of child welfare and feel like they've done something terrible and that they aren't a good mother," says Anstiss Agnew, Forestdale's executive director. "The model is meant to reassure and teach at the same time."
- Recognizing that pediatricians are the only professionals to regularly see most babies, the **Children's Hospital at Montefiore** in the Bronx pairs an infant mental health clinician with pediatricians. At the hospital's children's clinic, this psychologist or licensed social worker—who has the more parent-friendly, less stigmatizing title Healthy Steps Specialist—works alongside pediatricians to help ensure that young patients and their parents get appropriate mental health screening, referrals and treatment along with their physical checkups and vaccines. The infant and toddler specialist also trains pediatricians and medical students, helping to make them more comfortable in talking with patients about issues like post-partum depression, trauma and substance abuse.
- **The Family Court in the Bronx** has partnered with early childhood specialists at the **Early Childhood Center**, who provide treatment to parents of young children involved in Family Court while sharing their expertise with judges and other court officials. The Jewish Board of Family and Children's Services' Institute for Infants, Children & Families is planning a similar program for Manhattan Family Court, which will be funded by the state's Office of Children and Family Services.
- **The Riverdale Mental Health Association (RMHA)** provides mental health treatment along with services like work readiness training and job placement. **Chances for Children**, which works to strengthen relationships and attachment between parents and their young children, is based at RMHA and trains the association's clinicians on how to work with the families of young children who have experienced trauma, stress and attachment difficulties.

“We’re not really telling parents what to do so much as to get them to think about things through their kids’ eyes.”

“Oh, wow, that was so nice what you did. The baby was stumbling and you picked him up. That’s nice,” she remembers. “They enjoyed the fact that I was paying attention to them and their babies. Many teen moms don’t get that recognition.”

Over time, the therapist moves toward helping the mother experiment with new ways of thinking about and interacting with the child. She asks questions such as, “What do you think the baby is thinking?” or “How about you don’t pick up that toy right now and see what happens?”

Alvarez remembers one young mother who perpetually teased her 18-month-old daughter. She’d take away whatever toy the baby chose and proclaim it to be “Mommy’s toy.” She’d shake objects in front of her and then yank them away when the baby tried to grab them. When this mother picked her daughter up after class, she would try to make her jealous by pretending not to notice her daughter as she warmly greeted all the other children in the nursery. The little girl would often respond by shutting down, Alvarez remembers. This, in turn, caused the mother to comment that her daughter didn’t like her and did not want to play with her. She would tease the girl even more. It was a vicious cycle.

Alvarez asked the mom to play with her daughter while teasing her for one minute, as Alvarez videotaped. During the taping, the baby turned away from her mother. “See, she doesn’t want to play with me. She likes to play alone,” the mother said.

Then Alvarez told the mother to play with her daughter for another minute while she videotaped. But this time, Alvarez asked the teen to try out a form of supportive parenting, where the parent responds to the baby rather than directs her. Alvarez asked the young mother to follow her daughter’s lead, allowing her baby to show interest in a toy first, and then follow by showing an interest herself in whatever the baby did. “Do what she does. Talk about what she’s doing,” Alvarez instructed.

An amazing thing happened, remembers Alvarez. As the mother responded to her daughter’s lead, her baby slowly turned to her. Then she lifted a block up to show her. The mother, carefully matching her daughter’s movement, held up another block. Slowly, the daughter touched the mother’s block with her block. The mother turned to the camera, face alit, grinning, amazed that her daughter was playing with her. With the touching of those two blocks, Alvarez recalls, “it was almost like the Sistine Chapel.”

“Do you see what she did?” the mother asked, incredulous.

“Yes, I saw what she did,” Alvarez remembers saying.

“You saw what you did? You opened the world to her.”

Alvarez and the young mom would watch that videotape many times. Eventually, they began to explore the mother’s own upbringing. The teen’s mother had teased her throughout her childhood. Remembering this, the young woman began to recall how confusing that had felt. Alvarez believes that the combination of reflecting on her own childhood while experimenting with new ways of parenting paved a new way for her to relate with her daughter. “We made a new story for her, that she was not her mom, and her story with her daughter was totally different and didn’t have to repeat the past.”

New York City’s Pockets of Help for Infants and Their Caretakers

Chances for Children has since moved out of the high schools, where they trained social workers in 13 school nurseries, and into community centers and a clinic in the Bronx. Alvarez and Chances for Children’s three other therapists now work with caregivers of all ages in three neighborhoods. The organization has also trained six clinicians at Riverdale Mental Health Association. Along with the Early Childhood Center at Albert Einstein College of Medicine, they are among a very small number of programs in the city using relationship-based therapy with young children and their families.

Some of these programs work individually with parents and their babies; others bring caregivers together for guided playgroups. Some send therapists to work in families’ homes, while most work only in clinics or community settings. Some follow models developed at universities and demonstrated to be effective through research. Others, like Chances for Children, are homegrown programs, picking and choosing among already established best practices while tailoring interventions for individual families. All aim to reach the city’s most vulnerable babies and their caretakers: Teen moms with their babies living in foster homes; families living in homeless shelters; toddlers whose behavior their parents just can’t manage. Almost all of these families teeter on the brink of poverty or are already there. “Poverty just deprives people of the supports that make it easier to cope with the enormous demands of very young children,” Chinitz explains.

All of the programs are strength-based, dedicated to building relationships with caregivers by pointing out the positive aspects of their parenting. “We cheer on the parent

A Call for Help: Seeking Services for a Traumatized Tot

CHILD WELFARE WATCH has heard from many parents and advocates that New Yorkers seeking emotional and behavioral help for very young children are hard-pressed to find it. To see firsthand if this were true, I called New York City's hotline for mental health referrals to seek services for a 2-year-old.

I called 1-800-LifeNet and explained that a 2-year-old girl who had witnessed a violent event was having trouble sleeping, in addition to behavioral problems like tantrums and hitting. The operator sounded sympathetic. She said she thought the toddler probably needed play therapy. "But it's kind of difficult because a lot of agencies start at age 5," she explained. "There aren't a lot of services for this age."

She told me to give her my zip code and she'd see what she could find. Two locations in Brooklyn, where I live, popped up. Neither were anywhere near my home, but both worked with children under age 5. One, Kings County Hospital, did not list a minimum age requirement, but when I called they said they couldn't take children younger than 3. They suggested I try Early Intervention.

Early Intervention is by far the state's most comprehensive program for treating kids under 3, serving more than 75,000 infants and toddlers a year. The program, managed by the state and city health departments, works with toddlers suspected of having developmental delays or disabilities, or at high risk of developing delays because of "a diagnosed physical or mental condition."

In theory, the program can work with kids whose issues are behavioral and potentially rooted in trauma, like the child I called about. However, New York City's Early Childhood Mental Health Strategic Work Group—an advisory group of practitioners, researchers and others in the field—notes that in practice this is rarely the case. "It is the view of the committee," the group wrote in a 2011 report, "that it is infrequent that children are found eligible for services where social-emotional difficulties are the sole or primary basis of delay." The chair of the work group explained to me that Early Intervention professionals are not routinely trained to recognize and address trauma.

When I called Early Intervention, the receptionist confirmed that their focus was on disabilities and delays in things like talking or walking, but she suggested I go ahead and

schedule an evaluation. If the toddler did turn out to have a delay along with the behavior issues, she would likely be eligible for services. In the absence of a delay, it was not clear they could help.

The second Brooklyn referral I got from LifeNet was for the Park Slope Center for Mental Health, but the operator didn't sound too hopeful—it was listed as only serving kids 3 and older.

The childhood intake coordinator said they would work with children younger than 3, as long as the families agreed to bring the child in for weekly therapy. After the parent completes an initial intake with the center, she said, they are put on a wait list, which typically means another six-to-eight weeks before treatment begins. This is a long time in a young child's life, not to mention a new parent's.

LifeNet's final referral was for a center in Manhattan. The operator sounded apologetic about that—she knew schlepping anywhere with a tantrum-prone toddler was difficult, and something that many clinics discourage. But this was the only place on the list that specified that it served very young children.

The program, Butterflies at the University Settlement Society of New York, was a name I already knew. They are one of the city's "pockets of capacity" for infant mental health that clinicians had told me about—the programs that are often overwhelmed with referrals since there are so few of them. They are one of a handful of organizations to receive city funding for the treatment of very young children.

But when I spoke with Butterflies' director and identified myself as a reporter, I learned they would not have been able to work with the 2-year-old I described to LifeNet. Due to severe funding cuts, the program has downsized since its start in 2006. They now have just one full-time and one part-time therapist. Both spend nearly all of their time working with the children and teachers in University Settlement's Early Learn child care program, and accept very few outside clients. When they do, they prioritize local families with volatile situations, like ones referred from foster care.

Despite being booked to capacity, Butterflies' funding is not baselined in the city budget. Rather, it is on the chopping block year after year, always dependent on its funding being renewed by the City Council. —Kendra Hurley

as they cheer on the child," says Lindsey DeMichael, a therapist at the Attachment and Biobehavioral Catch-Up program for young children and their caregivers at Forestdale Inc., a Queens foster care agency. She and her colleagues visit with young children and their caregivers in their homes, following a highly-structured 10-week model developed by psychologists at the University of Delaware.

Each of these models aims to help children feel more safe and secure with their parents by increasing their positive interactions in clear and concrete ways. Therapists may try to reduce a parent's stress by finding legal help for a family on

the verge of eviction, or sending a depressed mom to a psychiatrist. They arm parents with the kind of fundamental information about child development that helped one mother understand that her 3-month-old baby could not actually be flipping her off when he lifted his middle finger, as she believed. Another mom who had been sexually abused needed help to understand that when her baby touched her breast while nursing, it was not a sexual gesture.

The bulk of the work in many of these programs involves helping parents become what Buckner of Chances for Children calls "baby watchers," parents who have a curiosity about their

child and their child's world, and who respond to their babies in a way that recognizes them as separate from themselves.

Take a situation where a father picks up his toddler son from child care and brings him to a grocery store, where the boy throws a tantrum as they wait in line. A parent who is not attuned to his child, or who is already stretched to the breaking point, might start screaming at the child. Or he might take the advice of others on the line who tell him he needs to take control and smack the child. This would likely exacerbate the situation, causing dad and child to feed off each other's anger and unhappiness. "It's a circle where everybody is bringing out the worst in each other," says Chinitz.

But a parent who reflects before reacting might try to understand why the toddler is so frustrated and even help him understand his own experience by saying something like, "I know you're very tired. We've been out all day." Relationship-based therapy tries to nudge parents to this point.

"Most kids who come to our attention at a very young age needing infant mental health care are responding to something in their caregiving circumstances, so there's very little useful work you can do with that child themselves without changing what's distressing with the caregiving situation," explains Chinitz. "We're really trying to shape the way parents respond to their children."

Championing reflective, supportive parenting, however, could be considered a mere personal or cultural preference. After all, parenting styles can differ radically among different cultures, generations, even spouses. Who has the authority to say what's the right way to parent? Complicating matters, the women running the centers and clinics that practice relationship-based therapy are overwhelmingly white, with advanced degrees, while the parents they work with are largely poor women of color. Parents in treatment sometimes find that when they bring new parenting skills back home, neighbors and family members disagree with the approach. The parents themselves frequently raise the question of whether the methods advocated by therapists are really right for their own families—families struggling to raise children with limited supports and resources, often in neighborhoods riddled with violence, addiction, unemployment and failing schools. For instance, many of the moms who come to the Early Childhood Center like to engage their children in educational activities, such as learning the alphabet. The therapists, on the other hand, prefer play for young children. Who's to say which is better?

Those in the field insist they take great efforts to stay open to these differences and remain mindful that plenty of children whose parents never get down on the play mat with them still grow up with ample love and stimulation. They say they make an effort to not be didactic, but to instead encourage parents to reflect on what worked and what didn't in the way they themselves were raised, and to experiment with new parenting techniques, like following a child's lead instead of teasing. This way parents can come to their own ideas of what will work for them

and their families. "We're really not prescribing a particular way of parenting, but trying to get parents to think about their parenting and not do things automatically, just because that's the way they were done in their families," says Chinitz. "We're not really telling them what to do so much as to get them to think about things through their kids' eyes."

Research suggests these interventions are having a positive impact. Studies have found that young children who received the Attachment and Biobehavioral Catch-Up intervention being used at Forestdale, for instance, experienced less stress and were more frequently securely attached to their caregivers than children who received a different intervention. In a peer-reviewed, control group study, Chances for Children found that

"Trauma in early childhood doesn't look like trauma to people who don't know what they're looking at. It can look like a behavior problem. It can look like bad parenting. It can look like neglect."

infants who had received its intervention showed an increase in interest in their mothers and responded more positively to physical contact, compared to another group of infants who did not participate in its program.

Another model, known as Child-Parent Psychotherapy, has been demonstrated to be effective and replicable through high-quality evaluation research and is thus widely recognized as an "evidence-based" program. It is one of the most influential models and is used in many clinics nationwide that do relationship-based work with young children. In New York, it is used at the Jewish Board of Family and Children's Services' (JBFCs) Institute for Infants, Children & Families, and is slated to soon be used by the Association to Benefit Children in Manhattan and the Jewish Child Care Association in Brooklyn to help families stay out of the foster care system. Among the findings: Children aged 5 and younger who had witnessed domestic violence and received this intervention



Franchesca Davis and her daughter took part in a dyadic therapy program for families involved in Family Court.

What Works: Characteristics of Effective Programs for Infants, Toddlers, and their Caregivers

HOW CAN A PRACTITIONER tell which programs are most likely to make a positive difference in the lives of children and their families?

In *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform*, five researchers attempt to answer the question. They examined programs that have been demonstrated through research to be effective and identified the characteristics commonly found among those programs. Programs that work for young children, they discovered, frequently have these characteristics:

- They are active and experiential rather than didactic; caregivers learn through doing and experimenting rather than simply through instruction.
- They are relationship-based, focusing not just on the child or caregiver, but the relationship between them.
- They address mental health issues and are led by skilled, professional staff.
- They are long-term, preferably lasting six months or more, and are delivered on a weekly or bi-weekly basis.
- They are often evidence-based, meaning they've been demonstrated to be effective through rigorous evaluation.
- They target a specific type of parent, such as one struggling with addiction or mental health issues, but tailor services to meet each individual family's needs.
- They take advantage of the window of opportunity just before and after a baby's birth when parents are especially receptive to help. Rahil Briggs and Andrew D. Racine explained the clinical significance of this moment in *Infant Mental Health Journal*: "Even in the most at-risk families, with previous histories of neglect or abuse, each new baby appears to present a brief opportunity to 'do it right this

time around! There is often a sense of hopefulness, rather than the hopelessness which sets in all too soon in our most stressed and underprepared families."

The California Clearinghouse for Evidence-Based Practices for Child Welfare is a good place to learn about specific therapies that work with caretakers and young children together, and that have been demonstrated through research to work well for families. These include:

- Child-Parent Psychotherapy, which has been found in peer-reviewed research to strengthen the attachment between infants and mothers, and to reduce symptoms of traumatic stress disorder and behavior problems in young children exposed to violence.
- The 10-week Attachment and Biobehavioral Catch-up program, which has been demonstrated to help young children experience less stress and become more securely attached to their caregivers than children who received a different intervention.
- Interaction Guidance, which uses videotaped interactions between children and caretakers to reinforce positive interactions and help caregivers learn about infant behavior and development. It has been found to improve mother-child interactions.

To learn more about programming that works, visit the California Clearinghouse for Evidence-Based Practices for Child Welfare (<http://www.cebc4cw.org>) and see *Beyond Common Sense: Child Welfare, Child Well-Being, and the Evidence for Policy Reform* by Fred Wulczyn, Richard P. Barth, Ying-Ying T. Yuan, Brenda Jones Harden and John Landsverk, published in 2005 by Aldine Transaction.

had a greater reduction in behavior problems and traumatic stress syndromes than those in a control group.

A Dearth of Government Support for the City's Youngest

In the 1990s, the philanthropist Irving Harris, who helped JBFCFS create a training program around infant mental health, made a prediction: In 20 years, the country would recognize the urgency of addressing infants' social and emotional needs, but there would not be a trained workforce of leaders able to rise to that challenge.

To many in the field, Harris' prediction has come to seem prophetic. Brain scan technology has turned the abstract notion that early childhood experience has immense influence into something concrete: We can now see that an abused child's brain can look and behave differently from the brains of other children. But despite the growing aware-

ness of the developmental importance of early childhood, New York City has yet to develop a systematic response to the emotional and social needs of babies and toddlers. The city and state health departments manage the Early Intervention Program, which funds services for children under age 3 who are at risk for or who have developmental delays. In theory, the program can work with small children on social and emotional issues, but in practice, it is not designed to address the impact of trauma.

The city has a handful of centers and clinics that some in the field describe as "little pockets of capacity" to work with young children, but few provide the kind of long-term dyadic therapy that the Early Childhood Center or Chances for Children provides. "There are really not treatment slots for young children, particularly children who are the most vulnerable, kids who need intensive services," says Evelyn Blanck, associate executive director of New York Center for Child Development and chair of the New York City Early

NEW YORK STATE AND CITY FUNDING FOR EARLY CHILDHOOD MENTAL HEALTH

Following is a list of all city and state funding for early childhood mental health services that *Child Welfare Watch* was able to identify. This does not include federal funding, such as Medicaid, or three federal grants that have been awarded to ACS, the Child Study Center at NYU Langone Medical Center, and Bellevue Hospital to support programs assisting NYC children with mental health needs, including some mothers who have experienced trauma and who are parenting children 5 years old and under. Nor does this chart include the city and state-run Early Intervention Program for children with disabilities and developmental delays.

FY 2012-13:

| Source of Funding | Funding Amount | Early Childhood Services | Agency/Program |
|---------------------|----------------|---|--|
| City Council | \$200,000 | Social emotional screening and trauma screening; Parental depression screening; Mental health consultation to staff; Mental health treatment, where indicated, to families | Safe Space |
| City Council | \$200,000 | Social emotional screening; Parental depression screening; Mental health consultation; Social emotional training to staff; Mental health treatment (dyadic therapy) | University Settlement |
| City Council | \$75,000 | Mental health consultation and training; Family workshops | JBFCs |
| City Council | \$100,000 | Social emotional screening; Maternal depression screening; Mental health treatment (psycho-education and supportive counseling) | OHEL Children's Home and Family Services |
| City Council | \$100,000 | Social emotional screening; Maternal depression screening; Social emotional training to staff (home visiting); Parent training (Parent Corps) | Child Center of New York |
| City Council | \$60,000 | Mental health consultation to staff; Mental health treatment | Staten Island Mental Health Society |
| City Council | \$400,000 | Social emotional screening; Maternal depression screening; Mental health treatment (dyadic therapy); Parental visit coaching (child welfare); Mental health consultation (family court; early care and education) | Albert Einstein College of Medicine's Early Childhood Center |
| City Council | \$100,000 | Trauma screening; Training on trauma | Safe Horizon Counseling Center |
| NYS OMH / NYC DOHMH | \$400,000 | Social emotional screening; Mental health consultation | New York Center for Child Development (NYCCD) |

NEW, KNOWN FUNDING FOR FY 2014:

| | | | |
|------|-----------|---|--|
| OCFS | \$131,500 | Mental health consultation (Manhattan family court); Mental health treatment (dyadic therapy for court-involved families); Intensive reunification and placement planning (child welfare) | Association to Benefit Children in Manhattan and Jewish Child Care Association |
| ACS | n/a | Mental health treatment (dyadic therapy) | University Settlement |
| ACS | n/a | Low intensity treatment | CAMBA |

Childhood Mental Health Strategic Work Group.

Last year, an analysis by the Citizens' Committee for Children estimated that nearly 47,500 New York City children ages 4 and under have a behavior problem as defined by the American Psychiatric Association, which includes diagnoses such as hyperactivity or oppositional defiance disorder. But at the state-licensed mental health clinics in Brooklyn, the Bronx and Staten Island, there were treatment slots for only 270, or 1 percent, of those children. (They couldn't identify the unmet need citywide, due to the lack of data for Queens and Manhattan.) The analysis found treatment slots to be especially lacking

in the community districts needing them most.

Those in the field say that a large part of the problem is that the level of state and city funding has been inadequate for a long time and isn't getting any better. "Relatively few public dollars are targeted to mental health services for New York's youngest children," the Early Childhood Mental Health Strategic Work Group wrote in 2011.

Ten years ago, Chinitz set out to change this. The Early Childhood Center was inundated with referrals for struggling young children. The city's children who had been born at the height of the crack epidemic were rapidly becoming parents

themselves, and many had been abandoned by their families and grown up in foster care with few models for how to parent.

Five of the infants that the Early Childhood Center worked with at the time had each witnessed their mother's murder. A number of the toddlers and young preschool children had been sexually abused. Many young children in their clinic had bounced from one foster home to another or had been kicked out of child care centers and preschools because their behavior was so difficult to manage. Then there were the referrals the center could not accept, because they simply did not have the resources. Chinitz believed that waiting until these children were 5 or 6—an age for which there are far more services available—was wasting valuable time.

So she began leaving the clinic each day to knock on the doors of power, making impassioned pleas for government officials and policymakers to invest in the field. She spoke about the aggressive and hyper-vigilant toddlers who had witnessed street shootings or seen their mothers beaten by their fathers or their mother's boyfriends. She spoke about young children in foster care who had not had an opportunity to form an attachment with a trusted adult. She talked about the impulsive and irritable children, whose stressed, sometimes depressed mothers struggled to manage.

Sometimes she referenced the Nobel prize-winning economist James Heckman, who has demonstrated how investing in effective early childhood interventions can yield huge cost savings for society. According to Heckman, there is a steep decline in these savings even by the end of a child's third year of life. "The longer society waits to intervene in the life cycle of a disadvantaged child, the more costly it is to remediate disadvantage," Heckman wrote. "Gaps in development open up early and are extremely difficult and expensive to close."

In 2004, then-City Councilmember Margarita Lopez took heed. She organized a hearing and pressed for funding for a handful of early childhood programs. This led to an important recognition among the city's child-serving mental health clinics. Previously, most everyone assumed these clinics could not serve children under age 5. But Lopez helped clarify that this was not the case, and made these clinics aware that they could amend their licenses to treat children of all ages if they were not already authorized. Nonetheless, the larger problem still lingered, as Harris had predicted: Most clinics lacked the expertise to do dyadic work with young children and their caretakers.

Today, nearly 10 years after Councilmember Lopez responded to Chinitz's pleas, not a lot has changed. Few clinics can work with babies, though how many no one knows for sure because the state's Office of Mental Health does not keep track.

In the last few years, the Office of Mental Health has begun funding nine agencies in New York City to screen for early childhood mental illness. This screening does not provide money for treating the children or training people to provide the interventions. "We are going to identify all these people

who need services, but with no money to train, where will they get served?" asks Dorothy Henderson, director of early childhood trauma services and associate director of training at JBFC's Institute for Infants, Children & Families. "There's not a lot of people who can work with babies."

During the recession, JBFC had to close the training program Irving Harris had helped start, which had produced many of the city's infant mental health leaders. Meanwhile, the City Council has remained one of the only sources of government funding for early mental health treatment. That funding, which also covers services like screening and evaluating, has decreased from its height of over \$1.6 million about five years ago to the \$1.25 million to be distributed among eight organizations in fiscal year 2014, and the money is at risk of disappearing each year. Meanwhile, most mental health initiatives serving children under 5 rely on private funding and negotiating creative ways to get Medicaid to pay for dyadic work.

Some in the field say a large part of the funding challenge is the misperception that little children are immune to their surroundings, including stress and trauma. "Trauma in early childhood doesn't look like trauma to people who don't know what they're looking at. It can look like a behavior problem. It can look like bad parenting. It can look like neglect," says Bonnie Cohen, director of the University Settlement's Butterflies Program, which provides early childhood mental health services.

But Joaniko Kohchi, a child development specialist at the Early Childhood Center, believes infants get routinely overlooked because they can't do harm. "Mental health, in general, people don't want to talk about unless they have to, and they only have to when someone is dangerous," says Koachi. "Little babies don't scare people. They don't need to be incarcerated."

Franchesca Davis counts her daughter Haylee among one of the lucky ones to have benefited from the advocacy efforts. About a year after Davis lost custody of 9-month-old Haylee, the two began receiving therapy tailored for families involved in Family Court. Just 19 years old, Davis had always known she didn't want to punish Haylee by hitting her, the way she herself was raised, but she didn't have a clear idea of how she did want to parent.

Relationship-based therapy has helped her figure it out. Today Davis shares custody of Haylee, now 4, with the girl's father, and Haylee lives in Davis' apartment three days each week. Davis still remembers how strange it felt the first time she sat down to play with her daughter at the Early Childhood Center. It was just the two of them, with nothing in between them. At home, the baby usually stayed in the crib, with the TV on. Now, when Davis watches that first video of them playing before they received dyadic therapy, she shudders—you can tell she and Haylee have a bond, she says, but she seems so cold with her daughter, so bossy. Yet in the final video ECC made of the pair, "We're like kids in a candy store. We were together in unison." ❀

Seen and Heard

A video-feedback parenting program helped my son and me.

BY PIAZADORA FOOTMAN

MOST PARENTS WHOSE children enter foster care have to take parenting classes in order to get their children back. I went to two parenting classes that didn't help before I found a program that worked for me.

The ones that didn't help were the ones where the instructor read to us from a big parenting skills book or played old videos of moms trying to get their kids to listen. Then the instructor would say, "Ok, what did you learn?" or just, "Hey, use the skills you saw today in this video."

I'd sit there thinking that the strategies didn't apply to my son. The book would say to put your kid in a time out if he acted out, but when I tried time out with my son, it only made him angrier. When I told the instructor that, she just said, "Keep trying." I felt defeated, like a failure.

At the time, my 5-year-old son was living with my grandmother because I'd been arrested and then placed in a mental health facility for 18 months. By the time I moved back home, I'd overcome an addiction and was managing my bipolar disorder. Xavier was about to come back home and I felt overwhelmed because we still didn't have that mother-son respect level. I wanted it to be that I spoke to my son once and he would listen, period, end of story. But Xavier was not listening the first, second or third time I told him to do something. I had to understand that that's not quite how kids are.

Eventually the court sent me to a different kind of parenting program, a video training at a program in the Bronx called Chances for Children. Each week, they took video of me playing with my son and then the therapist discussed it with me. At first I felt like, "Ugh, I don't want to be here. It'll just be a repeat of the last two classes." But it was different. With the video, I got to see the problems between my son and me from a different point of view.

During our video sessions, Ms. Martha would have Xavier and me play on the carpet with different toys. In the middle of the session, she'd stop the tape to show me what she noticed. She said that it was good that I even wanted to play with my son, and that she could tell that we normally play with one another. She also noticed that when we were coloring, Xavier longed for my approval of his picture. Ms. Martha

told me this meant Xavier cared about what I thought, which is a sign of a mother-child bond.

Ms. Martha also showed me how I was frustrating Xavier by moving too fast from toy to toy. I kept changing the toys because I was bored with them instead of waiting for him to finish. This would make Xavier upset. He would try to get the same toy again. I thought Xavier was too young to understand playing. I wanted to teach him how to follow instructions so he could play with his toys how they were meant to be played with. I didn't understand his way of playing, that it didn't matter if he followed the instructions if he was enjoying himself.

It was hard to watch the first day's video. When I saw myself pressure Xavier into playing with a new toy because I was tired of playing with the old one, I felt like I was being a bully, not a mom. But after that session, I felt amazed. Ms. Martha had already helped me understand why my son got frustrated when we played together; he was unable to finish tasks that he started. Martha told me it was OK if Xavier stayed on tasks a little longer than I preferred.

At first, when I tried to follow Ms. Martha's advice at home, it was a disaster. Xavier took so much time to play that he didn't want to stop to eat or take a bath or do anything that he wasn't ready to do! At our next session, I told Ms. Martha that I could not just simply let him play as long as he wanted. We had things to do besides play!

She told me about the egg timer approach. I would set the egg timer to go off 10 minutes before I wanted Xavier to do a different task. The countdown helped Xavier understand that playtime was almost over. At home, the egg timer approach didn't work immediately, but eventually it worked so well that I just gave Xavier early warnings and we gave the egg timer a rest.

From our video parenting sessions, I learned that Xavier needed me to be more patient with him and to hear him out. I also felt like he began to understand that when I gave him warnings that it was time to stop playing, he had to listen.

The biggest change was in my thinking. When my grandmother raised me, she acted like children should have no say-so, no thoughts, no feelings and, point blank, no voice. When Xavier was young, I found myself inhabited by my grandmother's ghost. I treated Xavier the same way.

The video parenting helped me realize that kids have their own minds and have real feelings too. Now that I've acknowledged that children are human just like me, I can talk with them instead of demanding. When I first went to the video parenting, I just wanted to get Xavier to listen to me. From our experience, I learned that I needed to listen to him, too. ✕

Piazadora Footman is 28 years old with three children, ages 12, 8 and 4. She is a graduate of Child Welfare Organizing Project's Parent Leadership/Advocate curriculum and the editorial assistant at Rise, a magazine written by and for parents in the child welfare system, where a version of this article first appeared. The latest issue of Rise focuses on the impact of trauma on parenting.



THE CONTEXT:

In recent years, scientists have begun to understand how children's earliest experiences shape the way their brains grow.

THE ISSUE:

Can science help us prevent—and recover from—the damage caused by stress and trauma in childhood?

The Science of Trauma

Together, behavioral psychology and neuroscience are reshaping our understanding of the damage caused by trauma in early childhood—and how good parenting heals the wounds.

BY ABIGAIL KRAMER

Fifteen years ago, a clinical psychologist named Philip Fisher and his wife applied to the State of Oregon to adopt a 2-year-old boy. Fisher had been working with older kids for many years, mostly in psychiatric treatment programs for youth whose behavior problems had gotten them into serious trouble. Fisher believed in his work—he'd seen that, in the right environment, kids could begin to exorcise demons that had plagued them, in some cases, since before their conscious memories began. But he was disturbed by the feeling that more could have been done if the children had been treated at a younger age. "There aren't many late starters in juvenile delinquency," he says. "Parents always said things would have been different if they had gotten help early."

AS HE WADED through the bureaucracy of his own son's adoption, Fisher's professional concerns collided with his personal life. The proceedings dragged on for nine months—a developmental lifetime compared to the speed at which a toddler grows and learns, adapting to the turbulence that is inherently part of foster care. Fisher worried that he was missing a crucial window of opportunity to impact the course of his child's life.

As it turned out, the nature of that developmental window (how it works, why it matters, how to influence it for the best) was the central concern of a newly burgeoning field of science—one that was, back in the late 1990s, just beginning to unriddle one of the fundamental mysteries of childhood: how the things we experience when we're very young—even when we're too young to remember—affect who we become later in life.

Child psychologists (along with most of the rest of us) have long understood that there's a connection between traumatic childhood experiences and poor life outcomes. "There's been a recognition for at least a century that children who are neglected or abandoned are at risk of problems," says Jack P. Shonkoff, M.D., director of the Center on the Developing Child at Harvard University. By the time Fisher filed his adoption request, studies had documented enduring links between stress and trauma in childhood and a long list of problems later in life, ranging from mental illness to obesity to cancer.

Until recently, however, scientists had little insight into how those links worked—or how early in life they can form. "The predominant belief," Shonkoff says, "was that if really bad things happen when children are very young, if you can get them out of those situations early, either they won't really know what's going on or they won't remember. There was a general belief that things that happen to very young children can't affect them years later."

Over the past decade and a half, Shonkoff, Fisher and a scattered constellation of researchers across the country have proven that belief wrong, engendering a very new understanding of what children need and how they grow. They have begun to look under the hood at the mechanics of development, revealing how early experiences—especially those involving trauma and chaos—get built not just into children's minds but their brains and bodies. It's a relatively young line of inquiry, but its breakthroughs have come about, in large part, through the crossbreeding of two long-established strains of thought: that of behavioral psychology—a field that accumulates its knowledge mainly through observation and self-reporting—with the bloodier science of animal brain development.

For several decades, neurobiologists have subjected animals like rats and rhesus monkeys—mammals whose brains grow in patterns remarkably similar to our own—to experiments designed to trace the impacts of psychological trauma

early in life. One frequently repeated experiment has been to traumatize baby rats by separating them from their mothers and siblings for significant periods each day. After weaning, the rats are not only likely to be cognitively impaired—less able to learn, remember and solve problems than other rats—but they exhibit behaviors that mirror mental illness in humans, like anxiety, depression and an unhealthy penchant for ethanol.

When scientists examine the rats through adolescence and adulthood, they find that the psychological problems are matched by an array of physiological abnormalities, the sum of which converge on a rather astonishing finding: The rats' experience of trauma early in life literally changes the way their brains develop, altering hormone function and stunting growth in areas that are essential, in humans, to thinking, remembering and controlling emotions.

Scientists at Shonkoff's research center explain the phenomenon through the metaphor of architecture: Infant brains (whether they belong to rats, monkeys or people) are genetically programmed to grow and make connections in response to experience. When babies' environments are healthy, their neural connections grow sturdy and effective, providing a strong foundation for future learning and development. When they are exposed to repeated stress, the effect is toxic, weakening brain growth in ways that can do permanent damage.

The ongoing challenge for child development researchers is to decipher the blueprints—to find out which experiences matter and trace the pathways by which they do harm. It's a project with tantalizing prospects—a kind of neurological treasure hunt that promises clues not just to further our understanding of brain development but, in its furthest extrapolation, to decode the enigmatic connection between biology and character. If we could better understand the physiological legacies of our experiences, might it be possible to map our personalities—even, to some extent, our destinies—onto a network of chemical pathways and neural wiring? How does adversity change who we are? How do our environments mark and define us? To what extent are we trapped by our pasts, and how do we understand the potential to overcome?

It's a body of questions with profound implications for our approach to early childhood. In the longstanding debate over nature versus nurture, says Jack Shonkoff, "the 'versus' is scientifically dead." In its place, he argues, these investigations charge us with a renewed imperative to fulfill one of the basic obligations of a social contract: improving the conditions in which children and their families live. "You put up a brain scan and people get excited," Shonkoff says. "Oh my god, this is real!"

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Human babies are born with approximately 100 billion neurons, each connected to thousands of others through an

Each experience a baby is exposed to—everything she sees, every song she’s sung, every time she’s held or fed or smiled at—sends a series of electrical impulses shooting through the developing circuits of her brain.

immensely intricate network of chemical pathways called synapses. Each experience a baby is exposed to—everything she sees, every song she’s sung, every time she’s held or fed or smiled at—sends a series of electrical impulses shooting through the developing circuits of her brain, strengthening pathways and inciting new synapses to grow. During the first few years of life, that growth happens exponentially. At its peak, the cerebral cortex region of an infant’s brain can produce two million new synapses every second—a warp-speed neural spider web that sets the parameters of a person’s capacity to think, learn and process emotion. Connections that are stimulated consistently over time will grow stronger. Others will weaken and die.

The raw materials of brain development are predetermined, encoded in the 23,000 genes we inherit from our parents. But the way those genes behave—whether they live up to their potential—is determined in large part by the inputs we get during the first few years of life.

Since the 1970s, psychologists have posited that the key ingredient to a child’s development is her emotional attachment to her caregivers. As babies, the idea goes, we depend on adults not just to make sure we’re fed and clothed, but to respond to our cries, our facial expressions, our inquiries about the world and our attempts to connect. Behavioral researchers are fond of quoting the psychologist Urie Bronfenbrenner, famous for founding the Head Start program for low-income preschoolers. “In order to develop normally,” Bronfenbrenner wrote, a child needs to interact with “one or more adults who have an irrational emotional relationship with the child. Somebody’s got to be crazy about that kid.”

Attachment theory has reigned as the dominant philosophy of child wellbeing for close to half a century. The trouble with hypotheses about behavioral psychology, however, is that they are difficult to test. In order to isolate the impacts of nurturing parenting, researchers needed the chance to study a control group—in other words, a large group of kids who never got to be nurtured. That opportunity arose with the fall of the Socialist Republic of Romania, when Western scientists discovered Romanian orphans.

In the mid-1960s, Nicolai Ceausescu, the Stalinist leader of Romania, invoked a series of laws designed to increase his country’s human capital by forcing up its birthrate. He outlawed contraception and abortion, subjected women to compulsory fertility tests and taxed families that produced fewer than five children. Childbirth shot up, as did poverty. The state was obligated to create hundreds of institutional orphanages to care for babies whose parents didn’t want or couldn’t care for them.

When Ceausescu was deposed in the 1989 Romanian Revolution, nearly 170,000 children were living in state institutions that Western reporters, newly allowed into the country, described as being more like warehouses than orphanages. Babies and toddlers spent day and night in rows of cribs, removed only to sit on pots they used as toilets. They were rarely held and had almost no one-on-one interaction. The buildings were mostly silent.

Thousands of Romanian orphans were taken into homes in the United States, where adoptive parents discovered that, despite the drastic change in their circumstances, many suffered from severe and persistent problems. A significant number had stunted growth or abnormally small heads. Many were cognitively impaired or had behavior disorders and extreme difficulty engaging in relationships. For some kids, some of the problems dissipated over time; others proved more stubborn.

In 2000, a team of American neuroscientists traveled to Romania’s capital, Bucharest, to study children in its orphanages, which remained the country’s default form of care for orphans and unwanted kids. Starting with a group of 136 children, aged 5 months to 2.5 years, the scientists ran tests to measure cognitive and emotional development, then compared the results to a group of same-aged Romanian children who lived at home.

In every domain, the researchers found evidence that institutionalization had done tremendous damage. Kids in the orphanages showed diminished electrical activity in their brains, slower neural reactions and weaker connections between areas of the brain that integrate information. Their

cognitive scores were at a level associated with mental retardation. They demonstrated almost no attachment to their caregivers and, when researchers tried to engage them with activities like peek-a-boo or puppet shows, no ability to experience amusement or joy.

The researchers assigned half the children to specially trained Romanian foster parents, leaving the other half in institutions. Over the next several years, they ran developmental tests aimed at finding out if, when and how the children's

“We’re not well adapted for the kind of chronic, persistent stress that can happen when parents are drug abusing or mentally ill.”

trajectories diverged. What would change when terribly neglected babies began receiving individualized care? Could the damage be undone?

The answer turned out to be both yes and no. At 30 months, the children who had been moved into foster homes showed a capacity to express positive emotions that was indistinguishable from children who had never been institutionalized. After a year of foster care, they matched the expressive and receptive language skills of children in the community control group, though their grammatical abilities remained low. By 54 months, their average IQ score had risen by about seven points—still much lower than that of kids who had never been in orphanages, but an improvement over children who had remained there. The latter group's average score dropped by one.

There was one area, however, in which foster care made almost no difference. All of the institutionalized kids—those who had been moved into homes as well as those who remained—were diagnosed with drastically higher rates of depression, anxiety, ADHD and conduct disorders than children in the community control group. At 54 months old, more than half were found to have a diagnosable psychiatric illness.

In a 2009 paper on their findings, the Bucharest Study researchers noted that the children's impairments—and im-

provements—were not evenly distributed: Kids who had been moved into families before the age of two made significantly more progress than those who moved when they were older. “Our results,” the researchers wrote, “strongly support intervention at earlier ages.”

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The lesson of the Bucharest study was rare in its lack of ambiguity: The absence of parenting is disastrous to babies' development.

But it's also a finding that begs to be turned upside down. For people who work with traumatized children and their families—especially in the child welfare system, with its mandate to decide the slippery question of when caregivers are good *enough*—the most relevant question is the degree to which good parenting can help. To what extent can the presence of an involved caregiver protect a child's brain from the harm caused by early stress and trauma? Which practices help children develop, and which don't?

An important clue seems to be hidden in the function of a stress-related steroid hormone called cortisol. When human beings encounter a threat, our brains launch an intricately choreographed, nearly instantaneous response designed to muster our metabolic resources to fight or to flee. Jolts of electricity shoot from the sensory organs, through the limbic system to the hypothalamus, a cluster of neurons nestled near the root of the brain stem. The hypothalamus triggers the pituitary and adrenal glands, which deluge the bloodstream with chemical signals that incite our hearts to pump faster, our airways to open and our glucose levels to rise. Cortisol is both the end product and the regulatory agent of the stress-response cascade, instructing the body either to relax or remain vigilant to danger.

Cortisol is indispensable, should you find yourself facing a stranger in a dark alley or the more abstract menace of a looming deadline at work. But it is markedly less useful for coping with the grinding, long-term stress that results, for example, when a child's family falls apart. “These systems were designed by evolution to deal with much more immediate situations,” says Philip Fisher, the University of Oregon psychologist. “We’re not well adapted for the kind of chronic, persistent stress that can happen when parents are drug abusing or mentally ill. In evolutionary terms, there wasn't a lot of survival... somebody takes over the parenting or the infant dies.”

In studies of children's stress-response systems, cortisol is often used as a marker of things gone awry. Under normal circumstances, both children and adults have regular, predictable patterns of cortisol production: We wake up in the morning with high levels, which decrease steadily throughout the day. When we encounter a stressful situation, our cortisol levels spike, then—if our systems are healthy—quickly return to baseline. When children's brains are exposed to cortisol too of-

ten and for too long—either because of traumatic experiences like neglect and abuse or simply because they absorb the atmospheric stress that so often tailgates intractable poverty—it can alter the structure of the genes that control hormone production, disrupting the stress-response system in one of two ways: Either children’s cortisol production becomes hypersensitive (quick to turn on and stubbornly resistant to being shut down), or it becomes chronically dampened, producing abnormally low levels of cortisol to start the day.

In a particularly damaging corollary, prolonged stress seems to stunt growth in parts of the brain that have large numbers of cortisol receptors. This includes the prefrontal cortex—a region most closely associated with a set of skills known collectively as ‘executive function.’

Executive function is not the same as intelligence, but it encompasses abilities that are crucial to learning, such as the power to control impulses, to shift attention from task to task, and to manipulate information in the short-term. Children living in poverty regularly score lower on tests of executive function than wealthier kids. Many scientists think the cause is exposure to ambient stress.

In 2002, a team of researchers in Pennsylvania and North Carolina launched a study designed to untangle the relationship between poverty, stress and brain function. Starting with a cohort of nearly 1,300 babies, they ran periodic tests until the children were 3 years old. First, they measured stressful conditions such as family crowding and the noise level and safety of babies’ homes and neighborhoods. Then they subjected the babies to briefly stressful situations, such as taking away a toy or repeating the child’s name while wearing a strange mask. Before and after each experience, the researchers took saliva samples to measure the babies’ production of cortisol.

As with previous studies, the researchers found that kids who lived amid greater levels of poverty and chaos were likely to have disrupted cortisol patterns, and that these kids did worse than other kids on measures of executive function. But the study also tested a potential mitigating factor: the relationships between babies and their mothers.

At each visit, researchers videotaped mothers interacting with their children. They then coded the videotape, rating mothers on qualities such as sensitivity, animation and the positive regard they expressed for their babies. What they found was that when mothers were rated as being particularly responsive and nurturing, their babies’ cortisol patterns were much more likely to be normal, regardless of whether they lived in poverty or chaos. Even in the cases where babies’ cortisol patterns were irregular, those with responsive mothers were likely to score higher on tests of executive function. In other words, having a nurturing mother almost completely mitigated the developmental damage that, in other children, correlated with stress.

In a 2011 journal article, the study’s authors posed a series of questions about their findings. “It is not clear,” they

wrote, whether particularly responsive mothers were affecting their babies “through a tactile and kinesthetic nurturing process” or through more contextual practices “such as structuring of opportunities and appropriate levels of stimulation.” It’s even possible, they suggested, that the behaviors they measured simply coincided with other markers of involved parenting, like exposing children to new situations.

Whatever the operative mechanism, the study was among a growing number that point to the good-news flipside of this research on trauma and development: Stressful environments are damaging to children’s growth, but committed caregivers have the power to protect them. Damage, in other words, is not a foregone conclusion.

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The question, for Philip Fisher, is how to make that good news relevant to kids whose relationships with their parents have already been disrupted.

Once his toddler’s adoption finally went through, Fisher found himself in the disorienting position of a service provider who has become in need of services. “Although the placement process was difficult,” he says, “the adoption went really well initially and we were very happy.” As his son approached ado-

Having a nurturing mother almost completely mitigated the developmental damage that, in other children, correlated with stress.

lescence, however, he started to struggle. Fisher realized that his family fell into a kind of social services hinterland. Few of the people traditionally designated to help troubled kids and families (grateful though he was for their support) understood the needs of children who had experienced the displacement of foster care or adoption. On the other hand, people who worked with families in the child welfare system—those in the best position to impact foster children’s developmental health—largely reserved their attention for older kids.

Working with researchers at the Oregon Social Learning Center, a think tank that develops service programs for kids

and families, Fisher set out to create a new model for providing foster care to preschool-aged children—one that would protect them, at least in part, from the long-term damage caused by trauma and stress. The goal was to isolate what scientists had learned about the benefits of responsive parenting—those practices that had proved most likely to protect children from developmental harm—and inject them into relationships that are, by definition, temporary.

The better we understand how children grow, the more possible it will become to sever the link between traumatic childhoods and chaotic adulthoods.

Under Fisher's program, which goes by the unwieldy name of Multidimensional Treatment Foster Care for Preschoolers, or MTFC-P, foster parents undertook a training program that emphasized a preschooler's need for structure, consistency and nurturing. They learned strategies to address negative behaviors, but were instructed to mete out approval much more frequently than punishment, and to respond readily to children's attempts to connect. The program also provided a great deal more assistance than is typically available to foster parents, including weekly support groups and home visits from a child development consultant. Kids in the program attended weekly therapeutic playgroups and worked one-on-one with a therapist if they showed evidence of developmental delays. Program staff were available 24 hours a day to troubleshoot any problems.

Fisher and his team tested the model with a group of 117 foster children in rural Oregon. Half were placed in standard foster homes; half went to foster parents who had been trained in Fisher's program. The researchers compared their outcomes to a community control group of low-income, preschool-aged kids who lived with their parents.

Over time, as might be expected in a program with so many supports, kids in the MTFC-P homes did better than kids in regular foster care by all the standard measures of child

welfare success. They moved between foster placements less frequently. When they went home to their parents, they were less likely to come back into the system. And when they were adopted, the adoptions were more likely to last.

Far more revelatory was what happened when researchers measured the children's stress-response systems. At the beginning of the study (and like foster kids in previous experiments), children in care were much more likely than other kids to have abnormal cortisol production. Nearly one-third came into the study with what Fisher describes as a 'blunted' pattern, starting off with low cortisol in the morning and experiencing a much smaller than normal decrease through the day.

As the study progressed, cortisol production among the children in traditional foster homes became even more abnormal. Their mean level of morning cortisol dropped by close to 30 percent, so the pattern became significantly more blunted over time. Meanwhile, morning cortisol levels among the children in the MTFC-P homes rose. By the end of the study, their cortisol production was indistinguishable from children in the community control group.

Fisher explains that much of what happened during the study remains mysterious. Scientists don't fully understand how or why cortisol patterns change, or even precisely what the changes mean for a child's long-term development. What was clear, however, was that something about the MTFC-P foster homes allowed very young children to reverse damage that had been caused by turmoil in their lives. Given the right training and support, caregivers were able to nurture children who then regained a measure of health. "It shows that plasticity works both ways," Fisher says. "It's not just that we say, 'bad things produce bad outcomes.' If we can maintain the right circumstances, things can get back on track."

In that sense, the premise of the model reflects that of the science that informs it. It rests on the hope that the better we understand how children grow, the more possible it will become to sever the link between traumatic childhoods and chaotic adulthoods. For the most part, chronically stressed children don't grow in isolation. They develop in the context of overtaxed families and of communities made unstable by poverty, violence, illness and incarceration. The science of infant development promises hope that we can wipe the slate a little bit cleaner—that if we are willing to build the skills of children's caregivers and to ease some of the burdens that limit their ability to provide responsive, nurturing care, it might be possible to loosen the grip of the past on the future. Fortunes can be reversed; children freed to reach their potential.

"Obviously there are going to be limits depending on how severe a child's experiences were," says Fisher. "You can't take a child that's experienced extreme deprivation and make everything hunky dory for them, but you can improve their trajectory. And for children who've experienced less severe adversity, there's potential to make things move in a really solid direction." ❀

Babies in Foster Care

Are they getting the help they need?

BY ABIGAIL KRAMER

EVERY YEAR, BOTH in New York City and nationwide, more babies under 1 year old are placed in foster care than kids of any other age. Even before they come into the system, many of these babies have lived tumultuous lives. According to national studies, more than 40 percent of infants who end up in foster care were born with low birth weight, prematurely, or both. Many were prenatally exposed to drugs. Some were neglected or abused. Unless they were taken into care directly following birth, they were separated from the caregivers and homes they knew.

Once these babies are in foster care, their lives don't necessarily become more stable. By nature, the system is often disruptive and slow to find kids a permanent home. Children may move from placement to placement, making and breaking bonds with caregivers. Medical records are lost; court dates are postponed. Even when the plan is to eventually return home, children may see their parents as infrequently as twice a month—a glacial pace, in baby time.

Research on child development suggests that turmoil and disruption at the very beginning of life can put babies at risk of long-term harm. There's no comprehensive data on mental health problems in foster care, but scattered studies have found that anywhere from 20 to 60 percent of foster kids under age 5 have significant developmental delays. That's compared to a rate of 4 to 10 percent among children in the general population. Other studies have found serious behavioral problems among 25 to 40 percent of foster children under age 6—a rate that's about eight times higher than estimates among kids in general.

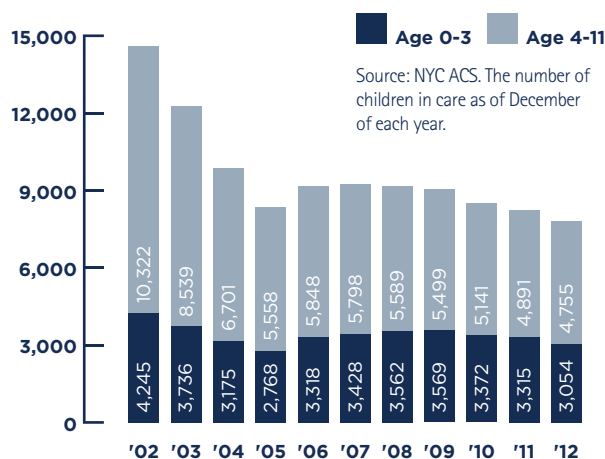
For years, experts in early childhood development have called on child welfare systems to rethink how foster care works for infants and very young children—not only to reduce the turmoil they experience in the system, but to implement strategies that deliberately improve babies' developmental trajectories. “We have a much better chance of having a healthy, happy person if we can intervene with a 7-month-old than a 17-year-old,” says Sheryl Dicker, an assistant professor of pediatrics at both the Albert Einstein College of Medicine and the City University of New York.

The challenge, says Dicker, is that in the perpetual scramble for scarce resources and limited attention, infants are easy to ignore. “A teenager can cause you trouble or show up at your doorstep,” Dicker says. “There's a sense that babies are portable and easy.”

Just over a decade ago, Dicker led a special effort by the New York State court system to start moving babies through

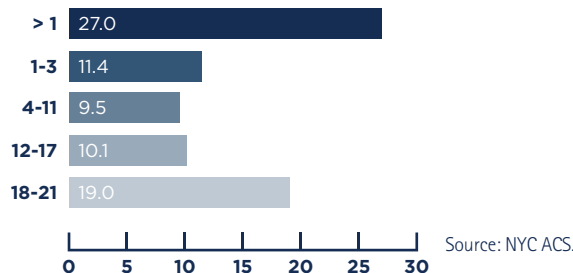
NUMBER OF CHILDREN AGED 0 TO 11 IN FOSTER CARE, BY AGE GROUP, 2002-12

The total number of children in foster care has dropped steeply over the years, but the number of infants and toddlers in care has declined to a much smaller degree.



MEDIAN LENGTH OF STAY IN CARE BY AGE AT PLACEMENT, CHILDREN ENTERING FOSTER CARE IN 2010

Infants who entered foster care in 2010 had a median length of stay of 27 months. Toddlers and older children were much more likely to return home quickly.



Learning How Babies' Brains Grow

IN THE PAST two decades, researchers have learned a great deal about how to protect children from the harm caused by early trauma or neglect. That knowledge does little good, however, if it doesn't reach the people caring for the kids who are most at risk. For babies and very young children in New York City's foster care system, that means not only the foster parents who take them in at times of crisis, but also the birth parents to whom most kids eventually go home.

Two years ago, the city's child welfare administration hired a researcher named Philip Fisher to develop a program that would help caregivers understand how baby and toddler brains grow. Out of the profoundly complicated and rapidly expanding universe of thought on infant neurobiology (and along with scientists at Harvard University's Center on the Developing Child) Fisher extracted a single concept that he considers to be the basic unit of infant development.

The idea is simple: It is in babies' nature—in their basic wiring—to initiate interaction with the adults who take care of them. What determines a baby's fate is whether she has a caregiver who responds. If she does, and especially if the responses are consistent and nurturing, her brain will make connections between sounds, expressions and objects, stimulating her neural circuitry to grow in the sturdy configurations that buttress future thinking and learning. Her relationship with her caregiver will become stronger, freeing her to explore her world and initiate further interactions—and so the cycle is set up to repeat itself.

"The underlying guiding principle is that healthy development is preprogrammed to occur," Fisher says. "But it requires the right kinds of input." When caregivers give that input, they create a kind of developmentally stimulating interaction that Fisher and his collaborators call 'serve and return.'

In order to teach parents how to recognize babies' serves and give them appropriate returns, Fisher developed a series of brief video clips, each designed to demonstrate the micro-moments of responsive parenting. In one, a mom picks up her baby. Through a succession of freeze-frames, we watch the baby begin to fuss. When his mother reaches for him, we see him look for her face. His eyes brighten and he kicks with excitement. The mother makes eye contact, speaking in a gentle voice as she takes the baby into her arms.

The interaction lasts less than half a minute. It's one that any parent in the room—even one who has lost custody of her child—has almost certainly experienced. Which is precisely the point, says Kristen Greenley, who manages Fisher's video project. A basic principle of the program is that if caregivers understand why their nurturing is so important—if they learn to see themselves as a powerful, positive force in their children's development—they will nurture more and, as a result, build stronger relationships and raise healthier kids. "We're showing them: You're already doing this," Greenley says. "Pay attention to when you're doing it. It's really good for your child."

The city's Administration for Children's Services (ACS) has adopted Fisher's work as one piece of a larger project to improve and standardize services for families in the child wel-

fare system. Under the broader initiative, which goes by the umbrella name of ChildSuccessNYC, parents attend a series of workshops, which are run as a cross between a parenting class and a support group. Facilitators instruct caregivers on developmental stages (what parents can reasonably expect from their children and when) and on parenting strategies intended to nurture children's development at each stage. Caregivers are assigned to practice the strategies at home and have regular, individual check-ins with caseworkers about their progress.

The workshops adhere to what are known as "evidence-based" models: They were tested in controlled trials involving large cohorts of foster kids, with results that showed better outcomes than those of kids whose caregivers weren't enrolled in the programs. However, the programs were developed for parents with children over age 5—kids whose problems are often

It is in babies' nature—in their basic wiring—to initiate interaction with the adults who take care of them.

more obvious than those of babies and toddlers. In New York City, foster care agencies are using Fisher's video clips in order to fill the gap.

So far, five of the city's foster care agencies have been trained to offer the ChildSuccessNYC workshops. More than 400 foster parents and nearly 350 birth parents have completed them. Close to half have children under age 5.

In other versions of Fisher's program, being implemented elsewhere, facilitators visit parents in their homes and videotape them interacting with their own children. Then they isolate examples of serve and return and play them back to parents in individual sessions, pointing out the connection they see in those moments. Fisher says that individual video screenings are the optimal way to run the program, but that they would have been too costly and time-consuming to meet New York City's requirements. "We have to be adaptable," he says. "One of the things we're waiting to see is, in the context of larger groups designed for older kids, how much will the infant material be infused? How much do the techniques get employed?"

ACS is working with an independent evaluator to assess the impact of the programs. The results will be available sometime next year. —Abigail Kramer

Special Programs for Babies in Foster Care

THERE ARE FEW universally required, specialized procedures for infants and very young children in foster care. However, many of New York City's foster care agencies have created or adopted distinctive programs aimed at supporting babies' developmental needs. Below are details on a few.

Mommy and Me Groups

For the past 12 years, SCO Family of Services has run "Mommy and Me" groups for foster kids aged 0-3 and their parents. The groups are offered twice each week and they take the place of traditional parent-child visits. Families meet in groups that range from two to ten parents, guided by a pair of facilitators. In a room stocked with toys and books, they engage in group activities, as well as playing with their children individually. Each session focuses on specific parenting topics, such as the value of using descriptive words when speaking with children, or the importance of smiling and using a warm tone of voice.

The goal, says Pam Potischman, director of SCO's Family Enhancement Services program, is to help parents read their babies' cues and respond in nurturing ways. "We find that parents already have the basics," she says. But they often lack accurate information about their infants' developmental capacities. "Something I often see is parents interpreting babies' behavior as aggressive," says Potischman. She tells the story

of a mother who scolded her 3-month-old for hitting when he waved his arms into her face. Meaningful education, Potischman says, happens when facilitators build relationships with parents. Once there's trust, they can provide information about babies' developmental realities and work with parents to help them see things from their children's point of view. "You can't just say 'Oh that's not aggressive.' You want to be careful about 'I know your baby better than you do.' You want parents to come to conclusions for themselves."

SCO's Mommy and Me program serves approximately 40 families each year.

Young Parents in Foster Care: Video-Feedback Parent Education

When teens in foster care have babies of their own, they are usually placed in specialized mother-infant foster homes or in group homes with other moms and their children. Foster care agencies have adopted a number of strategies to help young parents in their care learn to support their babies' development.

Inwood House, which operates group homes for pregnant and parenting girls in foster care as well as a cluster of mother-child foster homes, offers a program called SPIN Video Interaction Guidance. Over the course of 13 weeks, facilitators take video clips of young mothers interacting with their children, then edit

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foster care more quickly, and to pay better attention to their developmental health. The project, called "Babies Can't Wait," ran workshops for court staff and foster care workers on the developmental importance of stable, attached relationships. It hired social workers to monitor babies' court cases and developed checklists for lawyers and judges, designed to make sure infants and young children received consistent medical care and early intervention for developmental delays. It encouraged judges to prioritize babies' existing attachments when making placement decisions.

For about six years, the city's Administration for Children's Services (ACS) worked with Dicker's project to develop its own arm of Babies Can't Wait, intended to get very young children into permanent homes more quickly. Under the program, infants were placed with foster parents who were interested in adoption, but who were also expected to support parents' efforts to maintain bonds with their babies. "There was a real focus on making the first placement the last placement," says Dicker.

The statewide Babies Can't Wait initiative lost its funding in 2005, however, and over the next few years the ACS project withered, too. "When the money goes away, people get interested in other issues," Dicker says. "Since the project ended, it's up to individual judges. Nobody's there to push them. Some babies go home on day three and some stay in foster care for five years... It was a real priority then. I would

say it's not a priority now."

Ronald Richter, who served as a Family Court judge prior to becoming commissioner of ACS in 2011, contends that the Babies Can't Wait initiative left a permanent impact on the city's foster care policies. Now, he says, ACS mandates that foster agencies screen kids for developmental delays, and encourages them to place babies and young children with foster parents who will adopt them if they don't go home to their parents. As of July 2013, there were nearly 240 children in the system between the ages of 1 and 3 who had been legally freed for adoption. Only 33 of them were not in pre-adoptive homes, Richter says.

The agency is also in the process of testing programs that teach foster and birth parents about early childhood development (see "Learning How Babies' Brains Grow," page 24) and will launch a project this year to work with mothers of children under age 5 who have histories of trauma.

Most importantly, Richter says, babies come into a foster care system that's much smaller and faster than it was a decade ago. In 2010 (the most recent year for which there is meaningful data) babies under 1 year old stayed in foster care for a median length of 27 months. That's a significant drop from 10 years ago, when babies' median stay was over 34 months. But—as early childhood advocates point out—it's still a lifetime, to a baby. ❖

continued from page 25

the clips to focus on moments of positive interaction. They watch the videos with the young mothers, discussing what happened in those moments of connection—and what happens during other moments when the connection is strained.

"Many of our teens have unrealistic expectations" of their babies, says Nancy Meyers, who facilitates the SPIN program. "They think that finally someone will love them and heal this emptiness inside them. But babies don't actually often act like they love you. They scream in the night. They want to play with a toy instead of kissing you. You can feel abandoned if you don't understand what's developmentally appropriate." By showing teens a visual record of their best parenting moments, says Meyers, "we help the parent see how they are attached to the child, how the child seeks them out."

Inwood House has used the SPIN program for eight years with approximately 150 young parents.

Home Visiting Programs

Several foster care agencies have partnerships with organizations that provide one-on-one home visits to teen parents living with their own children in foster care. The agency Leake and Watts uses a model called the Parent Child Home Program, through which paraprofessionals visit young parents and their babies twice a week for two years, modeling behaviors that encourage parents to play and interact with their children, increasing their language skills and school readiness.

Leake and Watts has been operating the program for two

years, and expects to serve 60 young mothers this year in the agency's mother-child program.

Healthy Families New York provides the state's largest home visiting program. Each year, their New York City programs serve many young parents living in foster care with their babies.

Nurse-Family Partnership, which provides home visits by registered nurses to new parents from pregnancy through a baby's second birthday, is a national program run in New York City by the Health Department. It has served approximately 245 young mothers in New York City foster care since 2006.

Attachment and Biobehavioral Catch-Up

Foster care agency Forestdale, Inc. has adopted a video feedback program for parents and foster parents with children between 6 and 24 months old. Under the program, which is called Attachment and Biobehavioral Catch-Up, or ABC, therapists work with families individually for 10 weeks, talking with parents about babies' developmental needs and supporting them while they interact with their children. The primary goal, says Lindsey DeMichael, a therapist at Forestdale, is to encourage nurturing behaviors, teaching parents to follow their children's lead and express delight in their babies' accomplishments. "In-the-moment commenting on what a parent is doing can really support positive behaviors," says DeMichael. Videotaping nurturing interactions "helps them see themselves in a positive light with their kids."

Forestdale's ABC program has served approximately 10 birth and foster families. —Abigail Kramer

FURTHER READING: Selected resources, reading, and studies cited in this issue

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THE COST EFFECTIVENESS OF EARLY INTERVENTIONS:

See The Heckman Equation website: <http://www.heckmanequation.org>

A six-year statistical survey monitoring New York City's child welfare system

WATCHING THE NUMBERS

PROTECTIVE SERVICES

| | FY 08 | FY 09 | FY10 | FY11 | FY12 | FY13 |
|--|--------|--------|--------|--------|--------|--------|
| REPORTS OF ABUSE AND NEGLECT: | 64,572 | 64,748 | 65,114 | 65,731 | 63,521 | 59,675 |
| Hotline reports declined 8 percent two years after a 2011 peak. | | | | | | |
| PERCENTAGE OF REPORTS SUBSTANTIATED: | 39.9 | 42.0 | 41.9 | 40.1 | 39.6 | 39.8 |
| Child protective workers found reason to suspect abuse or neglect in two-fifths of reports. | | | | | | |
| PENDING RATE: | 5.4 | 4.8 | 4.5 | 4.8 | 3.9 | NA |
| The monthly average of new cases per child protective worker has been declining. | | | | | | |
| AVERAGE CHILD PROTECTIVE CASELOAD: | 11.0 | 9.3 | 9.1 | 9.4 | 8.7 | 8.2 |
| Caseloads continued to decline. | | | | | | |
| ACS SUPERVISION ORDERED BY FAMILY COURT (PREVIOUS CALENDAR YEAR) | 6,177 | 5,556 | 5,822 | 4,913 | 5,180 | 5,050 |
| This is the total number of court-ordered supervision cases as an outcome of Article 10 filings. | | | | | | |
| CHILD FATALITIES IN CASES KNOWN TO ACS (PREVIOUS CALENDAR YEAR): | 41 | 49 | 39 | 46 | 43 | 50 |

PREVENTIVE SERVICES

| | | | | | | |
|---|--------|--------|--------|--------|--------|--------|
| FAMILIES RECEIVING ACS-CONTRACTED PREVENTIVE SERVICES (ANNUAL, CUMULATIVE): | 23,809 | 24,788 | 23,063 | 21,535 | 19,172 | 19,297 |
| The number of families in preventive programs has stabilized after a decline. | | | | | | |
| NUMBER OF CHILDREN IN PREVENTIVE CASES (ACTIVE, JUNE): | 33,022 | 31,584 | 27,532 | 23,294 | 22,952 | 25,762 |
| The number of children in preventive cases is 22 percent below its peak in FY 2008. | | | | | | |
| PERCENT OF PREVENTIVE CASES REFERRED BY ACS: | 76 | 68 | 64 | 71 | 72 | 72 |
| The large majority of cases in preventive services are referred by ACS Child Protective Services. | | | | | | |

FOSTER CARE SERVICES

| | | | | | | |
|--|--------|--------|--------|--------|--------|--------|
| NUMBER OF CHILDREN ADMITTED TO FOSTER CARE: | 7,401 | 7,406 | 7,108 | 6,313 | 5,698 | 4,316 |
| A record low in 2013, down 50 percent since 2002. | | | | | | |
| NUMBER OF CHILDREN DISCHARGED FROM FOSTER CARE: | 7,587 | 7,557 | 7,181 | 7,055 | 6,453 | 5,416 |
| Discharges continued to outpace admissions. | | | | | | |
| TOTAL FOSTER CARE POPULATION (ANNUAL AVERAGE): | 16,701 | 16,439 | 15,895 | 14,843 | 14,013 | 12,945 |
| The number of children in foster care fell 53 percent during the Bloomberg mayoralty. | | | | | | |
| MEDIAN LENGTH OF STAY FOR CHILDREN BEFORE RETURN TO PARENTS (MONTHS): | 9.3 | 8.3 | 5.3 | 6.4 | 5.5 | 6.8 |
| Length of stay remained well below the recent historical average. | | | | | | |
| PERCENTAGE OF CHILDREN WITH REUNIFICATION GOAL (PREVIOUS CALENDAR YEAR): | 51.3 | 51.6 | 51.1 | 51.5 | 52.1 | NA |
| About half of the children in foster care at any point in time are expected to return home. | | | | | | |
| PERCENTAGE OF SEPARATED SIBLINGS (PREVIOUS CALENDAR YEAR): | 48.3 | 44.2 | 48.1 | 47.4 | 47.1 | NA |
| Fewer than half of siblings in foster care were living apart from one another in 2011. | | | | | | |
| RECIDIVISM RATE (%) (PREVIOUS CALENDAR YEAR): | 10.0 | 12.3 | 11.3 | 12.6 | 13.6 | NA |
| This is the percentage of children returning to foster care within one year of discharge. | | | | | | |
| PERCENTAGE OF FOSTER CHILDREN IN KINSHIP CARE (JUNE): | 32.3 | 33.9 | 35.0 | 34.9 | 34.4 | 32.5 |
| Kinship care remained about one-third of the foster care system. | | | | | | |
| PERCENTAGE OF FOSTER BOARDING HOME PLACEMENTS IN BOROUGH OF ORIGIN: | 54.0 | 57.8 | 58.8 | 60.5 | 57.9 | 60.7 |
| This number includes residential care as well as foster boarding homes. | | | | | | |
| PERCENTAGE OF FOSTER BOARDING HOME PLACEMENTS IN CONTIGUOUS COMMUNITY DISTRICTS: | NA | 32.7 | 31.2 | 35.1 | 33.5 | 32.8 |
| The number of children placed in foster homes close to home remained at one-third of the system. | | | | | | |

ADOPTION SERVICES

| | | | | | | |
|--|-------|-------|-------|-------|-------|-------|
| PERCENTAGE OF CHILDREN WITH ADOPTION AS A GOAL (PREVIOUS CALENDAR YEAR): | 29.2 | 28.0 | 30.3 | 31.1 | 30.7 | NA |
| This number has been flat for many years. | | | | | | |
| NUMBER OF FINALIZED ADOPTIONS: | 1,472 | 1,344 | 1,165 | 1,186 | 1,295 | 1,310 |
| Finalized adoptions continued to increase as a percentage of the number of children in care. | | | | | | |
| AVERAGE TIME TO COMPLETE ADOPTIONS (YEARS): | 3.4 | 3.2 | 3.2 | 3.0 | 3.1 | 3.0 |

It takes three years to finalize once a child is considered appropriate for adoption.

All numbers above reported in NYC fiscal years unless otherwise indicated. Sources: NYC Mayor's Management Report, NY State Office of Children and Family Services Monitoring and Analysis Profiles, NYC Administration for Children's Services Monthly Flash and data requests.

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THE NEW SCHOOL

72 Fifth Avenue, 6th Floor
New York, NY 10011
(212) 229-5418
www.centernyc.org

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Associate Editor: Abigail Kramer
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