chances for children

2021 Program Evaluation

Introduction

This report covers the period of January 1 through December 31, 2021. During this second year of the COVID-19 pandemic, Chances for Children delivered services via telehealth to pregnant moms and to families throughout the Bronx with children up to age five: we reinvented, restructured, and refined our strategies to provide the highest quality care via of telehealth. We learned what does and what does not work for consultation, dyadic therapy, group intervention, and evaluation. We learned that telehealth can be deeply effective and that we can reach families who might never have been able to access services or travel to our offices. We learned firsthand how basic internet services, and the hardware needed to operate within the virtual world are inaccessible to many families. We continued to learn ways to evaluate the practice and outcomes of the work we do in this new environment.

Our mission is to provide clinical group and dyadic services for families with young children to strengthen understanding, enhance sensitivity, and nurture relationships. Children and their caregivers (mothers, fathers, extended family members or other caregivers referred to below as "parents") participate together in services.

In this report we will give a snapshot of the situation in the Bronx, an outline of the programs provided by Chances for Children, and the outcomes of our evaluation for 2021.

A Bronx Snapshot

For the sixth consecutive year, Bronx neighborhoods are overrepresented in overall cumulative risk as well as in individual risk categories. These include: economic security, housing, education, family, and community. The highest risk ratings are in Mott Haven, Morrisania, Hunts Point, East Tremont, University Heights, and Highbridge/Concourse, all neighborhoods that we serve. With the onslaught of the COVID-19 pandemic, risks increased exponentially. Here is a snapshot of the Bronx in 2021:

- **Employment:** Prior to the pandemic, more than 70 percent of the workforce in the Bronx worked in essential or face-to-face industries.[1] By the second quarter of 2020, employment had fallen by 18 percent in the Bronx compared to 2019, with unemployment peaking at

[1] https://www.osc.state.ny.us/reports/osdc/recent-trends-and-impact-covid-19-bronx

nearly 25 percent in May 2020, *the highest rate among all the boroughs*.[2] Working in essential industries, residents were at high risk of contracting COVID-19 and could not work remotely. Not surprisingly, the impact in the Bronx was more severe, with the highest hospitalization and death rates in the city. In February 2021, the Bronx had the highest positivity rate in COVID-19 testing among all the boroughs, with subsequent declines similar to the rest of the city. Not surprisingly, in 2021, unemployment remained the highest in the city at 16 percent.[3]

- **Food insecurity:** Uncertain access to adequate food (food insecurity) is greater in the Bronx than in any other borough in the city: Feeding America estimates that 17.5 percent of all people and 23.5 percent of all children living in the Bronx have limited or uncertain access to adequate food.[4]
- **Housing:** In 2021, nearly 61 percent of renters in the Bronx faced a rent burden, where rent consumed 30 percent or more of their household incomes.[5]
- **Crime:** As of May 16, 2021, year-to-date major index crime in the Bronx was up three percent when compared to the same period last year, while citywide major index crime fell by four percent. Shootings increased citywide by 82 percent and by 152 percent in the Bronx.[6]

One index of risk related to COVID-19, created by the US Census Bureau, is the Community Resilience Estimate (CRE). This calculates individual risk within a geographical area based on 11 factors including income-to-poverty ratio, crowding in housing and in neighborhoods, unemployment, health insurance, and particular disabilities and health problems (including heart conditions and emphysema or asthma). There are three risk categories: zero risk, 1-2 risks, 3+ risks. *"*Compared *to the other boroughs, the Bronx had a larger share of population with three or more risks overall*."[7]

Each of these risk factors impinges on a family's capacity to provide a safe, healthy environment for their babies. The isolation imposed by the pandemic has increased despair and feelings of helplessness, feelings that even very little babies absorb. When a parent's mental health suffers, babies suffer; relationships suffer. The need is great.

We address the needs noted above using dyadic and group models of intervention. *Because of the COVID-19 pandemic, all services are now virtual, using telehealth platforms.*

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[2] ibid
[3] https://dol.ny.gov/labor-statistics-new-york-city-region
[4] Feeding America, *Map the Meal Gap*, technical note on 2018 measure at https://www.feedingamerica.org/sites/default/files/2020-09/Map the Meal Gap 2020 Technical Brief-Updated.pdf
[5] https://www.osc.state.ny.us/reports/osdc/recent-trends-and-impact-covid-19-bronx
[6] ibid
[7] ibid

Addressing and Supporting the Relationship Needs of Parents and Babies

Resilience is conceived and built within supportive relationships, and often babies' needs are forgotten when external stresses are so high. Babies and toddlers continue to communicate their needs through their behavior: they stop sleeping soundly, tantrums increase, they pull out clumps of hair, toilet learning disintegrates, they will not let a caregiver leave the room or alternately, they run away in the street.

Clinical Team

Our clinical team has expertise in infant mental health and includes four licensed clinical social workers. All of our therapists speak some Spanish. Three of six are Latina, and four of six are bilingual in English and Spanish. We are a multi-cultural, ethnically diverse team with the cultural competence to serve our client population that is 77.5% Latino/Latinx.

Program Overview

Parent-Child Dyadic Therapy Program:

The parent-child dyadic therapy that we provide is relationally based and trauma-informed. It aims to strengthen and solidify bonds of attachment between the parent and their infant or very young child and to improve parenting skills, including the ability to anticipate and appropriately respond to developmental changes in the infant over time. Using evidence-based, best-model practices in the field of infant mental health, we work both preventively and remedially to interrupt the intergenerational transmission of ruptured attachments, environmental and familial trauma, as well as to *prevent* psychological problems early in the life of the child and family before disruption has occurred.

The dyadic therapy program consists of three tiers: dyadic therapy, severe trauma focused therapy, and consultation. All services are currently provided via telehealth and are provided in English or Spanish depending on the needs of the family. The therapist and the parent and child meet together weekly over Zoom.

<u>Dyadic Therapy:</u>

Distinct from parenting programs that do not include the child, our parent-child therapy program is a strengths-based, dyadic model that prioritizes the relationship between parent (or caregiver) and the child. Repeated experiences with parents and children in which relationships are co-created during moment-to-moment interactions, continue to highlight for us the importance of relationship building as an essential vehicle for long-term change. Dyadic sessions do not follow a prescribed routine since different families have different needs at different times. Sessions may include the parent and child on screen, the parent alone on screen or by phone, and in some cases occasionally a third party (father, grandmother, or

sibling). Sessions may include video recording and video feedback, discussion of parental history that is impacting present behavior, supporting difficult decisions that a parent is making, processing grief and loss, problem solving, developmental guidance, and encouraging moments of joyful dyadic interaction. Throughout all sessions, behaviors are understood as communications and the perspectives of both parent and child are explored within the cultural context of each family.

Goals:

1. strengthen the child-parent bond
2. expand the parent's reflective capacity
3. increase the parent's developmental understanding
4. increase the parent-child positive interactions
5. assess for early developmental indicators
6. provide referrals

Dyadic Therapy

- Parent and child meet with infant mental health therapist
- 1 hour weekly for a series of 15 sessions
- The series is renewable
- Parents are screened for depression and children for developmental delays
- Referrals are made if indicated

Severe Trauma Focused Therapy:

This tier of intervention was created in 2018 in response to an alarming influx of referrals for children who had suffered severe, acute trauma. Severe Trauma Focused therapy requires a level of expertise different from the usual dyadic intervention and requires significantly more immediate family support, management of complex systems outside the therapy room along with the necessity for case conferencing. To address this need, we created a severe trauma therapy tier that provides: individual sessions with parents and collateral family members, parent-child dyadic therapy sessions, and case conferencing with lawyers, other therapists, and child protection workers. This intervention continues until there is a resolution of symptoms in the child and a return to a typical developmental trajectory.

Goals:

1. repair the impact of the trauma on the child's emotional, social, and overall development
2. strengthen the parent's capacity to keep the child safe and protected
3. help build a new relationship with a parent if a rupture has occurred in the primary parent relationship

Severe Trauma Focused Therapy

- Parent and child meet with trauma therapist
- Therapist meets with family members, collateral agencies, and courts
- Length of intervention is dependent on resolution of symptoms

Consultation:

Not every family needs full dyadic intervention. Consultation offers a short-term problem-solving arena, where parents get specialized infant mental health guidance that can help them decide what kind of service best fits their needs. It concludes with recommendations for the family and referrals to other professionals when needed.

Goals:

1. Support parents responding to typical developmental difficulties in children
2. Expand parental developmental understanding
3. Support parents navigating life transitions

Consultation

- Parent meets with infant mental health therapist for 1-5 sessions
- Recommendations are offered
- Referrals to other providers are given, if indicated

Parent-Child Group Program:

In addition, we offer two group programs: one to reduce isolation, give families a safe place to be together, and allow children to see and "play" with other children, the second to provide support to pregnant mothers and those with newborns up to four months.

Growing Together Group

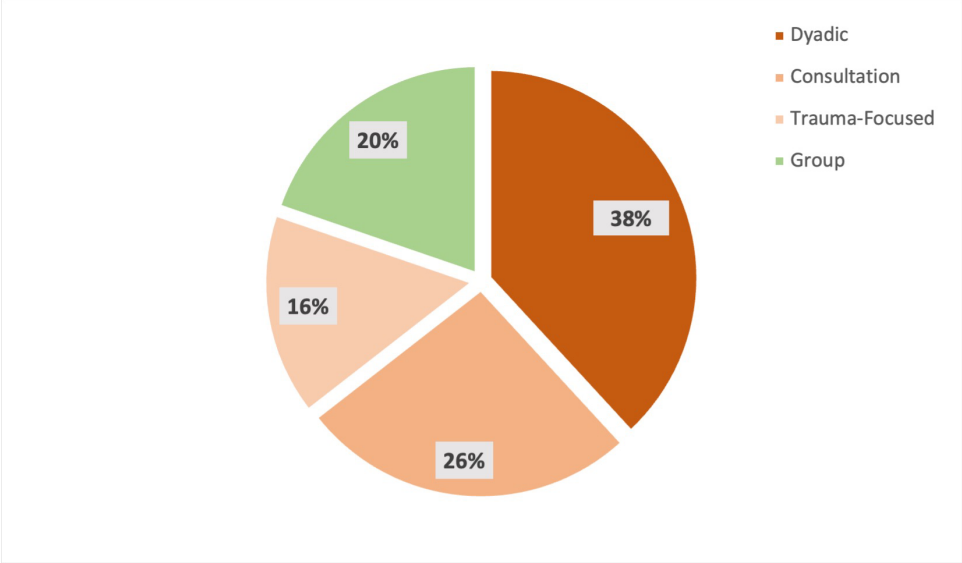
- Parent-child dyads meet together with two infant mental health therapist group leaders
- 45 minutes weekly for 8-10 sessions
- Group size: 4-8 parent-child dyads

Empowering Motherhood Group

- Pregnant mothers and mothers of newborns meet with an infant mental health therapist
- 90 minutes weekly for 6-8 sessions
- Group size: 4-9 pregnant mothers and mothers with infants

Program and Demographic Information

Program Distribution:



This year 151 interventions were provided to 133 unique families - some families participated in multiple services. The Dyadic Therapy Program (dyadic, trauma-focused and consultation) comprised 80 percent of the interventions provided to families. Chances for Children received 192 referrals and delivered 1,413 sessions (dyadic and group) with an attendance rate of 83%.

Cases:

	Dyadic	Group
Cases completed	69	11
Cases ongoing (open)	33	8
Prematurely discharged	16	2
Dropped out (< 5 sessions)	4	8
Total	**122**	**29**
Never began services*	24	17

*41 families were referred and assigned but never began services. These were removed from the count in this year's report.

Sessions: Session counts include both the dyadic and group programs.

	2021	2020
Sessions scheduled	1705	1497
Sessions attended	1413 (83% attendance)	1260 (84% attendance)

Referrals:

	2021	2020
Referrals received	192	140
Referrals declined or referred out	45	44

Demographics for Assigned Cases: Includes participants in the dyadic and group programs.

Parent Race/Ethnicity (120*)	N	%
Latino/Latinx	93	77.5
African American	10	8.3
African	6	5.0
Asian	4	3.3
Caribbean	3	2.5
Caucasian	2	1.7
Multi-racial	2	1.7

**The number in parenthesis indicates the number of responses available for the item.*

Child Gender (141*)	N	%
Male	69	49
Female	72	51

**The number in parenthesis indicates the number of responses available for the item.*

This demographic information is provided for participants the dyadic program only.

	N+	%
Single Parent (106*)	49	46.2
Parent Working or in School (115*)	49	42.6
ACS Involved (109*)	14	12.8
Foster Care (109*)	7	6.4
History of Domestic Violence (95*)	24	25.3
History of Trauma (32*)	15	36.9
History Mental Illness (96*)	27	28.1
Current Depression (34*)	19	55.9
Child Delay/Referred Out	23	

** The number in parenthesis indicates the number of responses available for the item.*

+ N = number with characteristic. Ex. 49 of 106 were single parents.

Case Management

Case management refers to the time spent finding resources for families from food, to hospital beds, to diapers, to secure shelter for domestic violence victims. It includes calls to foster care agencies, lawyers, and child protective services (Administration for Children's Services or ACS). It includes writing letters to courts, attending special education meetings, and making early intervention referrals. Having food to feed the family and having funds to pay the rent are critical elements in providing secure bases for relationships to flourish; however, a large percentage of the families referred to us have significant concrete needs. Migdalia is a case in point.

Migdalia had come to America with employment in hand, but was fired when she became pregnant. For a short time, after the baby was born, the baby's father helped her out, but ultimately funds ran out and she became homeless. Fearful of shelters, she and baby slept on the street. Eventually she found a room, and was referred to us by her child's pediatrician who gave her formula for the child because Migdalia rarely ate and so was not producing adequate breast milk. Migdalia needed everything, food, clothing, daycare so that she could work, but the system is not set up for people who cannot afford a phone. During the pandemic most offices were operating virtually; the making and keeping of virtual appointments was virtually impossible without consistent phone access. Needless to say, case management was extremely high and extremely time consuming. With Migdalia and other families who need intensive case management, our therapists work intensively to connect the family to services to address their needs.

Of the dyadic cases seen in 2021, 34.5% had high case management needs and only 13% had no case management needs as reported by our therapists.

Evaluation of the Dyadic Therapy Program

Dyadic services are evaluated using the following tools:

- Clinical Rating Scale
- Parent Reflective Functioning Questionnaire
- Center for Epidemiological Studies Depression Scale (CES-D)
- Pre-Intervention Questionnaire
- LookSee Checklist
- Exit Survey

The Clinical Rating Scale: The Clinical Rating Scale (CRS) consists of three sets of questions designed to rate the parent-child interaction. One set describes parent behavior, one child behavior, and one dyadic interaction, giving us three domains of information about each parent-child interaction, for example, the parent's use of language with child. The scale is rated as close as possible to the first observed therapy session with the dyad, again in the middle of the intervention and finally at the end. (Because this is a clinical tool, it can also be used by clinicians at any time during treatment to monitor progress and assist in treatment planning.) This tool was created last year as a pre-post therapy measure because our prior practice of rating pre-post therapy parent-child video recorded interactions was not possible initially during the pandemic. However, not all of families referred to treatment have access to a video-based platform. For those we have relied on phones, texts, or whatever the family could access; therefore, the number of cases reported on below only reflects the dyads for whom we had full video access.

Center for Epidemiological Studies Depression Scale (CES-D): This is a widely used instrument that screens for individuals at risk of depression. Because depression in general, and perinatal depression in particular, are so prevalent it is important to capture its presence and severity quickly for further referrals if indicated. Our therapists complete this 20 item self-report measure with parents.

Parent Reflective Functioning Questionnaire (PRFQ): The capacity for a parent to "see the world through their baby's eyes" and understand behavior (including their own and other adults') as influenced by mental states (wishes, beliefs, thoughts) contributes to healthy relationships. It allows parents to think and reflect rather than to react impulsively. The PRFQ is a measure of this capacity. The PRFQ is a self-report measure completed with the therapist. It consists of 18 statements and asks the parent to rate the statement on a scale of 1-5 from strongly agree to strongly disagree.

The Pre-Intervention Questionnaire (PIQ): The purpose of this questionnaire is both clinical and demographic. It consists of nine questions: one questions is answered as yes or no, four questions are answered (1-5) strongly agree to strongly disagree, and four questions elicit comments. This orients the therapist to the specific problem that caused the referral, its

relation to the pandemic, the parents' level of concern, parent and child level of stress, and supports available to the family.

The LookSee Checklist: Formerly the Nipissing District Developmental Scale (NDDS), this is a developmental screening tool for children from birth to age five and indicates whether there is need for referral to additional services.

Exit Survey: This survey is completed anonymously and is administered over the phone by an independent external researcher (outside of the CFC team). It consists of nine questions rated on a 1-5 scale of strongly agree to strongly disagree and includes a comments section. Because it is anonymous, it cannot be correlated with the PIQ, but gives a general picture of client satisfaction with services, the help they received, their relationship with their therapist, their understanding of how the COVID-19 pandemic affected their child, and the degree to which receiving services from Chances for Children was able to relieve some of the stresses experienced during this time. The survey is given to parents who completed either dyadic or group services. These results can be found at the end of the group section of this report.

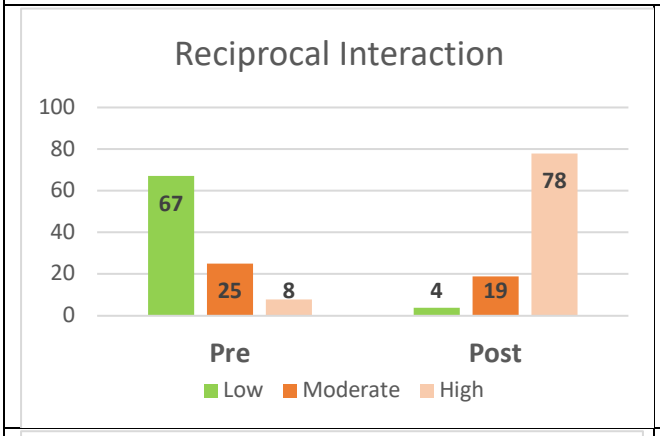
Results from Dyadic Therapy Program

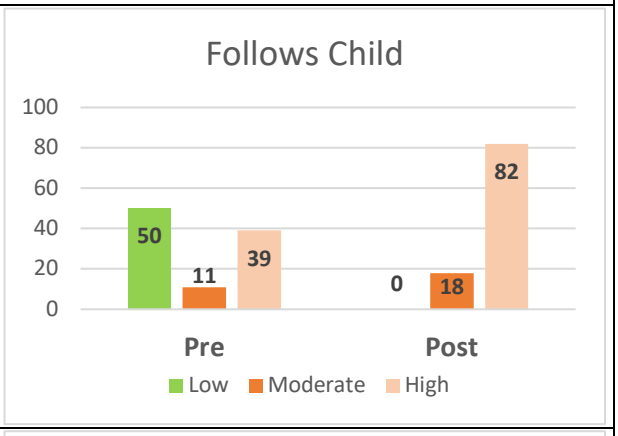
The Clinical Rating Scale: This year there were 27 parent-child dyads for whom we had pre-post intervention ratings, and we see strong improvement across all three factors of parent, child, and dyad. The left side of the charts (below) indicates the status of the feature listed in the title at time one (pre-intervention). The right side indicates the post intervention results at time two. Each side shows the percentage of participants scoring low (green), moderate (orange) and high (peach) on that feature.

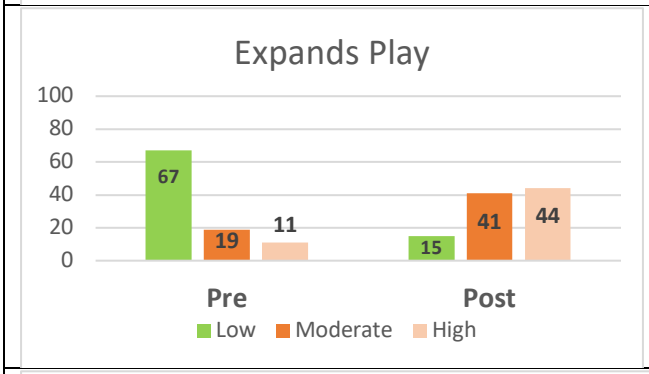
Across all parental behaviors, we see a trend that most parents exhibited poor (low) levels at baseline but improved so that the majority of parents showed high levels after our intervention. This was especially true for Reciprocal Interaction, Expands Play, Matches Pace, Use of Language, and Follows Child's Lead. For example, pre-intervention 67% of parents exhibited low levels of Reciprocal Interaction and 25% showed only moderate levels. After participation in our Dyadic Therapy Program, 78% showed high levels of Reciprocal Interaction. Only 4% still were exhibiting low levels. Improvements were statistically significant based on the Related-Samples Wilcoxon Signed Rank test (p-value ranging .001–.004 in all areas except Parental Intrusion p=.077).[8]

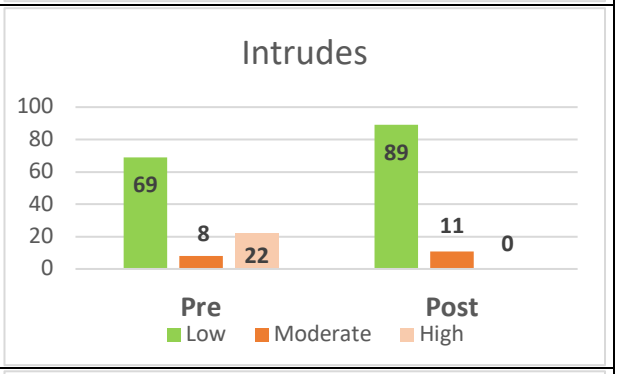
[8] The bulk of parents (21/27) were not intruding at baseline thus had no room to improve. Testing only the 6 who did initially intrude, improvement after the program was significant, p=.026.

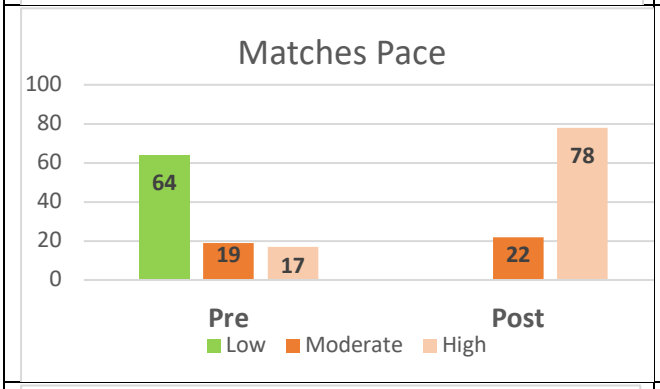
Clinical Rating Scales 2021 – PARENTS (n=27)

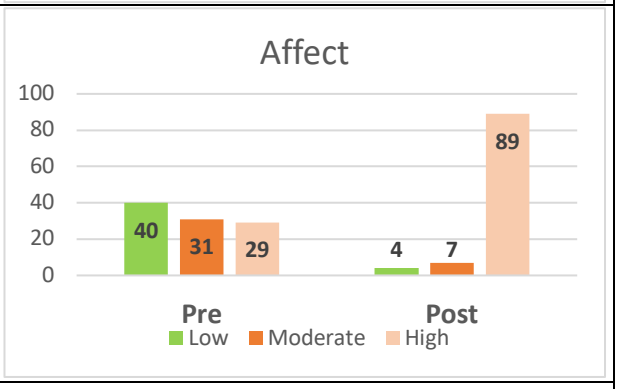


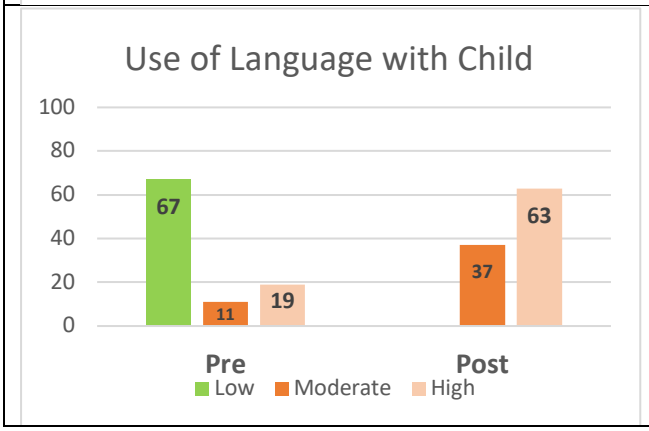










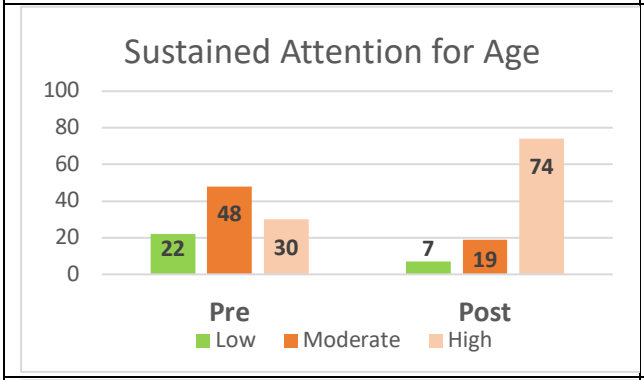


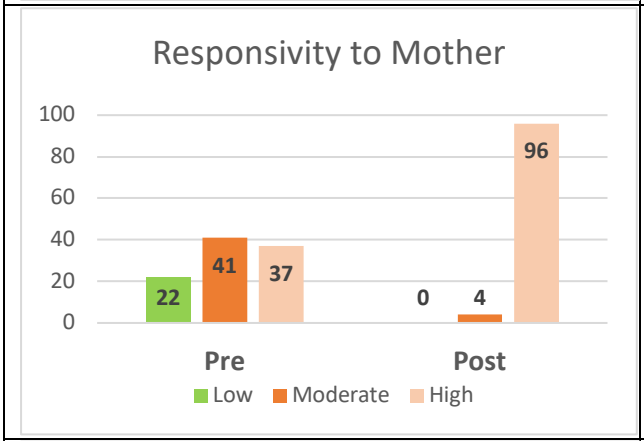
Notes:

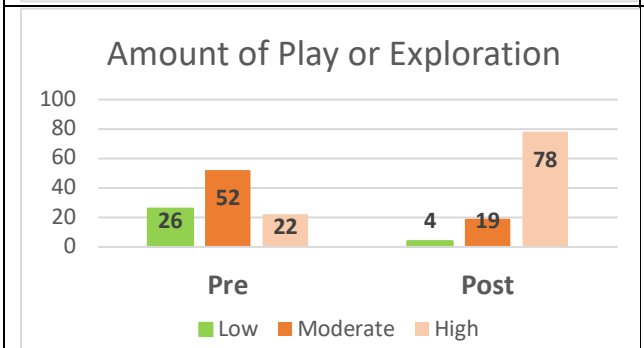
- Percentages with different levels of each trait, pre and post participation in the dyadic therapy program.
- Low (1,2) Moderate (3) High (4,5).
- All improvements statistically significant (< .004) except Intrusion (p=.077).
- Percents may not total 100% due to rounding.

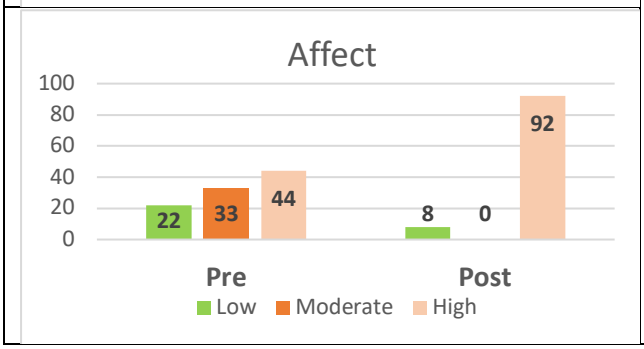
Clinical Rating Scales 2021

CHILD (n=27)

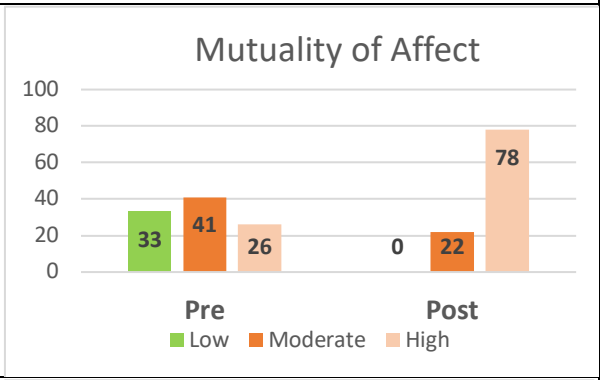


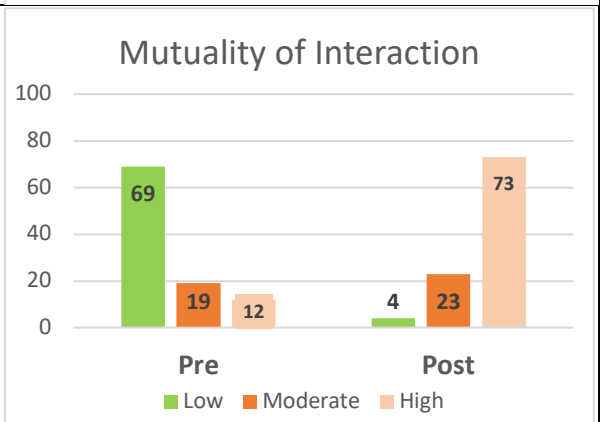






DYAD (n=27)





Notes:

- Percentages with different levels of each trait, pre and post participation in the dyadic therapy program.
- Low (1,2) Moderate (3) High (4,5).
- All improvement statistically significant ($p < .001$).
- Percents may not total 100% due to rounding

Parent Reflective Functioning Questionnaire (PRFQ): This year the PRFQ was used primarily as a clinical instrument at the beginning of an intervention to clarify for the therapist the ways that a parent could be helped to think more reflectively about the child. In particular, certain questions alert us to a tendency toward negative attributions about the child (ex. "My child cries around strangers to embarrass me") and others to a rigidity of thinking ("I always know why my child acts the way he or she does"). Analyzing the baseline of PRFQ scores this year, we note two interesting things: first, in the aggregate, the pre-intervention baseline this year was consistent with what we have found in the prior years, and second, compared to a normative sample of community parents, the parents in our program, prior to intervention, evidenced poorer mentalizing skills in all three categories measured (pre-mentalizing, interest and curiosity, certainty of mental states.)[9] Because of telehealth constraints, we chose not to administer the post instrument this year or last; however, we plan to reinstate this next year as in the past we have shown significant increases in parents' mentalizing capacities.

Center for Epidemiological Studies Depression Scale (CES-D): Our results here are staggering. With data from 34 parents, the rate of depression this year was 55.8% (19 of 34 parents), in contrast to last year when it was 27% (12 of 45 parents.) Indeed, the Journal of the American Medical Association (JAMA) reports a prevalence more than three-fold higher during the COVID-19 pandemic than before[10] which is consistent with our finding. Parents with positive scores are investigated further and referred out for specific treatment.

The Pre-Intervention Questionnaire (PIQ): We collected information on 53 parents. The questionnaire gives us a snapshot of the families at baseline. Of these, 42% of parents reported that the issues bringing them to CFC were pandemic related, 52% reported feeling only rarely or occasionally effective in managing their child's behavior at baseline; 58% reported being very troubled by the problem bringing them to us for services. Most interestingly, at baseline 79% of parents reported their own stress level as being high or very high, yet only 32.7% reported their child's stress level as high or very high, with 29.1% reporting average levels and 38.2% reporting low or very low levels of stress in their children.

We were interested in seeing if what parents reported on the Pre-intervention Questionnaire was related to any of the Clinical Rating Scale's baseline levels for that child. We discovered:

1. Parental report of higher Child Stress on the PIQ is associated with both lower baseline levels of Child Positive Affect (Spearman's rho= -.631, p=.002) and lower Amount of Play (Spearman's rho= -.573, p=.007).

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[9] Pazzagli,C.. Delvecchio, E., Raspa, V. Mazzaschi,C. ,Luyten, P. (2018). The Parental Reflective Functioning Questionnaire in Mothers and Fathers of School-Aged Children, Child fam Stud 27:80-90 Comparisons to Pazzagli et al involved 1-sample t-tests, p.=.001 - .005. All showed moderate effect sizes.

[10] . *JAMA Netw Open.* 2020;3(9):e2019686. doi:10.1001/jamanetworkopen.2020.19686 (Lower income, having less than $5000 in savings, and having exposure to more stressors were associated with greater risk of depression symptoms during COVID-19.)

2. In children reported to have high levels of Stress on the PIQ none were seen to have high Affect on the CRS at intake, whereas in children reported to have low levels of Stress, 75% were found to have high Affect on the CRS.
3. When children were reported to have high levels of Stress on the PIQ at baseline, none (0%) were seen to have high Amounts of Play on the CRS at baseline; whereas in children reported to have low levels of Stress, half (50%), were found to have high Amounts of Play on the CRS.
4. In parents who reported that the issue bringing them to Chances for Children was Pandemic Related, children had both a higher ability to Sustain Attention (Mann Whitney U = 24, p=.03) and higher Positive Affect (Mann Whitney U=22, p=.02) than those for which the issue was not Pandemic Related.
5. Across the four PIQ measures and 13 CRS measures, 52 tests were conducted. We acknowledge the multiple comparisons and find these results interesting and worth understanding. Future work can confirm or refute these findings.

The LookSee Checklist: 23 children were identified as needing referral to early intervention services and referrals were made.

Parent-Child Dyadic Therapy – A Family Story

A little girl with sleek pigtails tied neatly in pink bows, pointed across the room at her brother. "Jared is touching the stove" she said into the screen and rolled her eyes. Jared was her middle brother, Jacob the youngest. This was my introduction to the M. family on screen; the message was loud and clear: Jared was "the problem."

Jared had been referred to Chances for Children by his preschool (recently reopened) which was about to expel him for bad behavior. We have written previously about the preschool to prison pipeline and the astonishing numbers of preschoolers who are suspended and expelled from school with rates higher than children in grades K through 12. Most of these children have no access to programs that could prevent this; fortunately, Jared's family came to Chances for Children.

Janine, Jared's mother, a gentle soft-spoken mother with three children under the age of five, explained that she was at her wits' end. Jared was so unlike the other children, she could not take him anywhere, on the bus, to the store, she was afraid to go out with him. He didn't listen, he was always into something, creating chaos.

I asked Janine if she could play with each child separately on the screen for a few minutes and then with the three children together as we video recorded the play. As she had described, the baby Jacob and his sister played with quiet, focused attention; Jared however had different ideas. After a few minutes with the toys, Jared began inspecting the family vacuum cleaner which was off in the corner of the living room. Little by little he took it apart, using parts for scarves and hats, ultimately constructing a tent for himself from the hose and various attachments.

Now that we are able to use video recording again, I was able to review this with Mom and we began to think about Jared together. I remarked on his ingenious use of the vacuum and wondered if this was typical of Jared's behavior and if perhaps, he was more interested in the real world around him than in typical toys. With great surprise, she agreed and began describing how he had taken apart their alarm clock and followed her around as she cleaned paying close attention to everything she did and copied it. Aloud I wondered if perhaps Jaden had a different sort of mind than the other children, might he become an inventor, a scientist? The "chaos" that he created began to have meaning and purpose. Janine began to think about her son in a different way.

In our work together, as mom offered Jared the consistent opportunity for the three of us to be together, Jared began to share some of his experience of himself as the bad child. He drew monsters again and again. In a particularly poignant moment, he pointed to a monster and said, "Mommy monster." To her great credit and courage, mom was able to reflect on this and then to think about what people's faces look like when they are really angry at you. And further, how when everyone thought of Jared as bad, as a monster, it became a self-fulfilling prophecy, his expectation of himself and his behavior.

The remarkable openness and courage of this family to face their monsters was deeply moving and had great rewards. In a follow-up with mom a year later, she reported Jared was settled comfortably into kindergarten and there had been no complaints at all.

The Dyadic Program: Looking Ahead to the Future

We are very pleased to report that we are using video recording again with families who are able to access Zoom and that we now have a secure, HIPPA compliant method of recording and viewing videos with families and storing the videos. This will allow us to provide pre-post intervention analysis of parent-child interactions next year. These videos will be coded by trained independent researchers who are blind to time of video and family information and are not members of the CFC team. This is the best way to provide unbiased, reliable, and valid outcome data on our clinical work.

In addition, new or revised assessment tools are already in use:

1. In 2021 we piloted and are now using the AMBIANCE-brief (Atypical Maternal Behavior Instrument for Assessment and Classification). During the past year, we invested in training our team in the use of this scale which screens for the acutely disrupted communication between parent and child that has frequently led to disorganized attachment, the category that carries the worst prognosis for future health and success of the child. The importance of identifying this vulnerability early cannot be overestimated, and we trust that it will deepen our ability to provide important treatment to the families we serve.

2. Since we added pregnant mothers to our group program in 2021, we designed a new instrument, the Pregnant/Parenting Group Pre-Post Intervention Questionnaire, that assesses the impact of these groups on the participant mothers. We anticipate sharing results in 2022.
3. For 2022, we have replaced our Pre-Intervention Questionnaire with a new Parent Demographic Survey that will allow us to capture information about all participants in a more uniform way.
4. We have also updated our Exit Survey for 2022.

The Group Program and Evaluation

Evaluation of the group program is predominantly qualitative with quantitative data from our Exit Survey (described above, and results reported below). Also as described above, the newly designed Pregnant/Parenting Group Pre-Post Intervention Questionnaire is being implemented in 2022.

Growing Together Group

This year we offered bilingual parent-child Growing Together Groups in the spring and fall.[11] The spring session with five mothers and babies were occasionally joined by older children. Babies ranged in age from 1.6 months to 34 months; of the parents three were English speaking, two Spanish speaking. The fall group was comprised of five mothers (three English speaking, two Spanish speaking) and five babies/toddlers again occasionally joined by older siblings. Both groups met weekly using a video platform for 45 minutes for 8-10 sessions. The group interventions included a predictable and consistent routine: our welcome song, a reflective discussion often accompanied by an art project to enhance it, an active-play activity that included dancing, singing, reading, or blowing bubbles, and our goodbye song.

<u>Reflective Discussion Themes and Snapshots:</u>

- Telling the story of baby's name
- Sharing family traditions that the parent would like to share with baby
- Sharing special objects and family activities (ex. a mom brought a stuffed animal to share; meanwhile, her toddler decided to bring his grandma's suitcase which he plays with every day)
- Describing a place where we belong (ex. a mom said: "we are a familia of moms - even though the group is for a short time, we get to share moments of our children's behaviors and interactions."

[11] CFC did not offer a summer parent-child group in 2021 because the city was opening up and parents and children, able to be outside were less available. At least five consistent dyads are necessary for a group to be successful; however, the summer group was under-enrolled and was not viable.

Mother's Comments - Favorite Parts of the Group:

- "Finding community with other moms."
- "Hearing everyone talk about their babies and realizing our struggles and stories are similar even if our lives are different."
- "Having a place to talk where I don't feel judged."
- "Singing, dancing, and reading stories together!"

One Mother's Reflections:

Recently, one of the dyads needed to say goodbye to the group as her child was entering fulltime daycare so that the mother could work. Mom told the group, "When I first found Chances for Children, I was looking for something to help my child with his development. What I really appreciated about everyone was that they focused on the parent-child relationship and the strengths that of the relationship. I got more than I could have dreamed of. I am so grateful to everyone, the therapists, parents that shared their stories and even the kids – seeing them interact with each other on the screen. You all created a safe zone to share the stressors and the realness of being a parent."

Empowering Motherhood Group

Started in 2021, this group was offered at one of our collaborating sites, the Cardinal McCloskey Early Head Start Program. The goal is to provide emotional support to pregnant mothers and mothers with newborns through a lens of infant mental health that encourages secure attachment and a reflective stance. Groups were 6-8 sessions and lasted one and a half hours and nine mothers attended, all Spanish speaking. One group was offered in the spring and one in the fall.

As with all groups, this group followed a predictable routine consisting of a warm-up (being with baby this week of the pregnancy), playtime activity for babies in utero or newborn, body-based affect regulation activity, topics for reflection (cultural expectations about motherhood), and a closing lullaby.

Meet Our Empowering Motherhood Group

As the Zoom windows open for the Empowering Motherhood Group every Thursday, mothers co-create a space in which all feelings, immense and small, unwelcomed and welcomed, have a safe and reflective place to be. I am surprised because it is a cold, glum, winter day and yet everyone comes, nine mothers, two of them joining today for the first time.

We are all amazed as Carmelita arrives! She gave birth only a week ago, a first-time mother recently relocated from Honduras, terrified of giving birth all alone during the pandemic. All the mothers, some of them breastfeeding, others heavily pregnant with their feet on pillows, spontaneously applaud. Carmelita teary-eyed says, "I would have never been able to make it without all of you! When I was in the middle of it all, I kept on singing our lullaby to my "bebé,"

and I told him: you have all these “madrinas” waiting for you. We are not alone, and your daddy is here too. I have been very scared of not knowing what to do, but I remember what Elaine said, “my baby and I are getting to know each other.”

Suddenly, Carmelita shows us her bebé Carmelito. One by one, all mothers bring their babies to the windows of the screen, newborns and babies in bellies, to greet him. Carmelita says, “See I told you bebé. We are not alone! There is love here!” All mothers blow kisses and we begin to play peek-a-boo.

One by one, mothers join the peekaboo fest! Elaine says, “See, this is why I can’t wait to come here! I would have never known that my baby had his own feelings, and that he would let me know…or that it is ok to talk about how hard is to be pregnant or have a newborn. No one told me that it would be this hard! And if you say something, everyone is disappointed or worse! I love that we can talk about our feelings, the real ones, the ones no one wants to talk about, like when we get desperate or something. Like these are real feelings all moms have, even my own mom had them! Now I understand why she sometimes was so hard with me.” Now, Elaine hugs her very pregnant belly and says looking down, “Juanito you know that mommy is learning, and I will be the best mommy I can be! We will learn together.”

Suddenly there is silence, mothers are reaching into each other’s windows hugging each other, feeling deeply connected, even during the pandemic.

We take a deep breath. Time to sing our lullaby and say until next time! “Arroro mi niño; Arroro mi sol; duermete pedazo de mi corazón! (Shhhh, my child, Shhhh my sun; go to sleep my heart).

Exit Survey Results

As stated above, the exit survey was conducted with both dyadic and group participants. Data was collected from 55 participants. (Not all parents were able to be contacted, the researcher attempted to contact each parent by phone at least three times).

With one exception (described below*) all respondents agreed or strongly agreed that:

- Sessions with my therapist have helped begin to resolve the problem that brought me to Chances for Children.
- Interactions with my therapist have been a source of support during this time of isolation.
- Chances for Children offered me strategies and activities that help me play with my child and support her/his development.
- I look forward to speaking with my therapist.
- I feel like I understand my child better since receiving services from Chances for Children.
- I would recommend Chances for Children services to other families.

With the exception of two parents, all parents agreed or strongly agreed that:

- Participation in Chances for Children program has helped me feel less stressed during the COVID-19 pandemic.
- It is easier to find words to explain to my child why everything is so different.
- Chances for Children sessions have helped me understand how the COVID-19 pandemic impacted my child's behaviors.

*We were aware during intervention, that one mother was very frustrated by the telehealth platform and had significant difficulty making it function successfully. Because the survey is anonymous, we cannot know for certain but imagine that it was this participant who made her frustration clear in her exit survey responses.

Parent Comments Expressed in the Exit Survey

Parents expressed the following comments about the services they received (each comment is first noted in the language in which it was expressed):

- **My therapist was amazing. It was very helpful and comforting opening up to her.** Mi terapista fue increíble. Fue muy útil y recomfortante abrirme a ella.

- **Everything was perfect; the therapist was respectful and understanding; it was beautiful.** Todo fue perfecto; la terapista fue respetuosa y comprensiva; fue hermoso.

- En la pandemia, los ninos estan encerrados pero los talleres han ofrecido la oportunidad de socializar atravez de la pantalla, aunque no es lo mismo. **During the pandemic, children were in lockdown, but the groups offered the opportunity to socialize through the screen, although it was not the same.**

- Me encanto la terapeuta y me dio mucho apoyo, no tan solo a mi hijo sino a mi tambien. **I love my therapist; she gave me a lot of support, not only to my son but to me as well.**

- Agradecida con el apollo. Mi otro hijo tambien beneficio porque estaba en casa durante las sesiones. **I am so grateful for the support. My other son also felt the benefits because he was at home during our sessions.**

Supporting Collaborating Partner Organizations

Our clinical team provides consultation and training to early childhood and early education professionals and paraprofessionals working for organizations within the community. Our goals are to infuse infant mental health principles into these programs, to support early childhood practitioners and the parents they serve in dealing with pandemic stress, and to aid them in assisting families and their very young children with COVID-19 related illness and loss.

During 2021, our clinical team provided:

- **Training**: Six interactive, relationally based, trauma-informed trainings (ex. "How to keep in mind parents and their little ones without losing sight of yourself") were provided to early education professionals and management in collaborating Head Start Programs to support their coping with pandemic induced stress.
- **Consultation:** Regular weekly reflective consultation and relational developmental guidance was provided to directors, teachers, and early childhood professionals at McCloskey Early Head Start Home Based Program. Consultation was provided for four to six hours each week.
- **Interactive workshops** were presented to parents of the McCloskey Head Start Program. Seven workshops were provided and 27 parents attended. These workshops focused on helping young children understand loss and transitions in family life during the COVID-19 pandemic, parental stress management, parental practices in the context of culture and prevention of harsh childrearing practices, and general developmental guidance on typical stress reactions of young children.
- **Presentations** were provided to organizations in the community also serving families with young children to educate their staff about infant mental health. Thirteen presentations were conducted in 2021.
- **Virtual Open Houses** were offered to the community to raise awareness about the importance of infant mental health and strong parent-child relationships. Four virtual open houses were provided throughout the year and were attended by foster care workers, nurse practitioners, and other early childhood professionals.

Conclusion

2021 was an exciting year for Chances for Children. Our team continued to develop new strategies to deliver the services to the families who are part of our program and new ways to evaluate the work we are doing. In order to do this Chances for Children needed a strong leadership team and we now have it with Co-Executive Directors Silvia Juarez-Marazzo and Lillian Rountree. They are developing systems that will allow the organization to expand and ways to support our therapists so that they can provide the highest quality care to the families.

During the pandemic, predictable routines have been challenging for families and service providers: day care centers and schools continue to open and close; families are affected by job loss, illness, and death of loved ones. Consistency in our services is a major goal for Chances for Children and during the past year our therapists have shown up for appointments every week at appointed times and the families have responded by showing up for those appointments using whatever technology is available to them. Our evaluation for 2021 shows successful outcomes.

We are deeply grateful to our funders who have so generously made it possible for us to support some of our city's most vulnerable infants, young children, and their families.