Helping Young Children Who Have Experienced Trauma: Policies and Strategies for Early Care and Education

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Executive Summary

Many young children are exposed to traumatic life events.[1,2] Almost half of children in the United States—approximately 35 million—have experienced one or more types of trauma,[3] and young children are at especially high risk compared to older children. Over one quarter of all children with confirmed cases of child abuse and neglect are under age 3, and victimization is most common for children under 12 months old.[4] Unintentional injuries, such as drowning, falls, burns, choking, and poisoning, also occur most frequently among children ages 5 years and younger.[5] In addition, children who experience domestic violence are disproportionately young, with 60 percent under age 6 at the time of exposure.[6]

Early childhood trauma occurs when a young child experiences an event that causes actual harm or poses a serious threat to the child's emotional and physical well-being. These events range from experiencing abuse and neglect to having a parent with substance abuse issues or being separated from a parent.[7] Trauma is different from regular life stressors because it causes a sense of intense fear, terror, and helplessness that is beyond the normal range for typical experiences.[8]

Trauma has been shown to negatively impact early brain development, cognitive development, learning, social-emotional development, the ability to develop secure attachments to others, and physical health.[9] However, each child's reaction to trauma is unique and depends on the nature of the trauma, characteristics of the child and family, and the overall balance of risk and protective factors in the child's life. While almost all children experience distress immediately after a traumatic event, most return to their typical functioning over time with supports from parents and other caregivers.[10] Generally, trauma that begins early in life, takes multiple forms, is severe and pervasive, and involves harmful behavior by primary caregivers has been linked to the most serious symptoms of posttraumatic stress and negative child outcomes.[11]

Despite trauma being widespread and detrimental to the well-being of infants, toddlers, and preschoolers, few early care and education (ECE) programs and state systems are prepared to offer care that is *trauma-informed*—with all adults able to recognize and respond to the impact of trauma on young children, and to infuse trauma awareness, knowledge, and skills into program culture, practices, and policies.

In this report, we describe early childhood trauma and its effects, offer promising strategies for ECE programs and systems to help young children who have experienced trauma, and present recommendations for state policymakers and other stakeholders looking to support trauma-informed ECE for this vulnerable group.

Promising strategies for trauma-informed care in early care and education

To address the needs of young children who have been exposed to trauma, ECE programs and systems can provide *trauma-informed care* (TIC). TIC supports children's recovery and resilience using approaches that have been shown, through evaluation, to work—that is, TIC uses *evidence-based* approaches.[12]

Although TIC is a relatively new approach, several promising approaches to TIC have emerged:

- integrating trauma-informed strategies into existing ECE programs to support children in those programs who have experienced trauma,
- building partnerships and connections between ECE and community service providers to facilitate screenings of and service provision to children and families,
- implementing professional standards and training for infant and early childhood mental health consultants that emphasize TIC, and

- supporting the professional development and training of the ECE workforce in working with and supporting young children who have experienced trauma.

Recommendations

Policies can play an important role in developing and supporting the programs and professionals in the lives of young children who have experienced trauma. The following recommendations would increase the availability of and access to high-quality, trauma-informed ECE and related supports for young children's healthy development. These recommendations have direct relevance to state-level policymakers, but also apply to program directors, community, state, and federal leaders in the field of early childhood, as well as advocates for other aspects of high-quality ECE programming (e.g., Quality Rating and Improvement Systems,[a] infant and early childhood mental health consultation[b]).

1. **Strengthen the early care and education workforce by increasing early care and education professionals' capacity to provide trauma-informed care.**

    a. Incorporate strategies that benefit children who have experienced trauma into ECE professional development.

    b. Increase the capacity of infant and early childhood mental health consultants to incorporate trauma-informed approaches.

    c. Increase support to ECE professionals who experience high levels of stress at work as a result of working with children who exhibit challenging behaviors related to trauma.

2. **Expand initiatives that help early care and education programs connect families with community services.**

    a. Invest in initiatives that help ECE programs connect families with children who have experienced trauma to screening and services that can address their needs.

3. **Provide children who have experienced trauma with high-quality, stable early care and education and strong early learning supports.**

    a. Establish policies for ECE programs that promote continuity of care and participation in ECE for children who have experienced trauma.

    b. Establish policies that promote the placement of young children who have experienced trauma in high-quality ECE programs.

    c. Develop policies that severely limit or prohibit the suspension and expulsion of young children, and require appropriate interventions for children who have experienced trauma and have social-emotional or behavioral difficulties.

    d. Establish screening and educational support policies that respond to both the social-emotional and early learning needs of children who have experienced trauma.

Historically, society has overlooked the impact of early childhood trauma, perhaps due to misconceptions that very young children do not fully perceive traumatic events, or that they will always "bounce back" from them. In reality, the first few years of life constitute a period during which children are highly sensitive to trauma—more so than during any other time of life.

[a] The U.S. Department of Health & Human Services' Office of Child Care defines QRIS as "a systemic approach to assess, improve, and communicate the level of quality in early and school-age care and education programs. Similar to rating systems for restaurants and hotels, QRIS award quality ratings to early and school-age care and education programs that meet a set of defined program standards." See https://qrisguide.acf.hhs.gov/index.cfm?do=qrisabout.

[b] The Substance Abuse and Mental Health Services Administration defines IECMHC as "an evidence-based approach that pairs mental health professionals with people who work with young children and their families." See https://www.samhsa.gov/iecmhc.

Introduction

In almost every early care and education (ECE) program across the country, there are children who have experienced trauma or who will, during their early childhood, experience traumatic events. Trauma in early childhood takes many forms, including abuse or neglect, witnessing violence, and having prolonged separation from or loss of a parent. An extensive body of research has documented the negative impacts of trauma on young children's behavior, learning, and other long-term school- and health-related outcomes.

The prevalence of early childhood trauma is difficult to establish, as researchers typically focus on specific forms (e.g., child abuse and neglect). However, one study found that 70 percent of children endure three or more *adverse childhood experiences*—highly stressful *or* traumatic events—by the time they reach 6 years old.[13] The high prevalence of trauma and the potential magnitude of its effects underscore a critical mandate for ECE programs and associated systems: to identify and implement promising strategies for supporting the healthy development of children who are victims of trauma.

Children in families at all economic levels experience trauma, but early childhood trauma occurs more often in families facing financial hardship.[14] Because many young children spend long hours in ECE programs,[15] it is important to understand the challenges of children who experience trauma, of their families, and of their teachers. It is equally important to identify features of programs (both center-based and in homes) that help these children form positive relationships, feel safe and secure, and enjoy learning and playing with their peers and caregivers.

This report includes:

- a definition of early childhood trauma, including different types, and its prevalence;
- the impacts of early childhood trauma on the child, family, and ECE programs;
- the special needs of young children who have experienced trauma;
- a description of trauma-informed care;
- promising program strategies to support the healthy development and learning of young children in ECE; and
- recommendations of policies that could increase the capacity of ECE providers to help children who have experienced trauma learn and thrive.

What is Early Childhood Trauma?

Early childhood trauma occurs when a young child (here, birth to age 6) experiences an event that causes actual harm or poses a serious threat to the child's emotional and physical well-being.[16] Trauma is different from regular life stressors, because it causes a sense of intense fear, terror, and helplessness that is beyond the normal range of typical childhood experiences.[17] Common types of trauma during this developmental period include:

- abuse and neglect;
- serious, untreated parent mental illness or substance abuse;
- witnessing domestic violence;
- prolonged separation from or loss of a loved one; and
- incurring serious injuries or undergoing painful medical procedures.

Some children face multiple types of trauma simultaneously or over time. Trauma exposure that begins early in life, takes multiple forms, is severe and pervasive, and involves the caregiving system (parents and other primary caregivers) is referred to as complex trauma.[18]

Historically, society has overlooked the impact of trauma on young children, perhaps due to misconceptions that infants, toddlers, and preschoolers are not capable of perceiving or remembering such circumstances or events.[19] Another myth is that young children always "bounce back" from adversity. In fact, research demonstrates that the first few years of life constitute a period during which children are highly sensitive to trauma, and more vulnerable to its negative effects than during any other period of life.[20] Children are aware of traumatic experiences when they occur and can show signs of distress beginning in the first weeks of life; long-lasting trauma symptoms have been found to begin in infants as young as 3 months old.[21]

The prevalence of trauma in early childhood is high.

Trauma is common in early childhood. Almost 35 million children in the United States (approximately 48 percent) have been exposed to one or more types of trauma,[22] and young children are at disproportionate risk compared to older children. Young children also are more likely to be victims of abuse and neglect,[23] drowning, burns, falls, suffocation, and poisoning,[24] and to live in homes with domestic violence.[25] For example, over one quarter of all children with confirmed cases of child abuse and neglect are under age 3, and victimization is most common among children under 12 months old.[26] Unintentional injuries (e.g., drowning, falls, burns, choking, poisoning) occur most frequently among children 5 years and younger.[27] Children who are exposed to domestic violence also are disproportionately young, with 60 percent under 6 years old.[28]

Research on adverse childhood experiences (ACEs) suggests that many young children also endure complex trauma. Approximately 70 percent of children experience three or more ACEs by the time they reach 6 years old.[29] Certain types of trauma are especially likely to co-occur in young children's lives. For example, between 30 and 60 percent of maltreated children live in homes with domestic violence,[30] and as many as 79 percent of children in foster care have experienced both child maltreatment and parental substance abuse.[31]

The prevalence of trauma exposure among children who are enrolled in ECE programs is not well understood. However, one national study of children who have experienced child abuse and neglect found that almost 30 percent of child-welfare-involved children were in child care programs, with 21 percent in Head Start.[32]

Early childhood trauma is unique.

Research shows that early childhood trauma differs from trauma that occurs later in life.[33] Not only is it especially prevalent in early childhood, but young children have different responses to trauma than do older children and adults. Infants and toddlers cannot verbalize their feelings, talk about frightening events, or describe their nightmares. Preschoolers have not yet fully developed the skills to express feelings of being afraid, overwhelmed, or helpless. As a result, young children exhibit a range of behaviors that adults may not recognize as reactions to trauma (e.g., excessive crying, distress, regression, aggression, withdrawal, physical symptoms, acting out traumatic events during play).[34]

Some of these behaviors may look similar to those of their peers, yet may not be amenable to typical approaches that adults use to address challenging behavior (e.g., redirection, helping a

Early childhood trauma generally refers to the traumatic experiences that occur to children ages zero to 6.

Because infants' and young children's reactions may be different from older children's, and because they may not be able to verbalize their reactions to threatening or dangerous events, many people assume that young age protects children from the impact of traumatic experiences. However, young children are affected by traumatic events, even though they may not understand what happened.

Source: National Child Traumatic Stress Network. Available at http://www.nctsn.org/trauma-types/early-childhood-trauma

child express feelings in a constructive way, removing a child from the situation). Sometimes, even strategies that normally work well to promote positive behavior (e.g., praise, a gentle touch on the shoulder, a reward) increase a child's stress, because they remind the child of a traumatic event.[35]

Because early childhood trauma can be both difficult to identify and to address successfully, it is essential that the adults who care for young children—including ECE professionals—learn how to recognize trauma reactions and respond appropriately.[36]

The Impacts of Early Childhood Trauma

Impact on children

Trauma takes a toll on children, parents, families, workers in ECE programs, and society generally. Many children return to functioning normally after a traumatic event, particularly if it was a single incident. Others, especially those who experience complex trauma, suffer serious and long-lasting consequences.[37] Generally speaking, more severe and chronic trauma leads to more problematic child outcomes.[38] However, the particular impact—and a child's ability to recover—depends on the age of the child, the nature of the trauma, and the presence of other risk factors (e.g., parental mental illness, poverty, community violence, social isolation) and protective factors (e.g., a nurturing caregiver, social support, concrete supports).[39] For instance, young children who live in poverty and are exposed to trauma are more vulnerable to its negative effects than are children living in higher-income families.

Impact on brain development. Early experiences influence brain development, and trauma can interfere with brain in several ways, including interfering with executive function and self-regulation, and limiting brain volume (which is critical to emotion regulation, cognition, and behavior).[41] *Executive function* and *self-regulation* skills are the mental processes that allow individuals to engage in planning, focus our attention, remember instructions, and balance multiple tasks at once.[42] Traumatic stress can reduce children's ability to cope with stress effectively, leading them to overreact or fail to respond appropriately.[43] Moreover, chronic trauma (e.g., neglect) is linked to smaller brain volume; poor information processing, self-regulation (the ability to control impulses, focus attention, solve problems, and organize behavior), and attention; and mental health disorders later in life.[44]

Impact on cognitive development and learning. Young children who experience trauma show cognitive and language delays that place them at risk for early learning difficulties and later academic challenges.[45] One study found that over one quarter of maltreated children had serious language delays.[46] A fifth of maltreated children had very low scores on a measure of attention, understanding of concepts, and other cognitive skills that predict school readiness. Without intervention, early difficulties with language or attention, or other delays, can persist and undermine school performance among young victims of trauma.[47]

Impact on social-emotional development. Early trauma is associated with myriad social-emotional problems in childhood, adolescence, and adulthood. Short-term consequences include difficulties coping with stress, feelings of helplessness, worthlessness, and hopelessness, low self-esteem, and feeling responsible for bad things that happen.[48] Behavior problems are also common,[49] and may lead to more serious behavior problems and poor social skills.[50] Post-traumatic stress disorder (PTSD) also can occur in early childhood. Approximately 39 percent of preschoolers develop PTSD following a traumatic event,[51] and PTSD has been described in infants as young as 12 months old.[52] Young children who experience trauma also are at high risk for anxiety and depression, difficulty with social situations, and trouble accepting praise later in life.[53]

Impact on attachment. Trauma threatens young children's ability to form and maintain secure attachment relationships.[54] Problems with attachment can stem from issues in relationships

with primary caregivers (e.g., loss of a parent, abuse, neglect, domestic violence) and create a blueprint for relationships later in life. Children may show mistrust, withdrawal, or aggression with others. They may also have difficulty developing and maintaining healthy friendships, romantic relationships, and positive interactions with authority figures.[55] Thus, it is critical when working with young children who have experienced trauma to support their primary attachment relationships.[56]

Impact on physical health and development. Some traumatic events can cause immediate physical harm (e.g., a car accident, physical abuse). In other cases, physical effects appear over time. For example, early childhood trauma can have long-lasting effects by causing biological disruptions that lead to health problems in adulthood, including heart disease, cancer, alcoholism, depression, drug abuse, obesity, and smoking.[57]

Impact on parents and families

Caring for a child affected by trauma can be challenging for parents and other primary caregivers (e.g., grandparents, other family members and kin; hereafter referred to as "parents"). A child's trauma can have a strong influence on other family members and their relationships.[58] Parents are most often children's source of support after a traumatic event. A parent's warm response following a child's trauma exposure is associated with fewer symptoms of PTSD,[59] whereas their overprotectiveness or avoidance may increase a child's risk for PTSD.[60]

Impact on parents. Caring for a young child who is a victim of trauma is stressful, which may negatively affect parenting. For instance, parents' distress may interfere with their ability to respond sensitively, contributing to further distress in the child.[61] Parents and other caregivers may also have been involved in the same traumatic event as their children (e.g., domestic violence, natural disaster, war).[62] In such instances, negative reactions from either the parent or the child may intensify symptoms in the other.[63] A child's trauma may be an emotional trigger for a parent who has been a victim of trauma. In some cases, parents may be overwhelmed by these triggers, and may respond to their own needs before those of their children.[64]

Impact on families. Caring for a young child who has experienced trauma also affects other aspects of family life. When families are stressed and their emotional resources are limited, daily routines may become more difficult, and conflicts within the parenting couple or sibling relationships may develop. In some cases, family members endure enforced separations and dangerous circumstances, such as those associated with domestic violence or child maltreatment.[65] Finally, adults may miss time at work because ECE programs have difficulty managing children's challenging behaviors and may suspend or expel children, or send them home early.[66]

Impact on early care and education programs

ECE programs are impacted by early childhood trauma through children's challenging behaviors, and the strain they place on ECE professionals who must manage them. Young children's externalizing (acting out) behaviors, in particular, have negative effects on ECE teachers and classrooms.[67] ECE teachers may experience high levels of stress, burnout, and turnover. Other negative effects of early childhood trauma on ECE programs include disruptions to routines, activities, and learning among other children.

Impact on preschool suspension and expulsion. Some young children entering ECE programs have problems severe enough to limit their ability to participate in routine activities, and thus to reap the full benefit of ECE.[68] Families of these children may even be asked to leave ECE programs. In fact, the national rate of preschool expulsion in state-funded pre-kindergarten programs is over 3 times the rate of expulsion in kindergarten to 12th grade (6.7 versus 2.1 per 1,000 children enrolled).[69] In private child care programs, the rate of preschool expulsion has been found to be even higher.[70] Black children and boys are at especially high risk for expulsions and suspensions, due in part to implicit bias by teachers and programs.[71]

Impact on teacher stress, burnout, and turnover. Job stress reduces the capacity of ECE professionals to work effectively with children who have emotional and behavioral problems.[72] For example, high levels of workplace stress have been shown to lead to teacher-child conflicts in Head Start.[73] Many ECE professionals feel unprepared to cope with these children, and may feel torn between attending to a particular child's needs or focusing on the group.[74] The demands of managing children with severe emotional and behavior needs, especially in the absence of adequate training, support, and self-care, often leads to secondary traumatic stress (feeling mentally, emotionally, or physically exhausted or overwhelmed by working with children affected by trauma), burnout, and turnover among staff.[75]

Such stressors, in combination with other factors (e.g., insufficient compensation, limited support from leadership) may contribute to high rates of teacher turnover. Each year an estimated 25 to 50 percent of preschool teachers leave their jobs,[76] and almost one fifth of center-based staff leave the field entirely.[77] Turnover disrupts teacher-child attachments, adversely impacts children's learning, and threatens the emotional well-being of all children in ECE programs.[78]

Impact on society

Early childhood trauma places a heavy burden on society. The behaviors and conditions associated with early trauma can lead to dependence on a wide range of systems, such as child welfare, juvenile and criminal justice, and physical and behavioral health. In addition, trauma that goes unaddressed early in life can manifest in later behaviors that disrupt school and work environments.[79] Moreover, there are financial consequences. For example, in the United States, the estimated total lifetime cost to society associated with one year of confirmed cases of child maltreatment is $124 billion.[80]

Meeting the Needs of Young Children Who Have Experienced Trauma

All children benefit from stable, safe, and nurturing relationships and environments.[81] However, these relationships and environments are particularly important for young children who have experienced trauma. Their presence and stability can help children recover from past trauma and develop the skills to cope and thrive.[82]

Presence and continuity of a nurturing caregiver. An extensive body of research shows that children who do well despite adversity have at least one stable and nurturing adult caregiver in their lives.[83] Adults who serve in this role can:

- facilitate children's coping with trauma by helping them process events and giving meaning to experiences,
- protect children from re-traumatization, and
- promote children's self-regulation skills.[84]

ECE professionals have a critical role in helping young children recover from trauma. Many young children spend much of their day in ECE programs (in 2011, approximately 60 percent of children under age 5 were in child care; preschoolers spend an average of 33 hours per week in care).[85] Children benefit from relationships with ECE professionals who care for them in trauma-sensitive ways. To provide this type of care, ECE professionals need adequate training on the impact of trauma on young children, on effective strategies for identifying and addressing trauma, and on helping families access community services. To prevent secondary traumatic stress[86] (the experience of feeling mentally, emotionally, or physically exhausted or overwhelmed by working with children affected by trauma), ECE professionals also need *reflective supervision*—a collaborative relationship between supervisors and program staff that promotes professional growth and improves program practices and quality.[87] And, they need time for self-care.

Children benefit when ECE staff also promote parents' well-being. When parents' physical, mental, and emotional needs are met, they are more likely to give sensitive care. A positive alliance between ECE professionals and parents, in which staff recognize families' strengths and values, encourage families to participate in children's education, and engage family members in planning to make progress toward their goals, is essential to children's social-emotional well-being. ECE programs can help young victims of trauma by working with parents and other caregivers to help them gain access to concrete supports (e.g., medical, mental health, educational, and legal services), emotional supports (e.g., social support, self-care), and other community services (e.g., evidence-based trauma treatment and other mental health services, primary medical care, supports from child welfare, Early Intervention,[c] home visiting[d]).

Environments that promote safety and trust. Environments that promote safety and trust, both at home and in ECE programs, help young children heal from traumatic experiences by restoring a

[c] Early Intervention are services for children, birth to age 2 with disabilities, and their families provided through The Program for Infants and Toddlers with Disabilities (Part C of IDEA). See http://ectacenter.org/partc/partc.asp for additional information.
[d] Home visiting consists of services that are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from birth to kindergarten entry, that target outcomes including maternal and child health; prevention of child injuries; reduction in/prevention of child abuse, neglect, and emergency department visits; school readiness and achievement; reduction in domestic violence; parenting skills; and referrals to community resources and supports. See https://homvee.acf.hhs.gov/HomVEE_Executive_Summary_Summary_03162017.pdf

feeling of control and predictability. Consistent routines and appropriate expectations are also important. In addition, ECE professionals can identify and limit those experiences that may re-trigger a child's trauma (e.g., smells, sounds, sudden movements).[88] They can prepare children to cope with these triggers, provide a safe space for verbal children to talk about their experiences and feelings, and offer opportunities for parents, too, to learn these skills and create safe environments at home.

Environments that promote self-regulation and social-emotional skills. Promoting children's self-regulation skills can help them heal from trauma.[89] Young children's experiences in the first years of life affect their ability to calm themselves, communicate effectively, get along well with peers and adults, take pride in their accomplishments, and become more aware of their feelings and behaviors. ECE providers also can help children by practicing *co-regulation*—nurturing interactions in which they model and coach self-regulation skills when children face stressful situations or trauma triggers. They can also work with families to learn how to support children's self-regulation skills.

Environments that promote early skills needed to succeed in school. To avoid serious delays in the language skills that promote self-regulation and success in school,[90] children who have experienced trauma are particularly in need of environments in which adult caregivers, including ECE professionals, actively promote their language development through conversations, interactive book reading, and activities that help build vocabulary and the ability to understand and use increasingly complex language.[91] Similarly, these children benefit from environments that offer strong supports in the social-emotional, early math, and language domains, so that they enter school ready to learn.[92]

Putting It Together: Trauma-Informed Care for Young Children

Researchers, practitioners, and policymakers recognize that addressing childhood trauma will take more than any single individual, service, or intervention. Thus, helping young children overcome traumatic experiences cannot be the sole responsibility of parents, the mental health system, or ECE staff. Rather, a systemic approach, often called trauma-informed care (TIC) or a trauma-informed approach, is needed. Defining *trauma-informed* is challenging, due to variations in interpretation of its components. The National Child Traumatic Stress Network's definition of a trauma-informed service system is a helpful starting point (see text box).

A trauma-informed child- and family-service system is one in which all parties recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.

Source: National Child Traumatic Stress Network http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

TIC includes all of the people in young children's lives. For an ECE program, TIC means increasing knowledge and skills among bus drivers, classroom assistants, teachers, family service workers, program leaders, families, mental health consultants, and anyone else who comes into contact with young children.

In TIC, training ECE staff and increasing their awareness about early childhood trauma is critical, but it is not enough.[93] TIC also requires collaboration with other community service organizations to address the needs of traumatized children proactively and to establish program, local, and state policies that address their unique needs.[94] Successful TIC requires coordinated efforts at all levels.

If we overlook the impact of trauma on young children, we may inadvertently prolong their exposure, cause re-traumatization, and impede their process of recovery. ECE programs that become trauma-informed and trauma-responsive settings, and that collaborate with other service systems, support the optimal development of all children, including children with and without formally documented trauma. Fortunately, there are a number of promising TIC strategies for young children that can be effective in ECE systems.

Promising Strategies for Meeting the Needs of Young Children Exposed to Trauma

Despite the fact that the majority of ECE professionals work with traumatized children every day, promising strategies within ECE programs and systems for addressing the needs of those children have only recently begun to emerge. Moreover, few strategies have been rigorously evaluated. Nevertheless, (though not all of these have been evaluated), a number of innovative approaches, including initiatives within existing ECE programs, have been implemented.

Here, we review some of these promising practices. See "Appendix A" for more detailed descriptions of these strategies and evidence of their effectiveness.

Integrating trauma-informed care into early care and education programs

Several early childhood trauma strategies have been designed to be integrated into existing ECE programs. Some take the form of curricula emphasizing evidence-based or evidence-informed approaches to meeting the needs of young, trauma-impacted children and their families. Others focus on establishing partnerships between ECE and mental health. Still others offer services in a wide range of settings that include ECE. Below are a few examples of promising approaches to the integration of TIC in ECE.

Trauma Smart (TS) is an early education/mental health partnership designed for Head Start classrooms. The goals of TS are to reduce the stress of chronic trauma, support children's social and cognitive development, and develop an integrated, trauma-informed culture for young children, parents, and staff. TS includes training, classroom consultation, intensive evidence-based clinical treatment, and peer mentoring of teachers. An evaluation of TS found that teachers reported significant improvements in children's externalizing behavior (including defiant and oppositional behavior) and attention. Parents reported significant reductions in externalizing behaviors, internalizing behaviors (depression, anxiety), and inattention/hyperactivity.[95] A rigorous evaluation (a randomized controlled trial [RCT][e]) is currently underway.

Kids in Transition to School (KITS) is a curriculum for ECE programs that promotes psychosocial and academic school readiness among children in foster care and/or at high risk for school difficulties. Delivered during the transition from preschool to kindergarten, KITS includes playgroups to enhance children's social-emotional skills and literacy, and parent workshops to promote involvement in early literacy and positive parenting practices. Evidence from RCTs indicates that children in KITS had lower levels of oppositional and aggressive behaviors compared to children in the control group;[96] KITS also had positive effects on early literacy and self-regulation skills.[97]

Let's Connect (LC) is an intervention that promotes resilience and well-being among caregivers and children who have experienced stressful life events such as trauma. LC includes teacher training, modeling positive interactions with children and their caregivers, live coaching of teachers, and ongoing consultation with teachers by a therapist. It can be integrated with evidence-based parent treatment (e.g., Trauma Focused Cognitive-Behavioral Therapy[f]). LC has been used in Head Start programs and schools. Pilot studies indicate that LC activities are feasible to implement, and are viewed positively by caregivers. They also found improvement in caregivers' communication of positive emotions and their connection and emotion-support skills with family members, and reductions in their communication of negative emotions with family members from pre- to post-treatment.[98] An RCT of LC in Head Start is underway.

Safe Start was developed by the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) to mitigate the negative consequences of children's exposure to violence and to enhance the well-being of children and adolescents through preventive interventions. Programs use different approaches: some provide services only to children; others serve children and their families. All include a therapeutic component, and many offer case management and/or service coordination for families. Intervention sites vary (e.g., homes, clinics, shelters, child centers, Head Start classrooms). An RCT of Safe Start in a Michigan Head Start program found significant improvements in reported symptoms of child PTSD, and in social-emotional competence and academic achievement.[99]

[e] An RCT is a study in which participants are assigned by chance to different groups. See https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0025811/.

[f] For additional information about Trauma-Focused Cognitive Behavioral Therapy, see https://tfcbt.org/about-tfcbt/.

Therapeutic early care and education programs

Some licensed child care programs provide a specialized therapeutic environment for children who have experienced trauma. This approach differs from those that emphasize general inclusion of young children with disabilities, including social-emotional disabilities such as PTSD, in high-quality early childhood programs.[100] The programs described below have demonstrated positive outcomes for children, and use specific strategies that may be applicable to inclusive classrooms and to the broader field of ECE.

Childhaven Childhood Trauma Treatment (CCT) provides therapeutic child care and optional specialized services for maltreated and/or drug-affected children and their families. Treatments focus on the child and caregiver together, using evidence-informed approaches. Results of an RCT showed that families in CCT showed more parental responsiveness and a more positive emotional climate compared to families in the control group. Children displayed less aggression, fewer physical complaints, less anxiety/depression, fewer social and attentional problems, fewer internalizing behaviors, and a greater degree of social acceptance by peers.[101]

Children's Relief Nurseries (CRN) offer services to families with young maltreated children and those at high risk for child welfare system involvement. Services are free, and include therapeutic ECE in classroom settings, home visits, parent education and support groups, respite care, case management and assistance accessing basic resources and other community services. Some nurseries focus on responding to trauma. For example, Portland's CRN/LifeWorks NW provides Child-Parent Psychotherapy (CPP),[102] adult mental health treatment, and other intensive programming. A recent evaluation found that CRN parents read more frequently to children, family functioning improved, and parent-child interactions were more positive. Parents had fewer risk factors (out of 23 targeted by the intervention; e.g., child welfare and foster care involvement, mental and physical health, poverty, and family violence) and reported high levels of satisfaction with services.[103]

Partnerships between early care and education and community service providers

To meet the needs of young children who have experienced trauma and their families, some ECE programs develop close partnerships with community agencies that can provide additional services. Examples include trauma screening, referral, and service coordination, including linking children and families to evidence-based trauma treatments and practices. ECE programs also can help connect families to court and legal services that are trauma-focused. Below are several promising initiatives in these areas.

The Centralized Referral System (CRS; "LINK-KID") provides free statewide trauma screening, referral, and follow-up services to evidence-based treatments for children in Massachusetts exposed to trauma through a toll-free number staffed by master's-level social workers. An initial evaluation found that the average wait for a first appointment was 25.5 days, compared to 180 to 360 days for children seen in area local mental health agencies.[104]

Help Me Grow (HMG) promotes early identification of and supports for children at risk for developmental and behavioral problems. Core components include (1) outreach to child health care providers to support their use of screening and HMG resources; (2) a centralized telephone line that a parent, early childhood professional, pediatrician, or other concerned person can call to obtain information about screening and services for a family; (3) community outreach to encourage service providers to use HMG and network to coordinate services; and (4) data collection that helps identify gaps in services for families that can inform policy initiatives. Implementation research on HMG showed that 85 percent of children and families referred were connected with community-based programs and services, and that services were associated with an increase in protective factors.[105]

Safe Babies Court Teams (SBCT) is an initiative in which courts coordinate with child welfare agencies and other organizations to facilitate service delivery to infants and toddlers in the child welfare system. SBCTs have been replicated across the country. Each team is a public–private collaboration between ZERO TO THREE,[9] local courts, community leaders, child and family advocates, child welfare

[9] ZERO TO THREE is an organization that uses the science of early development to develop resources, tools, and policies to ensure that infants and toddlers have a strong start in life. https://www.zerotothree.org/.

agencies, ECE providers, government agencies, private philanthropies, nonprofit and private service providers, and attorneys committed to improving community response to child maltreatment. Evaluation findings show that SBCT is associated with significant gains in key child welfare outcomes (safety, permanency, well-being).[106] A second study found that children in SBCT reached permanency 2 to 3 times faster and exited the foster care system one year earlier than did children in a matched comparison group, and they were more likely to find a permanent home with a member of their biological family.[107]

Infant and early childhood mental health consultation

Currently operating in more than half the states, early childhood mental health consultation (IECMHC) is a multi-level preventive intervention where mental health professionals work with ECE professionals, programs, and families to improve children's social, emotional, and behavioral health and development. The approach includes observations, individualized strategies, and early identification of children with and at risk for mental health challenges.[108] Most IECMHC does not specifically focus on child trauma. However, Project Play in Arkansas has a trauma focus, prioritizing consultation services to ECE programs that serve children in foster care, helping staff understand children's behavior in relation to trauma, and placing a particular emphasis on working with ECE professionals to strengthen features of care that are important for children who have been exposed to trauma (e.g., continuity of care, and a nurturing relationship). A review of 14 studies that used rigorous methods reported generally positive results for key outcomes, including an increase in positive child behaviors and a reduction in challenging behaviors.[109] Studies also show that IECMHC prevents preschool expulsion,[110] reduces parental stress and missed work time,[111] and decreases teacher stress and turnover.[112]

Professional development and training

Accompanying increasing recognition of the mental health needs of very young children has been interest in related professional development and training opportunities for ECE professionals. A number of web-based trainings on child trauma show promise. In addition, endorsement systems for competence in infant mental health have helped guide development for professionals who work with infants and their families. Such systems can help equip ECE providers to work with young trauma victims. However, the majority of professional development and training efforts have not yet been rigorously evaluated. Below are several examples of promising approaches to professional development and training.

The Michigan Association of Infant Mental Health (MI-AIMH) Competency Guidelines and Endorsement offers a guide for individuals working with pregnant women and families with children from birth to age 5, and for those who provide training to those workers, on culturally sensitive, relationship-focused practices that promote infant mental health. Practitioner skills and knowledge in child trauma are a key component at all four levels of endorsement.[113] As of 2016, 27 states and 18 state infant mental health associations were using the MI-AIMH Competency Guidelines.

The Child Trauma Training Toolkit for Educators provides resources on child trauma for educators and parents working with different age groups, including preschool-aged children. It also includes information on traumatic grief (an intense response to grief following the death of a loved one), and on self-care for educators to address secondary traumatic stress.[114]

Trauma Informed Care: Perspectives and Resources is a web-based, video-enhanced resource tool that offers eight modules designed to enhance federal-, state-, local-, and provider-level work to become trauma-informed. Each module includes an issue brief, a video, and a resource list.[115]

High-quality early care and education

High-quality ECE is an essential foundation for trauma-informed care. ECE programs that meet high quality standards have the potential for both immediate and lifelong benefits for all young children, but particularly those from disadvantaged backgrounds, such as children who have experienced trauma. For example, maltreated children in ECE programs with better quality have better school readiness outcomes,[116] compared to children in ECE programs with lower quality. Moreover, a recent analysis of two well-known high-quality ECE programs—the Carolina Abecedarian Project and the Carolina Approach to Responsive Education—found significant benefits for disadvantaged children across multiple life-domains

(health, quality of life, education, employment, crime), and found a return on investment in high-quality early childhood programs of up to 13.7 percent per year.[117]

Recommendations

This section presents recommendations of policies and practices that can help increase access to high-quality, trauma-informed early care and education. While these recommendations have particular relevance to state-level policymakers, they also apply to program directors, community, state, and federal leaders in the field of early childhood, as well as advocates of other aspects of high-quality ECE programming (e.g., Quality Rating and Improvement Systems, infant and early childhood mental health consultation).

Some of these recommendations emphasize increased state and federal funding to expand supports for ECE programs, while others focus on state program standards, professional competencies, and administrative policies, such as states' plans for the Child Care and Development Fund (CCDF), the largest source of funding for child care assistance for low-income families.[118] Because individual ECE programs cannot be expected to meet all the needs of these children and families, the recommendations also call for policies that help ECE programs connect families to other community services.

Recommendation: Strengthen the early care and education workforce by increasing professionals' capacity to provide trauma-informed care.

Incorporate strategies that benefit children who have experienced trauma into ECE professional development. Although research evidence is lacking for specific models in ECE programs that benefit children who experience trauma, professional development (PD) is a component of a number of promising interventions that help ECE professionals acquire trauma-informed knowledge, skills, and practices.[119] State CCDF plans and professional development offered through quality rating and improvement systems should include strategies used in these interventions that help ECE professionals implement trauma-informed practices.[120] In addition, as the evidence base for particular strategies grows, states should promote their use through professional competency standards and training, and by ensuring that state professional development plans include TIC.

Increase the capacity of infant and early childhood mental health consultants to incorporate trauma-informed approaches. As a widely embraced, evidence-based, ECE program capacity-building strategy,[121] infant and early childhood mental health consultation (IECMHC) is well-positioned to promote a trauma-informed ECE workforce. States have increasingly invested in IECMHC, which has been shown to decrease teacher stress and turnover,[122] prevent preschool expulsion,[123] and reduce problem behaviors among children.[124] To increase the return on their investments and reach young children affected by trauma, states should implement professional standards and training for IECMHC consultants that emphasize TIC.

Increase support for early care and education professionals who experience high levels of stress at work. The stress commonly experienced by ECE professionals who care for children who have experienced trauma is not only detrimental to the well-being of ECE staff, but also can interfere with positive teacher-child interactions.[125] A recent report of the National Research Council, *Transforming the Workforce for Children Birth Through Age 8*,[126] discusses several potential strategies for reducing teacher stress, including training on self-care and mindfulness. As the evidence base for stress reduction strategies grows, states should promote their use through professional competency standards and training. This will ensure that infant and early childhood mental health consultants and professional development specialists acquire the skills they need to support the well-being of ECE professionals who work with children who experience trauma.

Recommendation: Expand initiatives that help early care and education programs connect families with community services.

Invest in initiatives that help early care and education programs connect families with children who have experienced trauma to screening and services that can address their needs. Many ECE programs do not have the capacity to meet the many unique needs of children who have experienced trauma. Some need specialized treatment, and many live in families facing challenges that pose ongoing risks to young children, such as parental depression, housing and food insecurity, and social isolation. State and federal investments in linkage systems, such as

The Centralized Referral System (LINK-KID) and *Help Me Grow*, can help ECE programs connect families to child and family services, including trauma screening, evaluation, and evidence-based treatment, that complement the supports provided in the ECE classroom. These systems also can help families obtain services, such as treatment for parents' mental health problems or financial assistance, that can help reduce stress and increase the odds of resilience among these children and their families.

Recommendation: Provide children who have experienced trauma with high-quality, stable early care and education and strong early learning supports.

Establish policies for early care and education programs that promote continuity of care and participation in early care and education for children who have experienced trauma. Children, particularly those who have experienced trauma, need and benefit from stable, nurturing care in ECE programs. QRIS and other ECE program standards should require that all infants and toddlers, including those who have experienced trauma, have a primary caregiver. When there is one adult who consistently cares for an infant or toddler, the child can develop a close, trusting relationship.[127] States also should promote continuity of program participation. Federal Child Care Development Fund regulations require states to provide 12 months during which the family is continuously eligible (according to state guidelines for eligibility) for subsidized child care. If a parent experiences permanent job loss or the end of an education or training activity, the state must give families a minimum of 3 months of extended child care assistance if it elects to terminate families' assistance under these circumstances. However, states have the option of extending assistance beyond this 3-month period or not terminating assistance before 12 months. In addition, CCDF rules offer a graduated 12-month phase-out for parents whose incomes rise above the state's income eligibility threshold. State policies that offer extended assistance to provide continuity of participation in ECE could greatly benefit this population of young children, who might otherwise experience disruptions in care.

Establish policies that promote the placement of young children who have experienced trauma in high-quality early care and education programs. Children who have endured trauma show more learning and social-emotional growth when ECE programs meet high quality standards. Examples of high-quality programs include Head Start Programs and Early Head Start (HS/EHS), ECE programs with their state's highest quality ratings, and programs accredited by the National Association for the Education of Young Children. Currently, children in foster care are categorically eligible for HS/EHS, regardless of family income.[128] The new Child Care and Development Block Grant Act[h] regulations encourage states to provide vulnerable children, including children who are homeless and in foster care, with access to child care.[129] Several states use contracts to create slots in HS/EHS and other high-quality child care for vulnerable children, including those who have experienced trauma.[130] In addition, increased state and federal investments in initiatives such as Safe Babies Court Teams, that promote collaboration among the courts, ECE programs, and other child-serving organizations, would help improve access for this population to high-quality ECE programs.

Develop policies that severely limit or prohibit the suspension and expulsion of young children, and require appropriate interventions for children who have experienced trauma and have social-emotional or behavioral difficulties. Children who have experienced trauma are at higher risk for expulsion than other children because they often demonstrate challenging behavior as a symptom of their distress; behaviors such as hitting, biting, or behaving recklessly may result in ECE programs' refusing to serve some children and families. Recent federal guidance directs states to establish prevention strategies, including infant and early childhood mental health consultation and professional development, that help ECE professionals address challenging behavior, and policies that eliminate preschool suspension and expulsion.[131] The need for such policies is critical for children who have experienced trauma and would endure further harm by losing the social-emotional and learning supports provided through high-quality ECE.

Establish screening and educational support policies that respond to both the social-emotional and early learning needs of children who have experienced trauma. Young children who are victims of trauma have a heightened risk for delays in

[h] CCDGB is the main source of federal funding for child care subsidies provided to low-income working families and for improvements in child care quality.

multiple areas, including lags in social-emotional, attentional, and language development.[132] State policies for children in ECE should require screening, assessment, and follow-up services across social-emotional, language, and other early learning domains, to ensure that lags in young children's school-readiness skills are addressed. These policies should also provide guidance about the provision of individualized learning supports in ECE programs and appropriate referrals to the Part C Early Intervention[133] and Part B Preschool Special Education services.[134]

Conclusion

High-quality early care and education programs offer young children who have experienced trauma a unique opportunity to recover and get on a path toward positive developmental and learning outcomes. Especially when these settings provide specialized supports, such as teachers and other staff trained in trauma-informed care, children can form trusting relationships with adults and peers that allow them to fully engage in play and learning. When the larger systems support ECE programs, helping connect and provide families with a range of services they may need, ECE programs can serve as a strong hub for children who experience trauma.

While we do not want to lose sight of the primary goal of preventing young children from experiencing trauma in the first place, given the high prevalence of traumatic events in the lives of children under age 6, it is critical that we use our growing knowledge of trauma to ensure they receive high-quality care, are protected from further harm, and have the opportunity to thrive.

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Appendix A: Promising strategies for trauma-informed care in early care and education

Strategy name	Target ages	Description	Evidence of effectiveness
Strategies that have been integrated into ECE programs			
Trauma Smart (TS)	3 to 5 years	TS is a multi-pronged initiative involving the entire organization that combines three evidence-based or evidence-informed modalities: Attachment, Self-Regulation, and Competency (ARC);[1] Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);[2] and Early Childhood Mental Health Consultation.[3] The goal of TS is to reduce the stress of chronic trauma, support children's social and cognitive development, and develop an integrated, trauma-informed culture for children (age 3 to 5 years), parents, and staff. The approach addresses child trauma, as well as secondary traumatic stress among caregivers. TS offers: (1) training using the ARC model, offered by Master's-level licensed clinicians to the many people in children's lives (e.g., Head Start staff at every level, parents, grandparents, informal day care providers, and others); (2) intensive clinical treatment for children with significant behavior problems and their caregivers (30 to 45 minutes for 12 to 24 sessions); 3) classroom consultation by clinicians to teachers and children using ARC and TF-CBT principals; and (4) peer-based mentoring to enable teachers and supervisors to support one another.	In an evaluation of TS with children who received intensive trauma-focused intervention (12 to 24 weekly sessions; 6 hours per month of classroom consultation) using a pre-/post-test design, teachers reported significant improvements in children's externalizing behavior, oppositional defiance, and attention. Parents reported significant reductions in externalizing behaviors, internalizing behaviors, and attention/hyperactivity.[4] A randomized controlled trial (RCT) is currently underway.
Kids in Transition to School (KITS)	4 to 6 years	KITS is a manualized curriculum in Oregon designed to promote psychosocial and academic school readiness in children (age 4 to 6 years) who are placed in foster care and/or are at high risk for school difficulties. KITS has two components: (a) a 24-session therapeutic classroom-based playgroup focused on enhancing children's social-emotional skills and early literacy; and (b) an 8-session parent workshop focused on promoting parent involvement in early literacy and positive parenting practices. Children attend a playgroup in ECE for the 2 months preceding kindergarten and once per week during the first 8 weeks of kindergarten. Parent groups meet every other week. Providers include an individual with a master's-level education or higher in a clinical or education field as well as teachers and assistant teachers. Training is offered on site, and KITS staff consult with schools about the needs of the child in kindergarten.	An RCT indicated that children in KITS had significantly lower levels of oppositional and aggressive behaviors compared to the control group.[5] Results of a second RCT demonstrated that KITS had significant positive effects on early literacy and self-regulatory skills.[6]

Strategy name	Target ages	Description	Evidence of effectiveness
Let's Connect (LC)	3 to 15 years	LC is a targeted intervention in Colorado for children (age 3 to 15 years) to promote secure and stable caregiving and healthy child development, and to reduce the negative effects of child trauma. LC works across home, school, and community contexts to identify and respond to children's emotional needs, promote healthy adult-child relationships, increase children's social-emotional competence, address challenging child behaviors, and integrate trauma-informed approaches. LC delivers training, modeling, live-coaching, and ongoing consultation by a therapist through 8 to 10 weekly sessions. LC can be integrated with other evidence-based interventions (e.g., Trauma-Focused Cognitive Behavioral Therapy, parent management training models). LC's four key components are: (1) teaching caregivers to respond to children's emotions; (2) building caregivers' self-awareness, mindfulness, and emotion regulation skills; (3) teaching caregivers behaviorally-specific Emotion Communication Skills (ECS) that are key to building children's emotional competence and emotional security; and (4) teaching children emotional competence skills. LC has been integrated into Head Start programs and schools.	Results of pilot studies indicate high feasibility of treatment components and caregiver satisfaction; significant improvement in caregiver's positive emotion communication skills, connection skills, and emotional support skills; and reductions in negative emotion communication skills from pre- to post treatment.[7] An RCT of LC in Head Start is currently underway.
Safe Start	0 to 12 years	Safe Start was developed by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to address the needs of children (age 0 to 12 years) who are exposed to violence. Safe Start's goal is to engage communities and to increase their knowledge and investments in preventing and mitigating the negative consequences of children's exposure to violence. Safe Start works with communities to create a continuum of services (e.g., prevention, early intervention, treatment, crisis response). Safe Start programs use different approaches: some provide services only to children, and others serve both children and their families or primary caregivers. All programs include a therapeutic component and many offer case management and service coordination. The intervention context also varies among programs (e.g., homes, clinics, shelters, child centers, Head Start classrooms).	A cross-site evaluation of Safe Start did not show universally positive impacts, but an RCT of Safe Start in a Head Start program in Michigan found significant improvements in caregiver report of child PTSD symptoms, social emotional competence, and academic achievement.[8]

Strategy name	Target ages	Description	Evidence of effectiveness
Therapeutic ECE programs			
Childhaven Childhood Trauma Treatment (CCT)	0 to 5 years	CCT is a childhood trauma treatment program in Washington State for young children (age 0 to 5 years) who are survivors of abuse and neglect and their families in a licensed child care setting. Children receive early intervention and treatment 5 days per week, as well as therapeutic care in a group setting. Treatments focus on dyadic work with the child and his or her caregivers using evidence-informed and evidence-based intervention approaches, such as Triple P, Parent-Child Interaction Therapy, Incredible Years, and Promoting First Relationships.	An RCT following children referred for maltreatment from infancy to early adolescence found that families in CCT exhibited more parental responsiveness, had homes with a more positive emotional climate, and encouraged maturity more compared to families in the control group (typical child protective services). Children in CCT displayed less aggression, somatic complaints, anxiety/depression, social problems, and internalizing behaviors, and more social acceptance. Caregivers reported that children had fewer attention problems.[9]
Children's Relief Nurseries (CRN)	0 to 5 years	CRNs consist of 14 nurseries in the state of Oregon. CRNs offer early prevention and intervention services to families with children (age 0 to 5 years) who are maltreated or at high risk for child welfare involvement. Services vary by site but usually include Child-Parent Psychotherapy (CPP), therapeutic classroom services, home visiting, parenting education, respite child care, parent support groups, parent/infant classes, music therapy, and case management. The CRN/LifeWorks NW in North Portland and East Multnomah County is a SAMHSA NCTSN grantee with a focus on implementing and expanding trauma-focused services in the CRN and across the states of Washington and Oregon. Children and families receive services free of charge.	An evaluation of 14 CRNs using a case-control methodology examining changes over time (from intake to 6, 12, and 24 months post-enrollment) found that parents read more frequently to their children, family functioning improved, and parent-child interactions were more positive. Parents in the program showed reductions in the total number of risk factors in their lives. Other findings included: increased parent employment, improved quality of parent-child interactions, increased frequency of reading to children, reduced number of family risk factors, improved family functioning and stability, reduced use of emergency room services, and increased rates of child immunizations. Parents reported very high satisfaction with services.[10]

Strategy name	Target ages	Description	Evidence of effectiveness
Partnerships between ECE and community service providers			
Centralized Referral System (CRS)	0 to 21 years	CRS was developed through support from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Child Traumatic Stress Network (NCTSN). Located at the University of Massachusetts Medical School's Child Trauma Training Center, the CRS provides statewide trauma screening and referral services. Adults (family members, court personnel, school staff, ECE and other early childhood service providers) with concerns about a child (age 0 to 21 years) who has experienced trauma can call a toll-free number to speak with Master's level social workers. Social workers provide resources and materials, trauma screening, and identify an appropriate EBT (e.g., Trauma-Focused Cognitive Behavioral Therapy [TF-CBT]; Child-Parent Psychotherapy [CPP]; Parent-Child Interaction Therapy [PCIT]; Attachment, Self-Regulation, and Competency [ARC]). Social workers then link the child to a local mental health provider trained in that EBT, and follow up with families and mental health agencies until the child has entered treatment. The CRS maintains an updated database of EBP providers across the state and facilitates communication among clinicians, families, and referral sources to ensure access to EBTs in a timely manner.	An initial implementation evaluation of the CRS found that the average wait time for a first appointment was 25.5 days, compared to a range of 180 to 360 days for children seen in area local mental health agencies.[11]
Help Me Grow (HMG)	0 to 8 years	HMG promotes early identification of children (from 0 to 8 years) at risk for developmental and behavioral problems. The program is administered by the Connecticut Children's Trust Fund and includes on-site training for pediatricians and family health care providers on early detection of child developmental and behavioral concerns and a centralized call center as a single point of entry for community services. The goal of HMG is to facilitate collaboration across service sectors, including child health care, ECE, and family support through comprehensive physician and community outreach and centralized information and referral centers. The core components of HMG are: (1) child health care provider outreach to encourage providers to systemize surveillance and screening and to use the call center; (2) community outreach to link families to services and to maintain an up-to-date directory of providers (medical, ECE, disability, mental health, family and social support programs, child advocacy and legal services); and (3) centralized telephone access for connecting children and their families to services and care coordination.	Implementation research on HMG shows that approximately 85 percent of children and families referred have been connected with community-based programs and services. Support from HMG and linkages to programs and services were associated with increased protective factors.[12]

Strategy name	Target ages	Description	Evidence of effectiveness
Safe Babies Court Teams (SBCT)	0 to 3 years	SBCTs connect infants (0 to 3 years) and their families with services to protect maltreated children from harm. Exposing the structural issues in the child welfare system that prevent families from succeeding, SBCTs promote healthy child development and ensure more efficient exits from the system. Judges collaborate with child development specialists to assemble teams of child welfare and health professionals, child advocates, and community leaders to tailor services to maltreated infants and toddlers and their birth or foster parents. SBCTs have been implemented nationwide, but each offers a slightly different approach. Teams typically consist of a collaboration between ZERO TO THREE, local courts, community leaders, child and family advocates, child welfare agencies, ECE professionals, government agencies, private philanthropies, nonprofit and private service providers, and attorneys. Some SBCTs have sought dedicated Early Head Start slots (e.g., Des Moines, Iowa).	Findings from an evaluation showed that SBCT was associated with significant gains on key child welfare (safety, permanency, well-being).[13] A second study found that children in SBCT reached permanency 2 to 3 times faster, exited the foster care system 1 year earlier than children in a matched comparison group and were more likely to reach permanency with a member of their biological family.[14] A third study revealed that children in SBCT accessed more services than the comparison group, including developmental screening (92 percent v. 25 percent), health care visit (94 percent v. 76 percent), and dental visit (29 percent v. 18 percent). The reduced costs of foster care placements covered two thirds of the average cost per child.[15]
Mental health consultation in ECE programs			
Early Childhood Mental Health Consultation (ECMHC)	0 to 6 years	ECMHC provides critical support to ECE programs that helps staff address the needs of children with social-emotional and behavioral difficulties. The aim of ECMHC is to build the capacity of teachers and childcare providers to promote the social-emotional development of all children in the setting and effectively address the needs of individual children with challenging behavior. ECMH consultants provide modeling, guidance, and feedback about effective practices, and may also assist with screening of children, referrals to services, and meeting with parents. Most ECMHC programs do not specifically focus on trauma, but programs such as Project Play in Arkansas prioritize consultation to ECE programs that serve children in foster care, emphasize relevant features of ECE (e.g., continuity of care, a nurturing relationship), and help staff understand children's behavior in relation to trauma.	A review of 14 studies of ECMHC that used rigorous methods reported generally positive results for key outcomes, including an increase in positive child behaviors and a reduction in challenging behaviors.[16] A study of seven statewide ECMHC programs[17] concluded that most achieved similarly positive results for child outcomes as well as positive changes in classroom climate that reflected increases in teachers' emotional support and sensitivity towards children. In a randomized control trial that evaluated Connecticut's ECMHC program, researchers found significant reductions in young children's challenging behavior, but no change in classroom climate.[18] Studies also show that ECMHC prevents expulsion,[19] reduces parental stress and missed work time,[20] and decreases teacher stress and turnover.[21]

Strategy name	Target ages	Description	Evidence of effectiveness
Professional development and training			
Michigan Association of Infant Mental Health (MI-AIMH) Competency Guidelines & Endorsement	0 to 5 years	The Competency Guidelines and Endorsement offers a guide for individuals who work with pregnant women and families with children up to 5 years old, and for those who provide training to them, on culturally sensitive, relationship-focused practice promoting infant mental health. The MI-AIMH Competency Guidelines identify the knowledge, skills, and reflective practices that support competency development across disciplines and service settings, and they serve as the framework for the MI-AIMH Endorsement, a professional development system for infant and family service providers.[22] As of 2016, the Endorsement system was licensed for use in 27 states and 18 state infant mental health associations were using the MI-AIMH Competency Guidelines.[23]	Not yet rigorously evaluated
Child Trauma Training Toolkit for Educators	3 to 18 years	The Toolkit was developed with support from SAMHSA's NCTSN. [24] It is a resource for educators, including ECE professionals working with preschool-age children. The Toolkit provides separate resources on the psychological and behavioral impact of trauma for preschool, elementary, middle, and high school students, as well as information on traumatic grief for school personnel, and information on self-care for educators to prevent and address secondary traumatic stress. Accompanying resources for parents and caregivers on understanding child traumatic stress and traumatic grief are included.	Not yet rigorously evaluated
Trauma Informed Care: Perspectives and Resources	0 to adulthood	This comprehensive, web-based, video-enhanced resource was developed by the National Technical Assistance Center for Children's Mental Health at Georgetown University and JBS International. This eight-module tool was designed to enhance ongoing federal, state, local, and provider level work to become trauma- informed. It focuses on trauma in the lives of children, youth, and young adults and their families, including foster and kinship families. Each module includes an issue brief, video, and resource list. The modules are: (1) Understanding the Impact of Trauma; (2) Trauma Informed Child Serving Systems; (3) Creating Trauma Informed Provider Organizations; (4) Evidence-Based Treatments Addressing Trauma; (5) Public Health and Fiscal Policy; (6) Family and Youth Perspectives; (7) One Year Later; and (8) New Frontiers.[25]	Not yet rigorously evaluated

Appendix A Endnotes

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