WASHINGTON STATE
Department of Children, Youth, and Families

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Prepared on behalf of the Trauma-Informed Care Advisory Group
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EXECUTIVE SUMMARY

In 2018, a Trauma-Informed Care Advisory Group (Advisory Group) was established by the Legislature in Engrossed House Bill (EHB) 2861. Its task was to develop a five-year plan for expanding the availability of trauma-informed early care and education experiences. The plan needed to include recommendations on the following seven elements:

1. Delivery of training to early learning providers and administrators in trauma-informed child care.
2. Changes to Early Achievers to better support providers serving high-needs children.
3. Outreach to parents to expand awareness about the availability of trauma-informed child care.
4. Analysis of available federal, state and local funding sources that may be used for funding elements of the 5-year strategy.
5. Best practices for supporting family child care providers in the provision of trauma-informed child care.
6. Child care staffing ratios, requirements for access to specialty providers and subsidy rates for providers specializing in trauma-informed child care.
7. Systems for tracking expulsions from child care and methods to reduce expulsions by 50 percent over 5 years.

The Advisory Group defined <u>trauma</u> as "an experience that overwhelms the body's ability to make meaning of it during that developmental stage."[1] The group clarified that, while this can entail specific traumatic events, it also includes factors such as emotional or physical neglect, threats to a feeling of safety at the community level (e.g., due to natural disaster, community violence or discrimination) and the pervasive impact of historical trauma.

Trauma can disrupt the architecture of a developing brain and thus can impair children's concentration, memory, organizational and language abilities[2]. With children who have trauma histories or neurodevelopmental differences, behaviors associated with children's efforts to function in environments and relationships within the early care and education system may create challenges for their care providers. Inadequate training and support for early care and education professionals results in increased stress and use of exclusionary disciplinary practices, such as expulsion, that are detrimental to young children's development and their families' emotional and economic wellbeing.[3]

While data regarding expulsion from early care and education settings in Washington is limited, the parent-report data currently available indicates a prekindergarten expulsion rate of 16.7 children per 1,000[4]. This is almost double the Washington ECEAP[5] expulsion rate of 8.73 per 1,000 from Walter Gilliam's 2005 study.

Suspensions and expulsions from early care and education settings disproportionately affect young children of color, with gender also a significant factor. Nationally, Black students make up

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[1]P. A. Levine and M. Kline, *Trauma through a child's eyes: Awaking the ordinary miracle of healing* (Berkeley, CA: North Atlantic Books, 2006), pp. 4-7; D. J. Siegel, *The developing mind, second edition: How relationships and the brain interact to shape who we are* (New York, NY: The Guilford Press, 2015), p. 190.

[2]U.S. Department of Health and Human Services, Early Childhood Training and Technical Assistance System (2018). Building a comprehensive state policy strategy to prevent expulsion from early learning settings, 2nd edition, p. 5.

[3]U.S. Department of Health and Human Services, Early Childhood Training and Technical Assistance System (2018). Building a comprehensive state policy strategy to prevent expulsion, p. 4; U.S. Department of Health and Human Services and U.S. Department of Education (2014), Policy statement on expulsion and suspension policies, pp. 4, 7.

[4]See Appendix H

[5]In 2006, ECEAP implemented and began enforcing a no expulsion policy.

18 percent of preschool enrollment, but they make up 48 percent of preschool children who are suspended more than once. Black and Latino boys combined represent 46 percent of all boys in preschool, but they represent 66 percent of same-aged children who are suspended[6].

A trauma-informed early care and education system is essential to ensure the wellbeing of young children, their families, and early childhood educators. Relationship-based practices recognize that development takes place in the context of relationships and that optimal development is contingent upon the health of the relationships between children and their parents and other primary caregivers. Early care and education programs should be centered on policies, procedures and practices that support families, teachers and children as they build relationships with and among each other.[7]

RECOMMENDATIONS SUMMARY
The following recommendations are presented on behalf of the Advisory Group. These recommendations are intended to support development of a relationship-based, culturally sustaining, trauma-informed and healing-centered early care and education system. The Advisory Group's vision is that this will be a system in which all young children and their families, including those who have experienced trauma and other adversity, access safe, responsive and engaging trauma-informed early care and education environments. Families will be able to thrive within nurturing, secure and consistent relationships with their early childhood educators, developing resilience and regulation that will enable children to flourish in school and life.[8]

CONTINGENCIES
- Racial equity must be integrated into all elements of trauma-informed child care.
- *All* children should have access to early care and education that is trauma-informed and that promotes their social and emotional development within the context of nurturing and responsive relationships with consistent caregivers.
- Increasing workforce wellbeing and retention, which is a critical component of quality care, requires provision of reflective supervision and compensation that includes wages reflective of the critical nature of early care and education.[9]

TRAUMA-INFORMED CARE PROFESSIONAL DEVELOPMENT
- Trauma-informed care (TIC) training should be on going, accompanied by implementation supports (for example, Infant-Early Childhood Mental Health Consultation)[10], informed by best practices, and available to broader audiences in addition to early childhood educators and administrators.
- Essential components should include:
  - Culture and equity
  - Brain science and stress physiology

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[6]U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy to prevent expulsion, p. 3.
[7]L. Sosinsky et al. (2016). Including relationship-based care practices in infant-toddler care: Implications for practice and policy, p. 2.
[8]From the Purpose to Practice document, Appendix B, adapted from Liberating Structures Purpose-To-Practice activity (http://www.liberatingstructures.com/33-purpose-to-practice-p2p/)
[9]See DCYF's report on the recommendations of the Child Care Workforce Development Technical Workgroup for further context on supporting child care businesses.
[10]IECMH Consultation is an evidence-based approach and best practice related to expulsion reduction. More information is available from the SAMHSA Center of Excellence for Infant and Early Childhood Mental Health Consultation at https://www.samhsa.gov/iecmhc.

- o Relational health (including attachment; regulation; and child, family, and staff resilience)
- Development and implementation of a professional development model, including selection of trauma-informed care professional learning curriculum, should occur in collaboration with content experts, early childhood educators and diverse communities statewide.
- Participation must be voluntary and incentivized or, if mandated, accompanied by an appropriate increase in subsidy rate.

FAMILY CHILD CARE PROVIDER SUPPORT
- In addition to the general TIC training and support, provide an additional supportive structure including communities of practice and access to mentoring, coaching and consultation.
- Provide release time financial compensation for participation in TIC training and communities of practice.

EXPULSION TRACKING AND REDUCTION
- Develop or purchase an expulsion tracking data system for use by the Department of Children, Youth, and Families (DCYF) across all early learning programs statewide.
- Track all exclusionary early care and education provider practices, including suspension and expulsion. This should include parent-reported data.
- Collect data disaggregated by child's race, ethnicity, gender, age and geographic location; provider or program type; and various other facility and early childhood educator characteristics.
- Develop a comprehensive state suspension and expulsion reduction strategy.
- Ensure adequate and accessible training on the new expulsion WACs.[11]
- Increase access to professional development that includes training on recognizing and addressing the needs underlying children's challenging behaviors and fostering their optimal social and emotional development in early care and education settings.
- Ensure systems-level efforts related to TIC, social-emotional learning and racial equity are integrated and strengths-based.

STAFFING RATIOS, SUBSIDY RATES, AND ACCESS TO SPECIALTY PROVIDERS
- A trauma-informed early care and education system should include different dosages of care that meet the needs of all children.
  - o Tier 1: Universal Trauma-Informed Early Care and Education
    - Foundational care offered universally
    - Subsidy rates within the 75th percentile of the market rate for this level of care.
    - All providers receive TIC and social-emotional learning trainings along with implementation support.
    - Give early childhood educators access to consultation from a multidisciplinary team of early childhood specialists within a regional health consultation hub.[12]
  - o Tier 2: Enhanced Trauma-Informed Early Care and Education
    - Align subsidy rates for this level of care with cost of quality.
    - Develop full definition of scope of this level of care and categorical eligibility criteria to ensure distinction from therapeutic level of care.
    - Provide full-day care within these programs.

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[11]See the Foundational Quality Standards, WAC 110-300-0340 and 110-300-0486
[12]See separate report from DCYF: Child Care Health Consultation in Washington State – Recommendations for Expansion

- Align staffing ratios and maximum group size with the *Caring for Our Children* recommendations.[13]
- Give early childhood educators priority access to consultation from the regional health consultation hubs.
  - o Tier 3: Therapeutic Trauma-Informed Early Care and Education
    - Expand availability of this level of care statewide to meet the identified need and to ensure access that is more equitable for children who qualify.
- In order to provide trauma-informed early care and education across all tiers of care for children with neurodevelopmental differences:
  - o Make relationship-based intervention models that incorporate trauma-informed practices accessible for young children with neurodevelopmental differences.
  - o Provide early childhood educators with strategies for providing responsive care for children with communication and sensory differences.
  - o Increase representation of adults with neurodevelopmental differences in professions within the early care and education field.

TRAUMA-INFORMED PRACTICES IN EARLY ACHIEVERS
- Identify strategies to increase coaches' ability to focus on interactions and social-emotional support.
- Identify strategies to decrease early care and education provider stress associated with Early Achievers data collection.
- Explore the possibility of a trauma-informed area of specialization, such as a specialized facility or individual provider license.

PARENT AWARENESS OF TRAUMA-INFORMED CHILD CARE
- Identify and adopt language and messaging regarding TIC that promotes families' valuing these services.
- Ensure that families can identify and access the level of care appropriate for their child.
- TIC professional development should result in improved partnerships between early care and education providers and parents.
- TIC training for families should take a multigenerational approach and provide practical supports to facilitate their participation.

ANALYSIS OF AVAILABLE FUNDING SOURCES
- Further analysis and recommendations by a workgroup with fiscal expertise is needed. This could be accomplished by a time-limited, content-specific subgroup of a continued TIC Advisory Group.

Because of the Advisory Group members' varied areas of expertise, they were better able to develop in-depth recommendations on certain elements. Recognizing this, and the limitations created by their compressed timeline, they have recommended continued work to further operationalize and build upon their initial set of recommendations.

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[13]See appendix J for details.

BACKGROUND AND CONTEXT

The U.S Census Bureau's American Community Survey[14] identified 534,526 children under six years old who lived in Washington State in 2016.

- 48.3 percent (approximately 258,176) were in non-parental care across settings, licensed or unlicensed, for at least 10 hours a week.[15]
- 38,895 children under five years of age received child care subsidy for licensed child care; of those, 10,244 received care in licensed family child care homes, 26,080 in licensed centers and 2,571 in both.[16]
- Around 11.2 percent of parents or guardians of children under six years old reported that, during the previous 12 months, they or someone in the family had quit a job, not taken a job or greatly changed their job because of problems with child care.[17]

Table 1. Birth through five years: ACEs prevalence, child care utilization, and child care problem impact on parental employment (2016 National Survey of Children's Health)

Children 0 – 5 years old	Indicator 6.13: **2+ ACES**	Indicator 6.21: **Received child care from others at least 10 hours/week**		Indicator 6.17: **Job change due to problems with child care**	
		Yes	*No*	*Yes*	*No*
Washington State	14.8%	48.3%	51.7%	11.2%	88.8%
Nationwide	12.1%	53.5%	46.5%	8.3%	91.7%

During this same year, 18.9 percent of children from birth through five years of age experienced one Adverse Childhood Experience (ACE)[18] and 14.8 percent experienced two or more ACEs, as defined by the 2016 National Survey of Children's Health (Table 1). Because the National Survey of Children's Health (NSCH) did not include questions regarding child abuse or neglect in the nine ACEs items included in the survey, we can assume that the rate is significantly higher. Additionally, 4.8 percent of children from one through five years of age were currently receiving services under an early intervention or special education plan.[14] With all parents working in close to 60 percent of families with children under six years old in Washington[14], many young children with neurodevelopmental differences or traumatic experiences are placed in care across all early care and education settings.

These children's efforts to function in early care and education environments and relationships may create challenges for their care providers. Trauma can disrupt the architecture of the developing brain and thus can impair children's concentration, memory and organizational and language abilities[19]. Inadequate training and support for early care and education professionals results in increased stress and use of exclusionary disciplinary practices that are detrimental to young children's development and their families' emotional and economic wellbeing.

Children with ACEs and neurodevelopmental differences are at increased risk of exclusionary discipline practices. In 2006, ECEAP implemented and began enforcing a no expulsion policy. As a result, data collected in Washington since then for children enrolled in ECEAP is based on

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[14]U.S. Census Bureau, 2012 – 2016 American Community Survey.
[15]Child and Adolescent Health Measurement Initiative, 2016 NSCH data query.
[16]Washington State Department of Early Learning (2017). The Early Start Act 2017 annual report.
[17]Child and Adolescent Health Measurement Initiative, 2016 NSCH data query.
[18]For ACEs definition, see Glossary.
[19]U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy to prevent expulsion, p. 5.

parent report from enrollment in early care and education settings *prior to* enrollment in ECEAP. Children whose parents, upon enrollment of their child in ECEAP, reported a history of child expulsion were:

- 2.5 times more likely to have an Individualized Educational Plan (IEP)
- 2.6 times more likely to have experienced household domestic violence
- 2.7 times more likely to have a family member with substance abuse issues
- 2.8 times more likely to have a parent with mental illness
- 3.0 times more likely to have experienced Child Protective Services (CPS) involvement.[20]

Transformation of the early care and education system to one that is trauma-informed is essential to promote the wellbeing of young children, their families and the professionals who provide early care and educational opportunities.

TRAUMA-INFORMED CARE ADVISORY GROUP

In 2018, a Trauma-Informed Care Advisory Group (Advisory Group) was established by the Legislature in Engrossed House Bill (EHB) 2861. Its task was to develop a five-year plan for expanding the availability of trauma-informed child care. The bill specified 13 categories of advisory group members, of which there was to be at least one of each selected by DCYF:

- One or more child psychologists
- A child care provider specializing in working with traumatized children
- A child care provider specializing in working with children with developmental disabilities
- An expert in research on ACEs and its impact on child development
- A child care provider who operates a facility in which a racially diverse group of children is served
- An expert in racial diversity in education
- A provider of the early childhood intervention and prevention services (ECLIPSE) program
- A representative of a nonprofit entity that provides quality improvement services to Early Achievers participants
- A parent of a child with three or more ACEs
- A representative of a nonprofit organization with expertise in developing social-emotional curricula for early learning environments
- Representative of a union representing child care providers
- A nonunion representative of child care providers
- Representative from a statewide organization representing (ECEAP providers

DCYF recruitment resulted in selection of 21 group members to fill all of these seats. The group began meeting in July 2018, with six full-day meetings bi-monthly from July 10 through September 27. Additional input was solicited from the Indian Policy Early Learning Committee (IPEL), the Parent Advisory Group (PAG), and ECEAP and Head Start parents and providers through the Washington State Association for ECEAP and Head Start (WSA).

The Advisory Group was asked to include recommendations regarding the following seven elements in the five-year plan:
1. Delivery of training to early learning providers and administrators in trauma-informed child care.

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[20]2015-2018 SY ECEAP risk factor data, Washington State Department of Children, Youth, and Families (DCYF)

2. Changes to the Early Achievers program to better rate and support providers serving high-needs children.
3. Outreach to parents to expand awareness about the availability of trauma-informed child care.
4. Analysis of available federal, state and local funding sources that may be used for funding elements of the five-year strategy.
5. Best practices for supporting family child care providers in the provision of trauma-informed child care.
6. Child care staffing ratios, requirements for access to specialty providers and subsidy rates for providers specializing in trauma-informed child care.
7. Systems for tracking expulsions from child care and methods to reduce expulsions by 50 percent over five years.

DEFINITIONS AND WORK SCOPE

The Advisory Group established shared definitions of key language in the bill. In this report,

- "Provider" refers to child care and early learning *agencies* (including centers, licensed family child care, and unlicensed friend/family/neighbor care)
- "Early Childhood Educator" (ECE) refers to early care and education *professionals* providing child care and early learning opportunities.

The group also defined the scope of their recommendations as including both child care and preschool settings ("early care and education") for children birth *through* five years old. This was motivated by the desire to include considerations related to the transition from preschool into kindergarten that typically occurs when a child is five years old and at the same time avoid duplication of parallel K-12 TIC and social-emotional learning (SEL) efforts.

EHB 2861 defined <u>trauma-informed child care</u> as

"child care in which providers recognize the signs and symptoms of trauma in children, incorporate an understanding of both the impact of trauma and the potential paths for recovery, and respond by fully integrating knowledge about trauma into policies, procedures, and practices while actively seeking to avoid re-traumatization."

This definition is consistent with the one provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). While this was a useful starting point, the Advisory Group identified the need for a definition that is more reflective of the unique developmental considerations of early childhood development and systems.

The National Child Traumatic Stress Network[21] has defined trauma-informed care from a more developmentally specific perspective. Their definition, adapted slightly to reflect the Advisory Group's charge, is early care and education in which providers:

- recognize and respond to the impact of traumatic stress on those who have contact with the system (children, caregivers and service providers);
- infuse and sustain trauma awareness, knowledge and skills into the organizational culture, practices and policies of agencies and programs; *and*
- act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family and support their ability to thrive.

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[21]The National Child Traumatic Stress Network (2016). What is a trauma-informed child and family service system? (https://www.nctsn.org/resources/what-trauma-informed-child-and-family-service-system)

The Advisory Group defined <u>trauma</u> as

> "an experience that overwhelms the body's ability to make meaning of it during that developmental stage."[22]

They clarified that this can include factors such as the absence of care in the form of emotional or physical neglect, threat to a generalized feeling of safety at the community level (e.g., due to natural disaster, community violence or discrimination) and the pervasive impact of historical trauma, in addition to specific traumatic events.

After establishing a common vocabulary, the Advisory Group identified outcomes and developed recommendations regarding the key elements of the five -year strategy. The Advisory Group's statement of the overarching purpose for providing trauma-informed early care and education is that:

> "All young children and their families, including those who have experienced trauma and other adversity, will experience safe, responsive, and engaging trauma-informed early care and education environments where they can thrive within nurturing, secure, consistent relationships with their early childhood educators, developing resilience and regulation that will enable them to flourish in school and life."[23]

Intended outcomes for their recommendations were identified for children, families, early childhood educators and administrators, providers and systems. Appendix A provides a relationship map of anticipated trauma-informed childcare outcomes based on these recommendations.

CONTINGENCIES

The Advisory Group thought about their work as providing recommendations which support the transformation of the early care and education *system*[24] to one that is trauma-informed and healing-centered. Trauma-informed care training is necessary but not sufficient to achieve this transformation; the systemic sources of trauma need to be addressed. A presentation by one of the Advisory Group members on the KISS framework developed by Dario Longhi (Appendix N) summarized this well: Training or Knowledge (K) is not sufficient, in and of itself, for people to change the way they think about the world (their mental model or insight). For people to actually have new Insight (I), they need to be exposed to other people's stories and have the opportunity to reflect on their own lived experiences. Once individuals have made this shift, then we need to support them in actually doing their work differently – to give them new Strategies (S) and reinforce this new way of doing work with changes to Structures (S) including policies, procedures and practices.

With this in mind, the Advisory Group provided foundational recommendations regarding the following topics, which they described as issues upon which the success of all their other recommendations is dependent.

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[22]P. A. Levine and M. Kline, *Trauma through a child's eyes*, pp. 4 – 7; D. J. Siegel, *The developing mind*, p. 190.
[23]Purpose to Practice document, Appendix B
[24]The workgroup considered issues around state agencies and staff, and the role they play in a trauma-informed system. However because of time constraints, the discreet scope of their task, and the desire to not duplicate the work of other existing groups (e.g., MSTIC) the group did not take up this topic.

RACIAL EQUITY

The Advisory Group considered it imperative to integrate racial equity into all elements of the implementation of their recommendations. Trauma-informed care within early care and education must build on the strengths of young children and their families; attend to root causes such as structural racism and related trauma that influence their feelings and behavior; and create welcoming environments that celebrate, affirm and sustain the cultural and linguistic diversity of families. All children and families have the right to early care and education environments and relationships that reinforce their sense of social and academic belonging and indicate to them that they are deserving of investment.[25] All opportunities and challenges related to trauma-informed care and social-emotional development must be considered from a racial equity perspective, with intentional integration of these mutually reinforcing bodies of work, in order to

- eliminate disparities in access to culturally-sustaining, trauma-informed care;
- eliminate disparities in developmental and academic outcomes; and
- ensure that *all* children are healthy and thriving.

SOCIAL-EMOTIONAL DEVELOPMENT

The Advisory Group recommended that *all* children should have access to high-quality early care and education that is trauma-informed. This foundation is essential to ensuring the success of all other system recommendations related to trauma-informed early care and education. At the most fundamental level, this equates to a system of early care and education that focuses above all else on the promotion of every child's sense of emotional and physical safety, their capacity to rely on adult caregivers for support to regulate their emotions during times of distress, and their access to nurturing and responsive relationships with consistent caregivers. Consistent supportive relationships with safe caregivers are foundational to a child's capacity to develop the requisite social, emotional, and behavioral skills that are essential to a child's ability to learn and thrive in kindergarten and beyond. Social, emotional, and behavioral skills are widely regarded as the most critical indicator of kindergarten readiness, and promotion of the development of these skills is a key element of high-quality early care and education.

EARLY CARE AND EDUCATION WORKFORCE WELLBEING & CONTINUITY

Another crucial element of quality care identified by the Advisory Group is a *consistent, stable workforce*. Research on development of the brain during early childhood has established that the relationship between caregiver and child is critical. Establishment of secure attachment bonds between children and their caregivers during the first years of life provides a buffer against stress and forms the foundation upon which development across all domains is built. When a child experiences frequent changes in their caregivers during this period of their lives, these losses can negatively impact the child's developmental foundation, altering the child's development across multiple domains and resulting in the behavioral challenges that often lead to expulsion.

> "Two fundamental conditions for triggering children's learning are the absence of anything frightening and the presence of a trusted adult who supports exploration and is available to provide comfort and protection when needed." [26]

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[25]The Aspen Education & Society Program (May 2018). Pursuing social and emotional development through a racial equity lens: A call to action, pp. 4, 6. (https://assets.aspeninstitute.org/content/uploads/2018/05/Aspen-Institute_Framing-Doc_Call-to-Action.pdf)
[26]M. D. S. Ainsworth (1969). Object relations, dependency and attachment: A theoretical review of the infant-mother relationship. *Child Development, 40*, 969 – 1025.

"This adult must be someone with whom the child has developed, over time, an attachment relationship."[27]

While the Advisory Group recognized that the scope of their work pertained to provision of recommendations about trauma-informed early care and education, they identified high staff turnover in this field as an issue that must be addressed in order for a truly trauma-informed system of early care and education to exist. The advisory group identified emphasized provision of compensation that includes wages reflective of the critical nature of this work as essential to increasing workforce retention and wellbeing. They also identified access to reflective supervision and consultation as essential to maintaining or improving staff morale and increasing retention.

TRAUMA-INFORMED EARLY CARE AND EDUCATION PROFESSIONAL DEVELOPMENT

The Advisory Group recommended a robust system of trauma-informed care (TIC) professional development to build upon a foundation of high-quality care. They considered essential components and delivery mechanisms for a TIC professional development model that would build upon a solid universal foundation of high quality supportive early care and education environments and nurturing, responsive caregiving relationships. From these considerations, the Advisory Group recommended that TIC professional development content and delivery be

- experiential,
- culturally-sustaining,
- informed by adult learning best practices, and
- a trauma-informed experience for participants and trainers.

All content development and plans for delivery of professional development training and associated supports should be developed or selected in collaboration with content experts. The training content and delivery should vary to some extent according to audience (for example, administrators, early childhood educators, parents, Infant Early Childhood Mental Health Consultants, Early Achievers coaches and data collectors). While the compressed timeline did not allow for thorough vetting and selection of any particular professional development curriculum or model, the Advisory Group did identify existing curricula to consider for possible adoption (see Appendix E). A brief overview of some of the curricula suggested by the Advisory Group is provided in Appendix P as part of a research brief on TIC training models and trauma treatment.

The Advisory Group also recommended collaboration with diverse communities statewide in the process of selecting, adapting and implementing a professional development model appropriate to the particular locale. This process should include opportunities for review in group settings exclusively for early childhood educators and for people of color to promote their ability to provide candid feedback. All professional development should be adaptable in order to be culturally and community specific.

The Advisory Group strongly recommended that participation in this professional development should not come as an unfunded mandate. The cost of training must be affordable for providers (ideally free) so that all providers have equitable access and thus all children have equitable opportunity to benefit. Providing financial compensation for ECE release time and for FFN

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[27]G. Cooper, K. Hoffman, and B. Powell (2017). Circle of Security in child care: Putting attachment theory into practice in preschool classrooms. *ZERO TO THREE Journal (37)* 3, p. 27.

participation, STARS hours (required in-service training), and incentives through Early Achievers would be meaningful ways of motivating providers to voluntarily participate. If at any point participation in TIC professional development is made mandatory, the Advisory Group recommended that this requirement must be tied to an appropriate increase in subsidy rate.

TRAUMA-INFORMED CARE PROFESSIONAL LEARNING CURRICULUM

The Advisory Group identified essential training components that must be included in the TIC training. These include culture and equity; brain science and stress physiology; and relational health, which includes attachment, regulation and resilience.

Culture and Equity

TIC curriculum must include an equity lens as the perspective through which all training components are presented. Intergenerational and historical trauma impacts all young children and their families, because *everyone* is negatively impacted by our history of racialization. Thus cultural, racial and historical trauma must be a focus of training for all early care and education professionals who will be working with young children and their families. Implicit bias should also be addressed, increasing participant self-awareness about how their various social identities, including their race, have shaped their own education experiences, influenced their interpretations of student behavior[28] and impacted their interactions with children and families.

As one of the Advisory Group members said:

> "Trauma that happens in the context of relationships needs to be healed in relationship, and trauma that happens in a cultural context needs cultural transformation."

The TIC trainings should support early care and education professionals to more effectively, frequently and openly communicate with families, especially across race, class and culture, to build mutual trust, understanding and support[29].

When the topic of TIC was discussed with the Indian Policy Early Learning Committee, they noted the need for a tribally-appropriate trauma-informed care curriculum. They explained that "language and culture are our protective factors" and expressed the need for funding in order to develop a curriculum for teaching children about language and culture, which were described as essential components of tribal members' process of healing after experiencing ACEs.

Brain Science and Stress Physiology

TIC professional development curriculum should include a strong foundation in brain science and the science of stress physiology. This component of the training would include information about trauma, toxic stress and the impact of adversity on a young child's developing brain and stress systems. Developmentally-appropriate strategies to promote executive function and sense of self would also be incorporated. Such strategies include training for ECEs on the connection between stress and behavior, as well as practical tools for setting limits without punishment.

Relational Health

Because young children's capacities for attachment, regulation and resilience develop in the context of relationships, these recommended components of TIC professional development are

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[28]L. R. Chatmon and K. Osta (2018). 5 steps for liberating public education from its deep racial bias. Education Week. (https://www.edweek.org/ew/articles/2018/08/22/5-steps-for-liberating-public-education-from.html)
[29]The Aspen Education & Society Program, Pursuing social and emotional development, p. 6.

presented as elements of early childhood relational health. Training on regulation (the ability to manage one's state of arousal, behaviors, physiology and emotions[30]) should focus on recognizing and addressing children's underlying needs rather than on changing their behavior and should clarify that regulation is not a "top down" directive to children to regulate themselves. Children co-regulate in the context of safe, stable, nurturing relationships with regulated adults; therefore, the self-regulation of ECEs, administrators and staff is critical. Children must be supported to develop regulatory capacity by reducing stress reactivity of both provider and child (rather than inadvertently increasing it by using punitive measures). Healthy attachment and regulatory capacity contribute to a child's resilience. TIC professional development should focus on the skills and relationships that are essential for all adults and children to be resilient and should emphasize that resilience can be promoted even without knowing a child's trauma history.

In addition, relational health training should focus on staff wellbeing. Of note, the Advisory Group identified "staff care" or "staff wellbeing" as preferable terms to staff "self-care" because the former terms frame staff wellbeing as a responsibility shared between employer and employee rather than an individual ECE responsibility. Training elements related to staff wellbeing should include information and support regarding both secondary trauma and the development of a system of staff care and wellness.

Inadequate supervisory support and burnout have been cited by front-line staff working with traumatized families as a cause of staff turnover. A supervisory model consistent with trauma-informed care principles should promote trust, empowerment, control and a model of the relationship desired between the ECE and child. The combination of reflective supervision (from an agency supervisor) and consultation (from an IECMH consultant or other outside consultant) is one such model. Qualitative studies indicate that reflective supervision and consultation can promote greater resilience among ECEs and administrators and decrease burnout and turnover.[31] Leadership commitment to prioritizing this practice is essential. Administrators providing reflective supervision should receive appropriate training and should also have access to their own reflective supervision or consultation. Infant-Early Childhood Mental Health (IECMH) consultation, with its primary focus on caregiver wellbeing and capacity, is a vehicle for providing staff support and reflective consultation.

TRAUMA-INFORMED CARE PROFESSIONAL DEVELOPMENT DELIVERY
Trauma-informed care professional development should be ongoing rather than a single training, and training must be accompanied by support for trauma-informed practices implementation. This support is envisioned as a core responsibility of (IECMH consultants.[32] While IECMH consultants would have a central role in TIC training and support, this mental health consultation system is still in development, pending funding, and is not expected to have the capacity to provide training and support for *all* providers of early care and education services. As a result, other existing entities who are already providing training and support were suggested by the Advisory Group as partners in the delivery of TIC training. The Advisory Group provided a list of potential delivery mechanisms for this training (see Appendix D). In order to support providers to efficiently access high-quality professional development, some mechanism will be needed to ensure they can identify and connect with qualified trainers. This could be

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[30]J. Van Horn (2018). Reflective supervision: A guide from region X to enhance reflective practice among home visiting programs, p. 63. (https://www.wa-aimh.org/rs-guidelines-project)
[31]A. Van Berckelaer (2011). Using reflective supervision to support trauma-informed systems for children: A white paper developed by the Multiplying Connections Initiative, p. 1.
(http://www.multiplyingconnections.org/sites/default/files/field_attachments/RS%20White%20Paper%20(2).pdf)
[32]See addendum: Infant/Early Childhood Mental Health Consultation: Proposed Services for WA

development and maintenance of an inventory of TIC trainers who specialize in early care and education or some other mechanism, depending on the professional development delivery structure that is ultimately adopted.

TIC professional development must be delivered by individuals who have participated in a train-the-trainer course specific to the model chosen by the DCYF. Because these trainings can often elicit significant emotional responses by participants, trainings should include adequate supports to create trauma-informed environments. This support should include in-classroom and out-of-classroom IECMH consultation from a consistent person with whom the ECE can develop a relationship. These IECMH consultants should reflect the communities (i.e., children, families, and providers) being served. Center-based early childhood educators, Family Home Child Care (FHCC) providers, and Family, Friends, and Neighbors (FFN) caregivers should also have access to a learning cohort for ongoing support related to implementation of trauma-informed practices.

An introductory *Child Care Basics* training module on TIC has been developed by DCYF. More in-depth, specialized training should be provided as well to build upon this initial training. Increasingly advanced training would focus on the provision of sensitive and attuned care that is responsive to an individual child's developmental needs, trauma and early childhood adversity, and behavioral manifestations of early childhood trauma and toxic stress.

Professional development must be delivered in an accessible manner. This includes offering trainings in different languages at different times and in different locations. Trainings should be primarily in-person to utilize experiential methods but could potentially include some hybrid elements (for example, use of technology such as web-based meeting software for elements of training that do not need to occur in person) to increase accessibility.

While these recommendations pertain to continuing education for the existing early care and education workforce, the Advisory Group recommended that TIC training be embedded in degree programs and ECE Stackable Certificates, and the state's core competencies as well. An additional delivery mechanism could be new employee orientation.

TRAUMA-INFORMED CARE PROFESSIONAL DEVELOPMENT AND TRAINING – PARTICIPANTS

The Advisory Group recommended that the audience for these trainings should be expanded beyond ECEs and administrators to include parents, Early Achievers coaches and data collectors ("raters"), licensors, IECMH consultants, child welfare staff, and other allied professionals serving young children and their families for consistency of implementation of trauma-informed practices across the settings and systems with which young children and their families interact. The Advisory Group was mindful of the barriers to participation that exist for both parents and professionals and recommended provision of incentives valued by potential participants such as free training, Early Achievers incentives, meals, quality child care for parents attending, substitute care for FFN and FHCC providers and parent subsidy for attendance.

TRAUMA-INFORMED CARE PROFESSIONAL DEVELOPMENT – SUPPORTIVE STRUCTURE

Because there is currently no coordinated statewide approach to provision of TIC professional development, the Advisory Group made the following structural recommendations:

- Trauma-informed early care and education efforts should be purposefully aligned and connected with those occurring through other trauma-informed initiatives such as Washington's Multi-System Trauma Informed Collaborative (MSTIC), and state agency

initiatives at the Office of Superintendent of Public Instruction (OSPI), Department of Social and Health Services (DSHS) and Health Care Authority (HCA).

- Whatever training models are implemented statewide should build on existing resources and utilize the expertise of the many community-based organizations that are already offering related trainings.
- Existing mandated trainings for ECEs should be examined to determine how TIC principles might be integrated.
- Additional and improved training should be provided to ECEs and to kindergarten teachers to prepare them to more accurately assess social emotional development (for example, through WaKIDS).
- A means of evaluating the efficacy of all TIC professional development should be identified. This could include use of Early Achievers and other relevant community data.

SUPPORT FOR FAMILY CHILD CARE PROVIDERS

Family child care providers were considered by the Advisory Group to be inclusive of licensed, family home child care providers; family, friends, and neighbor (FFN) child care providers; and other informal care providers. Family home providers typically care simultaneously for children spanning a wide age range (can be birth through 12 years), and care is often provided by just one ECE. Because FFN providers often care for a single family's children, all of the children in their care may have a similar trauma history. FFN providers are often the providers of choice for families from cultural or ethnic minorities. Providers of child care in licensed and unlicensed family-based care settings often feel highly isolated, and FFNs in particular tend to be poorly compensated at a subsidy rate of $2.50 per hour per child (Appendix I). These factors contribute to unique stress for family home and FFN providers. Special attention and resources should be offered to these providers to ensure they have access to TIC professional development and are able to implement trauma-informed care in their unique care settings.

While the recommendations related to TIC professional development should apply for FCC and FFN providers, the Advisory Group emphasized the importance of providing the following structure and support for these providers:

- Communities of practice and learning communities for reflective consultation, training and peer mentoring;
- Ongoing, sustainable access to mentoring, coaching and consultation from experts (including the possibility of a phone line through which they could access ad hoc consultation);
- Lead teachers/coaches in each region who are available to provide on-site support, model trauma-informed care practices and encourage learning and skill development; and
- Release time compensation for participation in training and communities of practice.

EXPULSION TRACKING AND REDUCTION

While no formal definitions exist for expulsion and suspension across the early childhood field, both fall under the category of provider practices that exclude a child from the early care and education environment. This could include in-program suspensions such as sending a child to the director's office, out-of-program suspensions such as limiting the number of hours a child may attend the program, "soft expulsion" in which providers encourage families to voluntarily terminate services, and expulsions that dismiss a child from a program permanently. Young children who are expelled or suspended are at increased risk of numerous negative outcomes. They are as much as 10 times more likely to drop out of high school, experience academic

failure and grade retention, and face incarceration than young children who are not expelled or suspended.[33] The association between preschool expulsion and later incarceration contribute to the commonly used concept of the preschool-to-prison pipeline.

National research[34] has identified child-specific factors that are correlated with the highest rates of expulsion: race, gender and larger size for age. Black children make up 18 percent of preschool enrollment nationwide but account for 48 percent of the preschool children who are suspended more than once. Latino and black boys combined represent 46 percent of all boys in preschool but 66 percent of all same-aged children who are suspended. Findings from studies of implicit bias suggest that adults overestimate black boys' ages relative to their white and Latino peers and that "the perceived threat commonly associated with black men may be generalized to black boys as young as 5 years old."[35] If administered in a discriminatory manner, suspension and expulsion may violate Federal civil rights laws.[36]

The program characteristics that are associated with increased rates of preschool expulsion are the same systemic barriers that need to be addressed in order to provide trauma-informed early care and education. These include programmatic policies, such as high adult-to-child ratios, longer staffing or operating hours, and a lack of behavior supports and early childhood mental health consultation for program leadership and staff. They also include ECE attributes such as higher levels of stress, higher rates of depression, and beliefs about stricter discipline.[37]

There is inadequate statewide data on exclusionary practices of children from early care and education settings, to provide an accurate picture of the extent of the issue, but advisory group members practicing in the field indicated that these exclusionary practices are likely more common than is widely realized. This assessment is supported by limited data on preschool expulsion in Washington State. Based on a 2009 survey of parents with children entering kindergarten, Cultivate Learning reported a pre-kindergarten expulsion rate of 16.7 per 1,000 children. This rate is almost double the one from Walter Gilliam's 2005 study, which gathered data using surveys of ECEAP program directors and reported a Washington State pre-kindergarten expulsion rate of 8.73 per 1,000. This was in contrast to a K-12 expulsion rate of 3.71 per 1,000. Thus, the data from Cultivate Learning indicates that the rate of preschool expulsion in Washington State may be significantly higher than previously identified by Gilliam's research and that parent report data indicates a higher rate than that reported by program directors.[38]

In 2006, the Department of Early Learning implemented a no-expulsion policy for ECEAP providers. Upon enrolling a child in the program, parent-reported data is collected. This includes information about the child's history of previous expulsions as well as other child and family risk factors. According to parent-reported ECEAP risk factor data summed over a period of three school years, the total number of children with prior expulsions upon entry into ECEAP was 285 out of three-year enrollment total of 33,641. Keeping in mind the limitations associated with smaller group comparisons, this points to apparent relationships between expulsion and other

[33]U.S. Department of Health and Human Services and U.S. Department of Education (2014). Policy statement on expulsion and suspension policies in early childhood settings, p. 3. (https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf)
[34]U.S. Department of Health and Human Services and U.S. Department of Education (2014), Policy statement on expulsion and suspension policies, p. 4; U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy to prevent expulsion, p. 3.
[35]U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy, p. 5.
[36]U.S. Department of Health and Human Services and U.S. Department of Education (2014), Policy statement on expulsion, p. 3.
[37]U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy, p. 2.
[38]Appendix H

early childhood adverse experiences (Table 2). Compared to children with no history of expulsion, children who had a history of expulsion prior to enrollment in ECEAP were at least:

- 2.6 times as likely to have experienced household domestic violence,
- 2.7 times as likely to have a family member with substance abuse issues,
- 2.8 times as likely to have a parent with mental illness, and
- 3.0 times as likely to have experienced Child Protective Services (CPS) involvement.

Table 2. ECEAP Enrollment Risk Factor Data
(Combined 2015-2016, 2016-2017, 2017-2018 School Years)

	Count	Domestic Violence	Substance Use	Parent Mental Illness	On IEP	CPS Involvement
No Prior Expulsion	33,356	12%	9%	16%	10%	11%
Prior Expulsion	285	30%	24%	42%	25%	33%

Children with challenging behaviors resulting from neurodevelopmental differences are also at significantly increased risk of preschool suspension and expulsion (Figure 1). According to the combined 2015-2018 ECEAP risk factor data (DCYF), children whose parents reported a pre-ECEAP history of child expulsion were 2.5 times more likely to have an Individualized Educational Plan (IEP) than children without a history of expulsion. Additionally, 73 percent of the children whose parents reported that they had a history of expulsion were boys.

Figure 1: Children with disabilities as share of preschool population and share of preschool suspensions and expulsions (Center for American Progress, 2018)
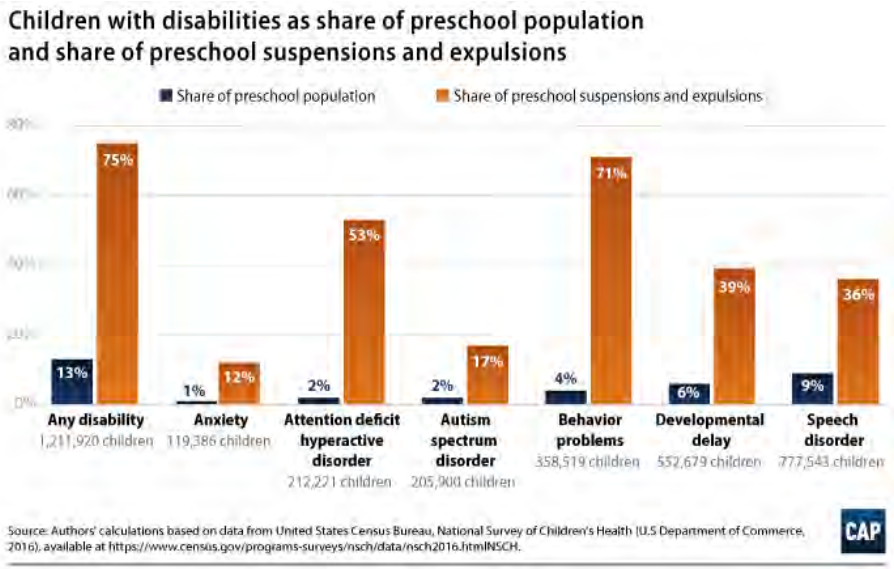
SUSPENSION AND EXPULSION TRACKING

In order to better understand the scope of early childhood suspension and expulsion in Washington, the Advisory Group recommended tracking all exclusionary provider practices, including suspension and expulsion. The Advisory Group recommended that DCYF create a statewide suspension and expulsion data collection system disaggregated by race, ethnicity, age, gender, geographic location, program or provider type, and various facility characteristics (see Appendix F for detailed lists). Because many disincentives exist which discourage accurate provider reporting of expulsion data, a feasible parent-report data collection mechanism should be identified. The Advisory Group identified three options for collecting data that could be tied into DCYF's existing data system. All of these options need further consideration to determine their feasibility due to the shift in practices and workload impact that would be required to implement them:

1. Include a question in WaKIDS that asks parents, "Has your child ever been removed from a non-parental care placement for behavioral reasons?"
   Because WaKIDS data is gathered at the time of a child's entry into kindergarten, the Advisory Group also recommended the following additional means of gathering data earlier, when it would still be possible to intervene on behalf of children to prevent suspension and expulsion from early care and education and thus improve educational trajectory.

2. Utilize a recurring large-scale parent survey to gather data on suspension and expulsion. The Washington State Department of Early Learning previously disseminated a parent survey regarding child care needs. The Department of Children, Youth, and Families could use a similar process for suspension and expulsion data collection

3. Collect parent-report data on suspension and expulsion when parents request a transfer of child care subsidy from one provider to another.

In whatever manner this data is collected, communication with parents about how that information is going to be used is essential to promote their sense of safety and thus their likelihood of providing accurate data.

SUSPENSION AND EXPULSION REDUCTION

Among other literature related to preschool expulsion (see Appendix G), the Advisory Group reviewed the U.S. Department of Health and Human Services tool *Building a Comprehensive State Policy Strategy to Prevent Expulsion from Early Learning Settings* (2018). The Advisory Group's recommendations related to tracking and reduction of suspension and expulsion are aligned with the expulsion policy and workforce development strategies identified in that document. However, more time is needed to utilize the full tool to develop a comprehensive state strategy. The Advisory Group recommended that this work continue after the delivery of this report.

Expulsion Policies

The Advisory Group expressed concern that adding expulsion rules to the Washington Administrative Code may have unintended consequences if not enough support is offered to both increase staff competence to manage challenging behaviors and to transition children successfully when that is the best option for the child. The Advisory Group questioned whether providers will accurately report incidences of expulsion to DCYF if there are structural disincentives to doing so. Additionally, the reports that are made are unlikely to accurately capture other exclusionary practices. The Advisory Group recommended that DCYF:

- Provide support for training on the new expulsion WAC (the DCYF licensing division is already moving in the direction of providing training related to the new expulsion WAC).

- Begin reporting on suspension and other exclusionary practices.
- Avoid creating punitive consequences for exclusionary practices, instead increasing supports for providers focused on increasing staff competence to manage challenging behaviors and to transition children successfully when appropriate.

Workforce Development

Beyond the other critical needs for TIC professional development, it is a key strategy for reducing, and ultimately eliminating, suspension and expulsion of young children from early care and education settings. A professional development system should focus on:

- Promotion of young children's social, emotional and behavioral health;
- Implementation of developmentally appropriate, nondiscriminatory intervention strategies; and
- Support for early care and education providers that will enhance their self-reflective capacity.[39]

An evidence-based expulsion reduction strategy should include a statewide implementation of professional development models that increase ECEs' ability to recognize and address the environmental, physiological and relational needs underlying a young child's behavior in order to meet their social, emotional and behavioral health needs in inclusive and natural environments.[40]

A representative from the Pyramid Model Consortium, Kristin Tenney-Blackwell, presented information to the Advisory Group regarding efforts to incorporate TIC principles into one such model, *The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children* or "Teaching Pyramid" as it is sometimes called[41]. Early Supports for Infants and Toddlers (ESIT) was recently selected to participate in a technical assistance project with the National Center for Pyramid Model Innovations to explore adoption of the Pyramid Model within early intervention programs. This provides an opportunity upon which the early care and education system could build. Cultivate Learning has also provided some training for Early Achievers coaches and providers in positive behavior supports based on the Pyramid Model.

Infant-Early Childhood Mental Health (IECMH) consultation is another potential delivery mechanism for training and implementation support. Statewide IECMH consultation is an evidence-based intervention for expulsion reduction. Research suggests that IECMH consultation can reduce disparities in expulsion, in part through interventions that address implicit bias among ECEs. Among other outcomes (Figure 2), IECMH consultation builds provider capacity to shift practices toward more positive behavior supports for young children, which is important because stricter disciplinary beliefs are correlated with increased expulsion rates.[42] As ECEs expand their implementation of Universal Developmental Screening, IECMH consultants would also be appropriate professionals to conduct trauma screening, support ECEs by making appropriate referrals, and support families to connect with the services to which they are referred. They would also support transition planning for children when that is determined to be in their best interest. This service should be:

- Implemented in a manner consistent with best practice guidelines from SAMHSA's Center of Excellence on IECMH Consultation,

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[39]U.S. Department of Health and Human Services and U.S. Department of Education (2014), Policy statement on expulsion, p. 3.
[40]U.S. Department of Health and Human Services and U.S. Department of Education (2014), Policy statement on expulsion, p. 10.
[41]Appendix K
[42]U.S. Department of Health and Human Services (2018), Building a comprehensive state policy strategy, p. 2.

- Available to all providers, open to any referral source (e.g., parents, ECEs, administrators, coaches, etc.),
- And required prior to expulsion or transition of a child from one provider to another.

**Figure 2. The Need for Early Childhood Mental Health Consultation
(The RAINE Group, 2015)**

THE PROBLEMS	ECMHC RESEARCH/ EVALUATION FINDINGS
• Of the **11 million children** in out of home care, **more than half** are in **poor quality care**, decreasing their odds of school readiness.[2,13]	• **Improvements in teacher-child interactions**[1,3,4,5]—the aspect of quality care most closely linked to improved child outcomes.[10,13] Several states have reported **improved quality of classroom climate** (e.g., CLASS scores in Emotional Support domain) associated with ECMHC[1,5,12]
• **10-20% of young children** in child care **have serious problems** with **emotions and behavior** and many more children have lower levels of challenging behaviors that compromise their ability to learn and reduce the teacher's ability to teach the other children[5,6]	• **Reductions** in children's **problem behavior** and **increases** in their **social skills**[4,5,8,9,14,15,16,17,18]
• **Preschool expulsion rates are 3.5 times** the rate of students in Kindergarten through 12th grade. Boys and children of color are disproportionately impacted[7,11]	• **Prevention of expulsion,** including among young children of color[5,7,8,9,15,16,17,18]
• **Families** with children at risk for expulsion **often miss work** due to problems in child care[18]	• **Families missed less work** and had lower parenting stress after ECMHC.[18] Improved parent-provider communication and collaboration[9]
• **25-35% of teachers** report high levels of **job stress and burnout**[19]— which predict higher rates of child expulsion and staff turnover	• **Decreases in teachers' stress** and **lower rates of turnover** associated with ECMHC[1,3,5]

The Advisory Group recommended exploration of trauma-informed, relationship-based models that would train and support providers to more effectively foster young children's social and emotional development and address challenging behaviors. Lack of knowledge about child development among ECEs and administrators contributes to increased likelihood of suspension and expulsion. Thus, increasing their knowledge about social-emotional development and their ability to distinguish truly concerning behaviors from developmentally appropriate behaviors is an important means of reducing exclusionary discipline practices. The Collaborative for Academic, Social, and Emotional Learning[43] has rated available evidence-based social-emotional learning programs and recommends programs that meet their criteria for being well-designed, evidence-based, high-quality classroom-based programs that provide both training and implementation support.

A recent Aspen Institute[44] article cautions that:

> "[e]fforts aimed at leveraging SEAD [social, emotional, and academic development] to improve outcomes for disadvantaged students may focus inordinately on addressing adverse childhood experiences (ACEs) and trauma. While these approaches have value, an exclusive focus on deficits leads schools to try to 'fix' students of color and

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[43]Collaborative for Academic, Social, and Emotional Learning (2012). 2013 CASEL Guide: Effective Social and Emotional Learning Programs, Preschool and Elementary School Edition. (https://casel.org/preschool-and-elementary-edition-casel-guide/)
[44]The Aspen Education & Society Program, Pursuing social and emotional development, p. 4.

students living in poverty, and thereby fail to recognize and capitalize on students' strengths and assets, including their tremendous resilience. In an effort to fix certain students or schools through SEAD programs, school systems can send the erroneous messages that students of color have greater deficits than assets, and that other— predominately affluent and white schools and students—do not need the benefit of SEAD, although they do."

Young children's social and emotional development occurs in the context of their families, communities and cultures. In order to align with principles of trauma-informed care while simultaneously promoting racial equity, the practices promoted by any professional development models adopted must support and build upon the strengths of young children and their families.

LEVELS OF TRAUMA-INFORMED CHILD CARE: STAFFING RATIOS, SUBSIDY RATES, AND ACCESS TO SPECIALIZED PROVIDERS

In thinking more broadly about child care staffing ratios, access to specialty providers and subsidy rates for providers specializing in trauma-informed early care and education, the Advisory Group envisioned three levels of care.

Figure 3: Proposed Levels of Trauma-Informed Child Care

Tier 3: Therapeutic Trauma-Informed Early Care & Education – *Intensive Intervention*

Tier 2: Enhanced Trauma-Informed Early Care & Education – *Targeted Social and Emotional Supports*

Tier 1: Universal Trauma-Informed Early Care & Education – *Available Universally, High Quality Supportive Environments & Nurturing, Responsive Caregiving Relationships*
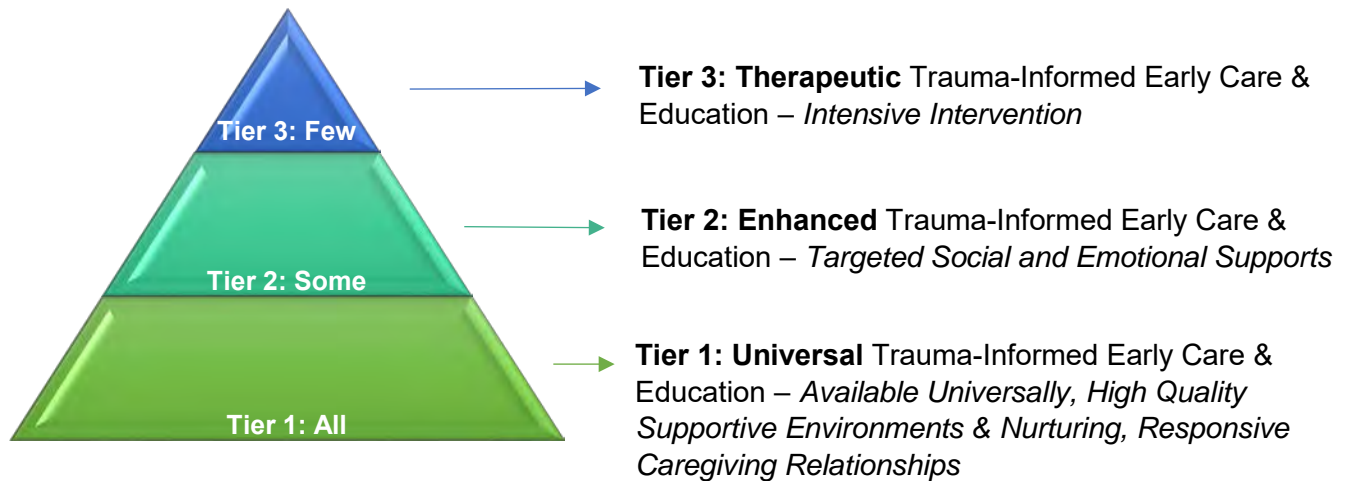
1. Tier 1 – **Universal** Trauma-Informed Early Care and Education: *All* children will have access to high quality, diversity-informed, relationship-based, and trauma-informed early care and education. This care would be provided in supportive environments within the context of nurturing and responsive caregiving relationships. In order to support providers to increase their ability to provide this level of care, the Advisory Group recommended the following:

   • Provision of trauma-informed, culture-sustaining social-emotional learning and TIC trainings and implementation support for all providers

   • Access to consultation (e.g., IECMH consultant, nurse, occupational therapist, etc.) from regional health hubs

- Subsidies within the 75th percentile of the market rate as established by the State of Washington 2018 Child Care Market Rate Survey[45]

2. Tier 2 – **Enhanced** Trauma-Informed Early Care and Education: An intermediate level of care is needed for some children, primarily those who exhibit behaviors due to trauma histories or neurodevelopmental differences that pose challenges beyond what most ECEs are equipped to manage. Enhanced child care has the potential to prevent many children's need for more costly participation in therapeutic child care or other specialized services. A full definition of the scope of enhanced trauma-informed early care and education is needed to ensure that these services are distinct from those provided through therapeutic child care and meet the needs of children who would not be able to access that higher level of care. Recommendations for this level of care include:

   - Program duration: Full-day programs would reduce the number of transitions for the very children who are most likely to struggle with transitions. Children in programs such as ECEAP and school district developmental preschools often have to transition from a morning child care provider to the ECEAP classroom and back to potentially a different child care provider in the afternoon, at times having to travel by bus from one program to the next. This would be challenging for all young children, but especially for those with trauma histories or developmental differences.

   - Eligibility: Categorical eligibility criteria should expand beyond income level to include other indicators of high risk for expulsion and other negative outcomes (though full eligibility criteria are yet to be determined).

   - Ratios: The advisory group recommended that the ratios and thus the maximum group size in Enhanced Trauma-Informed Early Care and Education settings be reduced. Staffing ratios and maximum group size should ideally be aligned with the recommendations from *Caring for Our Children[46]*, whose child-to-adult ratios are as follows:

     - Infants, birth-12 months = 1:3;
     - Toddlers, 13-35 months = 1:4;
     - Preschoolers, 3 years = 1:7;
     - Preschoolers, 4-5 years = 1:8.

     These ratios would be a reduction from the current licensing ratios, which are as follows:

     - Infants, 1-11 months = 1:4;
     - Toddlers, 12-29 months = 1:7;
     - Preschoolers, 30 months-6 years = 1:10.

   - Subsidy: Subsidy rates for these providers should be increased to enable them to afford additional training, staff, reflective consultation or any other supports necessary to enable their staff to provide this higher level of care. The Advisory Group recommended that subsidy rates be aligned with the cost of quality. The *Center for American Progress[47]* describes the U.S. average annual true cost of

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[45]Public Consulting Group (2018). State of Washington Department of Early Learning 2018 child care market rate survey final report, pp. 26-30. (https://www.dcyf.wa.gov/sites/default/files/pdf/reports/2018_Washington_State_Market_Rate_Survey.pdf)
[46]American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education (2011). *Caring for our children: National health and safety performance standards: Guidelines for early care and education programs, 3rd edition*, pp. 3-7.
[47]Center for American Progress (2018), Suspensions are not support: The disciplining of preschoolers with disabilities. (https://www.americanprogress.org/issues/early-childhood/reports/2018/01/17/445041/suspensions-not-support/)

quality for early care and education as around $27,000 for infants, $21,000 for toddlers and $16,000 for preschoolers.

- • Support: While Tier 2 providers would not necessarily have embedded mental health professionals, nurses or consultants, they would have priority access to consultation from a regional consultation hub (if funding is designated to create them). Professionals available to provide this consultation would include but not be limited to IECMH consultants (licensed or license-eligible mental health professionals), health consultants (nurses) and occupational therapists.

3. Tier 3 – **Therapeutic** Trauma-Informed Early Care and Education: The Advisory Group recognized that efforts are being made toward statewide expansion of the availability of therapeutic early care and education through the Early Childhood Intervention and Prevention Services (ECLIPSE) program. Providers such as Childhaven and Wellspring Family Services offer the highest intensity of care, and as a result they have embedded services such as early childhood mental health services, IECMH consultation and a health care provider such as a nurse practitioner. The Advisory Group recommended expansion of therapeutic early care and education statewide to more fully meet the identified need for, and ensure more equitable access to, this level of care for children who meet the categorical eligibility criteria (see Appendix L for details).

ADDITIONAL CONSIDERATIONS FOR CHILDREN WITH NEURODEVELOPMENTAL DIFFERENCES

The Advisory Group heard from parents and autistic adult self-advocates when developing these recommendations. The message was clear that many young children with neurodevelopmental differences are receiving care from early care and education providers who are not equipped to be responsive to their unique environmental and social-emotional needs. Short-term negative outcomes include decreased child emotional wellbeing, increased family stress, and child expulsion. Young children with neurodevelopmental differences experience chronic stress due to sensory issues and the expectations of neurotypical peers and adults which children with neurodevelopmental differences must accommodate. These experiences can be traumatic for many children, especially in the absence of buffering relationships with knowledgeable, responsive adult caregivers. As one autistic adult advocate stated,

> "Trauma is an unfortunate part of all of our lives. We don't know what autism looks like. We only know what autism plus trauma looks like."

Many ECEs do not have adequate training on how to support the social-emotional development of young children with neurodevelopmental differences whose behaviors pose challenges in the classroom. Many autistic adult advocates describe neurodevelopmental differences as *a different culture* rather than a disability or deficit. Young children with neurodevelopmental differences require care from providers with training related to communication and sensory differences. Adults with neurodevelopmental differences could support provision of more responsive care through increased representation in professions within the early care and education field. One example provided was the possibility of a "cultural consultant" role that would utilize the experiential knowledge of adults with neurodevelopmental differences to identify problematic sensory factors in classroom settings. Access to multi-disciplinary teams of early childhood specialists for the purpose of decoding behavior through the lens of sensory, motor, language and cognitive development is also recommended. Whether this multi-disciplinary team is embedded within a program or accessible through the regional health consultation hub would be dependent on the level of child care offered by a provider. Additionally, intensive interventions provided for young children with neurodevelopmental

differences should be informed by principles of trauma-informed care; and relationship-based models should be accessible for young children with neurodevelopmental differences and their families.[48]

TRAUMA-INFORMED PRACTICES IN EARLY ACHIEVERS

In addition to their potential role in providing TIC training, Early Achievers data collectors and coaches have the opportunity to ensure that data collection and continuous quality improvement of early care and education services is implemented in a trauma-informed manner. The Advisory Group developed high-level recommendations regarding practices intended to promote more trauma-informed data collection and support for ECE providers through Early Achievers.

The Advisory Group acknowledged that assessment can be inherently stressful. The rating process most obviously creates stress for early care and education staff, as reported by Advisory Group members who are center administrators. The Advisory Group was mindful that this process may be stressful for children with trauma histories as well. This *could* be due to the presence of a stranger in the room; however, children look to their trusted caregivers in order to determine whether a situation is safe or threatening. Emotional awareness, the ability to recognize and distinguish emotions experienced by oneself and others, is a key feature of emotional regulation. This develops in young children in the context of responsive relationships with primary caregivers. Even without histories of trauma, children can sense and are emotionally affected by their caregiver's stress. Children with trauma histories are likely to have an exceptionally heightened awareness of certain negative emotional states of their caregivers.[49]

As a result, identification of ways to decrease provider stress associated with the Early Achievers rating process is one important strategy for infusing trauma-informed practices into the Early Achievers program. Providing TIC training for the Early Achievers coaches and data collectors that will enable them to approach their interactions with providers in a more trauma-sensitive manner is an essential step in this process. Coaches and data collectors would benefit both from the TIC training previously described, and from additional training regarding best practices for trauma-sensitive observation and assessment through quality rating and improvement systems. Additional work is needed to identify these trauma-sensitive practices.

Increasing the coaches' emphasis on interactions and social-emotional support was also identified as a core recommendation for infusing trauma-informed practices into Early Achievers. More work needs to be done to identify specific strategies for this recommendation, though initial Advisory Group ideas included use of a more sensitive tool for assessment of interactions and ensuring that the classroom environment is more effectively addressed at the time a provider is working toward licensure so that the Early Achievers coaches do not have to spend so much time addressing environmental concerns.

Another idea was the possibility of adding a TIC Early Achievers area of specialization. This could mean that a score over a certain percentile on the interaction-focused element of the rating could be a component of a provider's designation as a trauma-informed early care and education provider. This idea has yet to be fully explored, but the Advisory Group recommended doing so.

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[48]Appendix M

[49]Y. Dvir., J. D. Ford, M. Hill and J. A. Frazier (2014). Childhood maltreatment, emotional   dysregulation, and psychiatric comorbidities. Harvard Review of Psychiatry, 22(3), p. 3.

PARENT AWARENESS OF TRAUMA-INFORMED CHILD CARE

The Advisory Group recommended that all families be provided with opportunities to participate in training about early childhood adversity and trauma-informed care using a multi-generational approach. However, they recognized that participation in these opportunities can be challenging for some families. They recommended engagement of families by trusted messengers (e.g., parent ambassadors) and providing practical supports for family participation (e.g., stipend for attendance, meals and high-quality child care during trainings) as means of addressing these barriers.

The Advisory Group recommended careful consideration of the language associated with training and services, suggesting use of language that ensures that parents will value trauma-informed early care and education and want their child's early childhood educators to be trained in this approach. They considered a strengths-based orientation, such as a focus on resilience, important.

While use of language that supports families' understanding of trauma-informed care as it pertains to and benefits all children's social-emotional development is important, families with children who have actually experienced trauma need to be able to identify providers of more intensive levels of trauma-informed early care and education. These resources could include:

- A searchable inventory with clear criteria for designation of early care and education providers who specialize in trauma-informed care. This would enable parents to identify the providers within their communities who provide the appropriate level of care for their child. For example, if criteria for designation as a trauma-informed early care and education provider were identified, this could be built into the Child Care Aware of Washington referral system.
- Additional means of communicating to families about available trauma-informed early care and education options through their existing relationships with service providers. Examples provided include hospitals and medical clinics, homeless shelters, meet-up groups, parks and other public spaces, ads on TV and other media such as radio, Parent-Teacher Associations and community-based organizations.

As part of the Advisory Group's efforts to engage other critical stakeholders on this issue, DCYF's Parent Advisory Group (PAG) was consulted. Recommendations from the Advisory Group were consistent with those from PAG, though the latter group offered more extensive recommendations on how to involve parents in trauma-informed care practices.[50]

FUNDING ANALYSIS

Five possible funding sources were identified by DCYF staff: cannabis tax, Washington State general fund, Temporary Assistance for Needy Families (TANF), Title IV-E (Foster Care & Adoption) and IDEA Part B funds (see Appendix O for full list). Additional recommendations from the Advisory Group included exploring opportunities to leverage the Family First Prevention Services Act, seeking funding from health care and family foundations, and including birth to three education in the basic education entitlement. They also recommended exploration of opportunities to leverage resources such as graduate student internships for nurse or occupational therapist consultants.

Also of note, DCYF has proposed TIC-related work in the application for the federal Preschool Development Grant. DCYF was awarded this grant, and first-year activities would include

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[50]See Appendix Q for more information

establishment of an advisory committee and workgroups, selection of training models (including statewide meetings to gather input from communities about selection, adaptation and implementation), development of a policy strategy for expulsion tracking and prevention, and development of a plan for integrating TIC and expulsion prevention into the statewide IECMH consultation model.[51]

The Advisory Group lacked the fiscal expertise and information necessary to conduct a comprehensive analysis of all available funding sources. They also struggled to recommend funding sources without having the time and resources to more fully develop the recommendations contained in this report. As a result, they recommended additional analysis and suggestions by a workgroup with fiscal expertise beyond that of this Advisory Group.

CONCLUSION AND NEXT STEPS

Because of the Advisory Group members' varied areas of expertise, they were better able to develop in-depth recommendations on certain elements of EHB 2861. Recognizing this, and the limitations created by their compressed time line, they have recommended additional work to further develop their initial set of recommendations. They recommended formation of a long-term Trauma-Informed Early Childhood group to advise DCYF and the Legislature. This group should include designated seats for tribal representatives and early childhood educators (in addition to administrators). This long-term advisory group could support other systems serving young children and their families (e.g., child welfare, health care systems) become more trauma-informed (see Appendix B). The advisory group would have time-limited, content-specific subcommittees which could focus on further developing the Advisory Group's initial high-level recommendations from this report. The Advisory Group recommended that funding be provided by DCYF for agency staffing of the long-term advisory group and for a stipend for participants.

Foundational principles underlying future efforts to build a trauma-informed early care and education system should include:
1. Relationship-based practice,
2. Culturally-responsive practice,
3. Reflective practice,
4. Parallel process,
5. Regulation, resilience and healing in addition to ACEs, trauma and toxic stress,
6. Ongoing training *plus* support for all early care and education staff from trauma-informed consultants, coaches and administrators,
7. Funding for implementation work and new requirements (no unfunded mandates),
8. Voluntary provider participation that is accessible by all, and
9. A grounding in research on brain science and early childhood development.

While aspects of the recommendations in this report may appear aspirational, they portray the comprehensive vision reflective of the Advisory Group's expert opinions and best thinking regarding what a quality trauma-informed early care and education system should be. The Advisory Group recommended investment in the holistic implementation of a trauma-informed

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[51]After finalization of this advisory group's recommendations, DCYF was notified that it was the recipient of a $5,270,656 federal Preschool Development Birth Through Five (PDG B-5) Grant from the Department of Health and Human Services. The PDG B-5 is a planning grant which will allow DCYF to conduct a comprehensive statewide birth through five needs assessment, followed by in-depth strategic planning and some key activities to help further advance the agency's work to support families and providers caring for our state's youngest children. DCYF will use the grant funding to facilitate collaboration and coordination among existing programs of early childhood care and education within a statewide mixed-delivery system to prepare low-income and disadvantaged infants, toddlers, and young children to enter kindergarten.

early care and education system as opposed to funding of individual pieces of their recommendations.

The Advisory Group recommended that if funding for statewide implementation of the full trauma-informed early care and education system is not available, the state and legislature should consider piloting the full system in specific communities or regions rather than funding isolated elements of their recommendations. This would best enable evaluation of the impact of implementation of the trauma-informed early care and education *system* that must be built in order to maximize the benefits of trauma-informed care for young children, their families and professionals in the field.

For reference, this report should be read in conjunction with the addendum "Infant/Early Childhood Mental Health Consultation – Proposed Services for Washington" (see Appendix R) and the report entitled "Child Care Health Consultation in Washington State – Recommendations for Expansion," as the Department of Children, Youth, and Families views these three documents as components of one larger, cohesive system.

ACKNOWLEDGEMENTS

PRESENTERS

Special gratitude goes to the following individuals (in chronological order of presentations) whose presentations informed the Advisory Group on particular content areas:

Kody Russell
Kitsap Strong
KISS Framework

Monica Oxford
Barnard Center for Infant Mental Health and Development
Relationship-Based Practice

Gail Joseph
Cultivate Learning
Early Achievers Expulsion Data

Kevin Cummings
DCYF
ECEAP Expulsion Data

Greg Williamson
DCYF
MSTIC

Mandy Davis
Trauma-Informed Oregon
Oregon's Trauma Informed Journey

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Sarah Wilhelm
King County Best Starts for Kids
Trauma-Informed Approaches in Public Health Seattle & King County and Best Starts for Kids

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Vasilya Mendybaeva
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Child Care Basics Trauma-Informed Care Module

Zack Sideek
The Square Pegs
Trauma and Autism

Rebecca Berg
Cooper House
Considering Trauma in Young Children with Special Needs

Christa Murray
Child Care Aware of Washington
Child Care Aware Data Overview

Jody McVittie
Sound Discipline
A Sample of Practical Brain Science

Kristin Tenney-Blackwell
Pyramid Model Consortium
Trauma-Informed Care & the Pyramid Model

GLOSSARY

Adverse Childhood Experiences (ACEs): Stressful or traumatic events occurring during the first 18 years of an individual's life. In the original CDC-Kaiser ACE Study[52], these included:

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Intimate partner violence
- Mother treated violently
- Substance misuse in household
- Mental illness in household
- Parental separation or divorce
- Incarcerated household member

The nine ACEs items used by the National Survey of Children's Health (2016)[53] include:
- Hard to get by on family's income
- Parent or guardian divorced or separated
- Parent or guardian died
- Parent or guardian served time in jail
- Saw or heard parents or adults slap, hit, kick, punch one another in the home
- Was a victim of violence or witnessed violence in neighborhood
- Lived with anyone who was mentally ill, suicidal, or severely depressed
- Lived with anyone who had a problem with alcohol or drugs
- Treated or judged unfairly due to race/ethnicity

Attachment: "[Attachment] encompasses the quality and strength of the parent-child bond, the ways in which it forms and develops, how it can be damaged and repaired, and the long-term impact of separations, losses, wounds, and deprivations. Beyond that, it is a theory of love and its central place in human life."[54]

Attuned (Attunement): Aware of and attentive or responsive to something. An example is a parent paying attention to their child's cues or signals, being aware that these cues are an attempt to communicate and connect with the parent, and responding in a sensitive way to the cues.[55]

Culturally-Sustaining: "seeks to perpetuate and foster–to sustain–linguistic, literate, and cultural pluralism as part of the democratic project of schooling"[56]

Early Childhood Educator: Early care and education *professionals* providing child care and early learning opportunities.

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[52]https://www.cdc.gov/violenceprevention/acestudy/about.html
[53]Child and Adolescent Health Measurement Initiative, 2016 NSCH data query
(http://www.childhealthdata.org/browse/survey/results?q=5545&r=49)
[54]Karen, R. (1998). Becoming attached: First relationships and how they shape our capacity to love, p. 3.
[55]J. Van Horn (2018), Reflective supervision, p. 61.
[56]D. Paris (2012), Culturally sustaining pedagogy: A needed change in stance, terminology, and practice, p. 93.

Expulsion: Provider practices that exclude a child from the early care and education environment through permanent dismissal of a child from an early care and education program.

Health Consultation Hubs: Regional shared interdisciplinary health services teams providing child care health consultation in all regions across the state. In addition to nursing and mental health consultation, other services that a child care provider or community may need will also be offered by these teams of early childhood specialists (for example, occupational therapists, inclusion coaches) for support in decoding the behavior of the young children in their care through the lens of sensory, motor, language and cognitive development in order to ensure optimal early care and learning opportunities in inclusive settings (pending funding).[57]

Individualized Educational Plan (IEP): A plan or program developed to ensure that a child (3-21 years of age) who has a disability identified under the law and is attending an elementary or secondary educational institution receives specialized instruction and related services.

Infant Early Childhood Mental Health (IECMH): The developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage and express emotions; and explore the environment and learn, all in the context of family, community and culture.[58]

Infant Early Childhood Mental Health Consultation (IECMHC): A prevention-based intervention that teams a mental health professional with families and adults who work with infants and young children (such as early care and education staff and administrators) to improve the social, emotional and behavioral health of children in child care and early education programs. This is achieved by building the adults' capacity to strengthen and support the healthy social and emotional development of children.[59]

Parallel Process: The way one relationship affects other relationships.[60]

Parent: Any primary caregiver (whether biological parent, other adult relative or unrelated adult guardian) who fulfills the parenting role.

Provider: Child care and early learning *agencies* or *programs* (including centers, licensed family child care and licensed friend/family/neighbor care)

Racial Equity: Racial equity means that race cannot be used to predict one's success, and our systems and structure work for everyone. It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain equity through proactive and preventative measures. Equity is distinct from equality, which refers to everyone having the same treatment without accounting for differing needs or circumstances.

Racialization: the act or process of imbuing a person with a consciousness of race distinctions or of giving a racial character to something or making it serve racist ends

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[57]See addendum: Child Care Health Consultation in Washington State – Recommendations for Expansion
[58]Zero to Three (2017). The basics of infant and early childhood mental health: A briefing paper. (https://www.zerotothree.org/resources/1951-the-basics-of-infant-and-early-childhood-mental-health-a-briefing-paper)
[59]Substance Abuse and Mental Health Services Administration, Center of Excellence for Infant and Early Childhood Mental Health Consultation (https://www.samhsa.gov/iecmhc/about)
[60]J. Van Horn (2018), Reflective supervision, p. 63.

Reflective Consultation: Support to enhance the reflective practice of ECEs and administrators that is provided by someone who is contracted by the agency or program to provide this service.[61]

Reflective Practice: A way of intentionally slowing down to take the time to "step back" from the immediate, often intense direct work with young children and their families in order to better consider what the experience means, both to the professional and to the family/young child.[62]

Reflective Supervision: Support to enhance the reflective practice of home visitors and/or supervisors that is provided by someone who is employed by the early care and education agency or program and for whom supervision is included in their job description. Reflective supervision is a form of ongoing, intentional, scheduled professional development that focuses on enhancing the reflective practice skills of ECEs and administrators for the purposes of program quality, including staff wellness and retention.[63]

Regulation: The ability to manage how alert, activated or aroused we are moment-to-moment so that we are able to function at an optimal level. We learn to regulate our states of arousal (quiet sleep, active sleep, quiet alert, active alert, active crying), our behaviors, our physiology (tired, hungry, body temperature) and our emotions.[64]

Relationship-Based Practice: Practices that recognize that development takes place in the context of relationships and that optimal development is contingent upon the health of the relationships between children and their parents and other primary caregivers. These include elements of a child care program that help support relationships between staff and the infants and young children in their care, centered around policies, procedures, and practices that support families, teachers, and children as they build relationships with and among each other[65].

Resilience: Relationships, resources, and individual qualities that protect children and families against risk and help them cope, adapt, and even thrive despite experiencing adversity[66]

Secondary Trauma: The stress or emotional pain that comes from hearing about the traumatic experiences of someone else. Also known as "vicarious trauma."[67]

Soft Expulsion: Provider practices that encourage families to voluntarily terminate early care and education services with that provider's program or agency.

Suspension: Provider practices that limit a child's ability to participate in early care and education opportunities within that agency or program. This may occur though:
- In-program suspensions (e.g., sending a child to the director's office), or
- Out-of-program suspensions (e.g., limiting the number of hours a child may attend the program each day).

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[61]J. Van Horn (2018), Reflective supervision, p. 63.
[62]Parlakian, R. (2001). Look, listen, and learn: Reflective supervision and relationship-based work.
[63]J. Van Horn (2018), Reflective supervision, p. 63.
[64]J. Van Horn (2018), Reflective supervision, p. 63.
[65]L. Sosinsky et al., Including relationship-based care practices in infant-toddler care, p. 2.
[66]C. I. Morrison, L. S. Beeber, and B. Jones Harden (2012), Finding family strengths in the midst of adversity: Using risk and resilience models to promote mental health. In S. J. Summers and R. Chazan-Cohen (Eds), *Understanding early childhood mental health: A practical guide for professionals,* p. 59.
[67]J. Van Horn (2018), Reflective supervision, p. 64.

Trauma: An experience that overwhelms the body's ability to make meaning of it during the individual's current developmental stage. This can entail specific traumatic events; it also includes factors such as the absence of care in the form of emotional or physical neglect, threat to a generalized feeling of safety at the community level (e.g., due to natural disaster, community violence or discrimination) and the pervasive impact of historical trauma.

Trauma-Informed Child Care: Early care and education in which providers
- recognize and respond to the impact of traumatic stress on those who have contact with the system (children, caregivers, and service providers);
- infuse and sustain trauma awareness, knowledge and skills into the organizational culture, practices and policies of agencies and programs; and
- act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.[68]

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[68]The National Child Traumatic Stress Network (2016), What is a trauma-informed child and family services system?

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APPENDIX A: OUTCOME MAP

Strategies

Training is delivered to early learning providers and administrators in trauma-informed child care (TICC).

Best practices for supporting family child care providers in provision of TICC are implemented.

Systems are created for tracking expulsions and suspensions from child care, and methods to reduce expulsions by 50% over five years are implemented.

Child care staffing ratios and subsidy rates for providers specializing in TICC are improved, and requirements for access to specialty providers for providers specializing in TICC are identified.

Changes are made to the Early Achievers quality rating and improvement system to better rate and support providers serving high needs children.

Outreach to parents is conducted to expand awareness about the availability of TICC.

All available federal, state, and local funding sources are used for funding elements of the five-year strategy.

Systems

Early care and education environments and systems positively and intentionally support each child's social, emotional, and cultural needs.

Stakeholders understand:

The impact of ACEs and other sources of toxic stress on child development including brain development, early learning, behavior, and lifelong health and well-being

The mitigating impact of provision of high-quality TICC and early learning support services on the impact of trauma and developmental delays

The implications of existing systems that have created the "preschool to prison pipeline"

Providers

Administrative and programmatic policies:

- Reflect knowledge of TIC and the importance of relational health
- Are responsive to the needs of each child, family, and ECE
- Support the well-being of all staff

Administrators & Early Educators

ECEs are well-trained, well-supported, and responsive to the needs of children in their care.

ECEs have increased reflective capacity.

ECEs better understand the children in their care, the impact of their own experiences on their work with children and families, and the impact of their work on their own well-being.

Collaboration increases between parents and early care and education staff on behalf of children in care, with a shared understanding of how trauma can affect the child.

ECEs, administrators, and other staff are less likely to re-traumatize children, families, and colleagues.

ECE stress decreases.

ECE retention increases.

Parental Caregivers & Families

Caregiving families trust that their children are receiving quality care.

Parents are able to participate in the workforce without distraction and stress related to their child's care.

Families experience increased economic security and stability.

Parents and families feel safe, valued, connected, welcome, and supported by their communities.

Parents have increased understanding of the impact of toxic stress on brain development.

Parents have strategies that enable them to better support their child.

Parents effectively access and coordinate foundational supports for their family and child as they navigate care.

Parents know that their children can heal and thrive.

Children

All children have reliable access to consistent, quality child care.

All children, regardless of social context, have the opportunity to be included in trauma-informed and culturally-aware early childhood care and education.

All children's brains develop optimally.

Children feel secure, valued, connected, and welcome; have the ability to self-regulate in the context of safe, attuned, and predictable caregiving relationships; develop resilience; and form healthy connections with peers.

Children are ready to enter Kindergarten.

Children are confident that they truly belong – in life, education, and beyond.

Trauma-Informed Early Care & Education

All young children and their families, including those who have experienced trauma and other adversity, will experience safe, responsive, and engaging trauma-informed early care and education environments where they can thrive within nurturing, secure, consistent relationships with their early childhood educators, developing resilience and regulation that will enable them to flourish in school and life.

PURPOSE
"Why is the provision of TICC important to you, children and families, early childhood educators, and the larger community?"

PRINCIPLES
"What rules must we follow in pursuit of this purpose?"

1. Relationship-based practice
2. Culturally-responsive practice
3. Reflective practice
4. Parallel process – child & family held by ECEs held by administrators, coaches, consultants, etc.
5. Regulation, resilience, and healing in addition to ACEs, trauma, and toxic stress
6. On-going training PLUS support for all ECE staff from trauma-informed consultants, coaches, and administrators
7. Funding and support – no unfunded mandates
8. Voluntary provider participation that is accessible to all.
9. Brain science and development foundation

PRACTICES
"What are we going to do? What will be offered to children, families, ECEs, and providers? How?"

1. Deliver training to early learning providers and administrators in TIC
2. Make changes to the EA program QRIS to better rate and support providers serving high needs children
3. Reach out to parents to expand awareness about the availability of TICC
4. Analyze all available federal, state, and local funding sources that may be used for funding elements of the 5-year strategy
5. Identify and implement best practices for supporting family [child] care providers in the provision of TICC
6. Adjust child care center staffing ratios, requirements for access to specialty providers, and subsidy rates for providers specializing in TICC
7. Develop and implement systems for tracking expulsions from child care, and identify methods to reduce expulsion by 50% over 5 years

CHILD & FAMILY

STRUCTURE
"How will we organize to continue efforts related to expansion of TICC?"

- TICC Advisory Group with content-specific sub-workgroups focused on topics such as expulsion, training, funding. The TICC Advisory Group would review workgroup recommendations to ensure that they are trauma informed.
- Cross-representation between the TICC Advisory Group and MSTIC as well as any other state level TIC-focused initiatives.
- Funding for staffing of this advisory group
- Funding to support advisory group participants as needed

PARTICIPANTS
"Who must be included to achieve this purpose?"

1. Children (birth through 5 years)
2. Parental caregivers/Families
3. Early Childhood Educators, administrators, and staff
4. EA coaches and raters, Infant-Toddler Consultants, IECMH and Nurse Consultants, and other outside support staff
5. Allied professionals (e.g., O/Ts, primary care providers, IECMH therapists, etc.)
6. Training organization staff and administrators
7. Tribes
8. Communities (e.g., military, communities of color, LGBTQ+ communities, religious communities, community based organizations, etc.)
9. TIC content experts
10. State and local government administrators and staff
11. Legislators
12. Funders

APPENDIX C: RECOMMENDATIONS SUMMARY

Trauma-Informed Child Care Expansion
Summary of Recommendations
Trauma-Informed Care Advisory Group 2018

CONTINGENCIES –
Racial Equity:
- Integration of racial equity considerations into all elements of TICC
  - Build on strengths of diverse children and their families
  - Attend to structural racism and related trauma that are root causes influencing their feelings and behavior
  - Create welcoming early learning environments that celebrate, affirm, and sustain families' cultural and linguistic diversity
  - Reinforce their sense of social and academic belonging
- Integrate racial equity efforts with TIC and SEL efforts

Social and Emotional Development:
- *All* children should have access to early care and education that is trauma-informed and that promotes their social and emotional development within the context of nurturing and responsive relationships with consistent caregivers.

Early Care and Education Workforce Wellbeing:
- Provide compensation that includes wages reflective of the critical nature of early care and education
- Increase access to Reflective Supervision and Consultation (training and practice)

TRAUMA-INFORMED CARE TRAINING –
General considerations:
- TIC training should be
  - Experiential
  - Culturally-sustaining
  - Informed by adult learning best practices
  - A trauma-informed experience for participants and trainers
  - Audience specific
  - Developed or selected in collaboration with content experts
  - Selected, adapted, and implemented in collaboration with diverse communities statewide
    - Opportunities provided for review by groups exclusively for ECEs and people of color
  - Voluntary and incentivized (or, if mandated, accompanied by an appropriate increase in subsidy rate)

Training delivery:
- On-going training (rather than a single training)
- Training accompanied by support for implementation of trauma-informed practices
  - IECMH Consultation from consistent person (relationship-based)
    - In-classroom and Out-of-classroom
    - IECMH Consultants reflective of communities served

- Train-the-trainer course
- Levels of training
  - Introductory through Child Care Basics module followed by increasingly advanced TIC topics
- Accessible trainings
  - Multiple languages
  - Varied times and locations
  - Primarily in-person and experiential but with hybrid elements (e.g., via Zoom)
  - In addition to continuing education, TIC training should be embedded into pre-service training

Training curriculum:
- Essential training components
  - Culture and Equity
    - Cultural, racial, and historical trauma
    - Implicit bias
    - Effective communication across race, class, and culture
    - Curriculum for Native American children that teaches them about Native language and culture
  - Brain Science
    - Information about trauma, toxic stress, and the impact of early childhood adversity on young children's developing brains
    - Developmentally-appropriate strategies for promotion of optimal social-emotional development
      - Strategies for teaching social and emotional skills
      - Practical tools for setting limits without punishment
  - Relational Health
    - Attachment
    - Regulation
      - Self-regulation of staff
      - Children's co-regulation in the context of safe, stable, nurturing relationships with regulated adults
    - Resilience
      - Cultivating child and family resilience, even without knowing their trauma history
      - Supporting staff wellbeing (a shared responsibility between employer and employee)
        - Administrator training
          - Development, implementation, and maintenance of trauma-informed employee wellness strategies
            - Reflective supervision
            - Development of TIC leadership skills
        - IECMH Consultation

Training Participants:

- Expanded audience
  - ECEs and administrators
  - Parents
  - Early Achievers coaches and data collectors ("raters")
  - Licensors
  - IECMH consultants
  - Child welfare staff
  - Other allied professionals serving young children and their families
- Incentivized participation
  - Free training
  - Early Achievers incentives
  - Meals
  - Quality child care for parents attending
  - Subsidy for parents attending
  - Substitute care for FFN and FCC providers

Training Supportive Structure:

- Build on existing community-based expertise and trainings
- Evaluate existing mandated trainings for opportunities to integrate TIC principles
- Provide training for ECEs and Kindergarten teachers to prepare them to more accurately assess social and emotional development (e.g., through WaKIDS)
- Develop mechanism for evaluating efficacy of all TIC training
- Connect and align with other trauma-informed initiatives (e.g., MSTIC, OSPI's K-12 efforts)

SUPPORT FOR FAMILY CHILD CARE PROVIDERS –

- Ensure application of TIC training and support recommendations to these providers
- Provide additional structure and support that meets FCC and FFN providers' unique needs:
  - Communities of practice and learning communities
    - Reflective consultation
    - Training
    - Peer mentoring
  - Access to mentoring, coaching, and consultation
    - Example: warm line for telephonic consultation in the moment of need
  - Regional lead teachers/coaches
    - On-sited support
    - Modeling of trauma-informed practices
    - Encouraging learning and skill development
  - Release time compensation for participation in training and communities of practice

EXPULSION TRACKING & REDUCTION –

Suspension and Expulsion Tracking:

- Track all exclusionary provider practices, including suspension and expulsion

- Create a system for collection of suspension and expulsion data disaggregated by child's race, ethnicity, gender, age, geographic location; provider or program type; and various other facility and ECE characteristics
- Collect parent-report data
  - Through WaKIDS (Kindergarten entry)
  - At earlier points in child's interaction with early care and education system
    - Through a recurrent large-scale parent survey
    - When parents request transfer of child care subsidy from one provider to another

Suspension and Expulsion Reduction:
- Develop a comprehensive state policy strategy utilizing the tool *Building a Comprehensive State Policy Strategy to Prevent Expulsion from Early Learning Settings* (2018)
- Expulsion Policy –
  - Ensure adequate and accessible training on the new expulsion WACs (licensing and Early Achievers)
  - Include reporting of suspension and other exclusionary practices as well as expulsion
  - Avoid creating punitive consequences for exclusionary practices; instead, increase supports for providers.
- Workforce Development –
  - Increase support for providers through access to Infant-Early Childhood Mental Health (IECMH) Consultation, with implementation that is
    - Consistent with best practice guidelines from SAMHSA's Center of Excellence on IECMH Consultation
    - Available to all providers
    - Open to any referral source
    - Required prior to expulsion or transition of a child due to behaviors
  - Seize the opportunity to build on ESIT's exploration of the possibility of statewide adoption of *The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children*
  - Explore trauma-informed, relationship-based training models related to promotion of young children's social-emotional development and use of developmentally appropriate, nondiscriminatory intervention strategies for addressing challenging behaviors
    - Ensure this builds on the strengths of children and their families and communities

LEVELS OF TRAUMA-INFORMED CHILD CARE: STAFFING RATIOS, SUBSIDY RATES, AND ACCESS TO SPECIALIZED PROVIDERS –
- **Tier 1: Universal** Trauma-Informed Early Care and Education
  High quality, diversity-informed, relationship-based, and adversity-informed early care and education for *all* children.
  - *Subsidy*: 75th percentile of the market rate (State of Washington 2018 Child Care Market Rate Survey, Public Consulting Group)
  - *Training*: TIC and relationship-based SEL trainings

- o *Support*:
  - Support for implementation of TIC and SEL practices
  - Consultation from a transdisciplinary consultation team through regional health/consultation hubs
- **Tier 2: Enhanced** Trauma-Informed Early Care and Education
  Targeted social-emotional supports for some children whose behaviors, due to trauma histories or neurodevelopmental difference, pose challenges beyond what most ECEs are equipped to manage.
  - o *General*: development of full definition of scope of this level of care to ensure these services are distinct from those provided through Therapeutic child care
  - o *Program duration*: Full-day programs to reduce number of transitions for children
  - o *Eligibility*: Identify categorical eligibility criteria, expanded beyond family income level
  - o *Ratios*: Reduce ratios and thus maximum group size, aligning it with the most current *Caring for Our Children* recommendations
  - o *Subsidy*: Subsidy rates should be aligned with the cost of quality
  - o *Support*: Priority access to consultation from regional health/consultation hub
- **Tier 3: Therapeutic** Trauma-Informed Early Care and Education
  Intensive interventions for the few children whose behaviors and/or experiences require the highest level of care.
  - o Availability of therapeutic child care should be expanded statewide to more fully meet the identified need for and to ensure more equitable access to this level of care for children who meet the categorical eligibility criteria.
- **Considerations for Children with Neurodevelopmental Differences:**
  - o ECE training on strategies for providing responsive care for children with communication and sensory differences
  - o Increased representation of adults with neurodevelopmental differences in professions within the early care and education field, including development of roles such as a "cultural consultant" that would assist with identification of environmental factors in classrooms that exacerbate sensory processing challenges
  - o Incorporation of trauma-informed practices into professionals' interactions with and interventions for children with neurodevelopmental differences and their families
  - o Access to relationship-based, trauma-informed intervention models (e.g., DIR Floortime) for young children with neurodevelopmental differences and their families
    - Training for professionals in utilization of these models

TRAUMA-INFORMED PRACTICES IN EARLY ACHIEVERS –
- Identify ways to decrease ECE provider stress associated with Early Achievers data collection
- Provide TIC training for Early Achievers coaches and raters
- Conduct a literature review to identify strategies for conducting trauma-sensitive observation and assessment through quality rating and improvement systems, and train coaches and raters on these strategies

- Identify strategies to increase coaches' ability to focus on interactions and social-emotional support
  - Explore possibility of use of a more sensitive tool for assessing ECE-child interactions
  - Explore possible strategies for ensuring environmental factors are more effectively addressed while provider is working toward licensure
- Explore possibility of a rating percentile above which a provider would receive one component of a TICC provider designation

PARENT AWARENESS OF TRAUMA-INFORMED CHILD CARE –
- Identify language and messaging regarding trauma-informed child care and TIC training that will promote families' valuing of these services
  - Clearly communicate to parents the intended goal of trauma-informed child care
  - Ensure that parents can identify the level of care appropriate for their child and access current information about the providers of these services in their community
    - Searchable online inventory; could be built into Child Care Aware of Washington referral system
    - Educate service providers who are "trusted messengers" for families (e.g., medical clinics, homeless shelters, meet-up groups, PTAs, etc.) to ensure that they can provide accurate information and referrals to families
  - Conduct a public awareness campaign to increase communities knowledge of ACEs, reduce stigma, and provide basic education regarding trauma-informed and developmentally-appropriate parenting practices
- Ensure parents can self-select into higher levels of care (Enhanced and Therapeutic)
- Ensure that TIC training and support result in improved ECE provider and parent partnership on behalf of children
- Take a multigenerational approach to provision of TIC training for families, utilizing trusted messengers such as parent ambassadors and providing practical supports such as meals and child care to promote families' participation.

FUNDING ANALYSIS –
- Potential funding sources include:
  - Cannabis tax
  - Washington State General Fund
  - Temporary Assistance for Needy Families (TANF)
  - IDEA Part B funds
- Explore opportunities to leverage the Family First Act
- Seek funding from health care and family foundations
- Include birth to three education in the basic education entitlement
- Explore opportunities to leverage resources such as graduate student internships in appropriate roles (e.g., nurse or O/T consultants)
- Federal Preschool Development Grant application includes request for funding that would support

- o Establishment of an advisory committee and workgroups,
- o Selection of training models,
- o Statewide meetings to gather input from communities re: selection, adaptation, and implementation of TIC and SEL training
- Further analysis and recommendations by a workgroup with fiscal expertise is needed.

GENERAL –
- Further work to fully operationalize and build upon TICAG's initial recommendations.
    - o Formation of a Trauma-Informed Early Childhood advisory group
        - ▪ Designated seats for Tribal representatives
        - ▪ Designated seats for ECEs
        - ▪ Time-limited, content-specific workgroups to fully operationalize initial recommendations (e.g., Early Achievers, Expulsion tracking system, Levels of Care)
        - ▪ Funding for DCYF staffing of advisory group
        - ▪ Stipends for group member participation, as needed
    - o Alignment of all efforts to build a trauma-informed ECE system with principles identified by the TICAG
- If funding is a barrier, the TICAG recommends implementation of full system, even if just in pilot communities, rather than piecemeal implementation of select strategies.

APPENDIX D: POTENTIAL TRAINING DELIVERY MECHANISMS

Trauma-Informed Care Training & Support
Potential Training Elements & Delivery Mechanisms
Trauma-Informed Care Advisory Group

Components –
Pre-service training
Ongoing training
Hands-on support and coaching
Reflective supervision and practice
Relationship-based practice
Community of practice

Systems & Programs –
IECMH Consultation System
Early Achievers
EHS, HS, and ECEAP
Infant-Toddler Consultants
Public Health
Community and State colleges
State-approved mentors
Birth to Three
MERIT/STARS
Child Care Basics

Organizations –
Green River College
WSU Extension (Chris Blodgett)
First Steps
Sound Discipline
Wellspring
Kitsap Strong
Best Starts for Kids
Imagine Institute
Barnard Center (UW)
WA-AIMH
Child Care Aware
Cultivate Learning

APPENDIX E: POTENTIAL TRAINING MODELS

Trauma-Informed Care in Child Care and Early Learning:
"Best Practices" Advisory Group Brainstorm
Trauma-Informed Care Advisory Group

- 1-2-3 CARE Toolkit – Spokane Regional Public Health District
- Attachment, Self-Regulation, and Competency (ARC) – The Trauma Center at JRI
- Building Your Bounce – Devereux Center for Resilient Children
- Circle of Security
- Collaborative Learning for Educational Achievement and Resilience (CLEAR) – Washington State University
- Conscious Discipline
- Developmental, Individual Difference, Relationship-Based (DIR) Floortime Model - The Interdisciplinary Council on Development and Learning (ICDL)
- Facilitating Attuned iNteractions (FAN) – Erikson Institute
- HeadStart Mental Health Consultation – Early Childhood Learning & Knowledge Center (ECLKC)
- Infant-Early Childhood Mental Health Consultation – SAMHSA Center of Excellence for IECMHC
- Mindfulness
- Neurobiology, Epigenetics, ACEs, Resilience (NEAR) Science Training
- PATH for E/C (website?)
- Positive Discipline
- Positive Indian Parenting – National Indian Child Welfare Association (NICWA)
- Promoting First Relationships (PFR) – University of Washington
- The Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (the "Teaching Pyramid") – Center on the Social and Emotional Foundations for Early Learning (CSEFEL)
- Recognizing and Addressing Trauma in Infants, Young Children, and Families – Georgetown University Center for Early Childhood Mental Health Consultation
- Reflective Supervision and Consultation (RSC)
- SaintA
- Sanctuary Model – Dr. Sandra L. Bloom
- Trauma Sensitive Schools
- Trauma Smart – Crittenton Children's Center
- Trauma-Informed Practices in Early Childhood Education (TIP-ECE) – WestEd
- Turnaround for Children
- Trauma-Informed Practice training videos – Zero to Three

APPENDIX F: EXPULSION TRACKING SYSTEM DATA

Suspension & Expulsion Tracking Data System Recommendations
Trauma-Informed Care Advisory Group

CHILD DATA
- Age
- Race
- Ethnicity
- Gender
- Caregiving history
- Dual Language Learner (DLL)
- Mobility (i.e., # of moves)
- Living conditions or context
- Birth order
- Medical history (e.g., pre-term delivery, medical home)
- Any diagnoses
- Medications
- Referral history
- Services received
- ACEs
- Reason for expulsion
- Child's social-emotional (SE) functioning with peers
- Child's SE functioning with ECEs
- Child's perception of ECEs
  - "Do you have a favorite?"
  - "Does someone help you?"
- Measure—observation of play behaviors and skills

FAMILY DATA
- Parents preferred method of receiving communication
- Relationship of parents to child (e.g., biological, adoptive, kinship care, etc.)
- Family's culture
- What do they feel is challenging about their child?
- What goals and dreams do they have for their child?
- Parent perception of family engagement
  - Family's/parent's connectedness to the Early Learning program
  - Parental involvement in the Early Learning program
  - "I feel welcome at my child's school."
- Parental confidence in facility
  - "I had a good experience at school."
  - "I know my child will be treated respectfully at school."
  - "Children like my child are treated fairly at school."
- Parental perceptions of access to resources/support

EARLY EDUCATOR DATA
- Education
  - Pre-service education (from what institution type?)

- o Education level
- o Hours of ECE training
- o Training in assessment
- o TIC knowledge base
  - ▪ Attachment
  - ▪ Brain science
  - ▪ Models for teaching brain science
- o Knowledge of red flags for mental health concerns or developmental differences
- o Knowledge of referrals for children
- o Knowledge of supports and resources for parents
- Attitudes and Practices
  - o Assessment of early educator beliefs
  - o Beliefs about the meaning of behaviors (e.g., respect does not equal compliance)
  - o ECE perceptions of behavior (reflective capacity)
  - o What behaviors do they feel are challenging?
  - o Beliefs about appropriate responses to behavior (e.g., children misbehaving should be excluded and/or have privileges removed)
  - o Approaches to challenging behavior
  - o What would they suspend or expel children for?
  - o What % of child's day is in play?
  - o What % of child's day is in front of a screen?
- Wellbeing
  - o Job satisfaction
  - o Perception of efficacy and meaning
  - o Work history (length of employment, why they have left centers)
  - o "Are you treated respectfully?"
  - o Stress
  - o Understanding of importance of self-care
  - o What are they doing for self-care?
  - o Level of support when sick or needing time off
  - o Living conditions
  - o Home life: needs met?

ADMINISTRATOR DATA
- What is the training/education of administrators?
- ECE background of whoever is running/developing program or policy
- Understanding of and ongoing commitment to trauma-informed work – infused into daily practice
- Administrator role in suspension and expulsion
- Support provided by administrator(s) to staff (type, frequency)

FACILITY DATA
- Child data
  - o Size of program
  - o Enrollment #s
  - o Waitlist #s
  - o % of students with ACEs
  - o Rates or # of children expelled and suspended

- Staff data
    - Staff turnover
    - Salaries
    - Understanding of importance of staff-care and wellbeing
    - % of early educators trained in TIC
    - Leadership training opportunities
    - Support for early educators (types, frequency)
- Administrator data
    - % of administrators trained in TIC
    - % of administrators trained in provision of reflective supervision
- Programmatic data
    - Amount of time "screens" are used for care
    - % of play time
    - What books do they have in the library for read alouds?
    - Use of rhythm, music and nature
- Policies & Procedures
    - Screening (e.g., types, frequency, rates)
    - Assessments
    - Suspension and expulsion policies and procedures
    - Soft expulsion practices
    - Systems for communicating with families (e.g., parent conferences)
    - How are parents informed about suspension and expulsion policies?
    - Who is in charge of making program decisions (e.g., curriculum)?
    - Professional development policies
    - Absence and employment policies (e.g., medical, vacation, sick leave, etc.)
    - Incentives
    - Culture/philosophy of centers/providers
    - System of referrals
    - Access to IECMH Consultation
    - Access to and frequency of reflective supervision and/or consultation
    - Connection to and sense of support from outside, community resources

SYSTEMS COMPONENTS
- Commitment to equity
- Clear mission for systems
- Clarity behind purpose
- Clear and central access point for systems
- Degree of connection/communication between systems. Collaboration between systems around similar topics to prevent duplication.
- Children should be the focus of policy/systems decisions (e.g., child impact)
- Universal developmental and behavioral screening
- Facility/provider characteristics predictive of need
- Commitment to assessment of mental health of ECEs and administrators
- % of workforce trained in TIC
- Means of connecting providers to TIC trainings
- Is there continuity of a TIC and developmental lens?

APPENDIX G: EXPULSION RESOURCES

Trauma-Informed Care Advisory Group
Child Childhood Suspension & Expulsion Prevention Resources

The following list contains information and resources that have been shared by advisory group members and professionals in other States related to tracking and reducing suspension and expulsion from early childhood settings. The list is by no means comprehensive, and inclusion does not connote endorsement by DCYF.

Implicit Bias & Early Learning Expulsion
- A Research Study Brief: Do Early Educators' Implicit Biases Regarding Sex and Race Relate to Behavior Expectations and Recommendations of Preschool Expulsions and Suspensions? (Yale University Child Study Center, September 2016)

Suspension and Expulsion Reduction: National Information and Resources
- Building a Comprehensive State Policy Strategy to Prevent Expulsion from Early Learning Settings, 2nd Edition (U.S. Department of Health & Human Services, Early Childhood Training and Technical Assistance System; June 22, 2018)
- Nishioka, V. (with Shigeoka, S., & Lolich, E.). (2017). School discipline data indicators: A guide for districts and schools (REL 2017–240). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Northwest. Retrieved from http:// ies.ed.gov/ncee/edlabs.
- Policy Statement on Expulsion and Suspension Policies in Early Childhood Settings (U.S. Department of Health and Human Services (HHS) & U.S. Department of Education, 2014)
- Information Memorandum: State policies to promote social-emotional and behavioral health of young children in child care settings in partnership with families (HHS Office of Child Care; September 8, 2015)
- Expulsion and Suspension Policy Statement (HHS Office of Child Care; November 7, 2016)
- Expulsion and Suspension Definitions (BUILD Initiative's Preventing Expulsion and Promoting Social Emotional Health Peer Learning Forum, August 2016)
- Preventing Expulsion Resource Library (BUILD Initiative, 2016)
- Suspensions Are Not Support: The Disciplining of Preschoolers With Disabilities (Center for American Progress; January 17, 2018)
- Pre-K Students Expelled at More Than Three Times the Rate of K-12 Students (*YaleNews*; May 17, 2005)
- We expel preschool kids three times as often as K-12 students. Here's how to change that. (*The Seattle Times*; May 21, 2016)
- Expelling Expulsion: Using the Pyramid Model to Prevention Suspensions, Expulsions, and Disciplinary Inequities in Early Childhood Programs (Allen, R. & Smith, B., November 2015)
- Expelled in preschool (The Hechinger Report; February 22, 2015)

State Examples of Suspension and Expulsion Reduction Efforts
- State has high rate of preschool expulsions, study finds (*The Seattle Times*; May 17, 2005)
- State and Local Action to Prevent Expulsion and Suspension in Early Learning Systems: Spotlighting Progress in Policy and Supports (U.S. Department of Education Office for Civil Rights, 2014)

- NYSED Field Memo: Suspension and Expulsion of Preschool Children (New York Special Education Department, July 2015)
- New York State Early Childhood Advisory Council Pyramid Model Initiative
- Minnesota Center for Inclusive Child Care Coaching, Consultation, and Resources
- New Mexico Early Childhood Suspension-Expulsion Resources: An Annotated Collection of Free Materials (Catlett, C., January 2017)

Resilience

Harry Potter and the Ordinary Magic of Resilience (YouTube)

Data collection on expulsion from early learning programs

What we know from Early Achievers Data Collection

Spoiler Alert: Some, but not a lot or enough

ECEAP Expulsion rate 2005

- Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Systems (Gilliam, 2005)
- Surveyed ECEAP program directors (n = 304)
- Prek Expulsion rate 8.73 per 1,000
- K-12 Expulsion rate 3.71 per 1,000
- More than twice the rate

ECE Expulsion rate 2009

- 2009 survey of parents with children entering Kindergarten in WA State (n=1,678)

- Q: *Was your child ever asked to leave a program due to problem behavior?*

- Reported an expulsion rate of 16.7 per 1,000

  (Joseph & Cevasco, 2011)

QRIS Logic model

Assessment: Quality Standards | Outputs: Star ratings | Demand for Quality | Quality Improvement | Improved child well-being

Direct observation
of classroom quality

Focal Child

Data collected on expulsion in WA QRIS

- Quality point is awarded if:

- Have not removed a child due to behavior

- There is evidence of "no expulsion" policy

- Evidence of transition plans/policies for changes in settings and providers
    - Evidence of written policy to support referrals and transitions
    - Evidence for broad practices for supporting referral and transitions
    - Evidence that children who were removed from the program were supported

QRIS Data from 2013-2014

Director Interview: Have you removed a child from care for behavioral reasons?

-

FAMILY CHILD CARE
(N=180)

■ removed child ■ not removed

not removed
44%
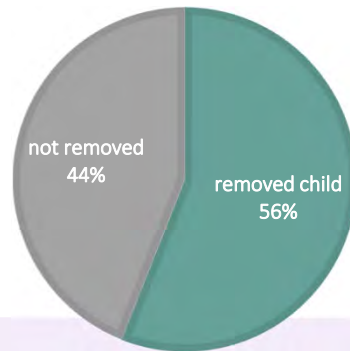
removed child
56%

CENTER CHILD CARE
(N=281)

■ removed child ■ not removed

not removed
31%

removed child
69%
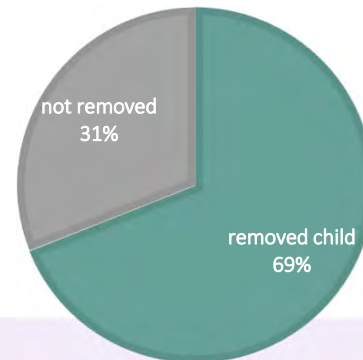
QRIS Data from 2013-2014

- Is there a "no expulsion" policy as well as policies and practices in place for a referral for more support and supported transitions?

FAMILY CHILDCARE
(N=180)

■ Policy in place ■ No policy ■ ■

Policy in place
18%
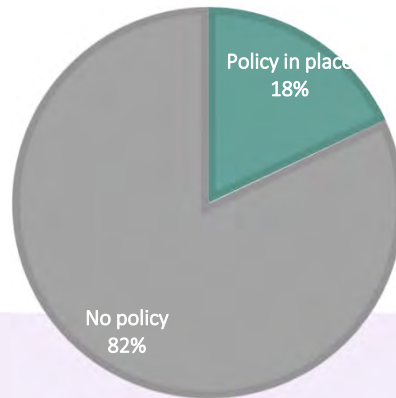
No policy
82%

CENTER CHILDCARE
(N=281)

■ Policy in place ■ No policy ■ ■

Policy in place
33%

No policy
67%

Family Engagement and Partnerships Point #8:

Evidence of supportive transitions for children who are removed due to challenging behavior or developmental needs.

64% Opted-In to FEP #8 (208 of 325 Programs)

Child Outcomes Point #1:
Developmental screening is on file for all children that have been enrolled for 90 calendar days and results are shared with parents

71% Opted-In to CO Point #1 (232 of 325)

FEP Point #8 Criteria 1:
Provider has a no expulsion policy in place.

Does not meet criteria — 198 95%
Meets criteria — 10 5%
Number of Programs

FEP Point #8 Criteria 2:
No child has been asked to leave the program due to behavioral or developmental needs in the last 12 months.

Does not meet criteria — 35 17%
Meets criteria — 173 83%
Number of Programs

FEP Point #8 Criteria 3:
Provider has a transition policy that includes at least 3 supports for each child that is asked to leave due to behavioral or developmental concerns

Does not meet criteria — 144 69%
Meets criteria — 64 31%
Number of Programs

Does not meet criteria — 44.40% 103
Meets criteria — 55.60% 129
Number of Programs

Family Engagement and Partnerships Point #8:
Evidence of supportive transitions for children who are removed due to challenging behavior or developmental needs.

64% Opted-In to FEP #8 (208 of 325 Programs)

Child Outcomes Point #1:
Developmental screening is on file for all children that have been enrolled for 90 calendar days and results are shared with parents

71% Opted-In to CO Point #1 (232 of 325)

FEP Point #8 Criteria 1:
Provider has a no expulsion policy in place.

Child Care Center	Does not meet criteria	134 64%
	Meets criteria	7 3%
Family Home Child Care	Does not meet criteria	64 31%
	Meets criteria	3 1%

0 50 100 150
Number of Programs

FEP Point #8 Criteria 2:
No child has been asked to leave the program due to behavioral or developmental needs in the last 12 months.

Child Care Center	Does not meet criteria	33 16%
	Meets criteria	108 52%
Family Home Child Care	Does not meet criteria	2 1%
	Meets criteria	65 31%

0 50 100 150
Number of Programs

FEP Point #8 Criteria 3:
Provider has a transition policy that includes at least 3 supports for each child that is asked to leave due to behavioral or developmental concerns

Child Care Center	Does not meet criteria	89 43%
	Meets criteria	52 25%
Family Home Child Care	Does not meet criteria	55 26%
	Meets criteria	12 6%

0 50 100
Number of Programs

Child Care Center	Does not meet criteria	27.59% 64
	Meets criteria	25.43% 59
Family Home Child Care	Does not meet criteria	16.81% 39
	Meets criteria	30.17% 70

0 50 100
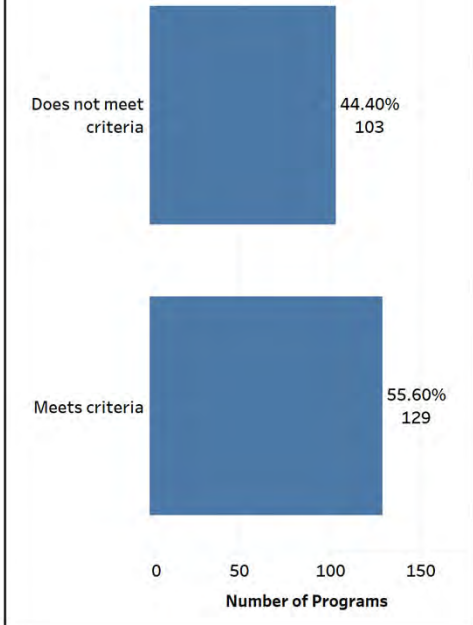**Number of Programs**

Family Engagement and Partnerships Point #8:
Evidence of supportive transitions for children who are removed due to challenging behavior or developmental needs.

64% Opted-In to FEP #8 (208 of 325 Programs)

Child Outcomes Point #1:
Developmental screening is on file for all children that have been enrolled for 90 calendar days and results are shared with parents
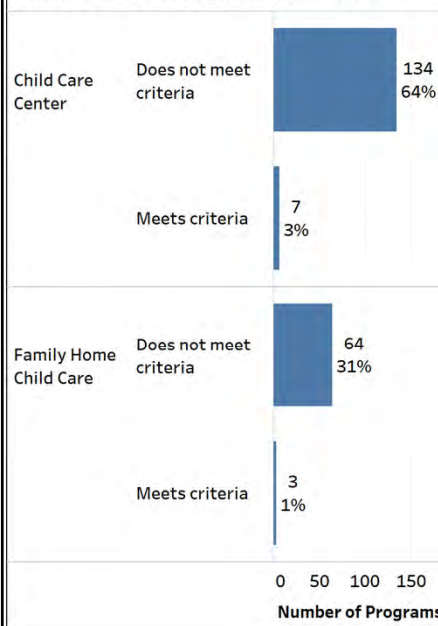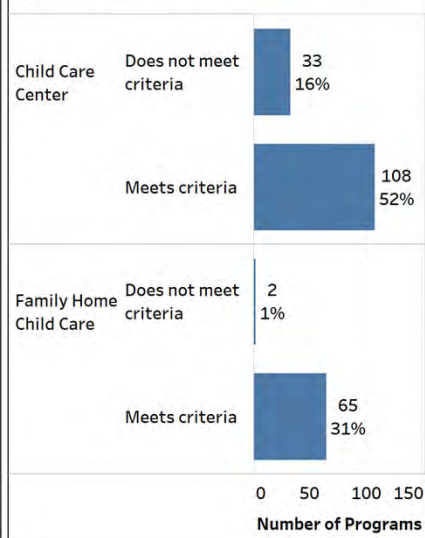
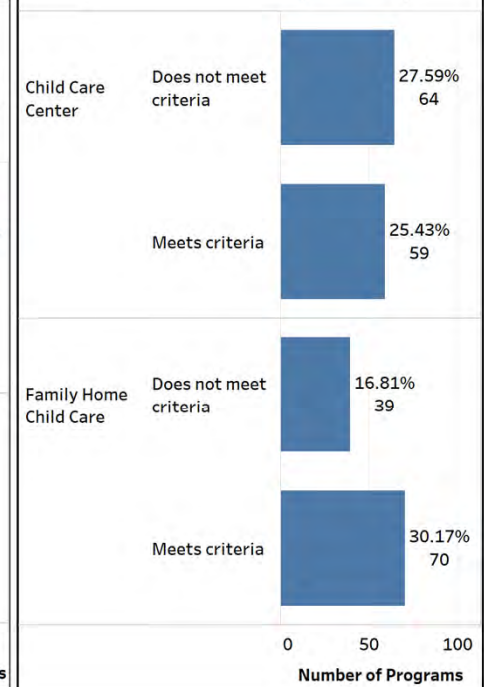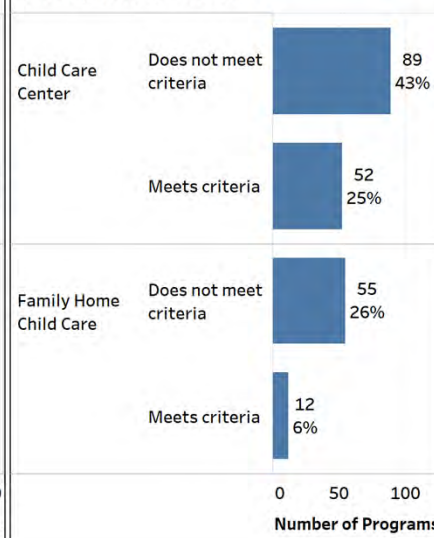71% Opted-In to CO Point #1 (232 of 325)

FEP Point #8 Criteria 1:
Provider has a no expulsion policy in place.

Region	Criteria	Value
Central	Does not meet criteria	20 / 10%
Central	Meets criteria	1 / 0%
Eastern	Does not meet criteria	19 / 9%
King County	Does not meet criteria	63 / 30%
King County	Meets criteria	6 / 3%
Northwest	Does not meet criteria	44 / 21%
Olympic	Does not meet criteria	21 / 10%
Southwest	Does not meet criteria	16 / 8%
Tacoma/ Pierce	Does not meet criteria	15 / 7%
Tacoma/ Pierce	Meets criteria	3 / 1%

Number of Programs (0 20 40 60 80)

FEP Point #8 Criteria 2:
No child has been asked to leave the program due to behavioral or developmental needs in the last 12 months.

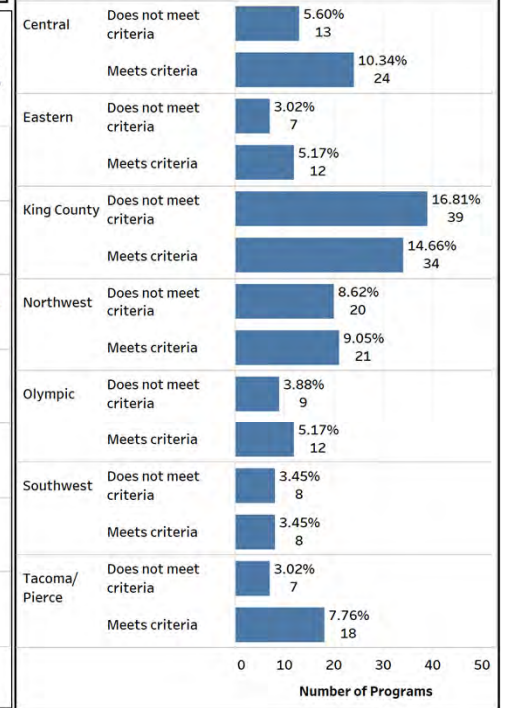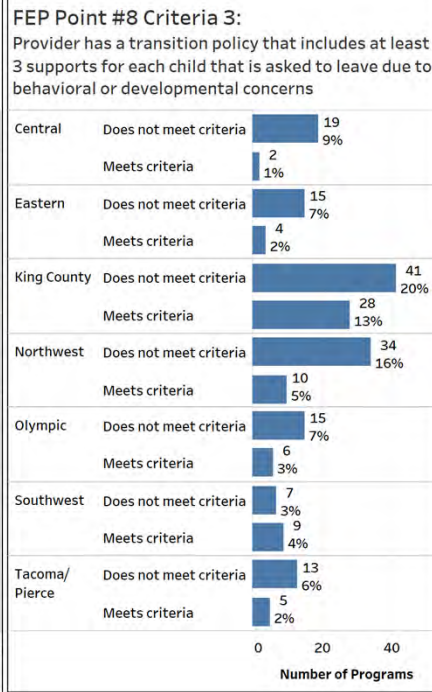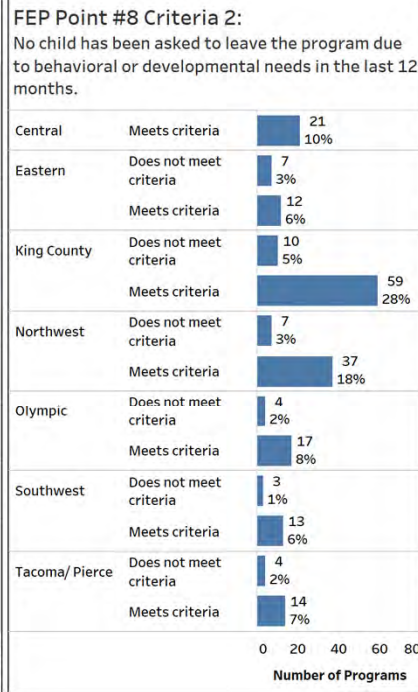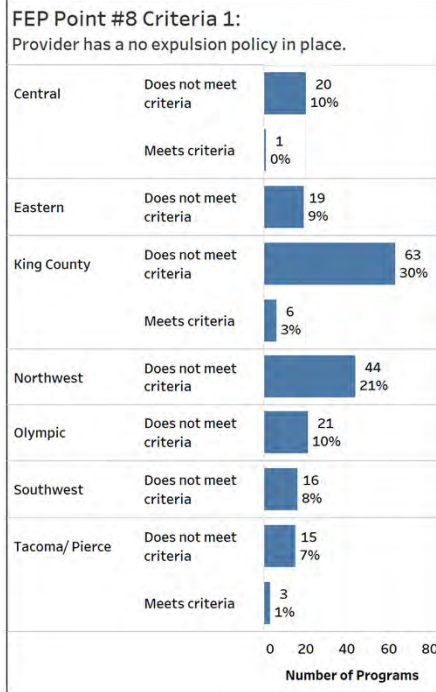| Region	Criteria	Value
Central	Meets criteria	21 / 10%
Eastern	Does not meet criteria	7 / 3%
Eastern	Meets criteria	12 / 6%
King County	Does not meet criteria	10 / 5%
King County	Meets criteria	59 / 28%
Northwest	Does not meet criteria	7 / 3%
Northwest	Meets criteria	37 / 18%
Olympic	Does not meet criteria	4 / 2%
Olympic	Meets criteria	17 / 8%
Southwest	Does not meet criteria	3 / 1%
Southwest	Meets criteria	13 / 6%
Tacoma/ Pierce	Does not meet criteria	4 / 2%
Tacoma/ Pierce	Meets criteria	14 / 7%

Number of Programs (0 20 40 60 80)

FEP Point #8 Criteria 3:
Provider has a transition policy that includes at least 3 supports for each child that is asked to leave due to behavioral or developmental concerns

Region	Criteria	Value
Central	Does not meet criteria	19 / 9%
Central	Meets criteria	2 / 1%
Eastern	Does not meet criteria	15 / 7%
Eastern	Meets criteria	4 / 2%
King County	Does not meet criteria	41 / 20%
King County	Meets criteria	28 / 13%
Northwest	Does not meet criteria	34 / 16%
Northwest	Meets criteria	10 / 5%
Olympic	Does not meet criteria	15 / 7%
Olympic	Meets criteria	6 / 3%
Southwest	Does not meet criteria	7 / 3%
Southwest	Meets criteria	9 / 4%
Tacoma/ Pierce	Does not meet criteria	13 / 6%
Tacoma/ Pierce	Meets criteria	5 / 2%

Number of Programs (0 20 40)

Child Outcomes Point #1

Region	Criteria	Value
Central	Does not meet criteria	5.60% / 13
Central	Meets criteria	10.34% / 24
Eastern	Does not meet criteria	3.02% / 7
Eastern	Meets criteria	5.17% / 12
King County	Does not meet criteria	16.81% / 39
King County	Meets criteria	14.66% / 34
Northwest	Does not meet criteria	8.62% / 20
Northwest	Meets criteria	9.05% / 21
Olympic	Does not meet criteria	3.88% / 9
Olympic	Meets criteria	5.17% / 12
Southwest	Does not meet criteria	3.45% / 8
Southwest	Meets criteria	3.45% / 8
Tacoma/ Pierce	Does not meet criteria	3.02% / 7
Tacoma/ Pierce	Meets criteria	7.76% / 18

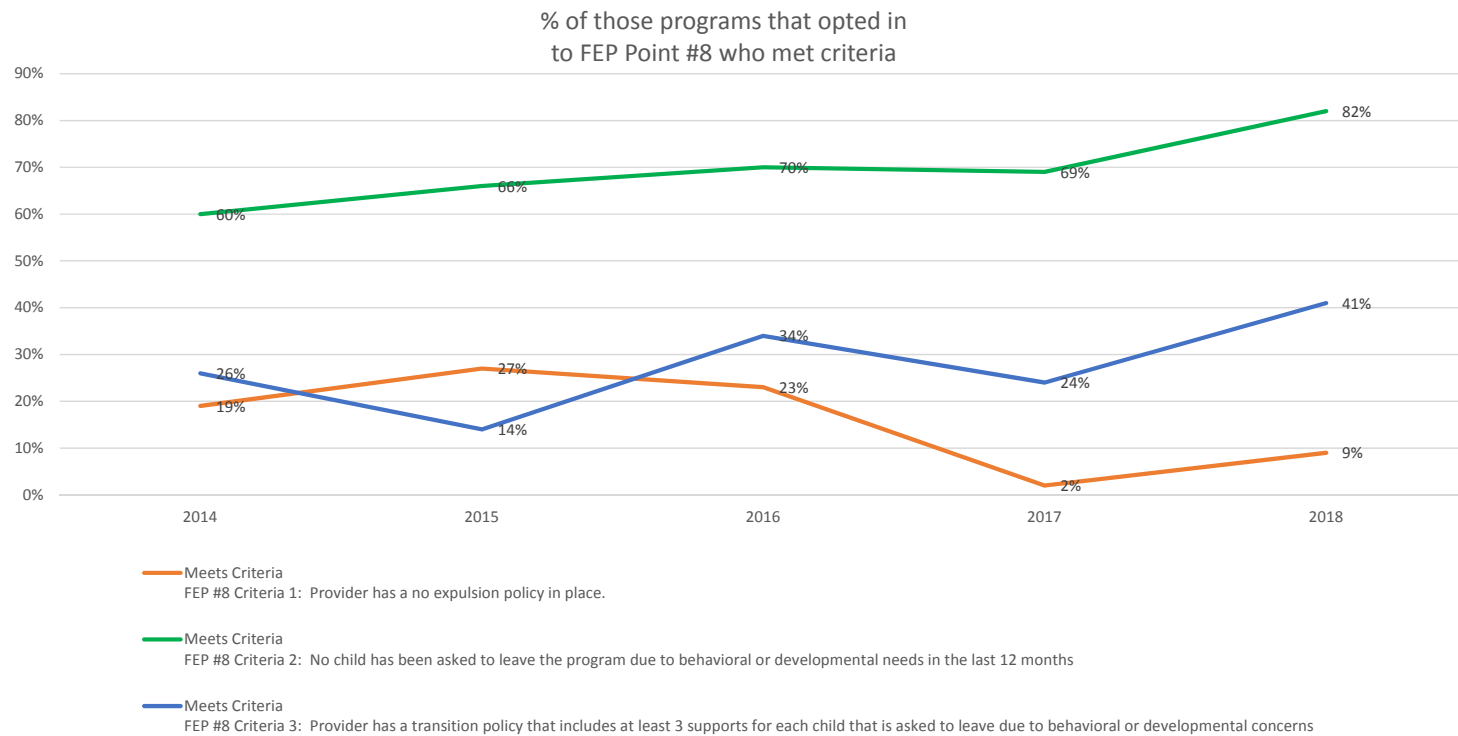Number of Programs (0 10 20 30 40 50)

First 3 Slides:

Time period: 8/1/2017-8/1/2018
Source: WELS/PRISM and Cultivate Learning Records Review Database

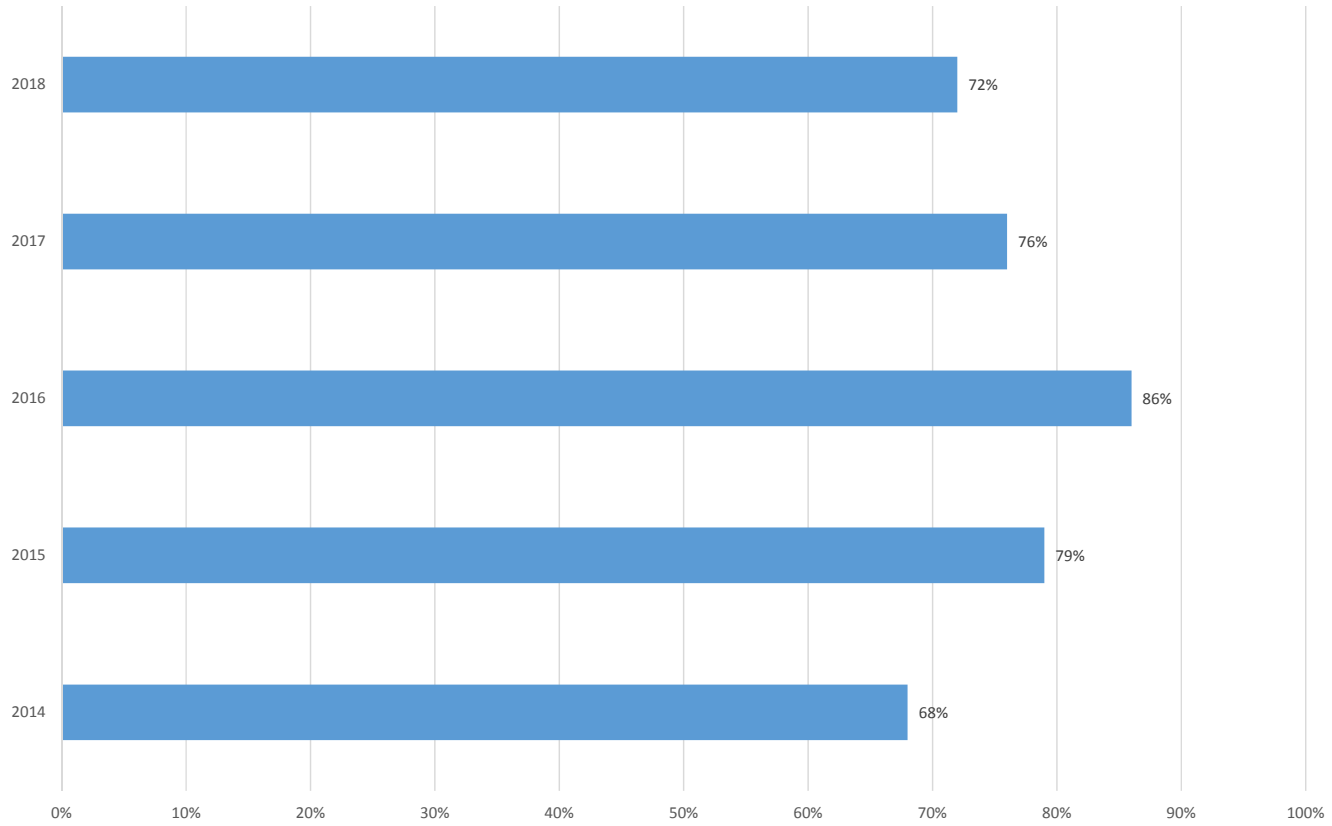Non-Reciprocity Ratings Released (Renewal and Initial): 721 Programs
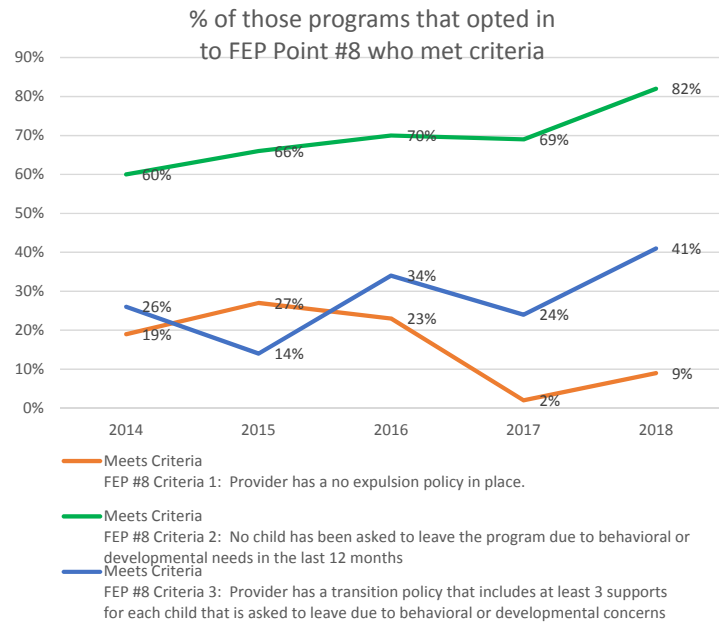# of Programs completed Records review: 325 (45% 325 of 721)

Not all programs completing records review opted-in to FEP Point # 8 or CO Point #1.

% of those programs that opted in
to FEP Point #8 who met criteria

Meets Criteria
FEP #8 Criteria 1: Provider has a no expulsion policy in place.

Meets Criteria
FEP #8 Criteria 2: No child has been asked to leave the program due to behavioral or developmental needs in the last 12 months

Meets Criteria
FEP #8 Criteria 3: Provider has a transition policy that includes at least 3 supports for each child that is asked to leave due to behavioral or developmental concerns

NOTE: Providers in 2018 did NOT have to participate in Records Review. All previous years were required to participate in Records Review. Therefore 2018 numbers are based on those providers that chose to participate in records review not the total number of programs rated.

% Opt-in to FEP Point #8

% of those programs that opted in to FEP Point #8 who met criteria

Meets Criteria
FEP #8 Criteria 1: Provider has a no expulsion policy in place.

Meets Criteria
FEP #8 Criteria 2: No child has been asked to leave the program due to behavioral or developmental needs in the last 12 months

Meets Criteria
FEP #8 Criteria 3: Provider has a transition policy that includes at least 3 supports for each child that is asked to leave due to behavioral or developmental concerns

% of Programs that Opted in to Child Outcome Point #1 who met the criteria
Developmental screening is on file for all children that have been enrolled for 90 calendar days and results are shared with parents

% Opt-in to FEP Point #8

% Opt-in to Child Outcome Point #1
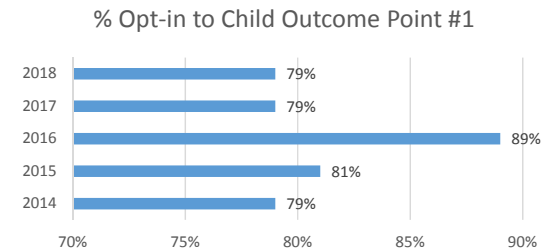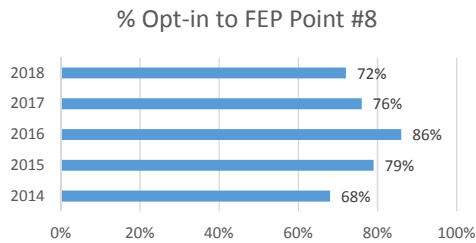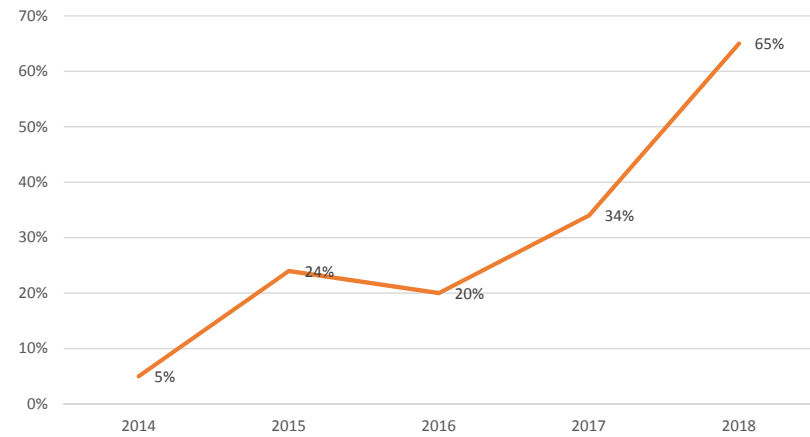
NOTE: Providers in 2018 did NOT have to participate in Records Review. All previous years were required to participate in Records Review.   Therefore 2018 numbers are based on those providers that chose to participate in records review not the total number of programs rated.

Thoughts

- Should this be required for Early Achievers?

- Should we make data collection more rigorous?

- Best info, non-duplicative and across sectors seems to be reported by parents of children entering kindergarten (part of WaKIDS?) We can get gender, race, ethnicity, language, # of times, from where, mobility, and kindergarten adjustment (social and emotional, early academics)

- Important to remember that historical data does not help children currently experiencing disproportionate disciplinary action

Thank you

APPENDIX I: WASHINGTON STATE REGIONAL SUBSIDY RATE MAP

Region 1	Region 2	Region 3	Region 4	Region 5

Spokane County	Region 6
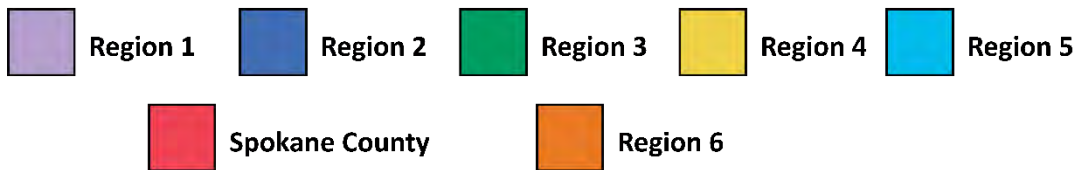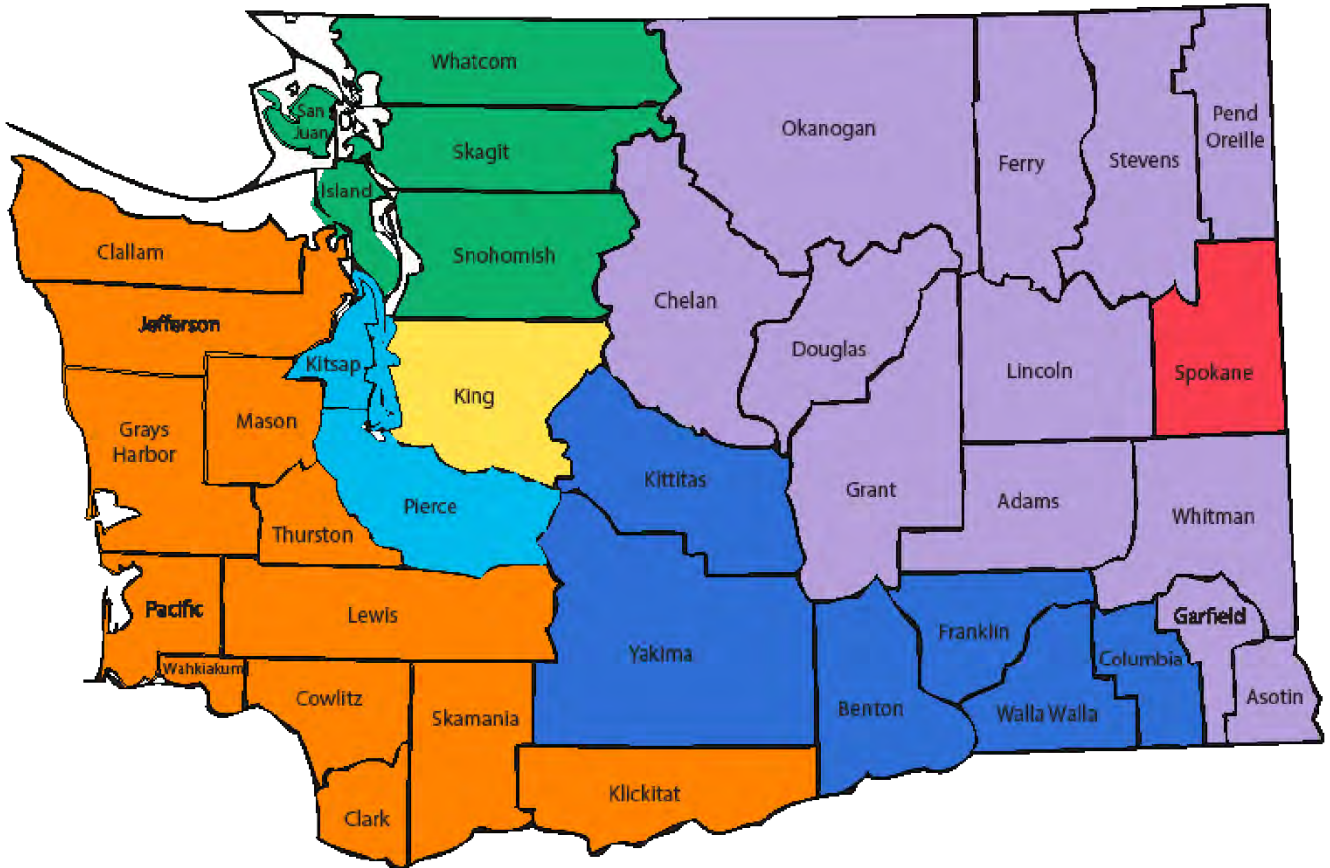
For child care centers only:

+ Clark County is in Region 6 but is paid at Region 3 rates

* Benton and Walla Wala counties are in Region 2 but are paid at Region 6 rates

^ Whitman County is in Region 1 but is paid at Region 6 rates

Relative Providers, Family, Friends, and Neighbors (FFN)	
Child needing most hours of care	$2.50 per hour
Additional children	$2.50 per hour

Licensed or Certified Family Home Child Care Rates

Region	Full/Half Day	Infant Rate (Birth – 11 months)	Enhanced Toddlers (12 – 17 months)	Toddlers (18 – 29 months)	Preschool 30 months – 6 yrs. Not enrolled in Kindergarten	School-age 5 – 12 yrs. Enrolled in school
Region 1	Full-Day	$30.21	$30.21	$26.28	$24.26	$21.56
	Half-day	$15.11	$15.11	$13.14	$12.13	$10.78
Region 2	Full-Day	$31.27	$31.27	$27.19	$24.93	$22.91
	Half-Day	$15.64	$15.64	$13.60	$12.47	$11.46
Region 3	Full-Day	$42.82	$42.82	$36.25	$36.25	$29.38
	Half-Day	$21.41	$21.41	$18.13	$18.13	$14.69
Region 4	Full-Day	$54.37	$54.37	$45.31	$40.78	$32.31
	Half-Day	$27.19	$27.19	$22.66	$20.39	$16.16
Region 5	Full-Day	$37.07	$37.07	$32.23	$27.19	$22.91
	Half-Day	$18.54	$18.54	$16.12	$13.60	$11.46
Region 6	Full-Day	$33.33	$33.33	$28.99	$27.19	$25.60
	Half-Day	$16.67	$16.67	$14.50	$13.60	$12.80
Spokane County	Full-Day	$30.93	$30.93	$26.89	$24.81	$22.03
	Half-Day	$15.47	$15.47	$13.45	$12.41	$11.02

Licensed or Certified Child Care Center Rates

Region	Full/Half Day	Infant Rate (1 – 11 months)	Toddlers (12 – 29 months)	Preschool 30 months – 6 yrs. Not enrolled in Kindergarten	School-age 5 – 12 yrs. Enrolled in school
Region 1	Full-Day	$34.03	$28.62	$27.03	$25.46
	Half-day	$17.02	$14.31	$13.52	$12.73
Region 2	Full-Day	$34.39	$28.68	$26.61	$23.53
	Half-Day	$17.20	$14.34	$13.31	$11.77
Region 3	Full-Day	$45.50	$37.93	$32.78	$31.82
	Half-Day	$22.75	$18.97	$16.39	$15.91
Region 4	Full-Day	$52.94	$44.20	$37.10	$33.41
	Half-Day	$26.47	$22.10	$18.55	$16.71
Region 5	Full-Day	$38.82	$33.41	$29.40	$26.12
	Half-Day	$19.41	$16.71	$14.70	$13.06
Region 6	Full-Day	$38.18	$32.78	$28.62	$28.01
	Half-Day	$19.09	$16.39	$14.31	$14.01
Spokane County	Full-Day	$34.81	$29.28	$27.67	$26.05
	Half-Day	$17.41	$14.64	$13.84	$13.03

Trauma-Informed Care Advisory Group
Comparison of Staffing Ratios for Child Care Centers

Program	Age of Children	Adult:Child Ratio	Max Group Size
Licensed Child Care Centers	Infants (1 - 11 months)	1:4	8
	Toddlers (12 - 29 months)	1:7	14
	Preschoolers (30 months - 6 years)	1:10	20
ECEAP	Preschoolers (3 - 5 years)	1:10	20
Early HeadStart & HeadStart	0 - 3 years	1:4	8
	4 - 5 years	~1:10	20
Caring for Our Children Standards	Infants (through 12 months)	1:3	6
	Toddlers (13 - 35 months)	1:4	8
	Preschoolers (3 years)	1:7	14
	Preschoolers (4 - 5 years)	1:8	16
	School-aged (6 - 8 years)	1:10	20

Pyramid Model Consortium

TRAUMA, TOXIC STRESS AND RESILIENCE IN EARLY CHILDHOOD

An Effective Workforce

The Pyramid Model: Promoting Social Emotional Competence in Infants and Young Children

[Assessment-based interventions result in individualized behavior support plans.]

Few Children → Treatment → Intensive Intervention

Children At-Risk → Prevention → Targeted Social Emotional Supports

All Children → Universal Promotion → High Quality Supportive Environments / Nurturing and Responsive Relationships

Effective Workforce

Critical Elements of Program-Wide Implementation Guided by the Leadership Team

Trauma Informed

An organization or system that…

- Realizes the widespread impact of trauma and potential paths for healing

- Recognizes the signs/symptoms of trauma

- Fully integrates knowledge about trauma into policies, procedures, practices and settings

The Pyramid Model and Trauma Informed Care

"Old Way" Approaches to Addressing Challenging Behavior	Pyramid Model	Trauma Informed Pyramid Model
Focus on behavior reduction	Focus on teaching new skills	Focus on teaching new skills and healing

"Old Way" Approaches to Addressing Challenging Behavior	Pyramid Model	Trauma Informed Pyramid Model
Quick fix	Focus on long term academic, social and health outcomes	Focus on long term academic, social, health and mental health outcomes

The Pyramid Model and Trauma Informed Care

"Old Way" Approaches to Addressing Challenging Behavior	Pyramid Model	Trauma Informed Pyramid Model
General intervention for all behavior problems	Intervention matched to purpose of the behavior	Intervention matched to purpose of the behavior and adults recognize that today's challenging behavior may be rooted in skills that have previously kept them emotionally and/or physically safe in unhealthy and unsafe situations.

Using a Trauma Sensitive Lens to Support Children and Families with Diverse Experiences

Pyramid Model Consortium
www.pyramidmodel.org

Knowing the Signs and Symptoms

Pyramid Model Consortium
www.pyramidmodel.org

Behavior = Communication
Behavior has meaning

- What a young child is experiencing

- What it is like to be in that child's body

- What it is like to be in that child's world

Pyramid Model Consortium
www.pyramidmodel.org

How might an ongoing awareness of children's innate ability to connect with others help us continue to support their social and emotional skills?
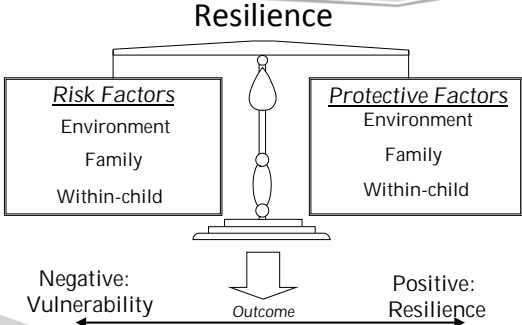
www.pyramidmodel.org

Beliefs and Feelings

Secure
- Adults are trustworthy and reliable
- Caregivers keep me safe and I can count on them when in need
- My caregivers love me and I feel comfortable with new caregivers
- Caregivers provide comfort when I am upset and help me feel better
- Caregivers are sensitive, predictable and nurturing

Insecure
- Adults are inconsistent and untrustworthy
- Caregivers fail to protect me, so I must rely on myself
- Caregivers leave me, so I keep myself at a distance from new ones
- Caregivers can't comfort me or help me regulate my feelings
- Caregivers act in frightening and unpredictable ways

Pyramid Model Consortium
www.pyramidmodel.org

Resilience

Risk Factors
Environment
Family
Within-child

Protective Factors
Environment
Family
Within-child

Negative: Vulnerability

Outcome

Positive: Resilience

Pyramid Model Consortium
www.pyramidmodel.org

Core Strengths for Children
Developed by Bruce Perry
http://www.childtrauma.org/

- Attachment
- Self Regulation
- Affiliation
- Awareness
- Tolerance
- Respect

Pyramid Model Consortium

www.pyramidmodel.org

All Hands on Deck are Needed

- Multiple lenses are beneficial

- Often children's behaviors and life circumstances are complicated needing various levels of expertise and perspectives

- Sometimes even coaches get stuck

- The field needs more support

Pyramid Model Consortium

www.pyramidmodel.org

A Process of Engagement…

…Embedded Within Relationships

"A product of the ecologies within which children are embedded that support their development… a set of interactions and transactions among people (children, teachers, parents, other caregivers), settings (home, school, and childcare) and institutions (communities, neighborhoods and governments)."

Mashburn & Pianta, 2006

Pyramid Model Consortium

www.pyramidmodel.org

- Contact Kristin Tenney-Blackwell for more information:
  ktenneyblackwell@gmail.com

Pyramid Model Consortium

www.pyramidmodel.org

Early **Ch**il**d**hood **I**ntervention and **P**revention **S**ervices

History of ECLIPSE in Washington State

- Department of Early Learning (DEL) Designated as lead agency in 2011

- Prior to DEL administration, program was managed by Department of Social and Health Services (DSHS)- Children's Administration (CA)

- Medicaid Treatment Child Care (MTCC) program operated in Washington for 20+ years under the leadership of DSHS-CA

What is ECLIPSE

- Early Intervention and Prevention Program:

- Targeted towards children age 0 – 5 years old
- Enrolled/ Receiving Medicaid
- Experiencing Biological, Familial, and Environmental Risk Factors
  - Abuse and/or neglect
  - Drug affected
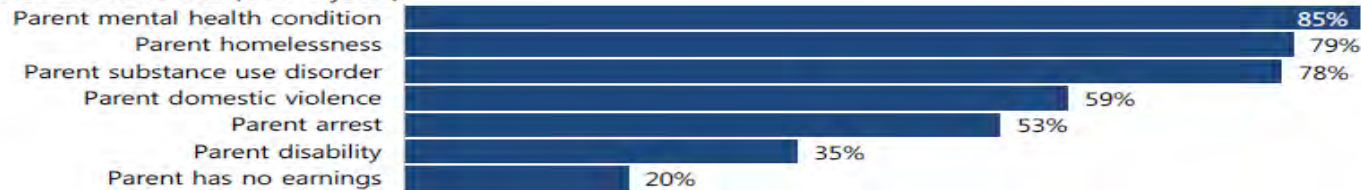 - Domestic violence
  - Homelessness

Parental and Child Risk Factors

FIGURE 1.

Selected Parental and Child Risk Factors for Childhaven Clients

Childhaven Population TOTAL = 300
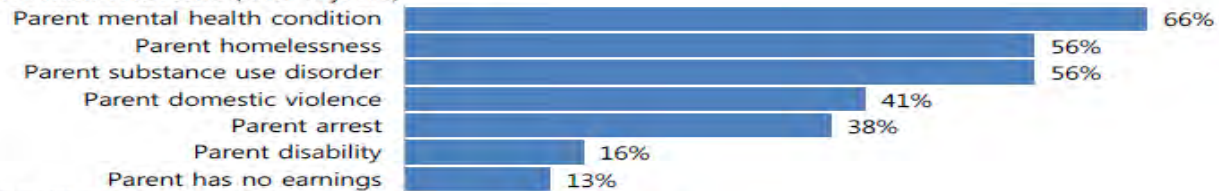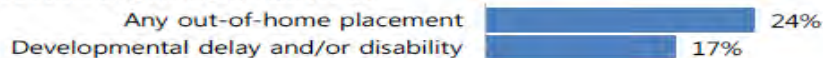
PARENTAL RISK FACTORS (Over 5 years)

Factor	Percentage
Parent mental health condition	85%
Parent homelessness	79%
Parent substance use disorder	78%
Parent domestic violence	59%
Parent arrest	53%
Parent disability	35%
Parent has no earnings	20%

LIFETIME CHILD RISK FACTORS

Factor	Percentage
Any out-of-home placement	57%
Developmental delay and/or disability	27%

Child Welfare Population Under Age 6[3]

PARENTAL RISK FACTORS (Over 5 years)

Factor	Percentage
Parent mental health condition	66%
Parent homelessness	56%
Parent substance use disorder	56%
Parent domestic violence	41%
Parent arrest	38%
Parent disability	16%
Parent has no earnings	13%

LIFETIME CHILD RISK FACTORS

Factor	Percentage
Any out-of-home placement	24%
Developmental delay and/or disability	17%

Medicaid Population Under Age 6[3]

PARENTAL RISK FACTORS (Over 5 years)

Factor	Percentage
Parent mental health condition	36%
Parent homelessness	26%
Parent substance use disorder	23%
Parent domestic violence	16%
Parent arrest	18%
Parent disability	6%
Parent has no earnings	12%

LIFETIME CHILD RISK FACTORS

Factor	Percentage
Any out-of-home placement	4%
Developmental delay and/or disability	4%

The ECLIPSE Program at Childhaven Short-Term Outcomes for Children Receiving Early Childhood Intervention and Prevention Services- page 3

[3] The child welfare population included all person-months (N = 930,997) for children under 6 years of age living in urban counties who had at least one month of Medicaid eligibility between November 2011 and June 2014. The broader Medicaid population included all person-months (N = 8,709,772) for children less than 6 years of age with Medicaid across the state in the same time period. See Technical Notes for details.

- ## ECLIPSE Services Are:

  - Medically Necessary as identified through psycho-social assessment

  - Targeted towards mitigating toxic stress

  - Center-based care in developmental appropriate environments for infants, toddlers, and preschool aged children.

    - Staff to child ratio 1:3 for 0-12 months, 1:4 for children age(s) 13-24 months and 1:5 for children 31 months to 71 months/5 years old

  - Incorporates family centered services- Parent Support Gatherings and Skills Training

  Services Include:

  - Social/Emotional and Behavior screening

  - Psycho-Social Clinical Assessment

  - Treatment Plan Development through MDT's

  - Daily individual and group activities and experiences that model, practice, and reinforce pro-social Interactions between peers and trusted adults.

  - Case Management through monthly home visits

  - Discharge Planning

  - Daily Transportation Services for children to and from home to school.

Who Delivers Services

- ## Current Providers
  - Year round daily services provided to children and families.
  - Two ELCIPSE Providers in WA State:
    - Childhaven in King County – 2 sites
    - Catholic Charities of Central WA in Yakima County – 1 site
- ## Provider Eligibility
  - Services must be provided by:
    - WA Licensed Child Care Center
    - Licensed by Behavioral Health and Recovery/HCA
    - Enrolled/ Rated/Involvement in Early Achievers
    - Licensed Mental Health Professionals who are registered with DOH and employed by each provider
    - Staff to child ratio 1:3 for 0-12 months, 1:4 for children age(s) 13-24 months and 1:5 for children 31 months to 71 months/5 years old

Child Demographics-Race/Ethnicity:

- Baseline from RDA Outcomes Report-Appendix Page 8- *The ECLIPSE Program at Childhaven Short-Term Outcomes for Children Receiving Early Childhood Intervention and Prevention Services*

	Childhaven Participants TOTAL = 300	Matched Comparison TOTAL = 300
Demographics (measured in the index month)		
Age in months	29	29
Female	40%	40%
White only	19%	22%
(Race/ethnicity categories below are not mutually exclusive)		
Hispanic	20%	19%
Black	51%	52%
American Indian	26%	20%
Asian	7%	9%
Native Hawaiian or Pacific Islander	3%	3%
Parent age (of youngest parent)	29	28

Who is referring Children/Families for Services

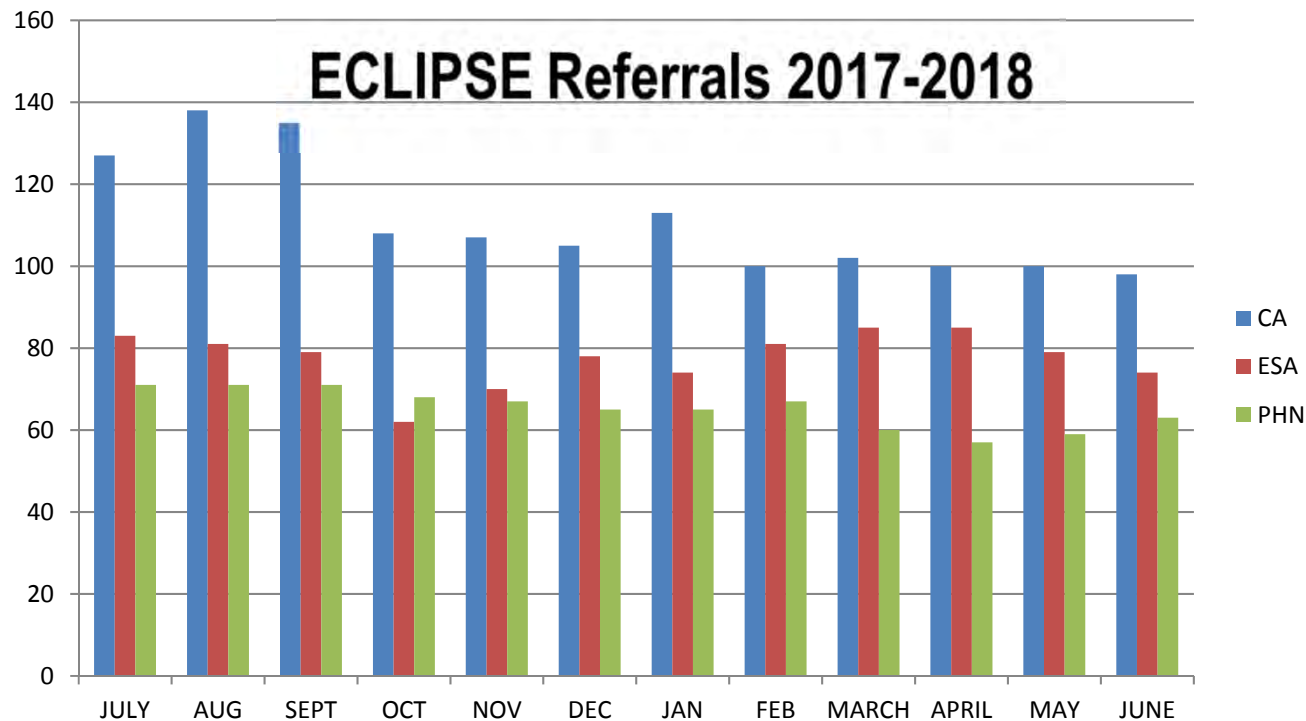- ## Participant Eligibility
  - ### Multi-agency referral network
    - DCYF/CW, DSHS/ESA, Local Public Health officers
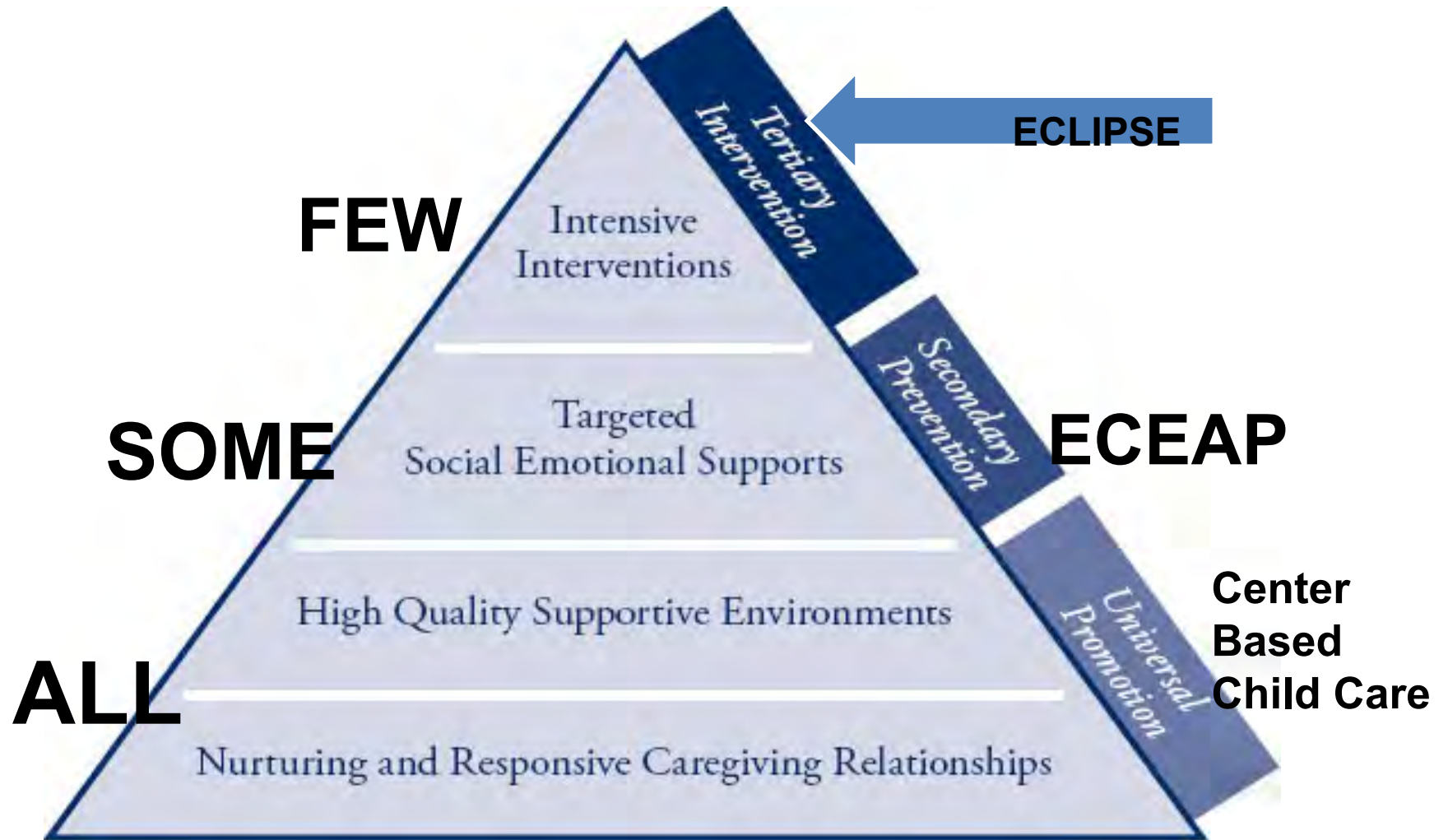 - ### Children currently enrolled in Medicaid and have additional risk factors
  - ### Approximately 315 children and their families served
    - Childhaven serves 245 children
    - CC serves 70 children

ECLIPSE Referrals 2017-2018

Legend: CA, ESA, PHN

This graph demonstrates the number of children enrolled in ECLIPSE per month per referral source which includes; Children's Administration (CA), Economic Service Administration (ESA), and Public Health Nurse (PHN).

ECLIPSE Tertiary Intervention based on:
PYRAMID MODEL FOR SUPPORTING SOCIAL EMOTIONAL COMPETENCE IN INFANTS AND YOUNG CHILDREN

FEW — Intensive Interventions — Tertiary Intervention — **ECLIPSE**

SOME — Targeted Social Emotional Supports — Secondary Prevention — **ECEAP**

ALL — High Quality Supportive Environments — Universal Promotion — **Center Based Child Care**

Nurturing and Responsive Caregiving Relationships

Technical Assistance Center on Social Emotional Intervention for Young Children;
www.challeningbehavior.org

Goal Towards Medicaid Reimbursement:

- In 2013 the WA received notification from the federal Centers for Medicare and Medicaid Services (CMS) that the program did not meet current CMS requirements
- Legislature has been funding the program at 100% state funds since July 2013.
- HCA and DEL have been working to address CMS concerns.
  - DEL and HCA staff developed concept paper to meet Medicaid requirements
  - Clearly defined program services
  - Possible State Plan Amendment (SPA) for ECLIPSE services through EPSDT/Well Child
  - HCA and DEL actively engaged with stakeholders in process

www.dcyf.wa.gov

Early Childhood Intervention and Prevention Services

Prepared by Veronica Santangelo, ECLIPSE Administrator
Email: Veronica.Santangelo@DCYF.wa.gov

Washington State Department of Early Learning

CONSIDERING TRAUMA IN YOUNG CHILDREN WITH SPECIAL NEEDS

Rebecca Berg, OTR/L

Cooper House

September 2018

REBECCA BERG OTR/L

COOPER HOUSE

- Who I am:
  - Occupational Therapist
  - Fellows Certificate in DIR/Floortime
  - IMH Health Training
  - Former preschool and early elementary special education teacher in a model school for kids with ASD, focusing on social emotional development

Where I work:

- Cooper House is a private practice in Seattle whose mission is to help children on the path to optimal development.
- Mental Health and OT providers working in close collaboration and transdisciplinary practice
- Direct services for children 0-5 and their families
- Fussy Baby Network, Smooth Way Home, and professional consultation and reflective supervision
- www.cooperhouse.org

OCCUPATIONAL THERAPY

- **AOTA, 2018**
- "Occupational therapy is the only profession that helps people across the lifespan to do the things they want and need to do through the therapeutic use of daily activities (occupations). Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent—or live better with—injury, illness, or disability."
- OT is concerned with PARTICIPATION:
  - Education
  - Play and leisure
  - Social Activities
  - Activities of Daily Living (dressing, bathing, feeding, sleep, etc.)
  - Instrumental Activities of Daily Living (meal prep, shopping, etc.)
  - Sleep and Rest
  - Work
- Rehabilitation, adaptation, and accommodation

- Sensory processing
- Visual reception
- Auditory
- Tactile
- Proprioceptive
- Vestibular Input
- Olfactory
- Gustatory
- Recognition
- Form Constancy
- Spatial Relations
- Position in Space
- Sequencing
- Solving problems
- Making decisions
- Level of arousal
- Orientation to person
- Orientation to place
- Orientation to time
- Orientation to situation

- Attention Span
- Motor Control
- Praxis
- Body Scheme
- Fine motor coordination and dexterity
- Visual motor integration
- Crossing midline
- Right left discrimination
- Laterality
- Bilateral integration
- Learning
- Memory
- Concept formation
- Categorization
- Spatial operations
- Generalization

- Initiation
- Time management
- Termination
- Coping skills
- Self control
- Social conduct
- Postural alignment
- Postural control
- Depth perception
- Body strength
- Range of motion
- Strength
- Endurance
- Stereognosis
- Kinesthesia
- Figure ground
- Topographical orientation
- Self concept
- Self expression

(Buckley and Poole, 2004)

DIR/FLOORTIME

Profectum, 2018
- Developed by Stanley Greenspan & Serena Weider
  - **D**evelopmentally Based
  - **I**ndividual Differences
  - **R**elationship-Based Approach
- Transdisciplinary Approach used by psychologists, occupational therapists, physical therapists, speech/language pathologists, art therapists, music therapists, recreation therapists, medical doctors, educators, and parents
- Pyramidal model of development
- Incorporates aspects of top-down and bottom up thinking

DEVELOPMENTAL MODELS: LINEAR & PYRAMIDAL
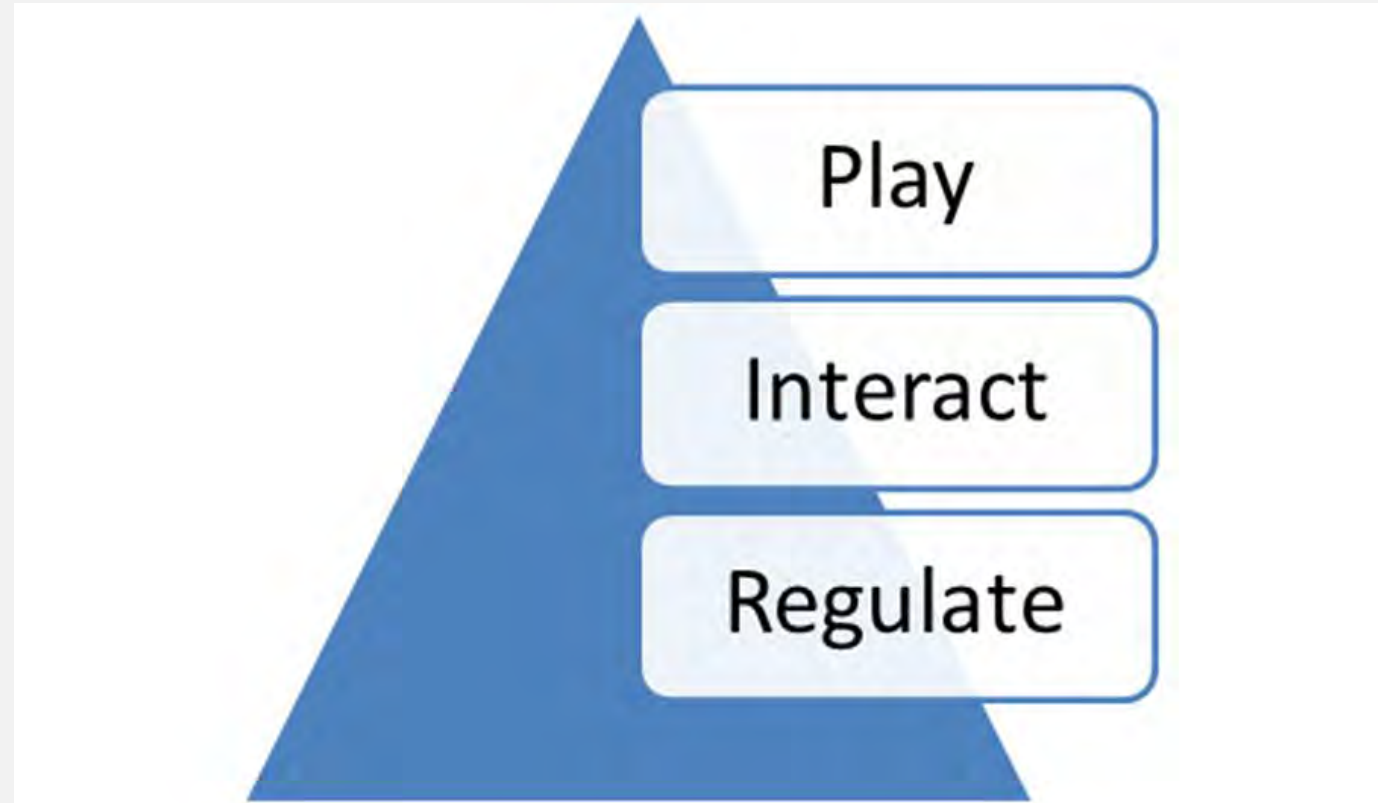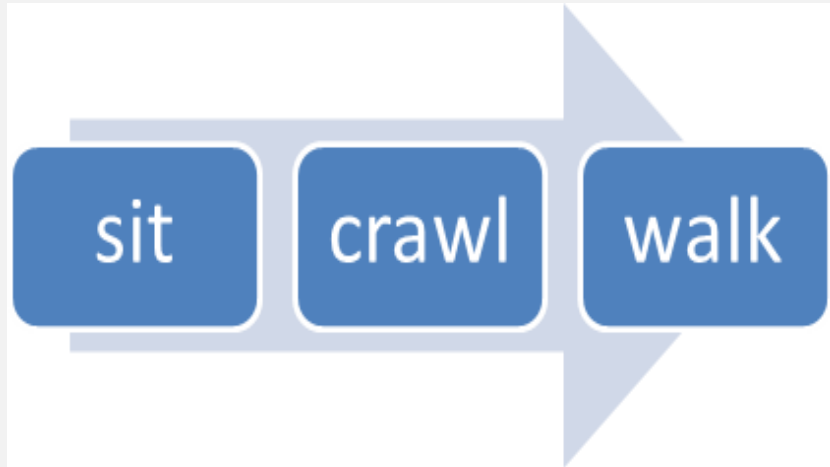
DIR FCD

Developmental:

Functional Emotional Developmental Capacities:

Level 1: Regulation and Shared Attention

Level 2: Mutual Engagement

Level 3: Intentional Two-Way Purposeful Communication

Level 4: Complex Problem-Solving, Sense of Self

Level 5: Symbolic Thinking, Language, and Emotions

Level 6: Building Bridges/Abstract Thinking

Individual Difference:

Sensory Processing

Postural Awareness and Control

Visual Processing

Auditory Processing

Functional Receptive and Expressive Communication

Praxis

Relational:

Relationship is both the means and end in mobilizing development

Parents as collaborators and partners

Biologically Based Individual Differences

Family, Community, & Culture

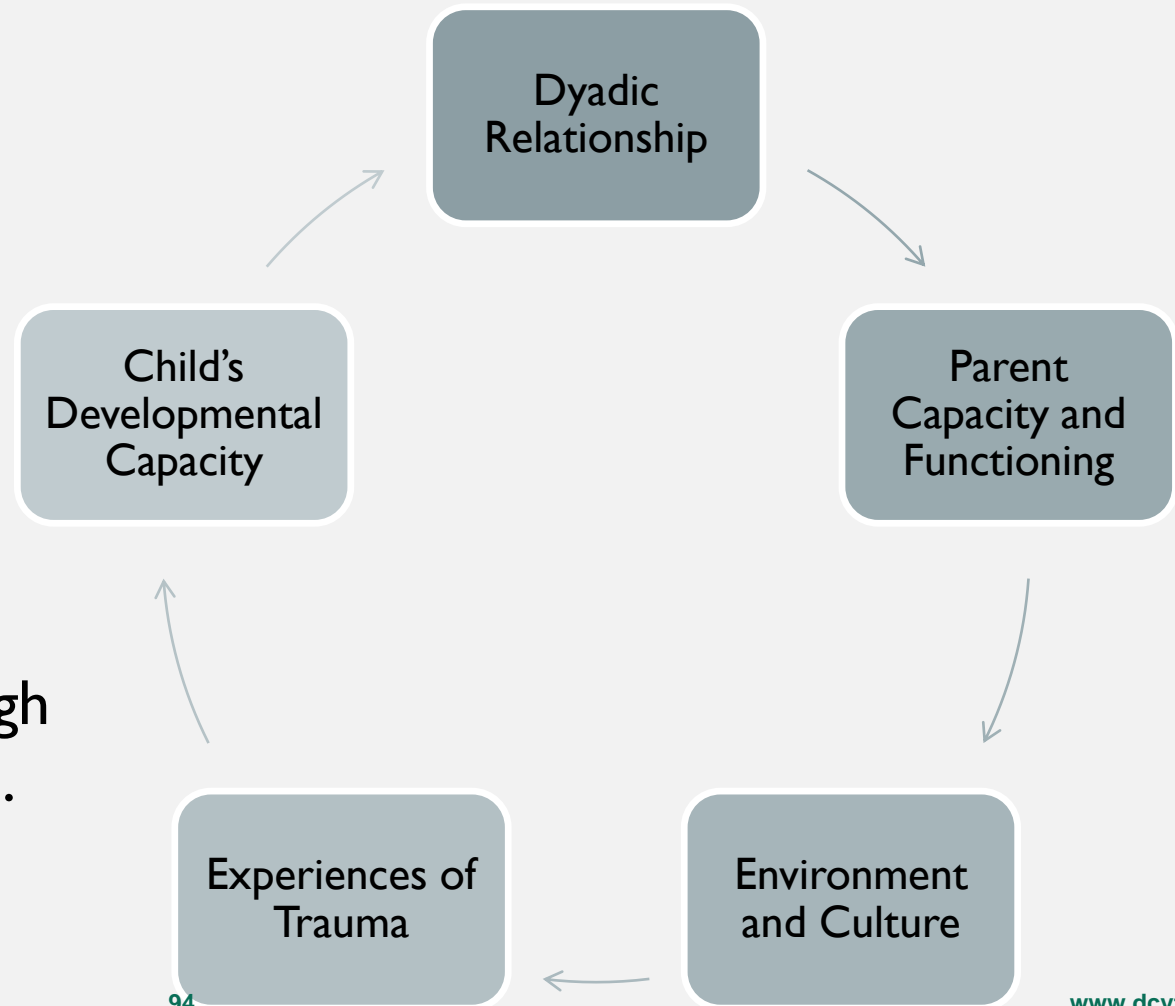*Affective Social Interactions*
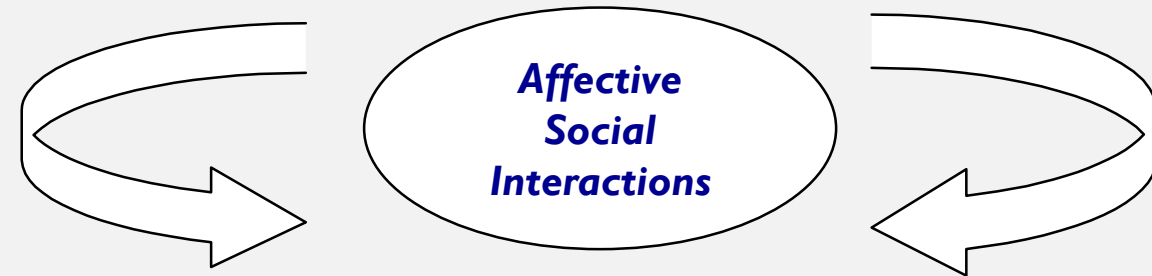
Functional Developmental Capacities
- *Regulation and joint attention*
- *Engaging and relating*
- *Simple two-way gesturing*
- *Complex problem-solving*
- *Creative use of ideas and symbols*
- *Analytic/logical thinking*

Profectum™   www.dcyf.wa.gov
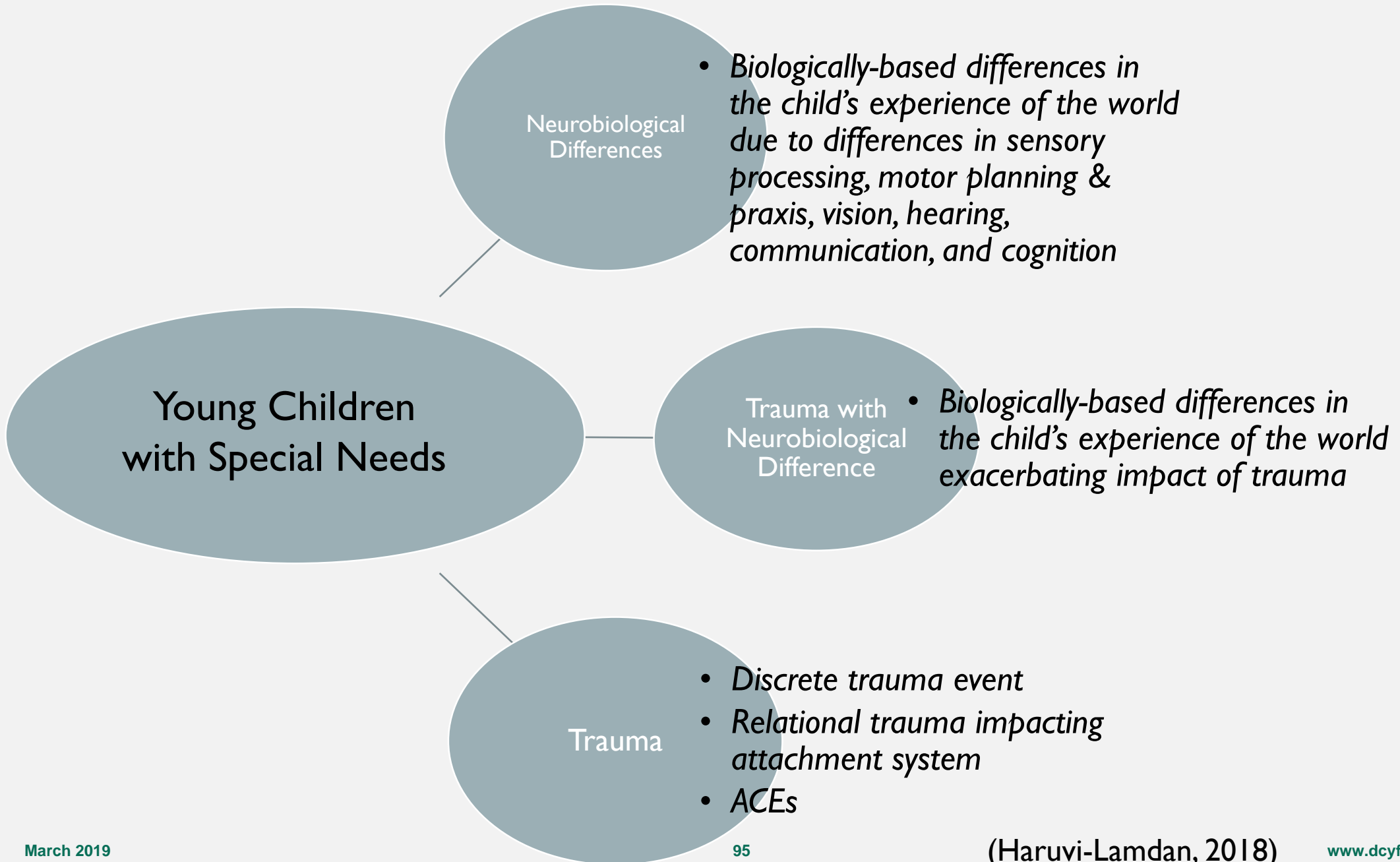
INFANT MENTAL HEALTH

Zero to Three (2004)
- "Infant-early childhood mental health is the developing capacity of the child from birth to 5 years of age to form close relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture."
- Relationship-based framework
- Developmental orientation
- Multidisciplinary approach
- Considers family's values and culture
- Emphasis on prevention

OT & DIR/FLOORTIME & INFANT MENTAL HEALTH

Our assessment process consider the child's functioning through five dynamic and intersecting lenses.

Young Children with Special Needs

Neurobiological Differences
- *Biologically-based differences in the child's experience of the world due to differences in sensory processing, motor planning & praxis, vision, hearing, communication, and cognition*

Trauma with Neurobiological Difference
- *Biologically-based differences in the child's experience of the world exacerbating impact of trauma*

Trauma
- *Discrete trauma event*
- *Relational trauma impacting attachment system*
- *ACEs*

(Haruvi-Lamdan, 2018)

STEFAN

- 4 years old
- History of very poor emotional regulation
- Outbursts with destructive actions (throwing, ripping, etc.)
- Difficulty with separation, dependence on Mom
- Rigid adherence to routines
- Poor transitions
- Perceived by others as intrusive
- Successful academically, but difficulty with peer interactions
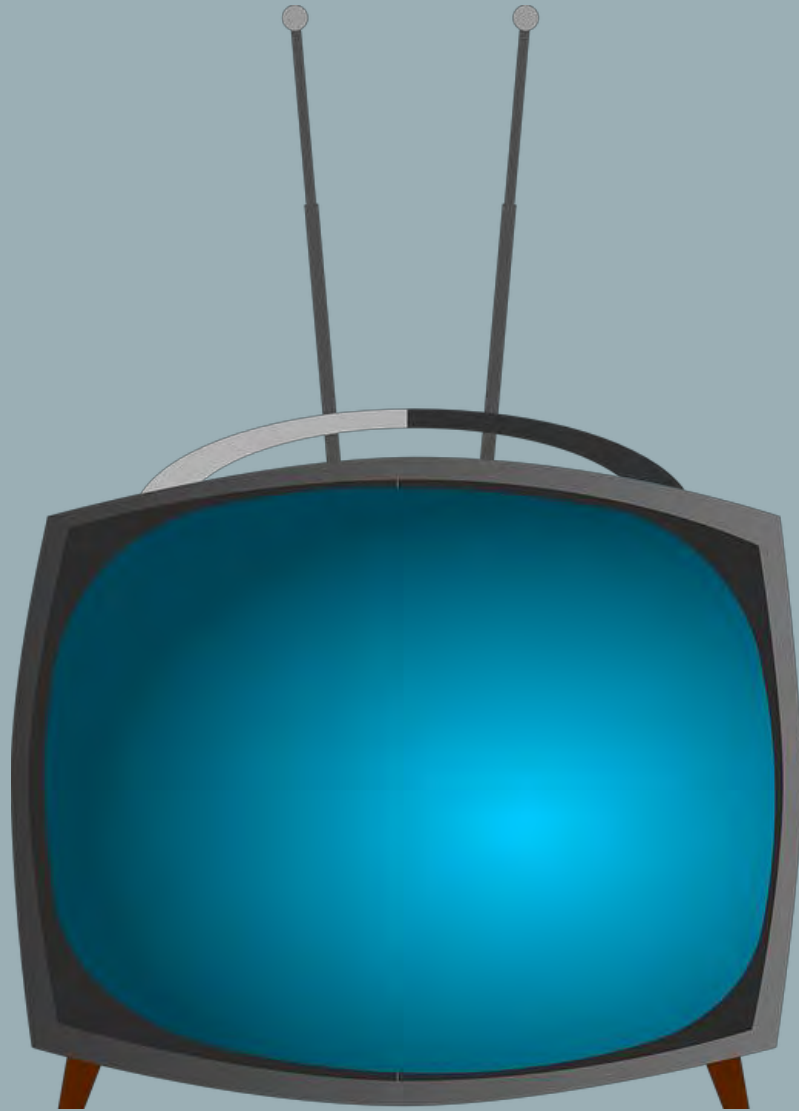
SYLVIA

3 years old

History of being a fussy, inconsolable baby

Frequent, prolonged tantrums at home

Difficulty with separation, dependence on Mom

Limited participation at school, clings to teachers
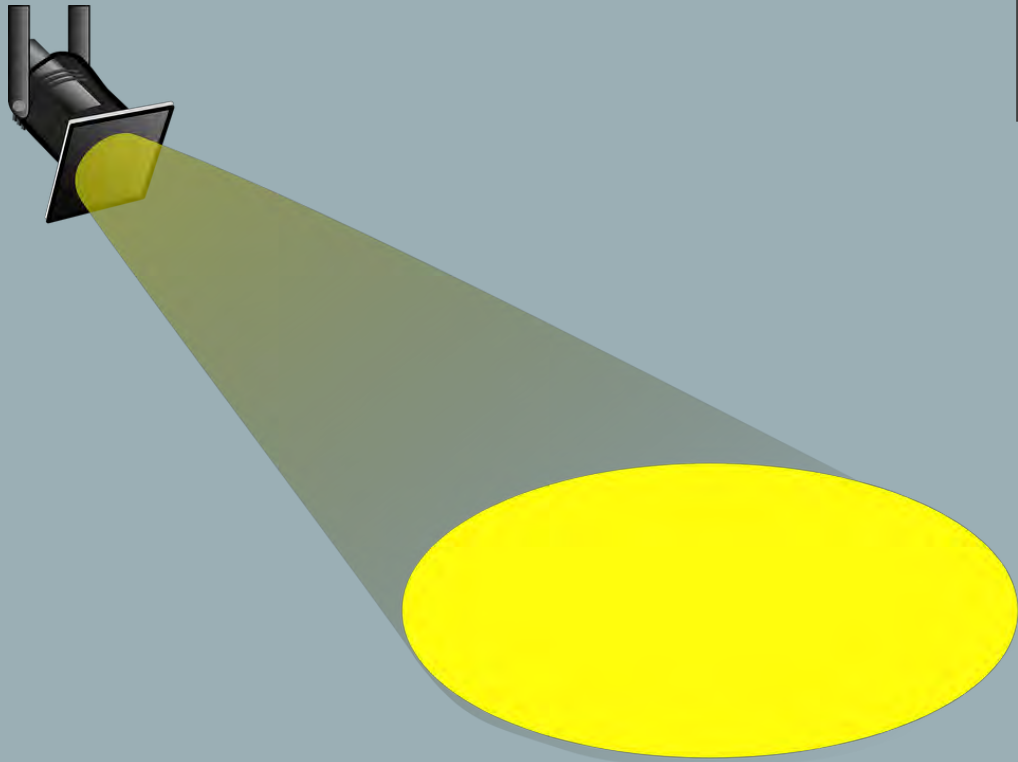
Difficulty with peer relationships

CONRAD

6 years old

Diagnosed ASD

Minimally verbal

Difficulty with all aspects of regulation, relating, and communicating

Among many other functional concerns, meltdowns when hair cut

LAURA

5 years old

Presents with poor coordination, bumping into things and frequent falling down (hx of two concussions from falling down)

Difficulty following directions

Distractible

Limited play skills

- The "neuroception" of safety is foundational to all development (Porges, 2011)

- Behavior has meaning. Behavior represents the child's best solution to feel safe. (Delahooke, 2017)

- For young children, *experience* is an interactive process, dependent on the caregiver's capacity for attunement and giving meaning to these experiences (Center on Developing Child, 2007)

- Relationships build the architecture of the brain; relationships are central to all learning and development. (Center on Developing Child, 2004)

- "Follow the child's lead" (Greenspan & Wieder)

  - Attune to the child's experience and affective state

  - Allow the child to set the pace and direction of play interactions

  - Foster joy, mastery, competence, and agency

- Supporting parents (educators) means supporting the child. (Delahooke, 2017)

- Collaboration and Reflective Supervision are critical aspects of professional development and maintenance. (Delahooke, 2017)

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How it Works:
Four Factors that Increase Trauma Informed Practices
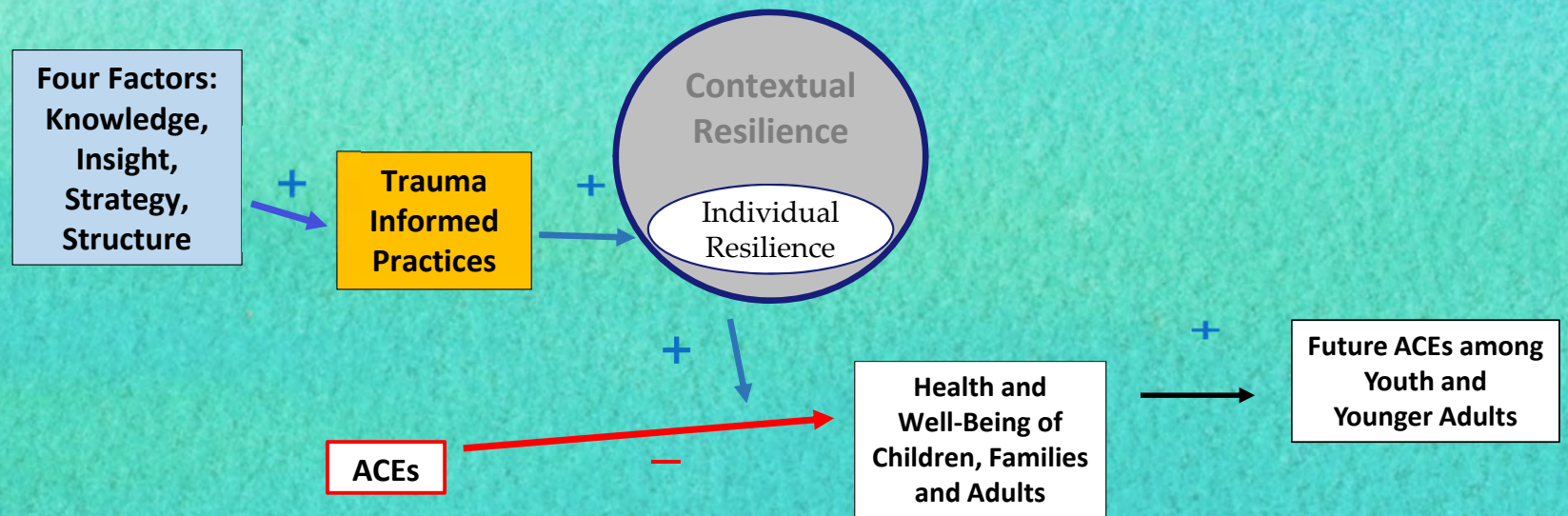
Research conducted by:
Dario Longhi, Marsha Brown
In Partnership with Community Resilience Initiative in Walla Walla, WA

Three sets of common Trauma-Informed Practices increase Resilience

1. **Practices to create safety, calmness, respect**
   – That enable developing trusting relationships and mutual supports

2. **Practices to build personal skills**
   – That increase socio-emotional regulation, problem solving, positive self image

3. **Practices to develop caregiver/staff skills and self-care**
   – That increase self-awareness, shifting mental models, reflecting together in learning organizations and partnering

Longhi and Brown (Developmental Evaluation 2015 - based on seven focus groups)

Four factors were found to support Trauma-Informed Practices

1. **Knowledge** - Trainings and Knowledge of NEAR science

2. **Insight –** Mental Model Shifts

3. **Strategy** - Development and Practice of Resilience Building Skills
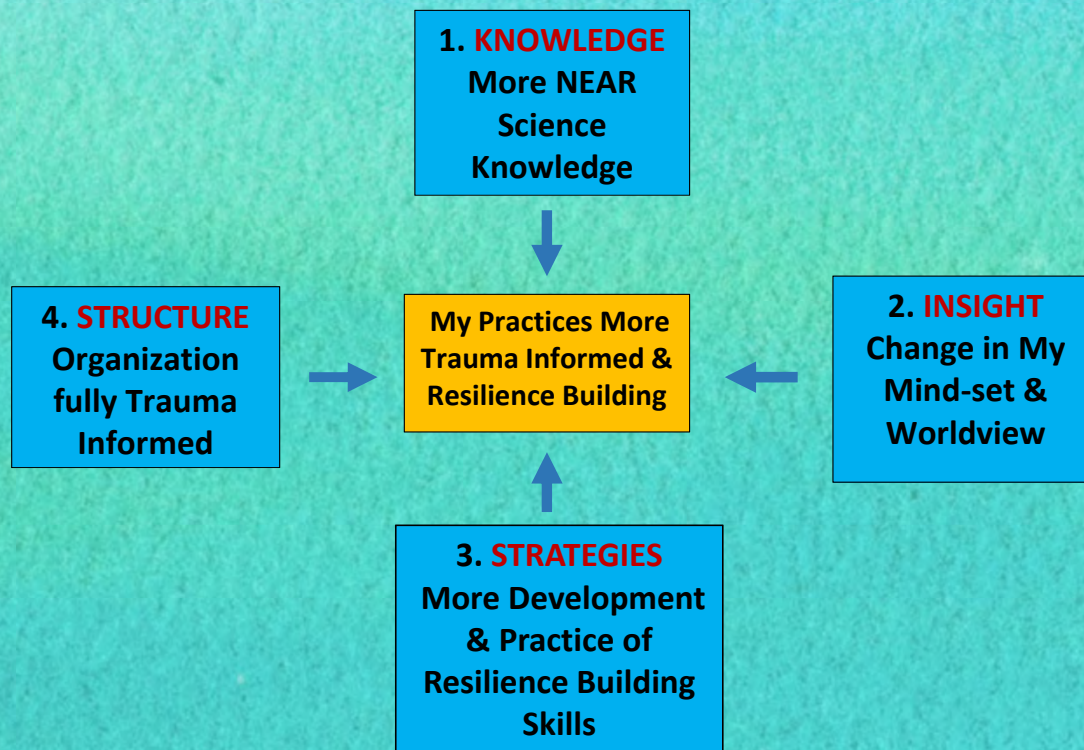
4. **Structure** - Organizational Structural Changes

All four factors were often found to act together

Five common conditions lead to mental model shifts

1. Being exposed to experiences beyond their own (stories)

2. Feeling sympathy for others and their situations

3. Empathizing with others' situations (being able to imagine what it would be like to be in someone else's shoes)

4. Reflecting on their own experiences

5. Understanding the full implications of the brain research (which states that the brain is shaped by one's social environment)

Jennifer Gruenberg (developmental evaluation from interviews of key players forthcoming)

Visual: Four Factors Found to Increase Trauma Informed Practices

1. KNOWLEDGE
More NEAR Science Knowledge

4. STRUCTURE
Organization fully Trauma Informed

My Practices More Trauma Informed & Resilience Building

2. INSIGHT
Change in My Mind-set & Worldview

3. STRATEGIES
More Development & Practice of Resilience Building Skills

Factor 1 Findings - Knowledge
Trainings and Knowledge of NEAR science

- Exposure to NEAR science Trainings and support (ongoing coaching & consultation) lead to

  more knowledge of effects of trauma and dimensions of resilience

- NEAR science trainings and increased knowledge lead to

  more changes in Trauma-Informed Practices (TIPs)

Knowledge - Experiences and Lessons

Experiences:

"More trainings have allowed me to change the way I approach a child or interact with them"

"..reframing how I respond to behavioral outbursts"

Lesson:

To increase the adoption of TIPs it is important to increase NEAR science trainings and support from leaders and funders

Factor 2 Findings - Insight
The Effects of Insight Factors

- Insight (through stories, empathy and reflection) leads to changes
  - in personal *mind-sets* (our auto-pilot actions) and
  - in *world-view* (our perceptions of what we think is true)

- Shifts in personal mind-sets and worldviews lead to changes in TIPs

The effects of Insight were found to be as strong as the effects of Knowledge on changes in TIPs

Insight - Experiences and Lessons

Experiences:

"I am more self-reflective/aware – Calmer more responsive rather than reactive"

"Including more self-care into my routine, being more aware/attuned with myself so I can help others when needed"

"Create 'brave spaces' as opposed to 'safe spaces.' We can't avoid problems, but we can work on them together"

Lesson:

To increase the adoption of TIPs, it is important to facilitate exposure to trauma stories, encouraging empathy and training in self-reflections

Finding 3 Findings - Strategies:
The Development and Practice of Skills to Increase Resilience
(self-regulation, problem solving, accountability and planning skills)

- Development and practice of resilience-increasing skills lead to higher implementation of TIPs, above and beyond the effects of:

    - Knowledge - NEAR science trainings and knowledge
    - Insight - Mind-set and worldview shifts
    - Structure – Organization Structural changes

- In addition, we found that these skills often occurred simultaneously with changes in organizational policies and supervisor actions

Increases in the development and practice of resilience building skills are important on their own in influencing greater adoption of TIPs.

Strategies - Experiences and Lessons

Experiences:

"Through trainings I've implemented many strategies. Each year add new ones."

"…see my clients as people who need support, trust and a series of successes, so I try to build on one small success, a job, interview, a home etc. as ways to build resilience"

Lesson:

To increase the adoption of TIPs, it is important to support the development and practice of Resilience skills along with NEAR science knowledge, Insight and changes in organizational structures.

Factor 4 Findings – Structure
Organizational Structural Changes

- Hierarchical organizations (like government agencies) are less likely to enact policy changes, and supervisors are less likely to create supportive work conditions for TIPs; thus TIPs are <u>less</u> likely to be implemented

- But if changes occur in organizational policies, mission and values and staff collaboration that
  - Encourage supervisors to create conditions of safety, trust, calmness and mutual support,
  - Then the whole organization becomes more fully trauma-informed and
  - TIPs are <u>more</u> likely to be implemented, even in hierarchical organizations

Organizational Structure - Experiences and Lessons

Experiences:

"Talking more and opening up to coworkers around me"

"Communication and team work have made a strong team!"

"Most of the time what was tried and taught didn't work…when <supervisor> brought 'trauma informed'… this approach made sense to me and I have been working on understanding it and practicing it better"

Lesson:

To increase the adoption of TIPs and sustain their implementation, it is important to support changes in organizational policies

The Four Factors Often Work Together

- All four factors often work together to increase the adoption of TIPs

  - 55 percent of the total effect of the four factors on TIPs is due to them working together

  - 45 percent is due to them working independently of each other

  The total effect of the four factors working together and independently explain a large part (56 percent) of the variation in adoption of TIPs among the 217 survey respondents

- Positive effects of Knowledge, Insight and supports from the community and Network partners work together to decrease the negative impact of hierarchical organizational structures

Experiences and Lessons of Four Factors Working Together

• **Experiences:**

Answering the question on the ways their understanding of behavior has evolved, a majority of respondents said that it was 'a process of continuous self-change'

"The process has been a conversion, it isn't an arrival, for me it's a journey"

Many mentioned the influence of many factors:

"Education, trial and error, practice, reflection, and consulting with supervisors and co-workers"

• **Lesson:**

The main force for change is the combined, reinforcing influence of greater Insight and NEAR science training and knowledge, along with organizational policy changes (developed through coaching & consultation) and community supports

KISS- a framework for community capacity building for Resilience

Knowledge   Insight   Strategies

Structures

Community Resilience Initiative (c) 2017

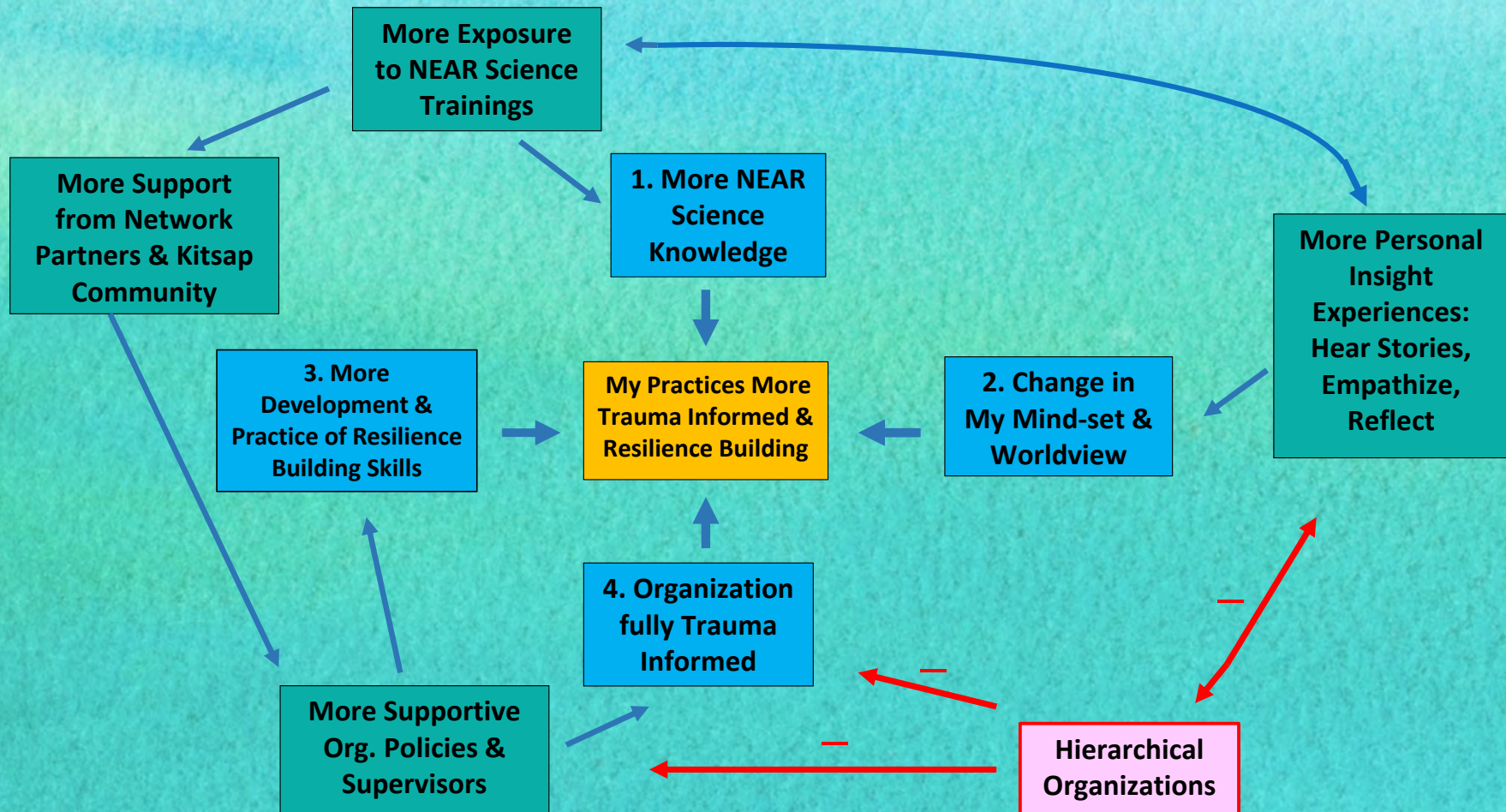# Wisdom from the community…

Recommendations for training delivery:

- *"Training with on-going follow up and monitoring during at least the first year of implementation… mentoring cohorts as our Educators learn to put theory in to practice!"*

- *"A universal ACES training for ALL EHS/HS/ECEAP/CC employees as well as cultural trainings on how each culture handles trauma…Being Native American and having experienced child hood trauma, others should be aware of their behavior and tones in voices, sudden movements, loud noises affect our little ones…"*

- *"On going… IN PERSON training and supports"*

- *"Coaching is imperative! Not just someone new coming in and making an action plan. Someone that can work hand in hand with the staff."*

Wisdom from the community…

Strategies to support implementation:

- *"As teachers we are always asking for more training in this at my program. We're pretty good about it but I always wondered about partnering with occupational therapists. Not sure what that would look like or how to make it happen but I have seen kids from trauma have huge improvements from OT."*

- *"Support the current tend of building reflective supervision/consultation into the early childhood profession. Trauma informed care goes top to bottom. Staff need to know their triggers as well as how to recognize them in children and families."*

- *"Yoga and meditation practice for providers. And money to provide an extra assistant teacher."*

- *"Smaller class sizes, more support in the classrooms to be able to individually help these children when needed. It is difficult to put any training into place when you have multiple behaviors, 17 kids and 2 teachers."*

Visual: Factors Found to Increase Trauma Informed Practices

More Exposure to NEAR Science Trainings

More Support from Network Partners & Kitsap Community

1. More NEAR Science Knowledge

More Personal Insight Experiences: Hear Stories, Empathize, Reflect

3. More Development & Practice of Resilience Building Skills

My Practices More Trauma Informed & Resilience Building

2. Change in My Mind-set & Worldview

4. Organization fully Trauma Informed

More Supportive Org. Policies & Supervisors

Hierarchical Organizations

What's Needed for Next Steps?

Help shift Culture (mindsets and policies) in early learning organizations to become more trauma informed:

- How to help change mindsets of staff by increasing opportunities for:

    hearing stories,
    gaining empathy and
    taking time for reflection?

- How to help change values and policies of early learning organizations?

APPENDIX O: POTENTIAL FUNDING SOURCES FOR TRAUMA-INFORMED EARLY CARE AND EDUCATION

Trauma-Informed Early Care and Education
Potential Funding Sources
Trauma-Informed Care Advisory Group

<u>Federal funding</u>:

Unlikely to be available –

- Title IV-B (Child Welfare) (DCYF)
- Child Care & Development Block Grant (DCYF)
- IDEA, Part C (Early Intervention) (DCYF)
- Maternal Child Health Block Grant (Title V) (DOH)
- Mental Health Block Grant (HCA)
- Substance Abuse Block Grant (HCA)
- Medicaid, including waivers (HCA)
- Social Services Block Grant (DSHS)
- Community-Based Prevention
- Community Prevention and Wellness Initiative (DSHS or HCA?)
- [Federal Preschool Development Grant (DCYF)]

Potentially available –

- Title IV-E (Foster Care & Adoption) (DCYF)
- IDEA, Part B (Special Education) (OSPI)
- Temporary Assistance for Needy Families, TANF (DSHS)

<u>State funding</u>: *(both potentially available)*

- Washington State General Fund
- Cannabis tax (I-502)

<u>Local funding</u>: *(All unlikely to be available)*

- Property levy
- Soda/Sweetened beverage tax
- Liquor revenue

Min Hwangbo, Cinthia Palomino, Emily Holm Tobin, Heather Cook, and Gail E. Joseph, PhD

Research Synthesis: Trauma-Informed Care

September 2018

The following research synthesis was prepared by Cultivate Learning Trauma-Informed Care doctoral student research team to support the state of Washington's effort to build a comprehensive support system to address Engrossed House Bill 2861 (EHB 2861).

Trauma-Informed Care in the Early Childhood Education

We define trauma-informed care (TIC) in the Early Childhood Education (ECE) system as an iterative and comprehensive approach that begins with trauma risk awareness and prevention. It is based on the understanding that trauma is pervasive, in which all parties (including children, care providers, family members, and social services) engage in care with the goal of supporting and empowering the affected or at-risk child while recognizing potential for and actively seeking to prevent trauma. All adults involved are committed to informed, active intervention, promoting healthy long-term development, and minimizing the risk of physical or emotional trauma to all involved in the system.

Comprehensive Approach to Implement Trauma-Informed Care System

We recommend implementing two or more evidence-based models together to ensure access to all individuals including children, parents, and early childhood educators. Below are some of our findings to maximize positive outcomes across all levels of care (from prevention-focused services to direct intervention services).

- Not all evidence-based models are early childhood specific or trauma-informed care (TIC) specific. E.g. The Early Childhood Mental Health Consultation (ECMHC) is early childhood-specific and centered on mental health, but it is not focused on trauma-informed care per se. Also, the Attachment, Self-Regulation, and Competency (ARC) framework is trauma-focused, but its target population ranges from 2 to 21 years old. See more information about evidence-based interventions and models in the sections below.

- A consultation-based model such as ECHMC would be particularly helpful in increasing awareness and knowledge of parents and teachers/child care providers on children's mental health and to help them learn strategies for how to deal with children's challenging behaviors (including developing individualized behavior support plans). However, this model does not include direct services for either the child or the parent, such as counseling or therapy.

- Based on the literature review, most TIC early childhood initiatives have used two or more evidence-based models and in specific communities or cities. Very few of these interventions have been implemented as a statewide initiative in early childhood care settings.

Evidence-based Models

Early Childhood Mental Health Consultation (ECMHC)[1]

Early Childhood Mental Health Consultation (ECMHC) is a tiered, consultation-based mental health model that aims to support caregivers in promoting children's social-emotional development. Consultation services range from prevention-focused (general) to individualized behavior plans/strategies (specific).

Three approaches to ECMHC implementation were identified in the systemic review of 14 peer reviewed articles. These include manualization, implementation of established curriculum, and individualized consultation services. The duration of consultation services ranged from two to six months. Results showed that ECHMC was related to a decrease in externalizing behaviors, an increase in prosocial behaviors, and a minor effect on internalizing behaviors of children.

The Attachment, Self-Regulation, and Competency (ARC) Framework[2]

The Attachment, Self-Regulation, and Competence (ARC) framework has multiple modalities including individual, group and family treatment, parent workshops, milieu/systems intervention, and a new home based prevention program. It has three core domains impacted by exposure to chronic, interpersonal trauma: attachment, self-regulation, and developmental competencies. Within the three core domains, ten core building blocks of intervention meant to translate across service settings and service delivery format, including non-traditional clinical settings.[3] Other researchers[4] implemented the ARC model reported positive child level outcomes including reductions in internalizing, externalizing, posttraumatic stress, depression, anxiety, anger and dissociative symptoms from pre- to post-treatment gains, which were maintained over a 12-month follow up period.

Head Start Trauma Smart (HSTS) Model[5]

Designed for children three to five years old, the Head Start Trauma Smart (HSTS) model is comprised of three existing evidence-based models:

- The Attachment, Self-Regulation, and Competency (ARC) framework: A complex trauma-focused intervention/model
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT): Delivery of targeted intervention
- Early Childhood Mental Health Consultation ECMHC: Tiered approach intervention

The Resource Development Institute[5] conducted an external independent evaluation of three Midwestern urban Head Start programs. Results include significant changes in children's attention problems, externalizing problems, attention deficit/hyperactivity problems, oppositional defiant problems, and internalizing symptoms based on Achenbach-Teacher report form and Child Behavior Checklist (CBCL).

Other Early Childhood Inclusive Intervention Models: Direct Services[6]

The National Child Traumatic Stress Network also suggested the following intervention models:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma Assessment Pathway (TAP): Assessment-Based Treatment for Traumatized Children
- Attachment and Bio behavioral Catch-up (ABC for Infants)
- Child-Parent Psychotherapy (CPP)
- EP: Early Pathways
- Let's Connect
- Parent-Child Interaction Therapy (PCIT)
- Strengthening Family Coping Resources (SFCR) for families
- Trauma Adapted Family Connections for families

Funding Trauma-Informed Care System

Funding Direct Services

The 2014 Substance Abuse and Mental Health Services Administration (SAMHSA) report[7] recommended to states to coordinate multiple sources of funding direct services including crisis hotlines, emergency services centers, mobile crisis teams, residential crisis services, social detoxification with crisis stabilization services, walk-in services, etc. Based on the interview responses of eight state cases, the following funding sources are reported to support the services addressed above:

- State general funds
- Medicaid funds including
  - Clinic option
  - Rehabilitation option
  - 1115 waiver
  - 1915(b) waiver
  - 1915(c) waiver
- Mental health block grant
- Local grant
- Private insurance
- Self-pay
- Emergency management agency funds i.e. FEMA funds
- Grant funding

The representatives from eight states also reported Medicaid crisis residential and intervention rates. Crisis residential rates were ranged from $139.54 per diem rate in Wisconsin) to $288 per day in Michigan. Intervention rates also differed by states as Illinois, Maine, and Texas billed rates by 15-minute increments from $29.97 to $47.77. Massachusetts billed a single rate per episode at the rate of $500 per episode whereas Wisconsin and Illinois applied rates based on the staff credentials and place of service. The range in Wisconsin was from $47.42 per hour for a paraprofessional to $148.16 per hour for a nurse practitioner or a psychiatrist.

Funding System Implementation

Connecticut: Project CONCEPT[8]
As one of five Administration for Children's and Families grant recipients in 2011 to support the development of trauma informed Child Welfare System, the state of Connecticut applied SAMHSA and Chadwick's collaborative approaches to implement systemic dissemination of the project CONCEPT: the Connecticut Collaborative on Effective Practices for Trauma.

In the first two years of implementation stage, the state initiated the project by focusing on child welfare workforce development. Two to four staff of the DCF volunteered to serve as the "early adopter" liaisons to local regional offices to provide monthly in-service trainings focused on trauma in their offices.

The 1,164 caseworkers and 487 administrators were trained by the end of 2014, resulted in mandatory pre-service and in-service trauma training for all new hires of child welfare team since 2014. Each office had its locally developed strategies to address worker wellness and secondary traumatic stress. $60,000 was split each year to all regional offices and facilities to support local activities via the train-the-trainer approach and implementation of the National Child Traumatic Stress Network Child Welfare Trauma Training toolkit (2013).

Massachusetts: Massachusetts Child Trauma Project (MCTP)[9]
The Massachusetts Child Trauma Project (MCTP) was launched as a statewide initiative to enhance both the capacity of child welfare workers and child mental health providers. Three mechanisms in all regions of the state were implemented. These include training welfare staff and resource parents to recognize and respond to child trauma, disseminating trauma focused evidence-based training, and implementing Trauma-Informed Leadership Teams (TILTs).

In the beginning of the project, understanding the impact of trauma and knowledge level of trauma were defined depends on the population and system sector that each personnel was involved. Two pathways including the Child Welfare Trauma Training Toolkit 3rd edition[10] and the Resource Parent Curriculum[11] were implemented as the layers of child trauma training in the initial year (October 2012 - September 2013) as an online module and a two-day in-person training. The group also referenced a recent research[12] which estimated as high as $500,000 to implement an evidence-based training that focuses on community level dissemination.

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APPENDIX Q: PARENT ADVISORY GROUP FEEDBACK

Feedback and Recommendations of the Parent Advisory Group (PAG)
Regarding Parent Awareness of Trauma-Informed Child Care

The Parent Advisory Group (PAG) of the Washington State Department of Children, Youth, and Families was consulted on multiple occasions as part of the Trauma-Informed Care (TIC) Advisory Group's efforts to learn more about challenges and needs families are experiencing related to accessing trauma-informed early care and education for their young children. Many of these parents expressed great distress about the impact of early care and education that has not been responsive to their children's needs. They told stories about their children and families who did not qualify for therapeutic child care, Head Start and ECEAP, or early intervention services; however, their children had histories of trauma or sub-clinical developmental issues resulting in behaviors that their Early Childhood Educators were unable to manage. Some of the outcomes they experienced as most distressing were significant negative impacts on their children's self-esteem and confidence: "My kid came home feeling like he was a bad child. What happened in that short time that led to that?" They provided the reminder that "situations that are traumatizing for the child are also traumatizing for the parent" and that "it's not just the child's behavior. There's trauma in the family, and the parents don't know how to handle this."

Recommendations from the TIC advisory group were consistent with those from PAG, though the latter group offered more extensive recommendations on how to involve parents in trauma-informed care practices. Based on their experiences, PAG members provided extensive feedback and recommendations, including the following:

- The PAG members agree with the TIC advisory group's assertion that trauma-informed care is best practice for all children, not just those who have experienced trauma or other early childhood adversity.

- Parents should be able to self-select into higher levels of care for their children, such as those envisioned as part of enhanced and therapeutic care.

- Trauma-informed care training and support for early care and education providers should result in improved partnership with parents on behalf of their children. PAG members stated that teaming with parents should be a *requirement* for early care and education providers.

- Messaging regarding trauma-informed child care should

    o use terms such as executive functioning, self-regulation, resilience, adaptability, and family-friendly, which they identified as broadly used by parents and consistent with families' values without being perceived as either threatening or as professional jargon; and

    o clearly communicate the end goal of trauma-informed early care and education which, in the parents' words, should be "safe, healthy, resilient, functional children who grow into adults who can contribute to society at large."

- Families should be able to access training regarding ACEs, resilience, and trauma-informed care; and practical supports and incentives for participation should be provided. They also thought a public awareness campaign could help increase awareness of ACEs and provide basic education on trauma-informed and developmentally-appropriate parenting practices.

APPENDIX R: INFANT/EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (IECMHC) SERVICE DEVELOPMENT FOR WA

BRIEF OVERVIEW OF IECMHC:

In 2016 the Washington Children's Mental Health Workgroup Final Recommendations Report and HB 1713 called for the development of an Infant/Early Childhood Mental Health Consultation (IECMHC) system in WA. The Department of Early Learning (now the Department of Children, Youth, and Families) began work on this effort in spring 2018.

The goal of developing this system is to strengthen the capacity of staff, families, programs and systems to promote positive social and emotional development. Additionally DCYF seeks to prevent, identify and reduce the impact of mental health challenges among children from Birth – 5 and their families.[1] Washington's IECMHC system will connect child care and early learning providers with evidence-based, trauma-informed and best practice resources regarding caring for infants and young children who present behavioral concerns or symptoms of trauma.[2] This strategy supports our national and state investments in child care, early learning and quality improvement efforts.

"Ultimately, IECMHC is focused on building adult capacity to support infant and young children's emotional development and to prevent, identify or reduce mental health challenges."[3] Through reflective consultation and partnerships with child care and early learning staff, mental health consultants (MHCs) help build staff capacity to understand the influence of their relationships and interactions on young children's development. Consultation services may be child/family-focused, classroom-focused and/or program focused, offering support across the promotion, prevention and intervention continuum, and individualized to meet the needs of providers, children and families.

- When a child's behavior is of concern to parents or child care/early learning staff, MHCs can help adults understand, assess, and address the child's needs by developing an individualized plan with specific strategies for parents and providers.
- Classroom-focused consultation involves MHCs working collaboratively with teaching teams to identify and address attitudes, beliefs, practices and conditions that may be affecting the quality of relationships between adults and children.
- Programmatic consultation involves MHCs supporting administrators, directors, principals and other leaders to make changes in their practices and policies to benefit all of the children, families, and adults in the early learning setting. Consultants often work with program staff at all three levels concurrently.[4]

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[1] Kaufman, Perry, Hepburn, & Hunter, 2013
[2] As required by HB 1713.
[3] ZERO TO THREE, 2016
[4] The RAINE Group, 2014

EVIDENCE BASE FOR IECMHC

Nationally, IECMHC has a growing evidence base which demonstrates positive impacts on child, staff and program-level outcomes. These include, but are not limited to:

- improved teacher-child interactions and classroom emotional climate;
- increased teacher sensitivity, efficacy and confidence;
- reductions in children's challenging behavior and increases in social skills;
- reduced child expulsion rates, including among young children of color;
- less work missed by families and lower parenting stress, and;
- decreases in teachers' stress and turnover rates.[5]

WA's service model will be based on other nationally recognized evidence-based models for best practice in IECMHC service delivery. Washington also has a unique opportunity to contribute to the evidence base in the field and to build on positive outcomes that other programs have demonstrated.

CURRENT SNAPSHOT OF IECMHC SERVICES IN WA

There is currently an unconnected and non-comprehensive set of IECMHC services in Washington:

- These services are currently available to children in Head Start and ECEAP settings, though practice differs widely from program to program.
- The Infant Toddler Consultation component of Early Achievers provides some health and mental health consultation to children aged birth to three years in some Early Achievers sites.
- The Seattle-King County Public Health Department currently employs three mental health specialists who provide consultation to a portion of the licensed child care centers in Seattle.
- The Snohomish County Health Department employs a half-time behavioral health specialist as part of their Child Care Health Outreach team.
- Project LAUNCH recently funded three part-time MHC positions in targeted communities through a grant which is due to expire in fall 2019. [6]

Despite the efforts articulated above, at this point in time, the vast majority of WA's 2,006 licensed child care centers and 3,354 family home child cares do not have access to IECMH consultation services. Further, Head Start and ECEAP program leaders report a continued need among program staff for additional support with challenging child behavior. Additionally, we have no data on whether any mental health consultation is being offered in license-exempt part-day preschool programs, Family, Friend and Neighbor care, other informal care settings, nor what mental health supports children, families and teachers in those settings might need.

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[5] Hepburn, Perry, Shivers & Gilliam, 2013, The RAINE Group, 2014; ZER0 TO THREE, 2016
[6] North Thurston, Chelan/Douglas, and Benton/Franklin

FOUNDATIONAL CONSIDERATIONS

In this system, Mental Health Consultants (MHCs) will work collaboratively with staff in child care and early learning settings to:

1. Strengthen prevention, promotion and intervention strategies to address social-emotional concerns and challenging behaviors[7]
2. Assist providers in recognizing the signs and symptoms of trauma in young children, and promote Trauma-Informed Care principles and practices
3. Provide consultation, training and ongoing support for parents, caregivers and others involved with the care and well-being of young children
4. Provide referrals for children and families who need additional service[8]
5. Coordinate with other service providers regarding individual, programmatic and systemic needs and concerns
6. Prevent expulsions, suspensions and other practices which contribute to adverse outcomes for young children[9]

Best practice guidelines from The Substance Abuse and Mental Health Services Administration's Center of Excellence for IECMHC indicate that mental health consultation services should be provided by experienced licensed or license eligible mental health professionals and supported through ongoing reflective supervision. It is DCYF's vision to use these best practices to develop a statewide system of IECMHC services which are ultimately available to all child care and early learning settings serving children aged birth to five. Ideally, MHC services will be state-funded and sustained, free to child care programs and families, and not restricted based on family income, or other specific eligibility criteria. It is DCYF's long term goal to create a network of regional child care/early learning "Consultation Hubs" which would provide health and mental health consultation services linked with other interdisciplinary supports such as environmental, nutritional, health education, business practices, and quality improvement coaching such as Early Achievers.

DCYF's model for IECMHC will also build on the 2009 Georgetown University Center for Child and Human Development framework for early childhood mental health consultation. This research outlines core factors deemed essential in developing effective IECMHC services, including a solid program infrastructure; highly qualified mental health consultants; and high quality services.

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[7] ZERO TO THREE, 2016; Duran, Hepburn, Irvine, Kaufmann, Anthony, Horen & Perry, 2009
[8] Items 2-4 on this list were required by HB 1713
[9] As required by EHB 2861

Finally, DCYF intends to adopt the following research-based[10] guiding principles that state IECMHC should be:

- Relationship-based
- Collaborative
- Individualized
- Culturally and linguistically responsive
- Grounded in developmental knowledge
- Evidence-informed
- Data-driven
- Delivered in natural settings
- Spans the continuum from promotion through intervention, and
- Integrated with community services and supports

DEVELOPMENT AND PILOT ESTIMATE

Initial work is underway within DCYF to develop the core building blocks for Washington's IECMHC system, including:

- Establishing eligibility (target population, geographic reach, and service delivery setting);
- Designing the service (dosage, capacity and access).
- Workforce development (core training, professional development and reflective supervision).
- Identifying infrastructure needs (logic model, theory of change, service organization, policies and procedures and implementation manual).

An initial investment of approximately $2.9 million would allow DCYF to establish foundational infrastructure for statewide program development and pilot IECMHC services in two regions. These funds would go towards:

- Hiring program management and support staff,
- Creating a comprehensive training and professional development plan for MHC workforce,
- Creating a data system and program evaluation protocol,
- Hiring a team of 16 mental health consultants and two regional supervisors. These consultants would be projected to serve 125-140 child care/early learning sites at any given point in time, depending on service model, intensity, duration and frequency of service, child/program needs and what is deemed clinically warranted.

DCYF recommends first piloting IECMHC services in licensed child care settings, with expansion to other early learning settings later as program capacity builds and funding is increased.

[10] Kaufmann, Perry, Hepburn & Duran, 2012

After a pilot period, DCYF would refine and improve its practice model in order to fully implement a system of IECMHC services available to all child care and early learning settings service children aged birth to five years. To accomplish this, an estimated $12.1 million annually would be needed to fund state infrastructure and regional MHC teams. This would fund approximately 75 MHCs and 9-10 regional supervisors who would serve 600-650 sites (impacting over 10% of the state's 5,360 licensed child care centers/homes) at any given point in time.

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