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

Research Synthesis: Trauma-Informed Care

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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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