Helping Young Children Exposed to Trauma:

A Systems Approach to Implementing Trauma-Informed Care

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About the Child Health and Development Institute of Connecticut:

The Child Health and Development Institute of Connecticut (CHDI), a subsidiary of the Children's Fund of Connecticut, is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive, and social development of children throughout Connecticut. CHDI works to ensure that children in Connecticut, particularly those who are disadvantaged, will have access to and make use of a comprehensive, effective, community-based health and mental health care system.

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Executive Summary

This IMPACT provides a summary of the research on the effects of early trauma exposure, discusses what Connecticut is doing across systems to support young children who have experienced trauma, and identifies recommendations to improve trauma-informed services for Connecticut's youngest children. Highlights include:

The prevalence and effects of early childhood trauma

There are more than 228,000 children under the age of six years old in Connecticut, at least a quarter of whom research suggests will have experienced or witnessed one or more potentially traumatic events during their first years of life. Exposure to trauma can lead to disruptions in development and cognitive, social-emotional, and behavioral functioning, and has been associated with costly long-term mental health and health outcomes across the lifespan. Effective trauma-informed systems can help mitigate these effects and support the health and resilience of all children.

Connecticut's first steps in addressing early childhood trauma

Connecticut has made significant investments to address childhood trauma across a number of systems including child welfare, behavioral health, juvenile justice, education, and pediatrics. More than 8,000 professionals have been trained to understand and recognize trauma across a number of systems, more than 50,000 children have been screened for trauma, and more than 13,000 have been provided trauma-informed evidence-based mental health services. Trauma-informed care is also a core value identified in Connecticut's Children's Behavioral Health Plan. While the focus of much of this work has been on school-aged children, recent efforts have begun to bring trauma-informed programs to those serving the state's youngest children.

Trauma has increasingly become a focus of trainings and professional development for the early childhood workforce, including preschool teachers, daycare providers, pediatricians, child welfare workers, and others. Some of these settings are beginning to screen young children for trauma. Evidence-based treatments are also becoming more available. Child First is a trauma-informed home visiting program that now serves approximately 1,000 young children and their families each year. Oupatient children's behavioral health clinics are also expanding access to evidence-based trauma-informed models for young children through the Early Childhood Trauma Collaborative, a grant awarded to CHDI and a collaborative of state and provider agencies from the Substance Abuse and Mental Health Services Administration as part of the National Child Traumatic Stress Network. And there are other promising small-scale efforts to support trauma-informed work with young children, including Department of Children and Families-funded therapeutic preschools and infant-toddler court teams operated by ZERO TO THREE. Finally, the

establishment of the Office of Early Childhood in 2013 demonstrates a statewide commitment to early childhood. Having a central agency focused on creating a cohesive, *high quality early childhood system* is important in facilitating the collaboration necessary to build a foundation for a trauma-informed early childhood system.

Addressing child trauma in Connecticut and closing gaps in care for young children

Even with Connecticut's investments in addressing childhood trauma, services for children younger than six still lag behind those available to older children and adults. This may be in part because of a disconnect between existing trauma-informed systems and early childhood systems. There is a need for systems to focus specifically on what trauma-informed care looks like for young children so that systems serving young children can begin to integrate practices and supports to better serve the youngest children exposed to trauma. Additionally, settings that might *already* serve those affected by trauma, such as child welfare agencies and mental health clinics, can further their understanding of how trauma profoundly impacts young children and how to best serve the youngest in their care.

A framework for trauma-informed care for young children

Connecticut is actively developing a comprehensive trauma-informed early childhood system of care. This IMPACT lays out a framework to expand Connecticut's robust systems of trauma-informed care to include younger children by infusing a trauma-informed approach into Connecticut's existing early childhood systems and highlighting the importance of collaboration between early childhood systems as well as linkages with other child-serving systems. Key components of this framework include:

- Workforce development
- Trauma screening
- Practice change and evidence-based practice
- Collaboration and communication across early childhood systems

Recommendations

This IMPACT includes a number of recommendations to continue supporting Connecticut's early childhood system to be trauma-informed, including the following key recommendations:

- All staff in home visiting and caregiver support programs, pediatric providers, and early care and education staff receive training and ongoing support about preventing, identifying, and responding to childhood trauma. Opportunities for cross training to improve collaboration and shared language across these systems are actively pursued.
- Early childhood systems and programs include trauma screening together with developmental/behavioral screening.
- The Department of Social Services includes trauma screening as a reimbursable service under Medicaid for pediatric primary care providers, and a billing mechanism for services to address "toxic stress" or similar designation for young children who are at risk due to trauma exposure but do not yet meet criteria for a diagnosable mental illness.
- The State increases the number of mental health providers trained to deliver evidence-based trauma-focused interventions for young children.

Nearly half (43%) of all Connecticut children who were confirmed by child protective services to have been maltreated are under the age of 6.

Introduction

There are more than 228,000 children under the age of six living in Connecticut.[1] Research suggests that at least one in four of these children will witness or experience a potentially traumatic event by age four.[2] Potentially traumatic events may include physical or sexual abuse, exposure to domestic or community violence, and separation from or loss of a caregiver. Young children can also experience other adversity or household dysfunction, including neglect or caregiver mental illness or substance abuse. Exposure to these various forms of trauma and adversity has been associated with impaired development and functioning. Research shows that exposure to trauma can have far-reaching effects on children well into adulthood and that interventions to support children who have experienced trauma can help to buffer its effects and promote children's resilience. Young children, particularly children of color and children living in urban environments, are at highest risk. For example:

- Children from birth to age five make up less than one quarter of children living in Connecticut. However, nearly half (43%) of all Connecticut children who are confirmed by child protective services (CPS) to have been maltreated are under the age of 6.[3]
- Young children are also more likely than older children to be present during domestic violence incidents that result in arrest;[4] thus, young children witness violence in the home and may also witness their caregiver(s) being arrested.
- Children of color continue to be over-represented in the child welfare system and rates of exposure to multiple traumatic events are significantly higher for African American (19%) and Latino (15.9%) children in Connecticut compared to non-Hispanic Caucasian children (6%).[5]
- Connecticut's largest and most racially/ethnically diverse cities also have rates of substantiated child abuse/neglect and family violence that are higher than national rates,[6,7] indicating that it is critically important to examine early childhood trauma in communities most affected by poverty and community violence to ensure that all Connecticut children have supports following exposure to trauma.

Because of the risks associated with early childhood trauma, Connecticut is actively developing a comprehensive trauma-informed early childhood system of care. This IMPACT lays out a framework to expand Connecticut's robust systems of trauma-informed care for older children to include younger children by infusing trauma-informed care into Connecticut's existing early childhood systems.

Young Children are Especially Vulnerable to Trauma

Trauma exposure can impact various domains of young children's development (see Table 1). Immediate support for young children after a potentially traumatic event and ensuring safety to prevent additional trauma exposure are critically important, as young children are especially vulnerable to the effects of trauma. For example:

- Young children with post-traumatic stress disorder recover more slowly than older children,[8] and early exposure to trauma is shown to cause more psychological distress than trauma beginning later in childhood.[9]
- Trauma in early childhood has also been linked to poor social-emotional development,[10] below-average academic literacy skills and behavior problems,[11] and long-term mental health issues.[12]
- Children who experience multiple types of trauma in early childhood are at greater risk for being exposed to multiple types of trauma later on in childhood as well.[13] It may be that risk factors that contribute to a child experiencing multiple types of trauma early in childhood tend to persist and contribute to additional trauma exposure late in childhood.
- Traumatic experiences in early childhood can have significant long-term effects, potentially extending into adulthood, such as greater risk for health and mental health conditions, substance abuse, criminal justice involvement, and premature death.[14]

Healthy relationships are essential for building healthy brains.[15] Early trauma exposure can compromise children's ability to form healthy relationships. Young children rely on caregivers to provide safety and security and to meet their basic needs (e.g., feeding, changing, setting routines). Healthy relationships with a caregiver allow most children to learn at a very young age that their needs are important and that the adults who care for them will respond to those needs with sensitivity and consistency. These early attachment relationships lay the foundation for how children develop their own sense of self and how they trust and interact with others. Quality attachment relationships are also able to help "buffer" children's brains from the effects of traumatic experience. Many young children can recover from a traumatic event with the support of caregivers and will not require mental health intervention.

However, caregivers have often experienced the same traumatic events as their children (e.g., domestic violence, community violence) or have their own history of childhood trauma. Caregivers in families where child maltreatment has occurred are more likely to report their own experiences of childhood abuse or neglect as well as poor attachment to their own caregivers.[16] Caregivers who are struggling with their own trauma may be less able to attend to the needs of their children and their children often exhibit more significant traumatic stress, insecure attachment, and other developmental problems.[17] Parents who abuse substances may also be at higher risk for abusive or neglectful behavior.[18]

Table 1: Potential Effects of Trauma on Young Children

Developmental Domain	Possible Effects
Cognitive	• Deficits in verbal development • Difficulties with focus and memory • Struggles with learning new skills or developing reasoning abilities • Increased rate/risk of learning disabilities
Social-Emotional	• Trouble regulating internal emotions • Difficulties in reading emotions in others • Trouble trusting adults • Difficulties making friends • Feelings of self-blame and shame can undermine self-confidence
Physiological	• Sleep difficulties or nightmares • Poor appetite, low weight, and/or digestive problems • Stomachaches and headaches
Behavioral	• Excessive temper and/or demands for attention • Excessive crying or displays of sadness • Regressive behaviors • Separation anxiety • Acting out the trauma in play or otherwise imitating the event(s) • Aggressive behavior towards peers or adults • Avoidant behaviors, withdrawing from typical activities that foster exploration and development
Physiological	• Structural and functional alterations in brain development. • Different levels of the stress hormone cortisol, which can compromise their ability to regulate stress. • Smaller brain volume, less connective matter in the brain, and differences in parts of the brain connected to memory and higher-level reasoning and thinking.

Despite the risks noted in Table 1, interventions to support young children who have experienced trauma yield positive outcomes for children. There are several trauma-informed mental health interventions that are effective for young children[19] and are shown to reduce children's emotional and behavioral concerns, parenting stress, and child welfare involvement for children exposed to trauma.[20] Virtually all of these interventions are relationship-based; they actively involve parents and caregivers in treatment together with the child to enhance the caregiver-child relationship and to increase caregivers' competencies to support the child. They also provide an opportunity to connect caregivers to additional resources or treatment as needed. Trauma-informed interventions for young children have been shown to reduce children's traumatic stress symptoms as well as caregivers' symptoms[21] and are linked to positive outcomes even for children with high levels of trauma exposure.[22] Table 2 summarizes selected trauma-informed interventions appropriate for young children.

Table 2: Early Childhood Mental Health Trauma Interventions

Intervention	Description	Evidence	Use/Needs in CT
Child First	Trauma-informed home visiting intervention for children from birth to age 6 and their caregivers. Combines case management with Child Parent Psychotherapy.	In a randomized controlled trial, engagement with Child First was associated with reduced parenting stress, improved child development outcomes, and decreased child protective services involvement several years after the intervention.[23]	Capacity is limited by existing funding and the lack of insurance reimbursement for this service. Child FIRST can serve around 1,000 families in the state, but still has long waiting lists.[24]
Child-Parent Psychotherapy (CPP)	Relationship-based dyadic intervention for children ages 0 to 5 who have experienced traumatic events or separation from a caregiver.[26]	A randomized controlled trial found significant long-term decreases in preschoolers' behavior problems.[27] CPP has also been shown to decrease maternal depression and symptoms of PTSD.[28]	Federal grants have allowed for CPP to be delivered in outpatient settings in three CT communities. Fewer than 20 clinicians are trained, limiting availability.
Child and Family Traumatic Stress Intervention (CFTSI)	CFTSI has a young child version for children ages 3 to 6 that is now available in five communities.	CFTSI has been found to reduce PTSD symptoms in older children[29] but research is not yet available for young children.	Capacity for this service is limited in Connecticut; currently, fewer than 30 clinicians offer CFTSI.
Attachment, Self-Regulation, and Competency (ARC)[30]	A flexible, components-based intervention for children ages 3+ who have experienced complex trauma and their caregiver(s). Includes a combination of direct child therapy, dyadic interventions, and parent training and consultation.	ARC has emerging evidence of effectiveness in reducing behavior problems and trauma.	Currently being disseminated through trauma-informed preschools and ECTC grant.
Attachment & Biobehavioral Catch-up[31]	10-session manualized, attachment-focused model for children age two years and under. Model can include biological parent and/or foster caregiver.	Has been found to increase maternal sensitivity, decrease children's stress hormones, improve children's cognition and executive functioning, and improve parenting behaviors.	Currently not available in Connecticut.

Note: These interventions were selected to represent both interventions currently used in Connecticut as well as empirically supported interventions also used outside of Connecticut.

Trauma symptoms in young children often look very different from those in older children and may be misinterpreted as developmental delays, regression, or behavior problems and missed as signs or symptoms of trauma.

Unique Challenges Related to Identifying and Intervening with Early Trauma

There are a number of challenges in identifying and treating trauma in young children:

- Caregivers of very young children may not seek mental health services, and providers may be less likely to make referrals for young children. This might be due to misconceptions about the impact of trauma on young children. Despite what we know about the harmful effects on young children, it might be assumed if children are too young to talk about an event or that they "don't understand," they won't be affected by trauma.
- Unlike older children who typically are in school settings, young children who are not enrolled in early care and education (ECE) settings may not interact with teachers and other adults and providers who could identify the signs of trauma exposure, leaving children who could benefit from trauma services unidentified.
- Identifying early trauma is even more challenging because trauma symptoms in young children often look very different from those in older children and may be misinterpreted as developmental delays or behavior problems rather than trauma reactions. Young children's limited (or absence of) language also makes it difficult to assess their internal thoughts, feelings, and understanding of trauma, which are important for diagnosis.
- There are fewer evidence-based mental health interventions for children ages six and younger than for older children. Of the 43 interventions in *Empirically Supported Treatments and Promising Practices* reviewed by the National Child Traumatic Stress Network , only seven are deemed appropriate for children ages birth and up and only two are developed exclusively for children younger than age six (https://www.nctsn.org/).
- Current reimbursement regulations make it difficult for mental health providers to diagnose and bill for services with very young children. In a 2014 review of Medicaid insured services provided in Connecticut, it was noted that services for children ages 0 to 3 are rarely authorized, and that young children rarely use behavioral health services.[32]

To ensure that vulnerable, young children are identified and referred to services, a comprehensive approach is needed across early childhood service systems.

A Comprehensive Approach to Early Childhood Trauma Includes Multiple Systems

Many systems and agencies in Connecticut are in place to meet the needs of young children and families and provide opportunities to prevent trauma exposure and to support young children who have experienced trauma. Professionals in many systems support the ***majority*** of Connecticut's young children, including ECE settings such as child care centers, Head Start, and preschools, as well as child health settings such as pediatric primary care. Professionals in other systems work with young children in a more ***targeted*** way, often in response to a traumatic event, including child welfare, court systems, parenting education programs, home visiting programs, Early Head Start, medical staff, domestic violence shelters, and community-based mental health providers. It is important for trauma-informed early childhood approaches to meet the unique needs of children and caregivers who are involved in these various systems and also to support consistency and communication across providers and systems. Although not an exhaustive list, the following systems are important components of a trauma-informed early childhood system in the state.

Early care and education settings

Formal early care and education settings, such as child care centers and preschools, contribute to the health and development of many young children in Connecticut. Early care and education is one of the few systems that interacts with the majority of young children and families and is an important point of connection for preventing, recognizing, and addressing trauma. The most recent census results find that almost 59,000 children in Connecticut ages 3 and older attended an ECE setting (including nursery school as well as public and private preschools) in 2016.[33] Four of five Connecticut children entering kindergarten have preschool experience.[34] Studies suggest that one-quarter to one-half of all children will have experienced a potentially traumatic event by kindergarten,[35,36] making ECE settings important for ensuring trauma-informed approaches to young children. The ECE system can support a range of children's needs associated with trauma exposure with a continuum of trauma-informed care, including traditional ECE settings that work with young children who may have experienced trauma as well as specialized trauma-informed preschool programs that specifically enroll children who have experienced maltreatment or child welfare involvement. Other early care and education settings, such as family child care homes and kith and kin providers, are also important settings in which providers may interact with children who have experienced trauma.

Case Study 1: Trauma-informed early care and education (LEAP preschool program)

This is a case study of a DCF-funded, trauma-informed preschool program for children who are DCF-involved and have struggled in a traditional preschool setting. The school employs a social worker as well as several teachers and teacher assistants who collaborate with DCF providers and family members to ensure the needs of children are being met.

In a preschool that heals, behavior is communication. When children are triggered by their trauma, sometimes they hide under tables, in cubbies, and they can even fit in a narrow gap between a refrigerator and the wall. Other children run when they are triggered; they run around the classroom, down the hall, around the gymnasium. Still others seek extra reassurance through physical connection like cuddles and rocking, or a song. Some children only know how to communicate their feelings through physical means such as hitting, kicking, throwing objects, and spitting. Children make their needs known through their behaviors and our challenge and task is to understand and respond to those needs, even when they are pushing us away. Often the pushing away means, "I need you right now and I don't know how to tell you."

Teachers and clinical staff help children regulate their strong emotions. We can remind the child who becomes easily aroused, "I can see that your unhappy is really big; let's see if we can calm down with you a little." For the child with low frustration tolerance, we can notice, "I see you are frustrated, but I believe you can handle it, and I am right here to help you." We also teach our children to notice how they feel emotions in their bodies; muscles can be tight, tummies can be icky, heads can be achy, and faces can be warm. We remind our children to breathe and offer lots of adult support for problem solving. Staff encourage children to show empathy for one another and use assertive language to tell a friend when his behavior is bothering them: "Stop! I don't like it when you take my toy; we take turns at school." Staff also acknowledge that the child who bothers others may not know what else to do, so staff prompt a different way to respond and model for them.

While the staff and children spend a lot of our day with a focus on emotions, there is also a focus on school readiness skills like letter recognition, writing, counting, science, art, and engaging in teacher-directed activities. Although the day may sound easy, it is really hard work for our team of committed adults. The staff use a high level of emotional energy tending to the emotional needs of our children. The team engages in regular group reflective supervision and encourages self-care practices. Staff celebrate when our teachers take a risk, such as the lesson involving live worms that could have gone wrong but didn't, and acknowledging a lesson learned from the group finger painting activity that ended in a mess. The team cares for one another, and the bucket of chocolate up in the cabinet … well, that helps too.

—Submitted by Tracy Krasinski, Wheeler Clinic Program Manager

According to the 2016 National Survey of Children's Health, 92.5% of children in Connecticut (around 223,000 children) ages 0 to 5 saw a doctor or other health care professional within the past year.[37]

Pediatric primary care

Child health services provide an optimal venue to prevent and detect trauma exposure in young children and to provide referrals for services, in large part because of their interaction with the vast majority of young children.

- According to the 2016 National Survey of Children's Health, 92.5% of children in Connecticut (approximately 223,000 children) from birth to age five saw a doctor or other health care professional within the past year.[37]
- The American Academy of Pediatrics (AAP) recommends that by age five, all children should have had 14 routine well-child visits, not including visits for illness.

Based on this frequent contact with young children, child health providers are well-suited to detect trauma exposure and provide referrals for services,[38] which is consistent with the concept of the pediatric medical home that is an important element of health care reform efforts. Many pediatric practices have or are beginning to explore the possibility of embedding a mental/behavioral health professional in their practice; however, these mental health professionals need to be knowledgeable about children 0 to 21 years old, and many may not have specific training with very young children. Pediatric practices can also help families nurture young children and build family resiliency that may serve to prevent future maltreatment or trauma exposure as well as buffer the effects of any adversity the child may experience.

Early intervention and family support services

Connecticut has an extensive array of early intervention and family support services, such as Birth to Three, that provides evaluations and services for young children up to age three with developmental delays. Birth to Three staff have been trained to identify social-emotional concerns and behavioral health issues through a variety of targeted trainings. In addition, Birth to Three mental health clinicians are all trained to administer appropriate screening to identify social and emotional strengths and provide caregivers with research-based strategies to promote children's resilience. While these assessments do not screen for trauma exposure or symptoms, they offer a starting point upon which to include screenings for trauma exposure and traumatic stress reactions, which may present as social-emotional challenges.

In addition, Connecticut has five home visiting programs in which staff are trained to work specifically with young children and their families: Early Head Start, Child First, Nurturing Families Network, Minding the Baby, and Parents as Teachers. A number of these home visiting programs are included under the umbrella of the Maternal, Infant, and Early Childhood Home Visiting program that is supported through federal funding (as well as state funding for some programs). These programs work with more than 3,000 at-risk families identified prenatally or perinatally annually, and there is a need for home visiting services for many more families.[39] Although different in scope and programmatic elements, each of these home visiting programs fulfills the goal of providing evidence-based support to vulnerable families that can increase children's well-being, promote positive parenting, prevent future exposure to toxic stress and trauma, and buffer the effects of trauma for children and families.

Case Study 2: Home-visiting mental health intervention (Child First)

This is a case study of a home-visiting clinical intervention for children ages 0 to 6 and their caregivers. The intervention (Child First) was developed to address early childhood trauma as well as intergenerational trauma.

Debbie* and her four-year-old daughter, Kate,* were referred to the Child First program by the DCF after multiple episodes of shared trauma. In Kate's short life, she had witnessed significant ongoing violence both in the home and the community. Additionally, the family had moved several times and Debbie was constantly stressed about food security and reliable transportation. Debbie herself had been neglected and abused as a young child through adolescence, which resulted in her not finishing high school, limiting her to working two jobs to support Kate and her two siblings. At the time of the referral, four-year-old Kate was making no verbal communication with people outside of her immediate family. Kate was also very aggressive in preschool and with family members and had made statements of self-harm. Debbie shared that Kate and her siblings were unlike other children because "they don't really have feelings" and that she was certain there was little she could do change this. The Child First intergenerational trauma lens supported the team in understanding Debbie through the perspective of her own childhood trauma. The Child First approach allowed the team to hold both the experiences and perspective of Debbie and Kate in the engagement, assessment, and treatment.

Through 13 months of meeting weekly with Child First, Kate and Debbie met their treatment goals and Debbie described finding an empathy and love for Kate that she had not known before. The clinician used Child-Parent Psychotherapy to help Debbie process the impact of her childhood trauma on her relationship with her children and to support Debbie and Kate to create a therapeutic space in their relationship. During these therapeutic sessions with Kate and Debbie, the clinician helped mom and Kate put words to their traumatic experiences, and Kate used family figurines, a doll house, and feeling cards provided by the clinician to share with mom how Kate experienced the trauma. The clinician normalized Kate's trauma responses, helped Debbie to join with Kate in her play to acknowledge Kate's experience, and support repair and safety in their relationship and home.

Debbie also worked with the Child First care coordinator to obtain her high school diploma and enroll in a certificate program. Debbie talked openly about how getting her diploma gave her a confidence in her abilities she had doubted in the past. At closing, Kate's aggressive behavior had decreased at home, had disappeared at school, and she was communicating with people outside of her immediate family. Beyond that, the parent and child who had started with the program both looked vastly different; the relationship that once shared rare occasions of connection and limited mutual understanding was now reflective of a parent-child relationship acknowledging the impact of their traumas. Their deep connection was uncovered, and their trajectory shifted.

—Submitted by Flora Murphy, Wheeler Clinic Child First Clinical Director

* Names and details have been changed to protect confidentiality

Child welfare

Connecticut's Department of Children and Families (DCF) is tasked with providing child protection and ensuring children's welfare, primarily through investigating and addressing children's exposure to maltreatment, including abuse and neglect.

- The most recent reported rates show that the number of Connecticut children ages 6 and under who have experienced child maltreatment is higher than national averages. Incidence rates range from 12.5 in 1,000 for children 6 years old to 29.5 in 1,000 children for children under 1 year old.[40]
- Based on their complex trauma histories and unmet health needs, children in the foster care system have been identified by the American Academy of Pediatrics as a population of vulnerable children in need of specialized assessment and treatment services.[41] In 2016, 5,602 children in Connecticut were placed in foster care due to abuse or neglect.[42]
- Children younger than 6 years old are placed in foster care by child protective services (CPS) at higher rates than older children, and infants (0 to 1) enter foster care at higher rates than any other age.

The CPS system is responsible for ensuring the safety of these children, preventing future maltreatment, and identifying appropriate behavioral health and other social services for children and families. Addressing the unique needs of young children who have experienced trauma is of particular importance within Connecticut's child welfare system.

Infant and early childhood mental health settings

Infant and early childhood mental health settings, including community mental health centers and some home visiting services, are in a prime position to provide targeted mental health support to children, including those who are experiencing traumatic stress. In fact, research has shown that early investment in children's mental health can pay off many times over in future cost savings.[43] However, young children are not accessing mental health services at the same rate as older children. In the most recent 2016–2017 National Survey of Children's Health, more caregivers of children ages 3 to 6 who needed mental health services reported that their child was not currently receiving services compared to any other age group. When such services were needed, 70.7% of 3- to 5-year-olds did not receive services, compared to 53.0% and 43.2% of 6- to 11-year-olds and 12- to 17-year-olds, respectively.[44] Of note, estimates for children under age 3 were not gathered. This lack of measurement is indicative of the common misconception that children under age 3 cannot benefit from mental health services. As noted previously, there are a number of mental health interventions available to treat trauma exposure in young children (see Table 2) that are associated with positive child and caregiver outcomes.[45,46] Many of these interventions are already in use in Connecticut; however, there remains a gap in availability and receipt of mental health services for young children.

Case Study 3: Community-based mental health intervention (ARC)

This is a case study of a community-based mental health intervention, Attachment Self-Regulation and Competency (ARC), which is a promising practice designed to treat traumatic stress by addressing the impact of trauma on the caregiver-child relationship.

Riley* was a three-year-old girl who was referred to treatment by the Department of Children and Families. Prior to coming to the clinic, Riley had been removed from her biological parents' home. According to reports from her older brother, their home life had included exposure to parental substance abuse, domestic violence, and sexual abuse. Riley came to treatment with her foster mother, Dana. Dana described Riley as a child who "terrorized" the other children in her home with her constant need for attention and aggressive outbursts. When her demands were not met, she would scream and cry, sometimes for hours. Dana was an experienced foster parent who had opened up her home to numerous children, but she was baffled by Riley's seemingly obstinate refusal to calm down, no matter what comfort was offered.

Dana's work started with education about the impact of chronic exposure to traumatic experiences (such as domestic violence) and neglect on the young child's developing brain. In Riley's family, it was difficult for her to anticipate what would happen next. Witnessing her mother being physically assaulted changed Riley's brain patterns—doorbells, knocks, spoons, backpacks, and other seemingly innocuous objects symbolized terror for Riley. The developmental areas that Riley should be working on, such as dressing herself or going to sleep on her own, were delayed due to her brain needing to reserve energy to be ever-aware of any potential danger signals. Dana came to learn that Riley's brain did not re-wire itself just because she was taken out of her mother's care. Instead, Riley perceived that the worst situation that could happen, did happen: she lost her mother. And Riley's brain failed to prevent that, even though it tried so hard to recognize all the danger signs.

Using ARC, Riley's clinician helped Dana learn to recognize situations or experiences that Riley might not tolerate. Dana learned to attune to warning signs or clues that Riley might be getting ready to "melt down," and utilize an intervention that kept Riley grounded. Dana found this to be incredibly difficult work, as Riley's needs included rigid, consistent routines so Riley could predict what would happen next, and consistent behavioral responses—because not responding the same way she had every other time would result in a behavioral outburst. Riley learned that kids who have experienced scary situations sometimes have "big feelings" or "big behaviors" as a result. She started to recognize times of day or situations that are "hard" for her, and that with the help of Dana, she could learn to reduce the intensity of her emotional reactions. Best of all, Riley learned these things through play, so eventually she also started to catch up on some of the developmental tasks she had fallen behind on.

—Submitted by Erica Mott, LPC, Special Clinical Initiatives Coordinator at Community Child Guidance Clinic, Inc.

*Names and details have been changed to protect confidentiality

If staff in early childhood settings are knowledgeable about and sensitive to the effects of trauma, they can more readily identify problems early on and more efficiently provide trauma-informed support and services.

Trauma-Informed Care: Definition and Components

The growing body of research about the harmful long-term effects of childhood trauma has led to development of the term "trauma-informed care" (TIC) and the creation of trauma-informed systems (see Table 3). The broad goals of TIC are to bring research and best practices for childhood trauma into child-serving systems with the ultimate aim of ensuring optimal outcomes for children at risk of or exposed to trauma. If staff in early childhood settings are knowledgeable about and sensitive to the effects of trauma, they can more readily identify problems early on and more efficiently provide trauma-informed support and services.

Table 3: Key Elements of Trauma-Informed Systems

SAMHSA's four key assumptions of a trauma-informed approach:	• A realization about trauma and its effects; • An ability to recognize the signs of trauma; • Methods to respond to trauma; • Resisting re-traumatization of individuals and staff.[47]
SAMHSA's 10 organizational domains in which a trauma-informed approach can be implemented:	Governance and leadership, policy, physical environment, engagement and involvement, cross sector collaboration, screening/assessment/ treatment services, training and workforce development, progress monitoring and quality assurance, financing, and evaluation.
CHDI's four key elements of trauma-informed systems for Connecticut and other states to consider:[48]	• Workforce development; • Trauma screening; • Practice change and use of evidence-based practices (EBPs); • Collaboration and communication across child-serving systems.

*Note: SAMHSA stands for the Substance Abuse and Mental Health Services Administration

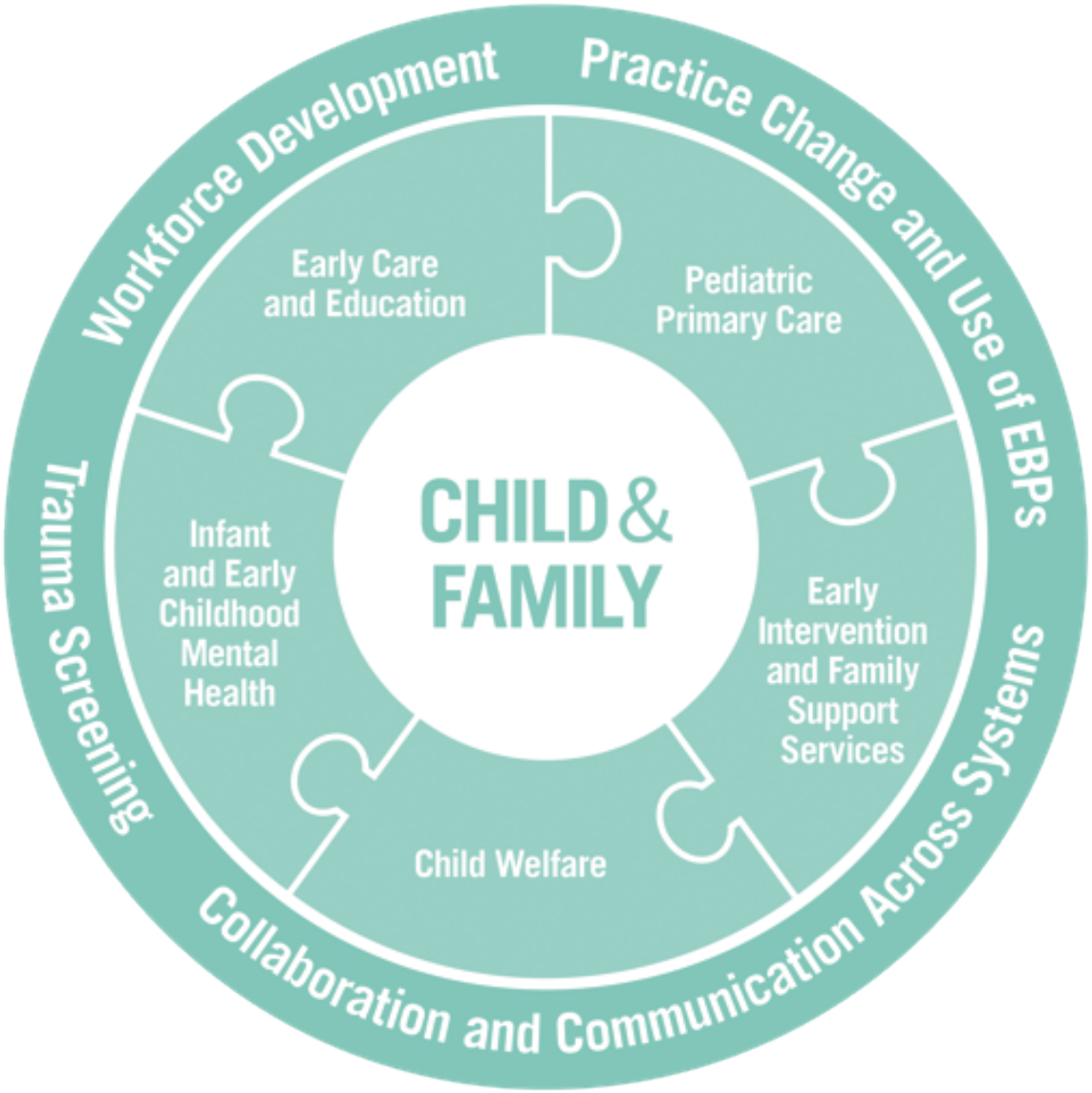
Connecticut has built a robust trauma-informed system for children over the past 10 years. Examples of this work are highlighted in Table 4.

Table 4: Examples of Connecticut's Trauma-Informed Work

- Since 2007, more than 8,000 professionals have been trained to realize and recognize trauma across a number of systems, including law enforcement and behavioral health care providers.
- More than 50,000 children have been screened for trauma and more than 13,000 have been provided trauma-informed evidence-based mental health services.
- The annual number of children receiving trauma-informed EBPs has increased from fewer than 500 in 2009 to close to 2,900 in 2018. Interventions disseminated have included: Trauma-Focused Cognitive Behavioral Therapy, Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems, Child and Family Traumatic Stress Intervention, and Cognitive Behavioral Intervention for Trauma in Schools (CBITS).
- In recent years, Connecticut has also been a pioneer in efforts to create trauma-informed school systems. The New Haven Trauma Coalition has integrated trauma-informed school programming into several schools in Connecticut, integrating workforce development, trauma screening, direct mental health care, and intersystem collaboration.
- Trauma-informed care is one of four core values identified through the Connecticut Children's Behavioral Health Plan.[49] Many trauma-informed efforts for older children, such as the implementation of CBITS in schools and trauma screening for youth in juvenile residential services, are identified as progress in the annual Behavioral Health Plan progress reports.[50]

Despite the great advances in Connecticut's trauma-informed system of care for children, there remains a need to address the specific needs of young children. The four elements outlined by CHDI are used to frame the vision of a trauma-informed early childhood system for Connecticut. As shown in Figure 1, these elements are important in the development of an early childhood trauma-informed system and can be integrated with established models that more broadly support the social-emotional health of young children.

Figure 1: A Trauma-Informed Approach to Early Childhood Systems



Integrating Trauma-Informed Care into Systems Serving Young Children and Families: Highlights, Gaps, and Recommendations

Connecticut has taken many steps to begin building a robust, trauma-informed early childhood system. These efforts include workforce development initiatives, the dissemination of trauma-informed evidence-based practices across the state, and policy changes such as those that support more comprehensive early childhood developmental screening, assessment, and referral. What follows are some of the highlights of Connecticut's efforts so far, organized by the components of CHDI's framework of trauma-informed systems, along with identified gaps and recommendations for future work to promote a trauma-informed early childhood system in Connecticut. Some elements of Connecticut's early childhood system would benefit from more expertise around child development, while other elements would benefit from more trauma expertise. However, all of Connecticut's early childhood systems would benefit from a template for integrating child development and trauma-informed care in effective ways. Building on the existing efforts that support healthy development, strengthening families and promoting the application of TIC will move Connecticut's early childhood system forward for children and families.

Workforce Development

There is currently no comprehensive data describing the individuals who comprise the early care and education workforce, and no federally supported survey of these staff as there is for the K-12 system.[51] In Connecticut, it is estimated that there are 15,860 members in the early childhood teaching workforce serving 224,135 children annually.[52] However, the early childhood system includes other professionals beyond those in the early childhood teaching workforce who are interacting with young children in domains beyond care and education, and it is a challenge to get a clear count of the members of the early childhood workforce.

Childhood systems differ in terms of their training on topics related to early childhood and/or trauma. Some systems, such as early care and education (ECE) settings, already include training and experience with the unique developmental needs of young children, but may not have specific training on the effects of trauma and trauma-informed practices. Other systems, such as child welfare, already have an awareness of the effects of trauma on children, but have not historically had as much professional development about trauma that occurs in infancy and early childhood.

In Connecticut, it is estimated that there are 15,860 members of the early childhood teaching workforce serving 224,135 children.[52]

A key part of workforce development in TIC includes having a healthy, supported workforce where secondary traumatic stress, or distress associated with working with traumatized individuals, is considered. This, in large part, depends on trauma-informed practices being promoted from the top down, where management and leadership within an agency operation incorporate a trauma-informed lens to support staff on the ground. Trauma-informed organizations, systems, leaders, and supervisors support their staff and promote wellness to buffer against potential secondary trauma as well as primary trauma that staff may experience.

Highlights:

- Connecticut is currently benefiting from a five-year SAMHSA grant as part of the National Child Traumatic Stress Network to expand trauma-informed services for children ages birth to seven. The Early Childhood Trauma Collaborative (ECTC) grant reflects a collaboration between CHDI, the Office of Early Childhood (OEC), DCF, and more than ten mental health agencies around the state. The grant provides trauma training to early childhood professionals, such as ECE staff, who provide services to young children and their families.
- OEC, in partnership with Eastern Connecticut State University's Center for Early Childhood Education, has received funding through a MIECHV Program Innovation Award to develop online training modules for home visitors. One of the first modules focuses on trauma in young children and how home visitors can support caregivers and families. The modules are interactive and include video and audio portions, as well as activities and resources. To date, more than 150 providers have been trained in these online modules.
- OEC has rolled out a curriculum for ECE workers on trauma and housing insecurity that was developed by CHDI as a train-the-trainer model. Many of the strategies for working with young children and the ideas of framing behavior are consistent with the Pyramid Model, a model of socio-emotional development used frequently by ECE workers. This training complements the Pyramid Model by providing another level of information so that teachers and educators can also apply a "trauma lens" as one of their tools in the classroom. More than 120 educators and other professionals have been trained so far in this curriculum.
- All staff at the Department of Children and Families (DCF) are trained in the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit, which includes information specific to young children, and DCF has published an *Early Childhood Practice Guide for Children Aged Zero to Five* that includes psychoeducation, resources, and practice guidelines for state child welfare workers.[53] DCF has also provided training to approximately 100 providers in the 2016–2017 year on "Promoting Health and Wellness for Infants, Toddlers, and Preschoolers in Child Welfare" that includes

information on trauma. The training has included child welfare staff and Head Start providers, and DCF has partnered with CT-AIMH in order to continue the training for future staff.[54]

- Connecticut offers trauma-informed training to pediatric primary care practices through CHDI's Educating Practices (formerly known as EPIC) outreach and training program, which includes a module on child trauma screening, identification, and referral.[55] In the past ten years, more than 1,700 pediatric providers in Connecticut have received this training.

Gaps:

- The Connecticut Association of Infant Mental Health conducted a needs assessment survey of 300 providers in the early childcare workforce, including early care and education providers, and found that 95% reported being interested in more training about trauma in early childhood (see Table 5).[56]
- Although Connecticut has made significant progress training pediatricians and behavioral health providers, not all child health providers have received training specific to early childhood trauma.[57]

Recommendations: *Workforce Development*

- All staff in home visiting and caregiver support programs, pediatric providers, and ECE staff should receive training and ongoing support for preventing, identifying, and responding to childhood trauma as well as intergenerational trauma and secondary traumatic stress.
- Agencies and systems can develop internal trauma expertise to supplement the training received by all staff. This can be done by developing a local champion/expert who can support staff who have received basic trauma training.
- Leadership in agencies responsible for early childhood and mental health services would benefit from enhanced access to early childhood trauma-informed training as well as resources for developing trauma-informed policies at the agency level. This will ensure that trauma-informed practices are sustained and supported.
- Higher education can incorporate education about trauma into early childhood training programs as well as early education and administration curricula.

Trauma Screening

Systematic methods for identifying children exposed to trauma and who are suffering from traumatic stress is an important component of a trauma-informed system. Screening provides an opportunity for early identification of trauma exposure and its potential effects. Without the direct questions included in screening, most trauma is unknown or not disclosed by caregivers or children. The best practices for screening are being followed when providers screen for and talk about exposure and traumatic stress reactions, which allows for engagement with caregivers to provide information about trauma, and also allows for professionals to normalize traumatic stress reactions, instill hope for recovery and healthy development, and ensure appropriate service referrals are discussed.

This may also offer an opportunity for the provider to talk with caregivers about their own trauma history. The NCTSN has listed several empirically supported measures that screen for child trauma and are appropriate for young children (https://www.nctsn.org/what-is-child-trauma/trauma-types/early-childhood-trauma/screening-and-assessment).

Highlights:

- Child First routinely screens for early trauma exposure as part of their intake and ongoing assessment, using the Traumatic Events Screening Inventory for Children-Parent Report Revised[58], which asks caregivers about children's experiences of maltreatment and other potentially traumatic events. Child First also screens caregivers for their own trauma exposure. Screenings indicate high rates of childhood trauma exposure in these programs: 85% of children and 98% of caregivers involved in Child First have experienced one or more traumatic events.[59]
- CHDI has developed and is testing a brief trauma screen (the Child Trauma Screen–Young Child) for children from three to six years old, which includes trauma exposure and traumatic stress reactions. This screen is intended for children in any system or setting and is being used by DCF to screen all children 3 to 6 years old who are placed into foster care as part of a multidisciplinary evaluation.

Gaps:

- Pediatric primary care settings in Connecticut currently are not reimbursed for trauma screening. While medical professionals can get reimbursed for developmental and behavioral health screening, there is not currently a mechanism to reimbursement for trauma screening.
- Research suggests that pediatricians may feel less comfortable assessing for PTSD than some other childhood mental health disorders and that consistent use of empirically supported trauma screening tools is rare.[60] Pediatrician-reported barriers to screening for behavioral health problems include limited time, insufficient knowledge, and a perceived lack of specialists as referral resources.[61] Currently, Birth to Three providers do not screen for trauma, despite screening more than 9,000 infants and toddlers and providing additional services to over 5,000 children in Connecticut per year.[62] There are more than 500 Birth to Three staff in Connecticut[63] who may benefit from trauma-informed training, including how to identify children who may be suffering from traumatic stress.

Recommendations: *Trauma Screening*

- Require Medicaid and commercial insurers to reimburse for trauma screening in pediatric primary care, in the same way that developmental and behavioral health screenings are currently reimbursed.
- Implement developmentally appropriate early childhood trauma screening by providers who interact with young children, particularly pediatric providers, Birth to Three staff, parent support staff, child welfare, and ECE staff. Provide training for staff to talk with caregivers about trauma, interpret and share results of screening measures, integrate knowledge about trauma into care plans and day-to-day activities, and provide basic information about trauma as part of the screening process. Explore opportunities to utilize the same screen across systems so that there is consistency in screening practices, and to share results across systems when permitted.

Table 5: Results of a Trauma Needs Assessment Among Early Childhood Staff

In 2017, the Connecticut Association for Infant Mental Health (CT-AIMH) completed a needs assessment, funded by the Early Childhood Funder Collaborative, that included a survey of 290 providers who serve children ages 0 to 6 across Connecticut. The purpose was to gain an understanding of the trauma-related needs of the early childhood workforce, including child care providers, home visitors, medical providers, and others.[64] Key findings included:

Trauma training:

- 82% of respondents reported that they had received some training on definitions and types of trauma
- 75% of respondents reported that they were interested in additional training on definitions and types of trauma

Screening:

- 51% of providers reported that they had not received training on screening for trauma and were interested in such training

Barriers to screening for trauma:

- Lack of staff trained in screening and referring for trauma (42%)
- Lack of education regarding the importance of screening and referring (30%)
- Lack of access to qualified service providers (29%)

Practice Change and Evidence-Based Practice

Within systems that are trauma-informed, all practices and services should incorporate current research and knowledge about trauma. This includes incorporating best practices related to trauma into existing programs as well as offering evidence-based trauma-specific practices, when possible. This also includes initiatives to prevent trauma exposure, particularly abuse and neglect, as well as to address the intersection of poverty and trauma-exposure.

Highlights:

- DCF has funded several trauma-informed therapeutic preschools within the state that serve children who are in the care of DCF and who have struggled within traditional preschool settings. These preschools have a smaller child-to-staff ratio, a dedicated social worker, and a focus on promoting attachment and relationships.[65] Staff are also trained in Attachment, Self-Regulation, and Competency (ARC), a promising practice developed for addressing childhood trauma exposure within a number of different settings (see Case Study 1 for a "day in the life" of a trauma-informed preschool).
- Child First is a trauma-focused home visiting model developed in Bridgeport, Connecticut, to address the unique needs of young children exposed to trauma and other ongoing stressors, such as those related to poverty. In a randomized controlled trial, caregivers receiving Child First services had lower parenting stress scores, and children had better outcomes compared to a comparison group. Child First families were less likely to have child welfare involvement following participation in the program than children in typical care, suggesting that home-visiting, trauma-focused services can also serve as a preventive intervention.[66] Annually, Child First serves 1,000 or more families and is currently funded in part by DCF and OEC.[67]
- Funding from the ECTC initiative is supporting dissemination of early childhood, evidence-based mental health interventions in outpatient settings across Connecticut. The first model disseminated was ARC. To date, 86 clinicians across 12 agencies have been trained in ARC and more than 270 children and their caregivers have received treatment. A statewide train-the-trainer program is currently underway to further develop capacity for training new staff in ARC. At the end of 2019, ECTC will begin training providers in Child Parent Psychotherapy.

Gaps:

- The majority of children receiving trauma-informed evidence-based treatments in Connecticut are ages 7 and older; fewer than 8% of children are 6 or younger.
- Many outpatient mental health agencies in Connecticut do not serve children younger than 4 years old because current Medicaid reimbursement practices require a diagnosis, and many very young children may not meet diagnostic criteria despite suffering from symptoms of trauma exposure.

Recommendations: *Practice Change and Evidence-Based Practice*

- State agencies can provide additional support to programs that promote health, socio-emotional development, resiliency, and child maltreatment prevention and recognize the importance of such interventions as part of a trauma-informed early childhood system.
- OEC and early childhood partners can evaluate evidence for and feasibility of increasing access to trauma-informed preschool programs and trauma-informed school-based services for young children.
- The Department of Social Services (DSS) can create a Medicaid billing code for "toxic stress," or a similar designation, so that young children who are at risk due to trauma exposure but do not meet criteria for a diagnosable mental illness can receive preventive mental health interventions provided by licensed outpatient mental health providers.
- Medicaid and commercial insurance can use the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) to conduct a crosswalk of DC:0-3 diagnostic criteria with existing diagnostic systems to enable providers to bill for early childhood services. DC:0-3 is a developmentally based diagnostic system for children ages 0 to 3 developed by Zero to Three. In 2016, DC:0-3 was revised and adapted for children ages 0 to 5 (DC:0-5).
- Community-based outpatient mental health clinics can increase the number of mental health providers trained in early childhood trauma-informed interventions. Mental health agencies, particularly those receiving DCF support or Medicaid reimbursement, should have clinicians trained in early childhood trauma treatment (see Table 2). Based on the developmental needs of young children, interventions for young children who have experienced trauma must include both the child and caregiver(s) in the child's treatment and should also include the opportunity for caregivers to address their own trauma.
- State legislators can support legislation to reduce the number of young children and families living in poverty in Connecticut, and to address the intersection of trauma and poverty. Initiatives such as paid family and medical leave can help to reduce family stress and improve attachment relationships.[68]

Collaboration and Communication Across Early Childhood Systems

Developing effective strategies for collaboration and communication between providers that interact with or are part of early childhood systems is an important step towards developing a continuum of trauma-informed care for young children. Collaboration ensures that families receive coordinated care while avoiding duplication of services. A trauma-informed system that is working well ensures that all child-serving sectors are speaking the same "language" with families about trauma and the effects of trauma. This common language ensures that families receive compatible, rather than repetitive or contradictory, messages and services from their providers, and that providers can more easily and effectively communicate with each other about trauma-related care.

Highlights:

- The Office of Early Childhood (OEC) was established in 2013 with the goals of creating a *cohesive, high-quality early childhood system*. The OEC oversees many of the programs listed above, such as workforce development for ECE and federal and state funding for home visiting programs. This office demonstrates a state-wide commitment to early childhood that is an important foundation for a trauma-informed early childhood system.
- Child Development Infoline (CDI) and Help Me Grow (HMG) are two cross-system referral systems already in place within Connecticut that can be leveraged to support young children affected by trauma. CDI is operated by the United Way of Connecticut and is a phone line that caregivers can call to ask questions about development of children of all ages. CDI can provide information on child development to caregivers and make referrals for children to appropriate services. HMG is an infoline that connects parents to developmental screenings and community-based developmental promotion services for their children. These referral systems already work to connect caregivers with other early childhood systems (such as Birth to Three and home visiting programs). Since HMG and CDI are housed within the 211 system, other family needs, such as caregiver mental health, can also be met.

- In 2014, Connecticut was chosen as one of six national demonstration sites to implement a federally funded, research-based infant-toddler court team based on the Safe Babies Court approach. The initiative was implemented through the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT). The Safe Babies Court approach is typically initiated by judges and includes training and resources on trauma as well as the development of a collaborative, cross-systems team that can work to support a young child in foster care and his or her family. Evaluation results indicate that children who had access to such a team had quicker exits from the foster care system and higher rates of reunification with caregivers than children who did not.[69] The Safe Babies Court approach represents a shift in court practices that takes into account the development, attachment, and well-being of young children and the need for multiple systems (e.g., court, child welfare, community mental health agencies) to work together to support young children and families. The QIC teams are operated by ZERO TO THREE and partners, and are funded by the United States Administration on Children, Youth and Families, Children's Bureau.
- In 2018, the statewide *Childhood Conversations and Together We Will* conference for ECE providers focused on trauma as the conference theme, which included discussions about creating a trauma-informed system. The 2019 conference also include a focus on trauma, highlighting its role in the larger theme of supporting and developing social-emotional skills in children.
- CHDI's ECTC grant is working to increase collaboration and communication between ECE and mental health agencies by training ECE providers to recognize trauma and to refer families to services when necessary, as well as training mental health providers in early childhood, trauma-informed interventions.

Gaps:

- Funding for QIC-CT has been cut in some cities and the court-based intervention has not been widely researched or disseminated across Connecticut.
- The insufficient workforce training on early childhood trauma mentioned above makes it difficult for agencies and systems to collaborate, as they may not all be equally versed in recognizing and responding to trauma. Limited cross-training opportunities have been available for staff working in different systems.

Recommendations: *Collaboration and Communication Across Early Childhood Systems*

- Establish or use an existing early childhood advisory group to inform the Children's Behavioral Health Plan Implementation Committee on issues of early childhood central to trauma.
- State agencies and early childhood stakeholders can develop a "data dictionary" of common trauma-informed terms that can be used across systems and used in trauma trainings to support a cohesive language across systems related to trauma and trauma-informed care.
- State agencies, early care and education settings, and other stakeholders can identify and attend cross-training opportunities that allow staff from different systems and programs to learn about trauma together, including how to share information and collaboratively develop plans of care.
- Child development referral systems (e.g., Help Me Grow, Child Development Infoline) can train early childhood service providers, such as educators and pediatricians, in helping parents use these referral systems to address concerns about early childhood trauma and trauma-related symptoms.
- Early childhood programs can develop a list of local partners/organizations with expertise in trauma (e.g., by soliciting staff input and informally surveying community organizations) to establish referral guidelines for improving local cross-system collaborations.
- Support better cross-agency longitudinal data collection that can examine child outcomes beginning prenatally through childhood to better identify efforts associated with children's well-being, including the Early Childhood Information System being developed by OEC. This will help with the evaluation of long-term outcomes and cost-savings associated with trauma-informed early childhood interventions over time.
- State agencies can identify and collect information about the effectiveness of practices that support collaboration across early childhood systems for young children who have experienced trauma, such as QIC-CT teams.

Conclusions

Like children in all states, young children in Connecticut are affected by trauma, and it is also clear that many services and supports exist and can buffer against the risks associated with trauma exposure. Connecticut is beginning to develop a comprehensive trauma-informed early childhood system of care. This approach requires working across systems, including early care and education, health care, early intervention and family support services, child welfare, and infant and early childhood mental health. These systems each have different needs in terms of workforce development, screening for trauma, use of evidence-based trauma-informed practices, and greater collaboration and communication between child-serving systems.

In terms of workforce development, providers across all of these systems can receive training in trauma and gain an understanding of the existing trauma-focused interventions and supports that are available to young children and their families. Screening for trauma can be integrated with other regularly occurring developmental and behavioral screenings. Further, screening and treating young children for trauma could be supported by changes in policy, making it easier for providers to receive reimbursement for these services. Changes in billing codes would allow for preventive services to be delivered to young children who are at risk but do not yet meet the criteria for a diagnosis. Evidence-based practices are available for young children suffering from the effects of trauma, but there are limits in terms of capacity and access to services.

There are many opportunities to build on the progress made so far, such as leveraging existing support from systems already working to enhance the well-being of Connecticut's young children and enhancing the capacity of the trauma-informed workforce to respond to the unique needs of young children. Intervening to buffer the effects of early childhood trauma can support the well-being of Connecticut's children and families and can have a lasting and meaningful impact on the overall health and well-being of Connecticut's population for years to come.

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