LOTUS VILLAGE CHILDREN'S WELLNESS CENTER INNOVATION PROJECT: BRIEF REPORT

A PORTRAIT OF NEEDS AND OPPORTUNITIES

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PREAMBLE

With the very humblest of beginnings in a partially renovated, aging apartment building in the heart of the historic African American district of Overtown, the Lotus House Women's Shelter opened its doors over a decade ago to women who lived on the streets. Word spread quickly of a new homeless shelter for women and soon Lotus House was overflowing with women and youth desperate for refuge, clinging to the possibility of a better way of life. Lotus House has since grown because turning away those we cannot help for lack of capacity is still the hardest thing we do. Thus, thanks to the generosity of so many in our community, we await the blossoming of our all new Lotus Village, a state-of-the-art, comprehensive homeless services facility with expanded capacity to shelter 500 women and children nightly and provide wrap-around services. Because it will include a wide range of embedded services tailored to the needs of those we shelter, this new facility will be the first of its kind on a national level.

We are indebted beyond measure to The Children's Trust for believing in this vision and for helping to shape, structure, and guide the planning process of the Lotus Village through an Innovation Grant that has allowed us to research the child care, education, and mental health needs of our sheltered mothers and children and identify evidence-based best practices for the Children's Wellness Center that will be an integral part of the Lotus Village.

Deep Bows to The Children's Trust,
Constance Collins, Executive Director
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CONTENTS

INTRODUCTION

Background.   Since 2006, Lotus House has provided shelter and holistic support services for women, children, and youth experiencing homelessness in the Overtown neighborhood of Miami, Florida. Redeveloped to become Lotus Village, the Village will be a state-of-the art comprehensive homeless services facility of 500 beds and dedicated spaces for counseling, resource coordination, social services supports, an in-take sanctuary, general health and dental clinics, a child center, computer room, library, salon, art and activities lab, children's play areas, working classroom kitchen, and extensive community activities spaces and gardens.

Purpose.   The purpose of this report is to present research-based recommendations for the early care and education components of the Children's Wellness Center, in Lotus Village which will provide trauma-informed, therapeutic early care and education that integrates healing and developmental services for children and mothers experiencing homelessness. Services will include child and parent therapy, and parenting education delivered for the purpose of strengthening and empowering families.
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Data Collection.   This report was generated as a result of literature review as well as input from key informants and stakeholders including resident mothers, staff, professors, researchers, program administrators, and child psychologists. Professionals had expertise in the areas of infant mental health, the promotion of social and emotional development of at-risk children, trauma-informed treatment, and classroom design. The research team also visited seven community-based programs that served clients experiencing homelessness, leveraged partnerships, offered program-wide mental health supports, operated on extended hours, and/or operated with a continua of approaches.

Report Organization.   Part I of the report describes the pressing needs of mothers and children experiencing homelessness. Part II of the report presents core principles of Lotus House services and Part III presents objectives and activity recommendations for the Children's Wellness Center.

PART I.   NEEDS: HOMELESSNESS IN OUR NATION AND ITS CONSEQUENCES

Children and families are the fastest-growing group of people experiencing homelessness in the United States. Although homeless counts vary, the National Center on Family Homelessness estimates a historically high 2.5 million children in America experience homelessness annually (Bassuk, DeCandia, Beach, & Berman, 2014 citing U.S. Department of Education, 2014; Tobin & Murphy, 2013). Among those seeking shelter nationally, children ages birth to five are the age group most likely to experience homelessness. The average family experiencing homelessness is headed by a single mother from a minority group who typically has children under age six (Tobin & Murphy, 2013). Polakow (2007) characterizes the vulnerability of single mothers and their young children as a "child welfare crisis of growing magnitude" (p.40). In addition, the average woman heading a family experiencing homelessness is under age 30 (Tobin & Murphy, 2013 citing U.S. Department of Housing and Urban Development). Relative to other mothers from the general population, young homeless mothers experience increased risk of depression, suicidal ideation, substance abuse, trauma exposure, and post-traumatic stress disorder (PTSD) (U.S. Department of Health and Human

Services, U.S. Department of Housing and Urban Development, U.S. Department of Education, 2016).

EFFECTS ON CHILDREN

Homelessness affects children directly by being a chronic stressor that disrupts their daily routines, safety, food security, as well as family, school, social and community ties (Bassuk et al., 2014). When it occurs in early childhood, homelessness is associated with delays in children's language, literacy, and social-emotional development (U.S. Department of Health and Human Services et al., 2016 citing Ziol-Guest & McKenna, 2014; Obradovic et al., 2009). At any age, children who experience homelessness are more likely than other children to have mental health, behavioral, and developmental problems (Brown, Shinn, & Kanduri, 2017; Lynch et al., 2015; U.S. Department of Health and Human Services et al., 2016).

Homelessness also affects children indirectly through the effect it has on mothers and the stress, anxiety, and depression that it often causes mothers. These affect the mother as well as the mother-child relationship (Averitt, 2003; Center on the Developing Child at Harvard University, 2009; Commission on Social Determinants of Health, 2008; Cosgrove & Flynn, 2005; Kingston, Tough, & Whitfield, 2012).

To compound effects, homelessness does not occur in isolation. Instead it is typically linked to additional factors that affect children negatively. These compounding stressors might include domestic violence, neglect or abuse, familial substance abuse, separation from family members, incarceration of a family member, and all the consequences of low family income such as poor access to health care, food insecurity, and a disparity evident to homeless children between the resources and goods available to them and those available to other children (U.S. Department of Health and Human Services et al., 2016).

Reactions to stressors and to stress thresholds vary widely and whether homelessness is a temporary disruption or a toxic stressor for a given child depends on a large number of individual and environmental factors, some protective, and some damaging.   Notwithstanding personal variability in responses, children who experience trauma, and particularly those who experience compounded trauma may struggle with self-regulation and impulse control, "often have difficulty identifying, expressing, and managing emotions," and may have "limited language for feeling states" and "unpredictable or explosive" emotional responses (The National Child Traumatic Stress Network, n.d., p.2).

PART II: AN OPPORTUNITY TO REDRESS DAMAGES

During the period of birth to age three, a child's brain produces 700 new neural connections per second (Zero to Three, 2017a) while simultaneously eliminating synapses and receptors through an "interactive process between genetic programming, cell function, and the environment" (Andersen, 2003, p.9). This plasticity in development provides an opportunity to redress damages and affect brain architecture in a positive manner (National Scientific Council on the Developing Child, 2007; Shonkoff, 2010) through supportive, secure, safe, and stimulating relationships in order to benefit social, emotional, and cognitive development (National Scientific Council on the Developing Child,

2012; Reyes & Lieberman, 2012).   In practical terms this means immersing children in a positive and nurturing environment while identifying deficits or damages and addressing those directly. Hence, protective factors, such as quality early childcare and education as well as therapeutic supports extended through the transition to independent living, can do much to set children's development in an appropriate course.

A STRENGTH-BASED EMBEDDED APPROACH TO ASSISTING FAMILIES

Equally important to the positive direct effects that intervention can have on children are the effects that a strength based environment and effective case management can have on mothers and the mother-child relationship (Hatton, 2001; Heslin, Andersen, & Gelberg, 2003). The fields of human services and education support the use of a strengths-based approach for assisting families as the most appropriate and effective way of improving families' quality of life (Xie, 2013). Strengths-based partnerships with families shift foci from problems, pathologies, and deficits to a focus on recognizing, affirming, drawing upon, and enhancing strengths and resources in children, families, and communities (Bryan & Henry, 2008; Huffman, Black, Bianco, Cohen, & Usher, 2008; Xie, 2013). Bryan and Henry (2008) describe strengths-based partnerships as utilizing resources in schools, families, and communities to build protective and empowering environments. These partnerships between service users and service providers value the knowledge each party possesses, allow for mutually established goals, and attend to the impacts of context (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). The partnerships create welcoming environments that are respectful to participants' needs for safety, respect and acceptance, as well as promote developmental assets and protective factors such as resiliency, social support networks, high expectations, and opportunities for meaningful participation (Bryan & Henry, 2008). For women to engage in a reality-based empowerment is an important cognitive shift that is necessary to resolve homelessness (Finfgeld-Connett, 2010).   This type of partnerships will be developed in the Children's Wellness Center through case management, childcare, education, and mental health services.

REDRESSING DAMAGE THROUGH CHILDCARE AND EDUCATION

High quality early care and education programs are characterized by supportive environments that have high rates of positive interactions, low rates of negative interactions, and are cognitively and physically stimulating at developmentally appropriate levels. In these settings, teachers are knowledgeable and skilled, implement an established curriculum with set routines, include assessment to guide instruction, display positive leadership, and support health in safe environments. In these care environments, teacher-child interactions are developmental assets that buffer the undermining effects of prior negative experiences (Mortensen & Barnett, 2016). Such programs establish strong family and community relationships (National Association for the Education of Young Children, 2016; Schulte & Durana, 2016). High quality childcare also predicts cognitive-academic achievement and few reports of externalizing behaviors in adolescence. Indeed, positive effects of care and early education escalate at higher levels of quality (Vandell, Belsky, Burchinal, Steinberg, & Vandergrift, 2010).   In addition, a consistent body of evidence suggests that high quality programs yield the greatest benefits for at-risk populations (Anderson et al., 2003; Barnett & Lamy, 2013; Burchinal et al., 2008; Campbell & Ramey, 1994; Currie, 2001; Darling-Hammond, 2010; Halle et al., 2009; Love et al., 2005; Peisner-Feinberg et al., 2001; Ramey et al., 2000). The quintessential example of high quality early care is the Abecedarian project, a randomized efficacy study of early intervention for at risk families, which demonstrated that high-quality, consistently

available early education persistently affected child cognitive outcomes and maternal educational advancement and employment, especially for young mothers (Ramey et al., 2000). Moreover, high quality care may especially favor children experiencing homelessness by providing a sense of consistency during a time of disrupted routines (Brown, Shinn, & Khadduri, 2017 citing Schteingart et al., 1995).

Embedding a therapeutic childcare center in a homeless shelter will meet the needs expressed by Lotus House mothers in a series of focus groups for accessible, affordable high quality care so that they can put their lives on their desired tracks. Being in the same facility as the residence, an in-house center gives staff the opportunity to provide support, provide prompt assessment of at-risk children, and build meaningful partnerships with mothers and children. Thus, the provision of a comprehensive support system embedded within Lotus Village addresses what Polakow (2007) describes as the "triple crisis confronting single mothers" (p.41) on the brink of or experiencing homelessness: lack of affordable housing, lack of healthcare, and lack of childcare.

REDRESSING DAMAGE WITH MENTAL HEALTH-SUPPORTIVE APPROACHES

Embedding additional therapeutic support services in the Lotus Village such as counseling and parent education similarly eliminates barriers to accessibility. Swick and Williams (2006) use Bronfenbrenner's (1979; 2005) ecological systems perspective to advocate for supporting families from their most personal relationships to the institutions and systems they encounter.

Mental health therapy for children provided as part of center-based early education programs incorporate the following best practices. One termed **trauma-informed services**, is applicable to almost any program. It acknowledges that trauma can substantially affect individuals' mindsets, actions, and well-being. It requires that staff recognize the effects of trauma and that staff respond in ways that convey acceptance of individuals, openness, and empathy. It entails the creation of safe environments for survivors to rebuild a sense of control and empowerment (Administration for Children and Families, Substance Abuse and Mental Health Services Administration, Administration for Community Living, & the U.S. Department of Health and Human Services., n.d.).

A second best practice, **motivational interviewing**, has been effective across settings and frameworks at supporting people with mental health and substance abuse disorders to make healthy behavioral changes. Through the interview process clinicians help clients establish goals and identify motivations take will galvanize them to undertake the actions necessary to accomplish those goals. This psychotherapeutic approach aims to empower people with techniques that include: "expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy" (Substance Abuse and Mental Health Services Administration, n.d; Zero to Three, 2016, p.26).

A third best practice, **reflective practice** is a "staple of ongoing support" for early childhood mental health consultants (Zero to Three, 2016, p. 26). Influenced by Reggio Emilia, reflective practice is a continuous, collective, and constructive meaning-making process engaged in by children and adults alike that sets the stage for all interaction (Paige-Smith & Craft, 2011). It is the practice of reflecting on one's own actions in order to support continuous learning. Reflection is a dialogic process that includes listening to oneself as well as listening and being listened to in relationship with others (Paige-Smith & Craft, 2011 citing Rinaldi, 2006). Environments that follow this practice are collaborative, founded on trusting-honest relationships that are safe, calm, and supportive (Gilliam,

2016; Zero to Three, 2016). Given these safe environments, self-awareness, careful observation, and flexible responses are fostered such that staff are empowered to assess their own work, strengths, and vulnerabilities such that it is able to generate mid-course adjustments to programs and to their practices if these are necessary (Emde, 2009; Zero to Three, 2016; 2017b).

An additional methodology that lends itself well to early childhood settings is to organize strategies and interactions into tiers on the basis of children's needs. This concept is the basis of the **Pyramid Model** (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky, & Fox , 2006; Kiron, n.d.). The base of the pyramid represents universal strategies for all children. Moving up the pyramid are increasingly specialized services for children who require targeted, coordinated supports such that the top of the pyramid represents individualized interventions for children who persistently exhibit challenging behaviors (Cimino, Forrest, Smith, & Stainback-Tracy, 2007; Hemmeter, Fox, & Snyder, 2014; Hemmeter, Snyder, Fox, & Algina, 2016). The model emphasizes the promotion of emotional literacy and the development of prosocial behavior through intentional social emotional supports.

 Thus, **trauma-informed services, motivational interviewing, reflective practice**, and **The Pyramid Model**, are commonly used evidence-based frameworks and resources of the Early Childhood Mental Health Consultation Programs (Zero to Three, 2016) which team mental health professionals with early care and education professionals to improve child behavior, child mental health and development, staff skills, and reduce staff stress (Gilliam, 2016). With these supports, children's outcomes are improved, staff satisfaction is enhanced, and staff turnover is decreased (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010).

EVALUATING PROGRAM EFFECTS AND CONTRIBUTING TO SCIENCE

To ensure that program objectives are met and programs undertake continuous improvements, at the Lotus House, programs that serve children and families include an evaluation component. Evaluation assesses program implementation, its intended and unintended effects, and results in feedback to decision makers at regular and logical intervals that allow for corrective actions if these are necessary. Also, because there is limited empirical evidence on the status and outcomes of families experiencing homelessness, our programs include a research component that has been established through a research-program partnership, i.e., collaboration between practitioners, program leadership, evaluators, and researchers, (Stein, Freel, Hanson, Pacchiano, & Eiland-Williford, 2013). For these components, data collection and utilization are embedded, collaborative, and comprehensive (Yazejian & Bryant, 2013). They are used to support clear, consistent, structured processes and protocols that inform reflective, responsive, and continuous cycles of informed growing, learning, and evolving. Thus, evaluation measures and assesses program effects. Research contributes to science by adding knowledge heretofore unknown or not verified about the population at large, not simply the specific group, generating knowledge generalizable beyond the specific group under study. In other words, research addresses the implication of obtained effects for the wider population.

PART III. SPECIFIC OBJECTIVES AND ACTIVITIES OF THE CHILDREN'S WELLNESS CENTER

Through a review of the literature on the needs of children experiencing homelessness and ways to address these, the reviewers identified four objectives and associated activities that would serve to strengthen families and enable them to transition to independent lives. A summary of these follows and readers who wish additional details may access the full report through this link.

1.   Create a comprehensive center for children.

2.   Provide therapeutic supports for families.

3.   Ensure continuous quality improvement through research and evaluation.

4.   Become a hub for engagement and demonstration.

OBJECTIVE 1. CREATE A COMPREHENSIVE CENTER FOR CHILDREN

To develop a model trauma-informed, therapeutic, early childcare and education center embedded within Lotus House utilizing innovative, promising best practices to support and promote the physical, socio-emotional healing, health, wellbeing, and school readiness of children in families experiencing homelessness.

Activities:
1.   **Partnership**. The staff shall continue to form a strengths-based partnership with families that acknowledges the primacy of families in promoting their child's learning and development and recognizes and values their expertise and contributions (Halgunseth, 2009; NAEYC, 2016). To ensure that children receive needed medical, psychological, and educational services in a culture that invites, engages, validates, and empowers mothers, each child's care team will include the child's mother and child-relevant professionals (e.g. teacher, transition coordinator, disabilities specialist, legal services, and/or healthcare partner) (NAEYC, 2016; Swick, 2004). Teams will use action plan goals, coordinate services, review results of services, and chart progress toward established personal goals.

2.   **Staff Competence.** The leadership will recruit, train, and support staff to be responsive to the unique needs of children and families. All teachers shall have at a minimum a Bachelor's degree in early childhood, course work in special education, and ESOL endorsement. In addition to having the same minimum credentials as teachers, the Wellness Center Director shall have a record of several years of being an excellent early childhood teacher and shall be highly skilled at motivating and leading staff in a way that is professional and empowering. All assistant teachers shall have a current Child Development Associate credential as well as training and/or coursework focused on infant and toddler development (Head Start Performance Standards, 2016). Staff shall have basic working knowledge of the relevant therapy modalities in which mothers and children participate, shall reflect the linguistic and ethnic composition of the families at Lotus House, and be skilled at building relationships with families. As evidenced through supervisory observations, staff shall demonstrate

competence in managing the full range of child behaviors; from highly disruptive to extremely withdrawn, from precocious to developmentally delayed or atypical, and do so in ways that are respectful of the child and promote self-regulation. Staff shall see children as individuals and have a sharp eye for their needs so that they can adapt interactions and responses to students' emotional needs, shifts in mood, or non-verbal cues (Thistle-Elliott, 2014).

3. **Professional Development**.   The Children's Wellness Center director shall conduct unannounced classroom observations on an ongoing basis at irregular times and structured observations with an established instrument every 6 months and will use observations to determine professional development needs. Professional development, shall be ongoing,, inclusive, and responsive to observed needs. Associated mental health professionals shall assist with the professional development efforts for early childhood education and care staff to ensure that classroom practices are consistent with the content of therapeutic practices. They will ensure that staff is trained to recognize signs of trauma and can engage in interactions consistent with the recovery process to actively resist re-traumatization (SAMHSA, 2015). Because caring for and listening to the stories of children and families who have experienced trauma places huge demands on the emotional well-being of caregivers (Knitzer & Lefkowitz, 2006; Osofsky, Putnam, & Lederman, 2008), staff's mental health needs will be supported with monthly group counseling sessions led by a Lotus Village mental health provider and individual sessions if needed. Additional supports can integrate and structure reflective processes, including reflective supervision and mental health consultation (Gilkerson, 2004; Knitzer & Lefkowitz, 2006).

4. **Curriculum**.   The Center shall have curricula and practices with the following characteristics.

   a. The curriculum, such as *The Creative Curriculum for Infants, Toddlers, and Twos* (Dodge, Rudick, & Berke, 2006; Teaching Strategies, 2014), shall be developmentally appropriate to promote children's social, emotional, physical, language, and cognitive development, and shall incorporate the *Pyramid Model for Promoting Young Children's Social-Emotional Competence* (Fox et al., 2003; Hemmeter et al, 2006) as well as regular assessment of children's growth in skills and abilities (Mackrides & Ryherd, 2011).

   b. Maintain small group sizes, i.e., low student-teacher ratios, that allow teachers to give each child the attention that is necessary, promote children's sense of safety and security, and as such affect favorably children's exploration, play, and learning (Maguire-Fong, 2015).

   c. Assign each child to a teacher who will function as the children's primary caregiver while children are at the Center, i.e., not with their mothers. This person will serve as s a single point of contact for all education-related matters, will be a member of the child's care team, work in close cooperation with mothers and child/family therapists, and develops a close partnership with the child and family.

   d. Create a peaceful physical and emotional environment that includes intimate spaces for children to collect themselves, a dedicated family room for breastfeeding or for mother and baby break time, space for family and staff meetings, and space for support services. The space shall be orderly and dynamic to invite child open-ended

exploration, discovery, interaction, and problem solving (American Montessori Society, 2017; NAEYC, 2016, 2017; Wurm, 2009) as well as promote responsive social interactions that support social emotional development (Bovey & Strain, 2000; Hunter, Blackwell, Allard, & Lucerno, 2011; Weinberger, 2000)

e. The Center shall embody the shelter's welcoming, inclusive, and trauma-informed environment**.** Anti-bias practices shall promote respect for human differences and a sense of pride in children and their families (Derman-Sparks & Edwards, 2010) because when someone's own self-worth is affirmed, they are less likely to judge others negatively (Fein & Spencer, 1997). Also, to counter the stereotypes and biases that young children develop (Baron & Banaji, 2006; Winkler, 2009), staff should provide children with examples and visuals depicting roles, abilities, and ethnic or cultural backgrounds that defy stereotypes (NAEYC, 2017).

OBJECTIVE 2. PROVIDE THERAPEUTIC SUPPORTS FOR FAMILIES

To provide holistic, therapeutic, health, educational, and community supports for the families' physical, socio-emotional healing, health, and wellbeing.

Activities:
1. **Embedded Services**.   The Center will include embedded community resources by establishing community networks and systems with therapeutic providers and quality early care and education providers such as Early Head Start, Head Start, and Miami-Dade County Public Schools.

2. **Transition Coordinator**. As part of the care team each family will be assigned a transition coordinator at intake whose job will be to assist families to plan and implement transitions as well as follow up after the family has transitioned from Lotus House. Also, the transitions coordinator will support children's emotional wellbeing by identifying for the children familiar aspects of new routines and/or environments, teaching children expectations of the new setting, ensuring that children have the tools to express needs and ask for help, as well as plan the continuation of early care/education and therapeutic services once families move to independent living arrangements (Fabian & Dunlop, 2007).

3. **Status Assessment**. Staff shall conduct assessments of children's developmental, social, and emotional status as well as assessments of mothers' and children's interactions to understand their strengths and needs, to guide subsequent therapy, and to determine the need for subsequent referrals. Assessment Instruments shall include:

   a. *Battle Developmental Inventory Screening Test* (BDIST) (Ringwalt, 2008) for children 6 months to 8 years of age, is intended to identify children at-risk for delay and in need of a comprehensive evaluation.

   b. *Dyadic Parent-Child Interaction Coding System* (DPICS) (Eyberg, Nelson, Duke, & Boggs, 2005) is a protocol and a coding system used to measure the quality of parent–child interactions with parents and children from 2 to 12 years of age that also has an adapted protocol and rating scale for dyads with children under 2 years of age.

c. **Parenting Stress Index IV Short Form** (PSI IV-SF) (Abidin, 1995) is an abbreviated form of the Parenting Stress Index for parents with children up to 12 years of age.

d. **Stress Index for Parents of Adolescents** (SIFA) (Sheras, Abidin & Konold, 1998) is an extension of the PSI IV-SF, a stress index for parents of adolescents aged 13 and above.

e. **Eyberg-Child Behavior Inventory** (ECBI) (Eyberg & Pincus, 1999) is a parent rating scale for use with parents of children aged 2 to 16 years of child disruptive behaviors and of the extent to which parents find children's behavior troublesome.

f. **Parenting Relationship Questionnaire** (PRQ) (Kamphaus & Reynolds, 2015) is a parent rating scale for use with parents of children aged 13 above.

g. **Child and Adolescent Trauma Screen-Caregiver** (CATS-C) **and Self-Report** (CATS-SR) (March, 1999) are screeners of traumatic events and symptoms that include a caregiver version for use with children up to age 8 and a self-report version that will be used with children aged 8 and above.

4. **Therapeutic Services**. Provide children and families with therapeutic services that include individual, group counseling, dyadic therapy, and parent education classes as needed and desired.

a. **Child-Parent Psychotherapy** (CPP) is a "relationship-based treatment for children birth to five years old who were traumatized by violence and are experiencing emotional, social, and cognitive difficulties" (Reyes & Lieberman, 2012, p.20). Using 12 to 55 sessions, CPP is based on attachment theory, trauma theory, and psychoanalytic insights, uses cognitive-behavioral and mindfulness strategies to effect improvements in mental health (The California Evidence-Based Clearinghouse for Child Welfare, 2006; 2015; Klain & Sandt, 2009).

b. **Parent Child Interaction Therapy** (PCIT) is a manualized 12-session parent-training intervention for parents of children from 2 to 12 years of age that teaches parents behavioral management strategies to promote their children's behavioral functioning, social-emotional development, and self-esteem as well as teach strategies to improve parent-child interactions and communication (Boggs et al., 2004; Hood & Eyberg, 2003; Nixon, Sweeney, Erikson, & Touyz, 2003, 2004; Schumann et al., 1998).

c. **Trauma-Focused Cognitive Behavioral Therapy** (TF-CBT) is a manualized 12- to 16-session parent-child psychotherapy for parents and offspring ages 3 to 18 who have experienced traumatic life events to help these manage thoughts and feelings associated with the traumatic events. (The California Evidence-Based Clearinghouse for Child Welfare 2006, 2015; The National Child Traumatic Stress Network, 2008; Saunders, Berliner, & Hanson, 2003).

OBJECTIVE 3. ENSURE CONTINUOUS QUALITY IMPROVEMENT THROUGH RESEARCH AND EVALUATION

To utilize data and research to continuously monitor and improve the fidelity, quality, and outcomes of the care, education, and supports, provided to children and families at the Children's Wellness Center.

Activities:
1. **Evaluation and Research.** Establish an ongoing evaluation and research agenda to assess program implementation and evaluate outcomes of the program objectives expressed in terms of desired maternal and child outcomes. Data sources should be diverse, comprehensive, and include the assessment of clients' satisfaction with services. Classroom processes should be evaluated with standardized observational protocols such as the *Classroom Assessment Scoring System (CLASS) for Infants and Toddlers* (Teachstone, 2016) and the *Teaching Pyramid Observation Tool* (Hemmeter, Fox, & Snyder, 2014). Teachers should use *Teaching Strategies GOLD,* which aligns with the research-based developmental objectives of *The Creative Curriculum,* to collect information about children's development and link it to classroom practices and interventions (Teaching Strategies, 2017). A centralized data management system that is easy to use, flexible, and secure is essential. It should enable data entry to be process- and outcome-oriented as well provide fidelity checks by indicating/not allowing variations from established protocols. Data should be easily retrieved and exported for analyses. Statistical analyses should be conducted by expert consultants.

2. **Feedback.** Ensure continuous quality improvement by establishing a feedback loop between the evaluation and research program and relevant decision-makers to implement corrective actions if necessary and to encourage staff growth and career development while supporting their stability (NAEYC, 2016).

3. **Advisory Council.** Elicit collaboration and input from community stakeholders, experts in the field of early child care and education, and service partners.

OBJECTIVE 4. BECOME A HUB FOR ENGAGEMENT AND DEMONSTRATION

To serve as a hub for deeper community engagement, collaboration, shared learning, and dialogue on homelessness.

Activities:
1. **Community.** Regularly open Lotus Village to the public with invitational and neighborhood activities that integrates Lotus Village with the wider community and with the immediate neighborhood. Coordination with the service community will translate into continued resources for families. Integration with the neighborhood community will ease families' transitions to independent lives.

2. **Dissemination.** Become a demonstration model for the nation by disseminating lessons learned to the wider national community.

CONCLUSIONS

This report presents recommendations for the Lotus Village Children's Wellness Center, as an innovative model that integrates therapeutic and developmental services for mothers and children experiencing homelessness and provides high quality childcare. The Center will model, study, refine, share information, inspire dialogue, and advocate for therapeutic early care and education that meets the needs of infants and toddlers and their mothers experiencing homelessness. Core program values include:

- To cultivate respectful, strengths-based partnerships with families,
- Professionals who are responsive to unique needs of children and families,
- Practices that are evidence-based and nurture socio-emotional wellness,
- Environments that are peaceful, safe, and soothing to promote healing and development,
- Collaboration to connect families to community resources that meet their current needs and prepare for smooth transitions, and
- Data utilization to continuously monitor and improve services and outcomes.

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