
LOTUS VILLAGE CHILDREN'S WELLNESS CENTER INNOVATION PROJECT

A PORTRAIT OF NEEDS AND OPPORTUNITIES

By: Sundari Foundation, Inc. dba Lotus House Women's Shelter, Miami, Florida. (2017). With special acknowledgement of our contributors: Miriam Altman, Ph.D., Laura Haim, M.Ed., Emily Arcia, Ph.D. of Emily Arcia Consulting Co., and Constance Collins, J.D., Executive Director, Lotus House Women's Shelter

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. Crack cocaine was ravaging an already impoverished neighborhood, struggling to somehow survive and define its identity in the wake of broader racial, social and economic shifts and the effects of a highway system that bisected and disbursed the once vibrant cultural mecca. Women who were homeless gravitated toward desolate railroad tracks, bridges offering shade, abandoned buildings at night, hospitals and alleyways.

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. A shelter of last resort for many, Lotus House was an experiment in humanity, innovation, holistic solutions, education, and empowerment to uplift those who survived by being invisible. Mostly, we listened and loved and helped craft common sense solutions that worked. Given sanctuary, time to heal, support, nurturing, counseling, basic health care, access to mental health care, tools and resources, women whose lives were presumed lost, even by them, one by one, found the healing, strength, community, and resources needed to make the transition to homes of their own. They built the foundation for new lives while with us, and parted to live stronger, safer, proud, and more resilient.

And Lotus House began to grow. In the second year of operation, overwrought at having to turn away so many women and youth who were homeless and pregnant for lack of facilities to accommodate infants, another building was purchased. We called it our "maternity wing" and designed an array of support services to nurture and support mothers and their newborn babies that was unique in Miami-Dade County. We did so once again, listening and responding to their needs. It

was then we learned that every woman, no matter how street hardened, melted at the sight of our infants, welcomed them with open hearts, and became grandmothers, sisters, aunties and family, in an unusual growing, extended family where love was often the only thing that was not in short supply. In the years to follow, we scraped together the funds to add building after building, welcoming more mothers and children of all ages, quickly outgrowing the capacity of the aging and deteriorating building stock that housed our families, much less the thousands who called or showed up at our door, only to be turned away. There was no room at our inn, so to speak. Turning those we cannot help away for lack of capacity is still the hardest thing we do.

Necessity truly is the mother of invention. With a decade of overuse, our buildings began to give way, and we resolved to rent substitute temporary buildings in our neighborhood and re-develop our campus. 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. Lotus Village includes program spaces for counseling and support services, a working classroom kitchen sized to deliver a half million meals a year, an urban garden nourishing body, mind and spirit, an in-take sanctuary, healing hands salon to soothe and uplift, computer library for adult education and after school programming, art and activities lab with alternative pathways to healing, children's play areas and soothing garden spaces for Lotus House women and children.

Aptly named, Lotus Village, because *it takes a village*, this new facility will be the first of its kind on a national level, the more so because it will include a neighborhood health clinic for women and children, with a special men's health initiative, and a children's wellness center including six classrooms offering early child care and education for newborns to age three, with a therapeutic overlay of child-parent therapy, play therapy, parenting classes, resource coordination, and linkages to key community partners to strengthen and uplift children and families. Lotus Village will not be an island but deeply embedded in and serving the neighborhood it calls home, preventing and bringing an end to homelessness. In addition to realizing our long awaited dream for new facilities tailored to the needs of the women, youth and children we shelter, Lotus Village will offer a platform for deeper community engagement, collaboration, shared learning and dialogue, on a local, state and national level. The Village promises to be a center for innovative, best practices, research and development for public and social policies to advance the health, wellbeing and school readiness of children experiencing homelessness and other risk factors.

Though many have carried us to the pivotal moment and many more will see the vision of Lotus Village to its potential, it is the support and shared mission of The Children's Trust that makes it possible for us to dream of embedding within a homeless shelter a model children's wellness center that nurtures, heals, supports and uplifts the divinely inspired and created children we are blessed to serve. We are indebted beyond measure to The Children's Trust for believing in this vision, for not only did they invite this proposal, but they have deftly helped give shape, structure and guidance to this planning process and the realization of this dream.

To that end, this Innovation Project includes two principal components. In the first, we are called to more deeply understand the child care needs of our sheltered mothers and children at Lotus House and the possibilities that research and evidence based, best practices may offer to meet those needs. For the past decade, our mothers, like other mothers all across our nation experiencing or at risk of homelessness, have struggled to find within reach the quality, affordable child care so necessary to achieving the financial self-sufficiency requisite to building safe, secure lives. Child care options in our impoverished neighborhood and nearby have been in a constant state of flux over the past decade, in and out of business, often with long wait times, under-staffed, and frequently, ill-suited to the special needs of mothers and children experiencing homelessness. If violence is the leading cause of homelessness for women, evidenced not only by national statistics but the reported trauma histories of the women we have sheltered over the past decade, then lack of high quality, affordable childcare is among the leading barriers to ending their homelessness and the promise of a brighter future.

Moreover, with an estimated 2.5 million children across America with no place to call home each night, we are losing a generation of children to the epidemic of homelessness. It is a crisis of epic proportion that is receiving far too little attention on a national level and we believe, the moral imperative of our time. The experience of homelessness is traumatic for children, marked by disruptions of family, school and community ties, food insecurity, and toxic stress. As this report discusses later, research associates homelessness and housing instability in early childhood with delays in children's language, literacy and social-emotional development, and children experiencing homelessness are at elevated risk of mental health, behavioral, and developmental problems. Mothers face overwhelming odds in providing for their children in times of transition while dealing with their own mental health issues, like depression, anxiety, and PTSD. The importance of an enhanced support system with protective factors to heal, nurture, and strengthen children and families is never more imperative than in the experience of homelessness. With lack of affordable housing, stagnant wages, challenges accessing health care and mental health care, and a myriad of barriers to ending homelessness, children are facing extended stays and literally growing up in homeless shelters across this country.

It is apparent from a review of efforts at the national level that solutions are going to be locally driven and community based if at all. The Housing First campaign advanced at the national level as the solution to homelessness has done little to stem the tide of homelessness for children and families in this country and resulted in fewer, not more, resources to homeless shelters now overflowing with children and families. Hence the numbers of children experiencing homelessness are at an all-time high and local communities are forced to bear the full burden of providing for and sheltering growing numbers of children and families. The numbers of children registered as homeless by Miami-Dade County Public Schools has advanced steadily year after year; at last count, over 6000 children! The lack of political will at the Federal level to tackle this growing issue and enormity of its size leaves local communities, especially urban areas with high market rental rates like ours, scrambling to find solutions. In the interim, our children are paying the price that jeopardizes our future as a nation.

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We are called to find innovative solutions that place children first and provide protective factors in times of transition. If we embrace an alternative dynamic, trauma-informed shelter with embedded holistic supports and protective factors, we may offer a window of opportunity for healing, nurturing, enrichment, strengthening and uplifting those in need to blossom into who they are meant to be.

To attain our goal of strengthening children and families experiencing homelessness and other risk factors we established the following objectives for this Innovation Project.

1. 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 and families experiencing homelessness and other risk factors, such as child or maternal exposure to violence, abuse, neglect, food insecurity, inadequate pre-natal care, substance abuse and/or other mental health issues, serious medical conditions, and extreme poverty.
2. To provide holistic, therapeutic, health, educational and community supports, tools, and resources for the families' physical, socio-emotional healing, health, and wellbeing as they build the foundation for brighter futures and transition to their new homes.
3. To utilize data and research to continuously monitor and improve the fidelity, quality and outcomes of the care, education, supports, tools, and resources provided to children and families at the center.
4. To serve as a hub for deeper community engagement, collaboration, shared learning, and dialogue toward informed public and social policies that advance the rights, health, wellbeing and learning of children first, that they might blossom into who they are meant to be.

Deeply mindful that our homeless shelter has never provided child care, we have turned to our “village” in this project, on a national, state and local level, for their knowledge, expertise, experience and advice, and found the treasure trove that helped guide the framework for the model which follows. To the mothers of Lotus House and all those who participated in the process of preparing this report and shared their knowledge, expertise, and learning so selflessly, we are deeply indebted. Helping to lead this effort were our consultants, Laura Haim and Dr. Miriam Altman, whose diligence, organization, research and dedication to the advancement of early child care and education in the context of Lotus Village are the underpinning for this report, and we are grateful beyond words. Their work was supported by Dr. Emily Arcia, a volunteer deeply committed to advancing our collective knowledge through research and evaluation; we give thanks for her input and guidance in helping to make our vision for a therapeutic children’s wellness center unfold. A special thanks to

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Donna MacDonald for her tenacious grasp of the potential for Lotus Village to be a national platform for excellence, and giving us the courage to reach and the means to realize our shared vision.

The second component of this Innovation Project is the development of a strategic plan, currently underway, to realize our goals and implement the vision and principles aspired to in this report for the Children's Wellness Center. I am often reminded, dreams come easily, but it is in the realization of those dreams that we are called to bring forth our very best, hard work and perseverance, sometimes in the face of all odds. If we have learned anything over the past decade, the path forward will be a winding road with many challenges, not the least of which is identifying the resources needed to uplift children who are among the most needy and fragile in our community. We will do so in collaboration with many. Some may say, trauma-informed, therapeutic early child care and education for children experiencing or at risk of homelessness is too costly, inasmuch as it calls for early developmental and mental health needs assessments for children, small class sizes, low child to teacher ratios, a framework for social and emotional learning as well as enriched classroom education, investing in the support and education of teachers so that they may give their very best to children in their care, and research to continuously monitor and improve services, share knowledge and advance best practices. To that, we proffer in response – the value of a life. Shall our dreams be any less than the dreams and hopes of our children?

We believe housing is as essential to a child's wellbeing and prosperity as food, education and health care. In times of transition, every child deserves shelter that is nurturing and supportive with deep protective factors such as therapeutic early child care and education to better assure their healing, growth and blossoming into who they are meant to be. Shelter can and should offer a window of opportunity to strengthen children and families. The challenges to implementing this model are many. No doubt, adaptations will be needed to the learning found in educational settings like universities and community clinics so that services are tailored to the special needs of our children and families and barriers to accessing services are eliminated. The outcomes in lives nurtured, supported, healed and school readiness - priceless. Trusting there will be many who are called to step forward and lift up those with the least that they might know the fruit of their potential realized. It takes a village.

Deep Bows to The Children's Trust,

Constance Collins, Executive Director

Lotus House Women's Shelter

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INTRODUCTION

Background. Since 2006, Lotus House has provided shelter and holistic support services for women, youth and children experiencing homelessness in the Overtown neighborhood of Miami, Florida. With the visionary leadership and generosity of key philanthropic partners, their aging campus is now being redeveloped to become Lotus Village, a state-of-the art comprehensive homeless services facility that will double the shelter’s capacity to approximately 500 beds nightly and provide expanded program space for counseling, resource coordination, social services supports and activities. Lotus Village will include an in-take sanctuary, computer room, library, salon, art and activities lab, children’s play areas, working classroom kitchen, and extensive community activities spaces and gardens. The shelter and its support services will be complemented by a women’s and children’s clinic (including dental care) and a therapeutic children’s wellness center offering early child care and education, serving both the shelter and its Overtown neighborhood.

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, “Children’s Wellness Center,” in Lotus Village. It is the aim of Lotus House to create a model for trauma-informed, therapeutic early care and education that integrates healing and developmental services for mothers and children experiencing homelessness. Recognizing their unique needs, the Children’s Wellness Center is being designed to offer child and parent therapy and parenting education in addition to quality early care and education, all embedded within Lotus Village and integrated into the shelter’s extensive wraparound services. Children’s needs, strengths, and rights will be foremost considerations to assure that they receive the comprehensive services they deserve. This wraparound support is designed to strengthen and empower children and families to break what is too often a cycle of homelessness.

Data Collection. The report references input from key informant and stakeholder interviews and focus groups. Two workgroups of more than 30 local stakeholders from 20 organizations convened to connect and share ideas. Interviews were conducted with over 25 workgroup members and national informants including professors, researchers, program administrators, and child psychologists. Areas of expertise included infant mental health, promoting social and emotional development of at-risk children, trauma-informed treatment, and classroom design. In addition to speaking with representatives from early care and education programs across the country, the research team visited seven community based programs with a focus on serving clients experiencing homelessness, leveraging partnerships, offering program-wide mental health supports, operating extended hours, and/or operating with a continua of approaches. Seventeen Lotus House participants and alumnae and many of the counselors and resource coordinators and management team supporting Lotus House families participated in focus groups and interviews. The hopes and fears they voiced will continue to influence powerfully the creation of an early child care and education center they can trust to promote the health and wellbeing of at-risk children.

Report Organization. Part I of the report describes the pressing need of the mothers and children nationally and at Lotus House for high quality early care, education, and mental health services due to their complex trauma histories and high special needs, which may have preceded and often precipitated their homelessness. We include an overview of scholarly and professional literature on the science of early childhood development and the impact of adverse childhood experiences on young children’s development and relationships. Key to mitigating such harm and supporting children’s development at this critical juncture is the recognition that shelter, with appropriate protective factors, can afford children and families a window of opportunity to leverage this period of transition by providing children with critical foundational support and services for their healing and growth. In Part II of the report, we present how Lotus House services were designed to mitigate harm. Part III presents recommendations for the Children’s Wellness Center, which were generated from the characteristics of the women and children sheltered by Lotus House, stakeholder input, and our literature review. Through the implementation of these recommendations we aim to provide a trauma-informed, integrated model of early care and education embedded within the Lotus House shelter where children can heal, learn, grow, and thrive.

Of National Significance. In carrying out this collaborative research process and sharing findings in a published report, we seek to initiate an ongoing exchange with colleagues locally and around the country about how to use the shelter experience to strengthen and heal women and children experiencing homelessness. Whereas the recommendations were developed in part from local feedback, the recommendations and considerations can inform dialogue with any program and/or shelter interested in therapeutic and educational services for young children and their mothers experiencing homelessness.

Critical Support. This report is based on a research process generously funded by The Children’s Trust, a dedicated source of expertise and resources, established by voter referendum, to improve the lives of children and families in Miami-Dade County. We thank The Children’s Trust for its leadership, input and support every step of the way. We gratefully acknowledge the collaboration of numerous individuals and organizations in Miami-Dade County and across the United States. For a full list of the many contributors, see Appendix I. Equally important, we express our deepest gratitude to the women and children of Lotus House for their open-hearted sharing in the hopes that those who follow in their footsteps will reap the benefits of a new kind of approach to early care and education, one that supports and nurtures their success on every level.

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

This section considers broad themes from the literature. We begin by describing the challenges mothers and children experiencing homelessness face: their vulnerabilities, the stresses on their relationships and on their interactions, which have serious consequences to their welfares. We close the section with a summary of opportunities for redressing or ameliorating the effects of trauma.

A NATIONAL PROBLEM

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).

The average female heading a family experiencing homelessness is under age 30 (Tobin & Murphy, 2013 citing U.S. Department of Housing and Urban Development). Young mothers experiencing homelessness face compounded stressors associated with their new parental responsibilities, gaining and maintaining employment, and establishing self-sufficiency as adults within the context of unstable environments and limited supports (U.S. Department of Health and Human Services, U.S. Department of Housing and Urban Development, & U.S. Department of Education, 2016). Relative to other mothers, 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 has a direct and an indirect effect on children. In itself, it is a chronic stressor for children, engendering disruptions in their daily routines, safety, food security, and family, school, social and community ties (Bassuk et al., 2014). When it occurs in early childhood, it 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 Ziolo-Guest & McKenna, 2014; Obradovic et al., 2009). At any age, children who experience homelessness are at elevated risk of 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 operates indirectly through the effects it has on mothers because maternal stress, anxiety, depression, and psychiatric diagnoses burden and affect children negatively. Maternal psychological distress has an adverse effect on infant cognitive development, behavior, socio-emotional status, and psychomotor development (Commission on Social Determinants of Health, 2008; Kingston, Tough, & Whitfield, 2012) and maternal clinical depression has been associated with a deleterious effect on young children's emotional development, social sensitivity, and self-concept (National Scientific Council on the Developing Child, 2004).

COMPOUNDED EFFECTS

National data show that the effects of homelessness are further compounded by additional traumatic events such as violence or abuse. The added vulnerability represents barriers to forming trusting relationships, identifying and seeking services, and engaging in supports for child and parent wellness (U.S. Department of Health and Human Services et al., 2016).

Young children are particularly vulnerable to the adverse influences of compounded stressors, violence, and parental mental health issues. The National Child Traumatic Stress Network (2016) describes complex trauma in terms of exposure to, and impact of, multiple traumatic events upon a child. Histories of complex trauma vary and may include abuse, domestic violence, food insecurity, neglect, and separation from family members. Traumatic childhood experiences commonly affect children's attachment and relationships, emotional and behavioral responses, physical health, self-concept, and future orientation and are linked to wide ranging, long-term health, economic, and social consequences (The National Child Traumatic Stress Network, n.d.). Children who have experienced complex 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).

Although stress can be positive or tolerable within the context of nurturing and responsive relationships that facilitate adaptive responses, ongoing traumatic experiences result in what has been termed toxic stress (Shonkoff, 2010). Toxic stress involves "prolonged activation of the body's stress-response systems in the absence of the buffering protection of stable adult support" (Shonkoff, 2010, p.360). Toxic stress early in life can disrupt brain development and impact long-term physical, cognitive, and emotional health, and increase the likelihood of later mental health problems (National Scientific Council on the Developing Child, 2012).

In addition to the significant challenges that mothers and children face individually, situations of trauma, stress, and violence can negatively affect the parent-child relationship and in turn disrupt the basic mechanisms by which child development proceeds. Although developmental frameworks vary, every theoretical model of human development highlights the effect of reciprocal adult-child interactions on development (Shonkoff, 2010). The attachment relationship, which is the emotional bond developed through interactions between young children and caregivers, serves a protective

function in the early years and plays a central role in expressing, managing, and regulating emotions and behaviors (Ainsworth, 1979). Ainsworth (1979) describes attachment, exploration, and learning about the environment as interrelated and emphasizes that the “presence of an attachment figure, particularly one who is believed to be accessible and responsive, leaves the baby open to stimulation that may activate exploration” (p.935). On the other hand, inattentiveness, disregard, or rejection of a young child’s signals relate to anxious forms of attachment relationships, which can be characterized by avoidance and anger (Ainsworth, 1979).

AN OPPORTUNITY TO REDRESS DAMAGES

What is known about brain development, including its points of vulnerability and windows of opportunity, provides hope for harnessing mediators of brain development to “alter trajectories following an insult” (Anderson, 2003, p.5). During the period of birth to age three, a child’s brain produces 700 new neural connections per second (Zero to Three, 2017). The immature, impressionable brain fine-tunes or sculpts itself by overproducing and eliminating synapses and receptors through an “interactive process between genetic programming, cell function, and the environment” (Anderson, 2003, p.9). Early life events shape developing infant and toddler brains and have greater impacts than later life events, such that early experiences be they adversities or protective factors affect later expressions (Anderson, 2003; Zero to Three, 2017). Indeed, decades of scientific advances and early childhood program development point to the strengthening influence of positive, early experiences on brain architecture (National Scientific Council on the Developing Child, 2007; Shonkoff, 2010). Early experiences, including relationships with family members, caregivers, teachers, and peers, critically shape the architecture of the developing brain and profoundly affect social, emotional, and cognitive development (National Scientific Council on the Developing Child, 2012; Reyes & Lieberman, 2012). But, research suggests that delays can be detected in the first months of life and are amenable to early intervention (Kingston et al., 2012). Neurobiology highlights the importance of early, intensive intervention for children who have experienced toxic stress to offset disruptions of neural circuitry and infrastructure in the growing brain that may have been caused by toxic stress (Shonkoff, 2010). Thus, the plasticity of the young brain presents a window of opportunity to provide protective factors, such as quality early childcare and education and therapeutic supports, even and especially during times of transition, such as placement in an emergency shelter.

REDRESSING DAMAGE THROUGH CHILDCARE AND EDUCATION

High quality early care and education programs can provide critical support for children and families encountering challenging situations, “in part, by offering security and constancy for children with familiar caregivers and peers” (U.S. Department of Health and Human Services et al., 2016, p.5). On the other hand, poor quality care can have deleterious effects. (Currie, 2001; Loeb, Fuller, Kagan, & Carrol., 2004; Vandell, 2004). Shonkoff (2010) asserts “large numbers of young children and families who are at greatest risk, particularly those experiencing toxic stress associated with persistent

poverty and also complicated by child maltreatment, maternal depression, parental substance abuse, and/or interpersonal violence, do not appear to benefit significantly from existing programs” (p.361). Thus, for a beneficial effect, the high quality of care must be assured because attendance alone is not sufficient.

High quality care is 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 cases, 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 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). 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 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).

A key aspect of high quality care is the fact that children establish stable, nurturing relationships and responsive interactions within supportive environments (National Scientific Council on the Developing Child, 2004; Shonkoff, 2010). All children, and especially those experiencing homelessness and frequent transitions, benefit from developing a secure attachment with a consistent caregiver, “a child’s close relationship with a caregiver cannot be overestimated. Through relationships with important attachment figures, children learn to trust others, regulate their emotions, and interact with the world...” (The National Child Traumatic Stress Network, n.d., p.1). Indeed, attachment theory suggests that caregivers can provide a “secure base” for learning and exploration through attentive, responsive, and sensitive, interactions (Ainsworth 1979; Kaiser & Rasminsky, 2012). Sensitive, responsive interactions require teachers to capitalize on their knowledge of individual children’s differing temperaments, activity levels, and cognitive and social development (NAEYC, 2017).

Because of the dynamic nature of child development, high quality care for children at risk of developmental delays or atypical development should include repeated screenings; preferably with a parent-completed tool combined with professional observation (Glascoe, 2005; Mackrides & Ryherd, 2011). Clinical observation and impression alone overlook children eligible for early

intervention, and it has been estimated that up to half of children in the United States with a developmental delay might not be identified before kindergarten entry, thereby jeopardizing windows of opportunity for early intervention (Mackrides & Ryherd, 2011).

High quality early care and education 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). As such, center-based care in a shelter setting can represent an important point of entry for reaching and supporting vulnerable children and families (Mortensen & Barnett, 2016). Without this assistance, families might not be able to access high quality care given its costs. Infant care costs more than college in 33 states and in Florida, the average cost of childcare is 81% percent of minimum wage, leaving little to sustain necessities like rent, food, and transportation (Schulte & Durana, 2016).

REDRESSING DAMAGE WITH MENTAL HEALTH SUPPORTIVE APPROACHES

Mental health therapy for children can occur independently or exist as part of center-based early education programs through various approaches. One approach, termed trauma-informed services, is applicable to almost any program. It acknowledges that trauma can substantially affect individuals' mindset, actions, and well-being and requires that staff recognize the effects of trauma and respond in ways that convey acceptance of individuals, openness, and empathy (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.).

Motivational interviewing is a clinical approach that has been effective across settings and frameworks in supporting people with mental health and substance abuse disorders to make healthy behavioral changes (Substance Abuse and Mental Health Services Administration, n.d; Zero to Three, 2016). The approach is based on the following principles: “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).

Reflective practice is a “staple of ongoing support” for early childhood mental health consultants (Zero to Three, 2016, p. 26). For early childhood educators influenced by Reggio Emilia, reflective practice is a continuous, collective, and constructive meaning-making process engaged in by children and adults alike (Paige-Smith & Craft, 2011). From this perspective, 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). The associated reflective leadership fosters the conditions that enable reflective practice to flourish. Reflective, collaborative, and regular interactions form the building blocks of reflective supervision - which focuses on work related experiences, thoughts, and feelings and is founded on trusting, honest relationships within safe, calm, and supportive environments (Gilliam, 2016; Zero to Three, 2016). Reflective supervision includes “sharing and learning, emotional support and dealing with vulnerability, and systems

sensitivity” and “using yourself as a tool and learning about the science of being with others” (Emde, 2009, p.664). Reflective leaders foster relationship based organizations through self-awareness, careful observation, and flexible responses (Zero to Three, 2017). In addition to providing a safe space to manage job related stress, reflective supervision can support professional learning by empowering staff to assess their own work, strengths, and vulnerabilities and allowing for internally generated mid-course adjustments (Zero to Three, 2016). Reflective work and supervisory relationships should strive for presence, commitment, reverence, and mutuality to allow for reflection on personal ‘ghosts in the nursery,’ how they influence relationships with children and families, and collectively use this understanding for professional growth (Weigand, 2007).

An additional approach that lends itself well to early childhood settings is to organize strategies and interactions into tiers on the basis of needs. This concept is the basis of the *Pyramid Model* (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky, & Fox, 2006). 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 persistent challenging behaviors (Cimino, Forrest, Smith, & Stainback-Tracy, 2007; Hemmeter, Fox, & Snyder, 2014; Hemmeter, Snyder, Fox, & Algina, 2016). Practices at each tier complement practices promoted through a range of professional and scholarly sources. For example, a culture of social and emotional wellness founded upon nurturing relationships and supportive environments is consistent with standards advanced across early childhood stakeholders including the National Association for the Education of Young Children (NAEYC) and Early Head Start. Relationships in which children see themselves as valued are beneficial to children in multiple ways, including fostering feelings of self-worth, of belonging, and in building the capacity for self-regulation (NAEYC, 2016). The model emphasizes the promotion of emotional literacy and prosocial behavior through intentional social emotional supports.

Expert early childhood professionals praise *The Pyramid Model* highly. Horizons for Homeless Children in Boston, an early care and education program serving many children experiencing homelessness, has successfully trained and mentored its child care staff using the Pyramid Model and called it a “game changer.” A program director emphasized the impact of establishing a common language and approach across early care and education staff, especially on relationship building, where children experiencing homelessness are concerned. As a leader at the child care center put it: “the Pyramid became the approach that staff could embrace and take on. The training was critical in my own learning, and I maintain that it is the best approach I have ever seen specifically around children and families experiencing homelessness.” She described the framework as structuring staff learning about how relationships and interactions support healthy development and reduce stress, how trauma impacts behavior, and how to set positive expectations and move communication from ‘prohibition mode’ to supportive feedback.

Multiple studies have examined practices associated with *The Pyramid Model* and the important role of coaching in enacting evidence-based practices appears as a theme across studies (Fox et al., 2011;

Hemmeter et al., 2016). For example, Horizons for Homeless Children followed up on training with coaching, and their data showed decreased mental health referrals and broadened support of caregiver/child relationships (Kiron, n.d.). In addition, a recent experimental evaluation of the effects of classroom-wide implementation of the *Pyramid Model* found that quality training and practice-based coaching affected teacher's practices, and children in intervention classrooms demonstrated better social skills and less challenging behaviors than children in other classrooms (Hemmeter et al., 2016).

The Pyramid Model, reflective supervision and practice, and motivational interviewing are commonly used evidence based frameworks and resources of Early Childhood Mental Health Consultation Programs (Zero to Three, 2016). Early Childhood Mental Health Consultation is a “multi-level preventive intervention that teams mental health professionals with early care and education professionals and families to improve child health and development in the social-emotional and behavioral domains” (Gilliam, 2016, p.8). Mental health consultation for staff working with children who have challenging behaviors may help address stressors, improve staff skills, sensitivity and confidence, reduce teacher reported externalizing behaviors, and decrease staff turnover (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010). Evidence suggests that accessible mental health consultation supports improve children's social skills and peer relationships, reduce challenging behaviors, and reduce teacher stress while improving teaching skills, confidence, and sensitivity with children (Gilliam, 2016). Hence, research underscores the importance of infusing early education with strategies derived from mental health fields and with linking early childhood and mental health professionals.

EVALUATING PROGRAM EFFECTS AND CONTRIBUTING TO SCIENCE

Programs that serve children and families should be evaluated to document effects and ensure continuous quality improvement. Given the dearth of empirically-based knowledge of the status and outcomes of these families experiencing homelessness, a research agenda that contributes to current knowledge would be particularly beneficial in this area. 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. In other words, it addresses the implication of obtained effects for the wider population.

Evaluation should assess implementation, its intended and unintended effects, and provide feedback to decision makers at regular and logical intervals, such as every six months or yearly, to allow for corrective action. The agenda may be collaboratively established and implemented through a research-program partnership, which is an interchange between evaluators or researchers, program leadership, and practitioners (Stein, Freel, Hanson, Pacchiano, & Eiland-Williford, 2013). The agenda should consider outcome data that documents effectiveness as well as program implementation data that informs continuous learning. Citing lessons learned from Early Head Start

evaluations, Knitzer and Lefkowitz (2006) recommend that programs serving vulnerable infants, toddlers, and families promote a research agenda that extends beyond outcome data to include program implementation data the results of which can improve program effectiveness. Data utilization efforts should be embedded, collaborative, and comprehensive (Yazejian & Bryant, 2013) and support clear, consistent, structured processes and protocols that inform reflective, responsive, and continuous cycles of informed growing, learning, and evolving.

THE LOTUS HOUSE: A MICROCOSM OF NATIONAL HOMELESSNESS

Lotus House is the only homeless shelter in Miami-Dade County with a wrap-around support system dedicated exclusively to serving women, youth and children. It offers a unique, multi-faceted, comprehensive support system including individual and group counseling, parent-child therapy, parenting classes, an array of educational supports for children and adults, vocational training and coaching, access to medical and mental health care and treatment, and move-out and housing assistance. Women come to Lotus House through referrals from homeless outreach teams, other shelters, rehabilitation centers, prisons, courts, and hospitals, as well as directly from the streets. Lotus House is known as a high special needs shelter serving women and children who are among the most fragile in the community. Many have complex, multifaceted presenting issues that precipitated their homelessness and serve as barriers to their safe transition.

Although Lotus House also serves women and youth without children, at the writing of this report, nearly 80% of residents are mothers and children. In 2016, Lotus House sheltered a total of 682 women and children including 188 mothers with a combined total 339 children. Before coming to Lotus House, 48% of women qualified as chronically homeless, defined as being continuously homeless for a period of one year or longer or four times in the prior three years. Almost all (99%) women residents reported histories of trauma and/or abuse, including childhood physical abuse (34%), childhood psychological abuse (39%), and sexual abuse (36%). Seventy-eight percent of mothers reported having experienced domestic violence, including 49% who were victims of violent crime and/or assault and 70% who had histories of other serious trauma. Based on assessments at in-take, all mothers had immediate and/or unmet medical needs.

For many women, Lotus House is a shelter of last resort. Although numbers fluctuate, in 2016, 27% were under supervision by and/or otherwise involved in the child protective system of the Department of Children and Families pertaining to allegations of child abuse, neglect, domestic violence and/or an inability to provide for their children. A staff member described the constellation of stresses and complicating factors affecting mothers by stating: “Our moms have severe mental health needs: PTSD, psychosis, along with complicating factors like being in the foster care system, growing up in poverty, families in poverty, mental illness and drug abuse, and their own abuse.” Despite these complicating factors, the resource enriched, solution-focused, approach of Lotus House has meant that over 80% of those exiting Lotus House have successfully transitioned to homes in the community, including nearly 88% in 2016.

In 2017, before expansion, Lotus House sheltered over 130 children on a nightly basis, most of whom were newborn to age 5. Upon completion of its new facilities in Lotus Village, the number of children sheltered nightly is anticipated to rise to over 280.

Consistent with the findings from national research, many of the children residing at the Lotus House suffer the effects of complex trauma and toxic stress. Thirty percent (30%) of children at Lotus House had developmental delays (speech, gross and/or fine motor, cognitive or global), 63% had mental health/behavioral issues, and the remainder was considered at-risk. A number of children at Lotus House also had specialized medical needs including respiratory issues, feeding tubes, cerebral palsy, and ambulation difficulties. Such intensive medical needs typically involved events like ambulance rides, hospitalizations, and medical procedures, which might further compound stressors and traumas for mother and child.

THE VOICES OF LOTUS HOUSE MOTHERS

Two major themes emerged from focus groups of mothers; the challenges presented by their children's behaviors and the lack of conveniently accessible, appropriate, and affordable child care. Indeed, the quality of early care and education within walking distance of the shelter was characterized as "atrocious."

Many mothers alluded to the challenges that their children's behaviors created; especially within the context of early care and education. One boy's biting, punching, kicking, and head-butting led to expulsion from two preschools. Another boy's "anger problem" and aggressive behaviors was associated with speech and language delays and a family history that required anger management. "He can't talk," said the mother, "When he can't talk, he gets mad." Other children were shy and uncomfortable in early childhood settings. Withdrawal can be so extreme that one child's teacher thought that he was unable to speak. "That's the problem," added the mother of another child, "if a child is not talking to them, and is shy or quiet, they {teachers} just move on."

The lack of conveniently accessible, appropriate, and affordable child care made it almost impossible for some mothers to search for jobs. In some cases, mothers had to interview for jobs with children in tow. "You are stuck," said one mother. "Who is going to let you go to an interview with a child? Then, they {another agency} don't want to give child care when [you're] not working...How are we supposed to get a job if we don't have child care and can't bring the child? I have brought my child once and trust and believe {me} I did not get the job." Another mother responded, "Yeah, they look at you like, 'Is this how it's gonna be when you get the job?'" Because childcare subsidies depend on seeking/being employed, mothers can often find themselves in a double bind.

Once employed, frequently mothers were required to adapt to changing or unpredictable work shifts, often at evenings, nights, or weekends, when childcare is not traditionally offered, public transportation is minimal or not available, and at a time in the mothers' lives when they did not have their own support systems. "We know, most jobs, hours vary. If you work at [company], you may work overnight or during the day." Hence, mothers had a constant scramble to arrange childcare during the

hours they worked and at a price they could afford. They were not aware of any centers that offered overnight, weekend, or sufficiently extended hours within walking or trolley distance of the shelter.

When accessible child care that met their scheduling needs was found, cost often became an additional barrier and if cost was not a barrier, mothers expressed concerns about the quality of the care provided. They described babies being left in cribs most of the day and older children playing without appropriate supervision. They worried that staff did not develop warm, caring relationships with the children and were frustrated by behaviors such as tantrums. Staff were seen using negative language, embarrassing the children, telling children they were “bad,” and shaming the mother. More than one mother described her child being expelled from early childhood programs due to the child’s challenging behaviors, which staff did not know how to manage. Lotus House staff concurred with mothers, *“Unfortunately we have had negative things happen. We want to make sure our kids are in a safe environment and treated respectfully, with teachers who know what’s normal, have appropriate expectations, and aren’t screaming at the children. We want them to be allowed to play, not just sit at a table all day.”* The experiences of the mothers at Lotus House is not unique. A recent national examination of childcare across the United States ranked early care and education in Florida as average, with an array of fragmented systems characterized by challenges related to affordability, quality, and availability (Schulte & Durana, 2016).

INPUT FROM LOTUS HOUSE STAFF

The input from Lotus House staff confirmed and expanded on maternal reports. Children were described as having had multiple exposure to traumatic events including *“death of parents, a lot of domestic violence and exposure, and substance abuse.”* Their internalizing and externalizing responses to stress were said to often take the form of *“either shut down, with limited talking, or...lots of tantrums and act{ing} out.”* And, the support from outside agencies was inadequate to deal with these problems because they typically did not offer services for mothers who struggled with behaviors like tantrums.

The explanation offered by Lotus House staff was in terms of the mothers’ own difficulties and how these exacerbated an already difficult situation. A Lotus House mental health professional noted that many mothers might never have had a secure attachment figure themselves, thereby affecting *“their way of integrating with the world by being passive or by being aggressive to get what they need.”* She referred to a book that undergirded her thinking. *“Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships”* emphasizes the multi-generational nature of attachment and contemplates how trauma may bring uninvited *“intruders from the past”* into the nursery: *“While no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script”* (Fraiberg et al., 1975, pp.387-388). But, suggest the authors, therapeutic intervention can change the script as *“the afflicted parents become the protectors of their children against the repetition of their own conflicted past”* (Fraiberg et al., 1975, pp.420-421).

PART II. OPPORTUNITIES: THE LOTUS HOUSE SERVICES

Part II of this document comprises a summary of key features of the Lotus House. These are presented as they existed at the writing of this report in 2017 and as planned for the expansion that will house twice the number of women and children as before its construction and will accommodate multiple support functions including a children’s childcare and education, i.e., the Children’s Wellness Center, and a wide range of services for children and mothers.

INTAKE PROCEDURES

Upon entry to Lotus House, each woman meets with an intake coordinator who is a mental health professional to tailor an action plan for her transition to permanent housing. The plan is multifaceted and includes a wide range of services for her and for her children. Depending on need, these may include: 1) physical health care and mental health care in the form of individual or group counseling and parent-child therapy; 2) education supports for children; 3) adult education in the form of parenting classes, job readiness training and employment coaching; 4) substance abuse treatment and recovery support; 5) social services support and coordination in the form of benefits assistance and advocacy; and 6) housing coordination and assistance with move-out. This voluntary action plan outlines each woman’s goals and the services, tools, and resources she may access to achieve her goals. It may be modified by her and her support team as circumstances warranted.

Within days of arrival, each woman at Lotus House meets with a multi-disciplinary support team that includes her resource coordinator, education/job coach, disabilities specialist if needed, housing coordinator and if she chooses, a counselor. Her resource coordinator serves as the lead connector for the support team and partners with each woman to help her achieve her action plan.

A STRENGTH-BASED APPROACH TO ASSISTING FAMILIES

Lotus House is predicated on principles of holistic, trauma-informed support, education, enrichment, and empowerment. Key to the success of this innovative approach is respectful, strengths-based partnerships with those served. The service model is not one of “doing to or for” participants, but rather shared learning and respectful partnering.

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 from problem and pathology-focused, deficit-based focus 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. In trauma-informed care, empowering partnerships between a woman seeking or receiving services and the service provider values the knowledge each party possesses, allows for

mutually established goals, and attends to the impacts of context (Elliot, Bjelajac, Fallo, Markoff, & Reed, 2005). This creates welcoming environments that are respectful to participants' needs for safety, respect, and acceptance, as well as promotes developmental assets and protective factors like resiliency through caring relationships, social support networks, high expectations, and opportunities for meaningful participation (Bryan & Henry, 2008).

INCLUSIVE, ZERO TOLERANCE FOR ABUSE, AND TRAUMA-INFORMED

Lotus House has embraced inclusivity, i.e., the inclusion of people who might otherwise be excluded or marginalized, as a guiding principle for operations because people thrive when they feel a sense of connection and respect for themselves and others. Lotus House has a Zero Tolerance for Abuse Policy and includes trauma-informed practices. Staff know the symptoms of trauma and have the capacity to make “discussions and interactions with survivors safe for each person to be, learn, and grow.” Key skills in trauma-informed practices include: an open stance, connection through engagement, availability/presence, empathy, avoidance of judgement, reflection marked by self-awareness, and responsibility for one's reactions to another person's trauma (Administration for Children and Families, Substance Abuse and Mental Health Services Administration, Administration for Community Living, and the U.S. Department of Health and Human Services., n.d.).

EMBEDDING SUPPORT SERVICES WITHIN THE SHELTER

Embedding a therapeutic childcare center in a homeless shelter will meet the needs expressed by mothers for accessible, affordable high quality care so that they can put their lives on their desired tracks. Being in the same facility, an in-house center gives staff the opportunity to provide early and deeper assessment of at-risk children, ready support and build meaningful partnerships with mothers and children. Similarly, embedding other therapeutic support services such as counseling and parent education 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. Thus, providing 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.

In anticipation of the opening of the Children's Wellness Center, staff searched for a model of another therapeutic early care and education center embedded within a homeless shelter that would give guidance on best practices. None was found, but with funding from The Children's Trust research was conducted to identify guiding principles for its development and operation. A summary of findings of best practices, along with the recommendations that the findings generated in support of our goals of strengthening children and families is presented in Part III of this document.

PART III. RECOMMENDATIONS

Recommendations, which follow below, are organized according to the four objectives that will allow us to attain our overarching goals of healing and strengthening children and families so that they will transition to successful independent lives. Whereas some program elements described below may be specific to the Children’s Wellness Center in Lotus Village, the guiding principles and recommendations should be relevant to other shelters.

1. **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 and families experiencing homelessness and other risk factors, such as child or maternal exposure to violence, abuse, neglect, food insecurity, inadequate pre-natal care, substance abuse and/or other mental health issues, serious medical conditions, and extreme poverty.
2. **To provide holistic, therapeutic, health, educational, and community supports, tools, and resources** for the families’ physical, socio-emotional healing, health, and wellbeing as they build the foundation for brighter futures and transition to their new homes.
3. **To utilize data and research to continuously monitor and improve** the fidelity, quality and outcomes of the care, education, supports, tools, and resources provided to children and families at the center.
4. **To serve as a hub for deeper community engagement**, collaboration, shared learning, and dialogue toward informed public and social policies that advance the rights, health, wellbeing and learning of children first, that they might blossom into who they are meant to be.

Table of Objectives and Recommendations

Objectives	Recommendations
To develop a model trauma-informed, therapeutic, early childcare and education center	<ol style="list-style-type: none"> 1. Develop partnerships with families by establishing a care team for each child that includes the mother, to communicate and coordinate among professionals interacting with children and families. 2. Recruit, train, and support educational and therapeutic staff to be responsive to the unique needs of children and families experiencing homelessness. 3. Establish ongoing professional learning and support across education and mental health professionals. 4. Identify a curriculum and establish practices that: <ol style="list-style-type: none"> a. are developmentally appropriate to promote children’s social, emotional, physical, language, and cognitive development, b. maintain small group sizes, i.e., low student to teacher ratios, c. include primary care giving, d. create a peaceful physical and emotional environment, and e. embody the shelter’s welcoming, inclusive, and trauma-informed environment.
To provide holistic, therapeutic, health, educational, and community supports, tools, and resources	<ol style="list-style-type: none"> 5. Embed community resources within Lotus Village by developing community networks and systems with therapeutic providers and quality early care and education settings. 6. Assign a transition coordinator at intake as part of the care team whose job will be to assist families plan and implement transitions. 7. 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 and to guide subsequent therapy and services. 8. Provide children and families with therapeutic services that include group counseling, individual and dyadic therapy, and parent education classes as needed and desired.
To utilize data and research to continuously monitor and improve	<ol style="list-style-type: none"> 9. Establish an ongoing evaluation and research agenda to assess program implementation and evaluate outcomes. 10. Ensure continuous quality improvement by establishing a feedback loop with the evaluation and research program.
To serve as a hub for deeper community engagement	<ol style="list-style-type: none"> 11. Regularly open the Lotus Village to the wider community with invitational and neighborhood activities. 12. Disseminate lessons learned to the wider national community.

**OBJECTIVE 1. TO DEVELOP A MODEL TRAUMA-INFORMED,
THERAPEUTIC, EARLY CHILDCARE AND EDUCATION CENTER**

- 1. Develop partnerships with families by establishing a care team for each child that includes the mother, to communicate and coordinate among professionals interacting with children and families.**

Strengths-based partnership. Sensitive, mutually respectful, collaborative relationships with families recognize the inextricable connections between families and their young children’s learning. These relationships acknowledge the primacy of families in promoting their child’s learning and development (NAEYC, 2016). Such strengths-based perspective complements ongoing, reciprocal, and meaningful, family partnerships (Halgunseth, 2009) in which families’ expertise and their contributions are valued and shape the interactions that build partnerships and promote progress.

Purpose and composition of the care team. Consistent with expert advice and to ensure that children’s needs are prioritized, a care team should be established for each child enrolled at the Children’s Wellness Center (NAEYC, 2016; Swick, 2004). A care team, which will include the mothers, will ensure that children receive needed medical, psychological, and educational services in a culture that invites, engages, validates, and empowers mothers. Teams should include representatives from the mothers’ shelter support teams along with child-relevant professionals (e.g. teacher, transition coordinator, disabilities specialist, legal services, and/or healthcare partner). Teams will use action plan goals and families’ needs and strengths to coordinate services for families to ensure that needs are met overwhelming mothers and children. Teams will review results of services and chart progress toward established personal goals. In their work, teams will facilitate consistent social, emotional, and behavioral supports across therapeutic, classroom, and family settings.

- 2. Recruit, train, and support educational and therapeutic staff to be responsive to the unique needs of children and families experiencing homelessness.**

Teacher credentials and competence. Highly qualified and competent staff is a necessity in all childcare centers. “Quality of care ultimately boils down to the quality of the relationship between the child care provider or teacher and the child. A beautiful space and an elaborate curriculum - like a beautiful home - can be impressive, but without skilled and stable child care providers, they will not promote positive development” (Shonkoff & Phillips, 2000, pp.314-315). In the case of centers for children who have experienced homelessness, the need for competence extends beyond the typical to include competence in addressing extremes in mental and physical health needs and its consequent behaviors. As such, their credentials and levels of competence shall meet or exceed the standards of potential partnership programs such as Early Head Start and Miami-Dade County Public Schools.

Ideally, all teachers shall have at a minimum a Bachelor’s degree in early childhood, course work in special education, and ESOL endorsement. All assistant teachers shall have a current Child

Development Associate (CDA) credential as well as training and/or coursework focused on infant and toddler development (Head Start Performance Standards, 2016). At all times, teachers and assistant teachers alike 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. Teachers shall see children as individuals and have a sharp eye for their needs.

Teachers as a source of family support. To be appropriate models for mothers and to be able to support the mothers' efforts, staff shall be trained as needed and have basic working knowledge of the relevant therapy modalities in which mothers and children participate such as Parent-Child Interaction Therapy. Teachers should reflect the linguistic and ethnic composition of the families at Lotus House where 75% of mothers identify as African American, Haitian, or Caribbean; 20% identify as Latina, and many Latina women primarily speak Spanish. Teachers need to be able to support English Language Learners and their families with conversations in the families' language of use, and with forms, signs, and communications written in English, Spanish, and Creole.

Successful teachers will be able to provide a stable learning environment and adapt interactions and responses to students' emotional needs, shifts in mood, or non-verbal cues (Thistle-Elliott, 2014). Teachers should have deep knowledge of childhood development and early care and education, as well as experience with observation, documentation, and curriculum planning. In addition, teachers should be aware of the effects of trauma on children and mothers, and be skilled at building relationships with families.

The Wellness Center Director shall have the same minimum credentials as teachers, a record of several years of being an excellent early childhood teacher, and be highly skilled at motivating and leading staff in a way that is professional and empowering.

3. Establish ongoing professional learning and support across education and mental health professionals.

Responsive to staff needs. Professional development, conducted in-house or at community partners' sites, by Lotus House staff, consultants, or community partners, shall be ongoing, multi-tiered, and responsive to needs. New staff will participate in competency-based professional development in the form of group or individual training, coaching, and mentoring, as necessary in order to be competent in the curriculum and practices in use. Continued professional development and reflective practices will be scheduled to maintain the standards set at entry and to add knowledge of trauma-informed care, toxic stress, and resilience, mental health treatment modalities provided at Lotus House, new developments in curriculum, and new pedagogy.

Classroom observations to support teacher professional development. The Children's Wellness Center director shall conduct unannounced classroom observations on an ongoing regular basis, at irregular times to ensure that all classroom activities and time segments are observed and

contribute to the specifications of continued coaching and professional development. Structured observations with an established instrument shall be conducted once every 6 months and several brief, 5 to 10 minute observations, shall be conducted weekly.

Input and participation from the mental health professionals. The mental health professionals who work with mothers and children at the Lotus House shall assist with the professional development efforts by helping to ensure that classroom practices are consistent with the content of therapeutic practices; for instance in ensuring a positive environment. They shall conduct job-embedded professional learning and coaching, and participate in care teams. They can ensure that staff working with children are trained to recognize signs of trauma and can engage in interactions consistent with the recovery process to actively resist re-traumatization (SAMHSA, 2015).

Staff's mental health need support 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, even when staff are experienced and well prepared academically. Without support, professional functioning can be compromised; caregivers can experience a diminished quality of life, or experience emotional symptoms resembling PTSD (The National Child Traumatic Stress Network, n.d; Osofsky, Putnam, & Lederman, 2008). Hence, resources to address staff depression and job stress should be provided to protect staff from the effects of secondary trauma or compassion fatigue (Knitzer & Lefkowitz, 2006). Supports can integrate and structure reflective processes, including reflective supervision and mental health consultation (Gilkerson, 2004; Knitzer & Lefkowitz, 2006).

4. Identify a curriculum and practices that:

- f. are developmentally appropriate to promote children's social, emotional, physical, language, and cognitive development,**
- g. maintain small group sizes, i.e., low student to teacher ratios,**
- h. include primary care giving,**
- i. create a peaceful physical and emotional environment, and**
- j. embody the shelter's welcoming, inclusive, and trauma-informed environment.**

A developmentally appropriate curriculum: *The Creative Curriculum for Infants, Toddlers, and Twos* is based on development and learning objectives that are aligned with Early Head Start school readiness goals (Teaching Strategies, 2014) and approved for use by local School Readiness providers (ELCMDM, 2015). Its strengths include linkage with ongoing assessment, availability of a range of professional resources, and continuity across levels of early education (Horn, Goble, & Branscomb, 2012). It complements NAEYC's (2017) emphasis on using curriculum objectives to guide ongoing child assessments - which yield information that supports individualized learning. It meets local and national standards and requirements and acknowledges the centrality of teachers with expertise as they build positive relationships, appreciate individual differences, and promote social-emotional, physical, cognitive, and language goals and objectives along a developmental

continuum (Dodge, Rudick & Berke, 2006; Horm et al., 2012). It strikes a balance between structure and flexibility because predictable routines provide children a sense of security and flexibility allows teachers to respond to children's interests and needs.

A developmentally appropriate curriculum: *the Pyramid Model for Promoting Young Children's Social-Emotional Competence* should be incorporated into classroom practices and professional learning (Fox et al., 2003; Hemmeter et al., 2006). It is an evidence-based framework organizing research-based, developmentally appropriate practices to promote social-emotional competence and to prevent and address challenging behaviors (Hemmeter et al., 2016). *The Pyramid Model* and its catalog of professional development modules and materials are offered at no cost by The Center on the Social and Emotional Foundations of Early Learning (CSEFEL); a resource center funded by the Office of Head Start and Child Care Bureau to disseminate evidence-based practices. Its framework is consistent with multi-tiered public health and response-to-intervention models that incorporate universal promotion practices, preventative strategies for those considered at risk, and individualized interventions for those with intensive needs. As such, the base of the pyramid represents universal approaches for all such as engaging experiences and environments, clear expectations, joint play, social problem solving, identifying and managing emotions, encouragement, feedback for children, and support for family members in using such strategies (Hemmeter et al., 2014; Hemmeter et al., 2016). Moving up the pyramid are increasingly specialized services for smaller groups of children who may receive targeted, coordinated supports in the classroom or in therapy to learn specific skills such as making friends, expressing and managing emotions, and solving problems. At the top of the pyramid, individualized interventions can treat persistent challenging behaviors through individualized support plans based on collaborative teaming, observation and functional assessment, and data-informed decisions (Cimino et al., 2007; Hemmeter et al., 2016).

Low student to teacher ratios. Groups that have low child-teacher ratios promote children's sense of wellbeing, including feelings of safety and security and as such affect favorably children's exploration, play, and learning (Maguire-Fong, 2015). They enable teachers to give each child the attention that is necessary and make it feasible to manage the noise and children's activity level. Also, low child-teacher ratios facilitate safety and sanitation. Hence, the Children's Wellness Center should meet or exceed the ratios set by NAEYC and Early Head Start.

Assign primary caregivers. In primary caregiving, each child is assigned a specific teacher who is a single point of contact for all education-related matters, is a member of the child's care team, works in close cooperation with mothers and child and family therapists, and develops a close partnership with the child and family. The primary care teacher is especially important in a center serving children who will shortly transition to a new educational setting (Maguire-Fong, 2015) as well as one in which new children join the class at any time during the year.

Create a peaceful physical and emotional environment. Through organization of the physical and visual space, the Children's Wellness Center should reflect the feeling of sanctuary that is the

planned for Lotus Village to promote a sense of safety and security. It should include intimate spaces for children to collect themselves, a dedicated family room for breastfeeding or mother and baby break time, and space for family and staff meetings. It should include spaces for support services such as parent-child therapy, group therapy, and resource coordination, as well as shared space for embedded community partners.

Because the physical space is a participant in children's learning (Wurm, 2009), in addition to being safe, it should be orderly and dynamic so that children can engage meaningfully with materials that invite open ended exploration, discovery, interaction, and problem solving (American Montessori Society, 2017; NAEYC, 2016; NAEYC, 2017). Also, the physical environment should promote responsive social interactions and support social emotional development (Bovey & Strain, 2000; Hunter, Blackwell, Allard, & Lucerno, 2011) while minimizing extraneous, decorative visual displays that may distract from learning (Fisher, Godwin, & Seltman, 2014). Photographs, books, and artwork that reflect children, their families, and communities cultivate a sense of belonging, and images showing regularly occurring daily events help infants and toddlers develop security through a sense of predictability (Hunter et al., 2011; Wardle, 1995). Materials such as rocking boats, wagons, and large painting surfaces promote cooperative social interactions and cozy, quiet spaces offer space for children to retreat, rest, calm down, release emotions, or feel on their own without being alone (Bovey & Strain, 2000; Hunter et al., 2011; Weinberger, 2000). With children transitioning to and from classrooms throughout the day, classrooms may also be arranged to create spaces where children can play together without distraction (Maguire-Fong, 2015).

Embody the shelter's welcoming, inclusive, and trauma-informed environment. Overall, the various components of the Children's Wellness Center should come together to be consistent with and embody the shelter's welcoming, inclusive, and trauma-informed environment. In the case of the Children's Wellness Center, inclusiveness will extend beyond children with special needs to support all children regardless of need, trauma history, race, language, gender identity, or any other characteristic. The Children's Wellness Center's anti-bias classrooms must recognize and addresses bias and promote respect for human differences and a sense of pride in children and their families (Derman-Sparks & Edwards, 2010). To counter the stereotypes and biases that young children naturally develop (Baron & Banaji, 2006; Winkler, 2009), staff should provide children examples and visuals depicting roles, abilities, and ethnic or cultural backgrounds that defy stereotypes (NAEYC, 2017), as well as intentionally connect curriculum with students' cultural and linguistic backgrounds. As such, children will learn "how to respectfully and easily live, learn, and work together in diverse and inclusive environments," they will develop a sense of pride in their families, and "a sense of belonging and experience affirmation of their identities and cultural ways of being" (Derman-Sparks & Edwards, 2010, p.3). Because, when someone's own self-worth is affirmed, they are less likely to judge others negatively (Fein & Spencer, 1997).

OBJECTIVE 2. TO PROVIDE HOLISTIC, THERAPEUTIC, HEALTH, EDUCATIONAL, AND COMMUNITY SUPPORTS, TOOLS, AND RESOURCES

5. Embed community resources within Lotus Village by developing community networks and systems with therapeutic providers and quality early care and education settings.

Staff from a wide range of community agencies expressed their willingness to eliminate barriers to accessing services and contribute to the wrap-around support system of the Lotus Village by bringing their services on site. These offers should be followed-up to establish partnerships that enable partners to provide on-site services on a regular basis and in so doing create a hub for community participation, advocacy, resource coordination, and problem solving. Early care and education through Early Head Start and Head Start as well as Miami-Dade Public Schools can ensure quality programs for the children because these programs or agencies have service models that are based on best practices.

6. Assign a transition coordinator at intake as part of the care team whose job will be to assist families plan and implement transitions.

A staff member dedicated to coordinating the development and implementation of each family's transition plan should be assigned at intake. The coordinator will assist with transitions-related documentation, establishing relationships with other early care and education programs if/as needed, and follow up after the family has transitioned from Lotus House by assisting the mother in connecting to, visiting, obtaining and sharing information with new service providers. The transitions coordinator should promote strategies that support children's emotional wellbeing during transitions such as identifying familiar aspects of the new routine and/or environment, teaching children expectations of the new setting, and ensuring that they have the tools to express needs and ask for help (Fabian & Dunlop, 2007). The coordinator could be responsible for inviting, organizing, and hosting onsite service partners in the resource coordination space. The transition plan should include the continuation of early care/education and therapeutic services.

7. 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 and to guide subsequent therapy.

At the writing of this report Lotus House used an intake procedure that included a psycho-social assessment that included a semi-structured clinical interview and assessments of children primarily from maternal report. It is recommended that the procedure be expanded to include psychometrically validated screening and assessment tools to identify families' strengths and needs that can inform services and that procedures become more standardized than they have been in the past; to include operational rules on which mothers and children are to receive specific assessments.

Expanded assessments should include medical, psychosocial, psychiatric evaluations, as well as collection of trauma histories. In addition to assessments on the women residents, developmental assessments should be conducted of the mothers' accompanying children as well as assessments of mother-child interactions. Older children who can reliably report on their own experiences should also be interviewed. Referrals for additional assessments should continue to be made if necessary to in-house or off-site sources.

The needs of new residents should be assessed promptly and comprehensively. Multi-domain assessment instruments for children ages zero to five that might be used include those completed by parents such as Ages and Stages Questionnaire, Child Development Inventories, and Parents' Evaluations of Developmental Status. There are also instruments that require professional administration such as the Battelle Developmental Inventory Screening Test, the Bayley Infant Neurodevelopmental Screener, and the Birth-to-Three Assessment and Intervention Screening Test of Developmental Abilities (Ringwalt, 2008). Instruments to assess the social-emotional domain include those that rely on maternal report such as the Ages and Stages Questionnaires: Social-Emotional, the Brief Infant/Toddler Social Emotional Assessment, and the Infant/Toddler Symptom Checklist. There are also instruments that require administration by a qualified professional such as the Achenbach System of Empirically Based Assessment, the Behavior Assessment System for Children, and the Vineland Social-Emotional Early Childhood Scales (Ringwalt, 2008).

Selection of appropriate instruments should take into consideration children's ages, the availability of instruments validated in the families' language of use, the purpose for assessment, the time frame for administration, scoring, psychometric information, and who may administer the tool (Ringwalt, 2008). In addition, given the fact that mothers experiencing homelessness may not be the most accurate or reliable reporters of their children's status because of maternal stressors and fear of negative system responses, it is advisable to assess children with performance instruments whenever possible. These instruments require purchase, administration by professionals trained to use the specific instrument, and a higher investment in administration and scoring time than maternal self-report instruments. Nonetheless, they are a worthwhile investment.

The *Battelle Developmental Inventory Screening Test* (BDIST) for children 6 months to 8 years of age has subtests for fine and gross motor, adaptive, personal-social, receptive and expressive language, and cognitive skills. It is intended to identify children at-risk for delay and in need of full evaluation. The screener has a range cutoff and age-equivalent scores that were normed on a sample of 800 nationally representative children. It is comprised of 96 items that use a combination of direct assessment, observation, and parental interview. Test-retest reliability and concurrent validity are considered from acceptably high to strong (Ringwalt, 2008). Administration requires approximately 30 minutes.

The *Ages and Stages Questionnaire* (ASQ-3) and the *Ages and Stages Questionnaire: Social and Emotional* (ASQ-SE) (Brookes Publishing Co., 2017) are screening tools for children between birth and six years of age. They rely on maternal response to questions about their children's

attainment of developmental milestones and behaviors. As screening tools they are low-cost, easy to understand, available in multiple languages, widely-used across settings, research-based, extensively evaluated, reliable, and valid (Brookes Publishing Co., 2017; Mackrides & Ryherd, 2011; Ringwalt, 2008). The ASQ-3 in particular, was normed with a large sample of children from diverse ethnic and socioeconomic backgrounds and has relatively high levels of sensitivity and specificity as compared to other common screeners of developmental delay (Mackrides & Ryherd, 2011). It aligns well with other community programs because it is typically required by funders and service providers including School Readiness, Early Head Start, and the Early Discovery Service Partnership (See Appendix II for community partner details). Results determine whether or not a full evaluation is necessary and can be used by mothers and teachers to identify developmentally appropriate experiences for the children.

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. The protocol includes parent-directed and child-directed play conditions as well as cleanup. The interactions are videotaped and scored in real time. Typically, two composite parent measures are used: do skills (behavior descriptions, reflections, praises) and don't skills (questions, commands, and negative talk). Also, children's average compliance levels across the parent directed play and cleanup situations can also be calculated (i.e., ratio of the number of acts of compliance to the number of commands). The DPICS is the assessment of choice for the *Parent-Child Interaction Therapy* and is used with parents and children from 2 to 12 years of age. An adapted play situation without cleanup and an adapted rating scale is used for dyads with children under 2 years of age.

Parenting Stress Index Short Form (PSI-SF) (Abidin, 1995) is an abbreviated form of the Parenting Stress Index. Its 36 items measure the degree of stress in the parent-child dyad from parental ratings of the items. It is appropriate for parents with children up to 12 years of age. The instrument yields scores on: 1) parental distress, 2) parent-child dysfunctional interaction, 3) difficult child, and 4) total score.

Eyberg-Child Behavior Inventory (ECBI) (Eyberg & Pincus, 1999). This parent rating scale is comprised of 36 items that assess the frequency of child disruptive behaviors and the extent to which the parent finds the child's behavior troublesome. The scale yields a total problem score which is the total number of behaviors identified as a problem and a score on the intensity of the problems which is derived from a 7-point rating of each troublesome behavior. As such, it identifies the problems that are of concern to the parent. Problems listed include externalizing and internalizing symptoms. The scale was standardized on a sample of 798 parents from the Southeastern United States. It is appropriate for use with parents of children 2 to 16 years of age.

The ***Parenting Relationship Questionnaire*** (PRQ) (Kamphaus & Reynolds, 2015) is a parent rating scale comprised of 71 items that yield measures of attachment, communication, discipline practices, involvement, parenting confidence, satisfaction with school, and relational frustration. The items, which were written at a third-grade reading level, were normed on a representative

sample of parents. The child and adolescent version is designed for use with parents of children 6 to 18 years of age and can be used to guide counseling as well as to measure the effect of interventions.

The *UCLA PTSD Reaction Index for Children/Adolescents-DSM-5* (UCLA-PTSD) (Steinberg et al. 2013; Steinberg & Stanick, n.d.) . The child/adolescent version of this instrument measures exposure to actual or threatened death, serious injury, or sexual violence as a victim or as an observer. It assesses the presence of intrusive symptoms, persistent avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity associated with the traumatic events experienced. It also assesses the duration of the disturbance, if the disturbance has caused clinically significant distress and that the disturbance is not attributable to the psychological effects of substance abuse or medical condition. The first part of the instrument is a clinician administered screener. The subsequent symptom scale includes 27 items to assess PTSD symptoms and 4 items to assess dissociative subtype. Children/adolescents rate, on a 5-point scale, the frequency of symptoms in terms of the number of days affected in the prior month. This index is the recommended instrument for use along with Trauma Focused Cognitive Behavioral Therapy.

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

The complex challenges faced by mothers and children experiencing homelessness and the resulting stress on their mental health and relationship call for a range of promotion, prevention, and intervention supports for mothers, children and their relationship. Serious maternal depression can interfere with mothers' ability to engage in the responsive "serve and return" exchanges with their children; exchanges that are necessary for the development of positive relationships which also build children's neural connections. Also, interventions with mothers alone may reduce maternal depression, but children can remain overlooked if intervention fails to engage children in ways that specifically address their needs (Center on the Developing Child at Harvard University, 2009). Following are evidence-based therapies offered at Lotus House as of 2017 with the intent of addressing the residents' needs, identifying implementation strategies necessary to ensure that the modalities are well suited to the population, and comparing the efficacy of the modalities. The modalities offered to mothers depend on clinical needs and children's ages.

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). CPP applies attachment theory, trauma theory, and psychoanalytic insights and uses cognitive-behavioral and mindfulness strategies in order "to help the child and parent regulate affect, repair their relationship, and regain joy in pursuing developmentally appropriate goals" (Reyes & Lieberman, 2012, p.24). CPP for parents and their children ages birth to three years old "helps the parent read, interpret, and respond to the infant's cues" (Klain & Sandt, 2009, p.78). The mental health professional guides the parent in

understanding her young child's feelings and point of view through joint interactions and role play (Klain & Sandt, 2009). CPP is relevant to infant and toddler mental health programs and has demonstrated effectiveness in improving attachment, social-emotional, and cognitive functioning, and reducing PTSD symptoms (Klain & Sandt, 2009 citing Lieberman et al., 2006; Reyes & Lieberman, 2012; California Evidence-Based Clearinghouse for Child Welfare, 2006; 2015). The CPP can entail from 12 to 55 sessions.

Parent Child Interaction Therapy (PCIT) is a manualized evidence-based parent-training intervention with extensive research findings that demonstrate its efficacy (Nixon, Sweeney, Erickson, & Touyz, 2003; Schumann et al., 1998) and long-term maintenance (Boggs et al., 2004; Hood & Eyberg, 2003; Nixon, Sweeney, Erikson, & Touyz, 2004) in promoting infants' and children's behavioral functioning. It is appropriate for parents of children two to twelve years of age. With foundations in attachment and social learning theories, the goals of PCIT are to teach parents: a) behavioral management strategies aimed at promoting infants' and children's behavioral functioning, b) strategies to improve parent-child interactions and communication, and c) strategies to promote infant's and children's social-emotional development and self-esteem. Treatment progresses through two distinct phases: Child-Directed Interaction (CDI) which resembles traditional play therapy, and Parent-Directed Interaction (PDI) which resembles clinical behavior therapy. During CDI, parents learn to follow children's lead in play by using the non-directive skills such as praising, reflecting children's verbalizations, imitating children's play, describing children's behavior, and being enthusiastic. During PDI, parents set limits to reduce child noncompliance and negative behavior. They learn to use effective commands and consistently follow through with timeout for noncompliance and learn how to deal with aggressive behavior and public misbehavior. During all sessions, the therapist coaches each parent in vivo either in person or via a one-way mirror using a wireless headset. The PCIT is typically offered in 12 sessions.

The Nurturing Parenting Program is an evidence-based program that focuses on the development of parents' empathy toward their children, understanding of age appropriate behavior, nonviolent discipline strategies, and awareness of the importance of attachment (Bavolek, 2000; Family Development Resources, Inc., 2015). The program consists of 16 sessions. Facilitators of these groups at Lotus House have found that giving women opportunities to reflect on their own experiences and receive support from others has allowed them to consider their own actions as parents and created bonds among previously isolated individuals.

The Strengthening Families Program is an evidence-based, 14 session family skills training widely implemented and found to strengthen family communication and resilience as well as prevent substance abuse for diverse families (Kumpfer, Alvarado, Tait, & Whiteside, 2007; Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008; Kumpfer, Whiteside, Greene, & Allen, 2010). In the multi-component intervention, small groups of parents practice strengthening skills including observation, communication, structured family activities, therapeutic play, communication, and reinforcing positive behaviors (Kumpfer et al., 2007; Kumpfer et al., 2008).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a manualized evidence-based parent-child psychotherapy for parents of children and adolescents ages 3 to 18 who have experienced traumatic life events (TF-CBT Web; The National Child Traumatic Stress Network Fact Sheet, 2008). In 12 to 16 sessions, trauma-sensitive interventions are combined with cognitive behavioral, family, and humanistic principles and techniques. Children and parents learn how to manage thoughts and feelings associated with the traumatic events. Therapy enhances growth, parenting skills, family communications, and feelings of safety. TF-CBT has proven to be effective in addressing posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust (Saunders, Berliner, & Hanson, 2003; The California Evidence-Based Clearinghouse for Child Welfare 2006; 2015).

Additional therapeutic supports may be required by mothers to address maternal mental health problems such as depression, substance abuse, PTSD, schizophrenia, bipolar disorder, anxiety, and other forms of mental illness. Some of these may require off-site referrals.

OBJECTIVE 3. TO UTILIZE DATA AND RESEARCH TO CONTINUOUSLY MONITOR AND IMPROVE SERVICES

9. Establish an ongoing evaluation and research agenda to assess program implementation and evaluate outcomes.

Evaluation of measurable outcomes. The Lotus Village should incorporate an evaluation and research component that defines objectives for all of its service components such as mental health services and childcare/education services in support of the overarching goal of strengthening families. The component must include clearly identified and measurable program objectives expressed in terms of desired maternal and child outcomes. These outcomes need to be reasonable in scope relative to the services offered, and in magnitude relative to what is known as a reasonable improvement for the participating population (Duran et al., 2009). Measurable outcomes for children should include key aspects of functioning within the educational, social-emotional, and developmental domains. The instruments and methods used for data collection should fit seamlessly with the services that provided. Data collection instruments should be of such psychometric soundness, i.e., reliability and validity, that they can be used to assess individual mothers/children's needs, guide services, and measure progress towards the established outcomes. Thus, instruments for evaluation and research should not be an added burden to mother and children.

Sources of data and stakeholder feedback. Data sources should be diverse and comprehensive. Focus groups and interviews should be conducted with families and staff to assess satisfaction with services and to collect suggestions for improvement.

Assessment of classrooms processes should be evaluated with standardized observational protocols such as the *Classroom Assessment Scoring System (CLASS) for Infants and Toddlers* and the *Teaching Pyramid Observation Tool*. The *CLASS for Infants* measures responsive caregiving through

dimensions of relational climate, teacher sensitivity, facilitated exploration, and early language support. The *CLASS for Toddlers* measures emotional and behavioral support and engaged support for learning (Teachstone, 2016). Teachstone also offers professional development materials that can be used to strengthen areas of practice based on observation. The *Teaching Pyramid Observation* documents the fidelity of implementation of the *Pyramid Model* implementation and can determine what professional development is needed to enhance implementation (Hemmeter, Fox, & Snyder, 2014).

Assessment of children within the classroom context. Teachers should use *Teaching Strategies GOLD* to collect information about children’s development and link it to classroom practices and interventions. The GOLD is an ongoing, observation-based assessment system that allows teachers to collect and document evidence of children’s developmental progress beginning from birth (Teaching Strategies, 2017). It aligns with the research-based developmental objectives of *The Creative Curriculum*. The system organizes information and produces comprehensive reports to inform teaching and interventions. The reports and portfolios may be particularly useful for children in transition because they can easily be shared with others to ease the transitions. Other instruments for the assessment of children’s status, child and maternal interaction and mental health, and progress in the various therapy modalities are described above under Objective 2.

Data collection and management. A centralized data management system that is easy to use, flexible, and secure is an 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. The Children’s Wellness Center might consider using ChildPlus, a web-based software tool for early childhood programs that was designed to meet the comprehensive data collection and reporting standards of Head Start and Early Head Start and is customizable to meet the unique needs of various programs. Features include the management of attendance and enrollment; health information including physical, dental, vision, immunizations, and referrals; screening and assessment data; goals, meetings, and case notes of family engagement. ChildPlus is the data management tool used locally by Early Head Start providers. Feedback on the software from users has been positive and described as enabling team approaches to case management, facilitating organizing data collection, having supportive and accessible training, and providing opportunities to customize features and access.

Valid analyses and interpretation. Although many programs contain reporting formats that present the results of assessments, often in very colorful and attractive formats, specific training and/or expert guidance is typically necessary for valid interpretation of results. This fact is true for interpretation of individual progress as well as for the attainment of measurable outcomes and the elucidation of program effects. Experienced clinicians and instructional supervisors should provide analyses and guidance at the child individual or classroom level and evaluators or researchers should provide guidance at the program level by conducting statistical analyses and interpretation.

Mid- and long-term outcomes. Given the dearth of information at the national level on the mid- and long-term outcomes of families who experience homelessness, the Lotus Village can make a substantial contribution to the literature by getting consent from families to follow them on a regular basis after they transition to their homes. To that end, it is recommended that the Lotus Village partner with Miami-Dade County Public Schools in order to follow-up on the status and location of enrolled children. These types of agency-school partnerships have been implemented nationally and locally - for example by the National Educare network, Horizons for Homeless Children in Boston, and United Way Center for Excellence in Early Education in Miami.

10. Ensure continuous quality improvement by establishing a feedback loop with the evaluation and research program.

Evaluation is necessary for continuous improvement. The evaluation and research function should address means for continuous learning and improvement, evaluation of intended and unintended program effects, and contribution to research on effective practices for young children experiencing homelessness. Continuous program improvement processes and management systems should encourage staff growth and career development while supporting their stability (NAEYC, 2016).

Advisory Council. Collaboration and input from community stakeholders, experts in the field of early child care and education, and service partners was essential to the process yielding this series of recommendations. We recommend continuing and expanding this collaboration and sharing the results of evaluation with an advisory council that can provide guidance and a community perspective to advance the quality of services.

OBJECTIVE 4. TO SERVE AS A HUB FOR DEEPER COMMUNITY ENGAGEMENT

11. Regularly open the Lotus Village to the wider community with invitational and neighborhood activities.

To be successful in its mission Lotus Village needs to coordinate and integrate 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 means that families are not isolated in a compound, their transitions to independent lives will be eased if they have established linkages prior to moving out, and families will be safer if they are seen by neighbors as part of their greater whole rather than seen as outsiders.

To this end, the Lotus Village should have permeable borders with periodic open-houses for community agencies and a yearly neighborhood street fair. In addition, because many families pursue independent lives in the immediate vicinity, alumni can serve as liaisons to new families that

transition out to the neighborhood, and Lotus Village can facilitate the connection between alumni and families in transition by hosting informal social events for them to become acquainted.

12. Disseminate lessons learned to the wider national community.

Lotus Village, with its resources, linkages, and wide community support is in an excellent opportunity to become a demonstration model for the nation. To fulfill this role, staff should identify venues for sharing the models developed and lessons learned.

CONCLUSIONS

We have presented research-based, provisional 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. We described the need for coordinated high quality early care, education, and mental health services for the mothers and children at Lotus House. Then, we discussed how the center's early care and education program design can expand on and integrate current Lotus House services.

Based on common themes that emerged from research, community workgroups, interviews, site visits and focus groups, we recommended Children's Wellness Center program features that align with the holistic principles guiding Lotus House service to children and families:

- 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
- data utilization to continuously monitor and improve services and outcomes

Although Lotus House did not set out to operate an early care and education program, a decade of work with mothers and children demonstrated how limited access to affordable and trauma-sensitive care has created barriers for families seeking stability. The Children's Wellness Center presents opportunities to develop a two-generation approach, integrating services for mothers and children, connecting with resources within and outside Lotus Village, and broadening ideas of what is possible for families experiencing homelessness. The Children's Wellness Center can 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.

We recognize that launching and sustaining the Children's Wellness Center is a difficult endeavor and anticipate encountering overarching challenges involving the balance of structure and flexibility necessary to allow for responsive relationships and meaningful outcomes. Still, the benefits of meeting challenges like engaging families, protecting staff from secondary trauma, coordinating transitions to and from Lotus House, and sustaining funding for a model with costly elements represent opportunities to learn, evolve, and improve, for the sake of our children and the future of our nation.

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APPENDIX I: ACKNOWLEDGEMENTS

Sincere thanks to the many people who contributed their time, passion, and expertise to inform this report and the design of the Lotus Village Children’s Wellness Center, including the following agencies, many of whom agreed to participate in an Advisory Council.

Children's Bereavement Center
Early Learning Coalition of Miami-Dade/Monroe
Equality Florida-Safe Schools Initiative
Florida Association of Infant Mental Health
Florida Department of Children and Families Office of Child Care Regulation
Florida Department of Health Miami-Dade County Women, Infants, and Children Program
Florida Department of Health Miami-Dade County Breastfeeding Programs
Healthy Start Coalition of Miami-Dade
Horizons for Homeless, Dorchester, Massachusetts
Jessie Trice Community Health Center
Kristi House Child Advocacy Center
Legal Services of Greater Miami
Lindsey Hopkins
Lotus House Women's Shelter
Miami-Dade Community Action and Human Services
Miami-Dade County Homeless Trust
Miami-Dade County Public Schools
Montessori Schools, Blue Door and Green Door, Miami, Florida
Robert Morgan Educational Center and Technical College
The Developing Mother
United Way of Miami-Dade Center for Excellence in Early Education
UMOM Family Shelter
The Children's Trust
University of Miami Early Discovery Service Partnership
University of Miami Linda Ray Children’s Center
University of Miami Mailman Center

We are especially grateful to the Lotus House participants and alumnae who participated in focus groups and interviews.

APPENDIX II: COMMUNITY PARTNERS

Community partners participated in workgroups and interviews. Participants had expertise including research, early childhood education, and infant mental health. Based on these conversations, below are summaries of participating organizations along with brief descriptions of services that intersect with the Lotus Village Children's Wellness Center.

Children's Bereavement Center. Conducts free support groups for children, adults, and families who have experienced the loss of a loved one. Looking to expand in Overtown, Lotus House could be site of groups or participants could join a group held locally. Offers training for staff working with families and children who have experienced loss.

The Children's Trust. Dedicated source of revenue established by voter referendum to improve the lives of children and families in Miami-Dade County. Provided innovation grant for planning and design of the Children's Wellness Center. Contributes space for planning, connects Lotus Village to network of community partners, and assists in developing innovative model of care. Future steps include exploring funding for Children's Wellness Center and for therapeutic summer programs for children with disabilities, parenting programs, and advocacy.

Community Action & Human Services (CAHSD)- Miami-Dade County *Violence Prevention and Intervention Division.* Provides protection and supportive services to victims of domestic violence and their dependents including emergency shelters, transitional housing, outreach, and Coordinated Victims Assistance Center (CVAC). Builds community awareness about domestic violence through training.

Early Discovery Service Partnership: University of Miami Mailman Center for Child Development. Offers free services to Lotus House children ages 0-5 who would benefit from intervention but do not meet diagnostic criteria to qualify for services via Early Steps or FDLRS. Interventions can occur in the ECE classroom setting or an onsite therapeutic office and may include small group language and behavioral, therapeutic, occupational therapy, and developmental/cognitive services.

Early Learning Coalition of Miami-Dade/Monroe. Established by the School Readiness Act, administers School Readiness and Voluntary Pre-Kindergarten programs and funding, and administers Quality Counts; also an Early Head Start-Child Care Partnership grantee. Prioritizes access to School Readiness funds of children experiencing homelessness. Potential for ELC staff to enroll families in funding programs on-site; conduct professional development; and provide materials.

Equality Florida Action. Working to secure equality and justice for Florida's Lesbian, Gay, Bisexual and Transgender Community. Collaborates by informing, educating, speaking, and connecting Lotus House staff and participants with culturally competent LGBTQ learning and training to ensure the environment is safe and supportive.

Florida Association for Infant Mental Health. Promotes awareness, programs, and services to climate a healthy emotional climate for young children. Offers expertise on the unique mental health needs of young children. Developing an infant mental health credential with anticipated roll out in 2018. Florida

Department of Children and Families, *Child Care Regulation.* Accountable for licensure of Florida's child care facilities to ensure a healthy and safe environment for the children and improve the quality of their care. Advising on design of center to ensure it exceeds licensing standards. Training, etc.

Florida Department of Health in Miami-Dade County, *Women, Infants, and Children (WIC) Program.* Federally funded nutrition program for women, infants, and children. Provides at no cost healthy foods, nutrition education and counseling, breastfeeding support, and referrals for health care and community services. Potential for WIC staff to provide services on-site at Lotus Village including benefits enrollment, breastfeeding support, and nutrition training.

Jessie Trice Community Health Center Federally qualified community health care center serves as a medical home offering physical and dental exams, medical tests, immunizations, and referrals.

Legal Services of Greater Miami. Largest provider of broad-based civil legal services for the poor in Miami-Dade and Monroe Counties. Provides advice and representation in individual civil cases, addresses systemic issues, and empowers clients through community education and self help clinic. Potential to holistically serve Lotus House participants, who otherwise might not seek their services, with legal guidance and representation to remove barriers in accessing benefits and fair treatment in areas including government benefits, housing, immigration, and education.

Linda Ray Children's Center: University of Miami Department of Psychology Operates programs to meet the special needs of infants and toddlers who are risk due to abuse, neglect, or other conditions. Collaboration could include referrals between the organizations and Lotus Village learning from The Linda Ray center's expertise in Early Steps.

Miami-Dade County Public Schools (M-DCPS), *Adult and Career Technical Education.* Opportunity to partner as a laboratory school for adult students (including Lotus House participants) preparing to obtain the Early Childhood Professional Certificate (ECPC), which is aligned with the child Development Associate (CDA) and is accepted by the Florida Department of Children and Families and Voluntary Pre-Kindergarten program as a staff credential. The program has four completion points representing levels of occupations within ECE. The complete program includes the DCF mandated 40 hour Introductory Child Care Training, five hours of literacy training, and 480 hours of direct work experience with children ages five or younger.

Miami-Dade County Public Schools (M-DCPS), *The Parent Academy.* Offers family empowerment and parenting skills classes. Offered to conduct on-site office hours and assist mothers with children currently in or transition into an MDCPS school or program.

United Way of Miami-Dade Center for Excellence in Early Education. Elevates the quality of early care and education by demonstrating evidence-based practices, educating adult learners, and advocating for policies that support quality for young children and their families.

APPENDIX III: FUNDING

Services will be offered at low or no cost to children and families and funded through a combination of public and private sources. Clients are expected to meet eligibility requirements for a range of public funding sources including School Readiness, Early Head Start, and Early Head Start-Child Care Partnership. A summary of major public funding sources expected to be accessed by Children's Wellness Center families follows.

School Readiness

The Florida Office of Early Learning is responsible for affordability, availability, and quality of School Readiness child care, primarily funded through the Child Care and Development Block grant. The Early Learning Coalition of Miami-Dade/Monroe is the regional organization responsible for administering School Readiness funding. CCDBG regulations were introduced in September 2016 to facilitate access and remove barriers to childcare for families experiencing homelessness. For example, lead agencies must prioritize children experiencing homelessness for childcare services. States also must allow immediate enrollment and establish a grace period to comply with documentation requirements and lead agencies must help families comply with requirements during the grace period. Child care providers are assured payment during the grace period in order to address child care provider hesitance to accept homeless families due to fear they may not receive payment for services rendered (National Association for the Education of Homeless Children, 2016). Lead agencies must expend funds on improving access to quality early care and education and offer outreach services for children experiencing homelessness (Department of Health and Human Services, 2016).

Early Head Start and Early Head Start - Child Care Partnership

Approximately 50 years ago, Head Start, a comprehensive preschool program for three to five year olds and their low-income families emerged with the goal of enhancing and equalizing children's early experiences. About 30 years later, congress created Early Head Start, which serves families and children ages birth through three. The programs include early education, family engagement, nutrition, and mental health. Early Head Start and Head Start are federally funded, with a local match, and local Early Head Start and Head Start operators follow federally determined quality guidelines.

In 2014, congress authorized \$500 million to support state and community expansion of high-quality early care and education for children birth to age three through the Early Head Start-Child Care Partnership initiative with the intention that communities partner with and support child care programs serving CCDBG funded children, particularly in high-poverty zip codes. Through layered funding, Early Head Start-Child Care Partnership grantees support child care centers and family child care providers with resources needed to meet Early Head Start standards and provide comprehensive services. The reimbursement rate for Early Head Start and Early Head Start-Child Care Partnership openings is also notably higher than School Readiness reimbursement rates. Options are available through a range of settings and community organizations including: Miami-Dade County, Miami-Dade County Public Schools, Early Learning Coalition of Miami-Dade/Monroe, and United Way of Miami-Dade.

Fundraising

Although an array of public services can and should be accessed by the Children’s Wellness Center participants, there is a need to plan for securing and sustaining funding associated with a therapeutic model with high immediate cost components. We use the term high cost only relative to other programs, recognizing that the costs of not supporting the social and emotional wellbeing, early education, and care of children experiencing homelessness in human suffering and on long term public health and welfare systems are far reaching and far outweigh the immediate costs of providing protective factors.

Higher costs relative to typical early care and education settings include high levels of teacher education, low teacher to child ratios, and availability of 24 hour care. Programs that we found that provided high quality early care and education to vulnerable populations noted the costliness of running their programs. For example, we learned from an interview of one university’s therapeutic ECE program that focused on attachment but no longer exists due to lack of funding. As another interviewee with experience leading a high quality early childhood program put it: “fundraising is the issue at the end of the day.”

Because public funds are not expected to sustain the Children’s Wellness Center therapeutic model, next steps include determining bottom line costs and defining strategies for covering potential budget shortfalls. A community stakeholder provided guidance on costs we should consider when defining costs of operating the Children’s Wellness Center. Cost determination will require solidifying numbers of children, rooms, staff, and salaries.