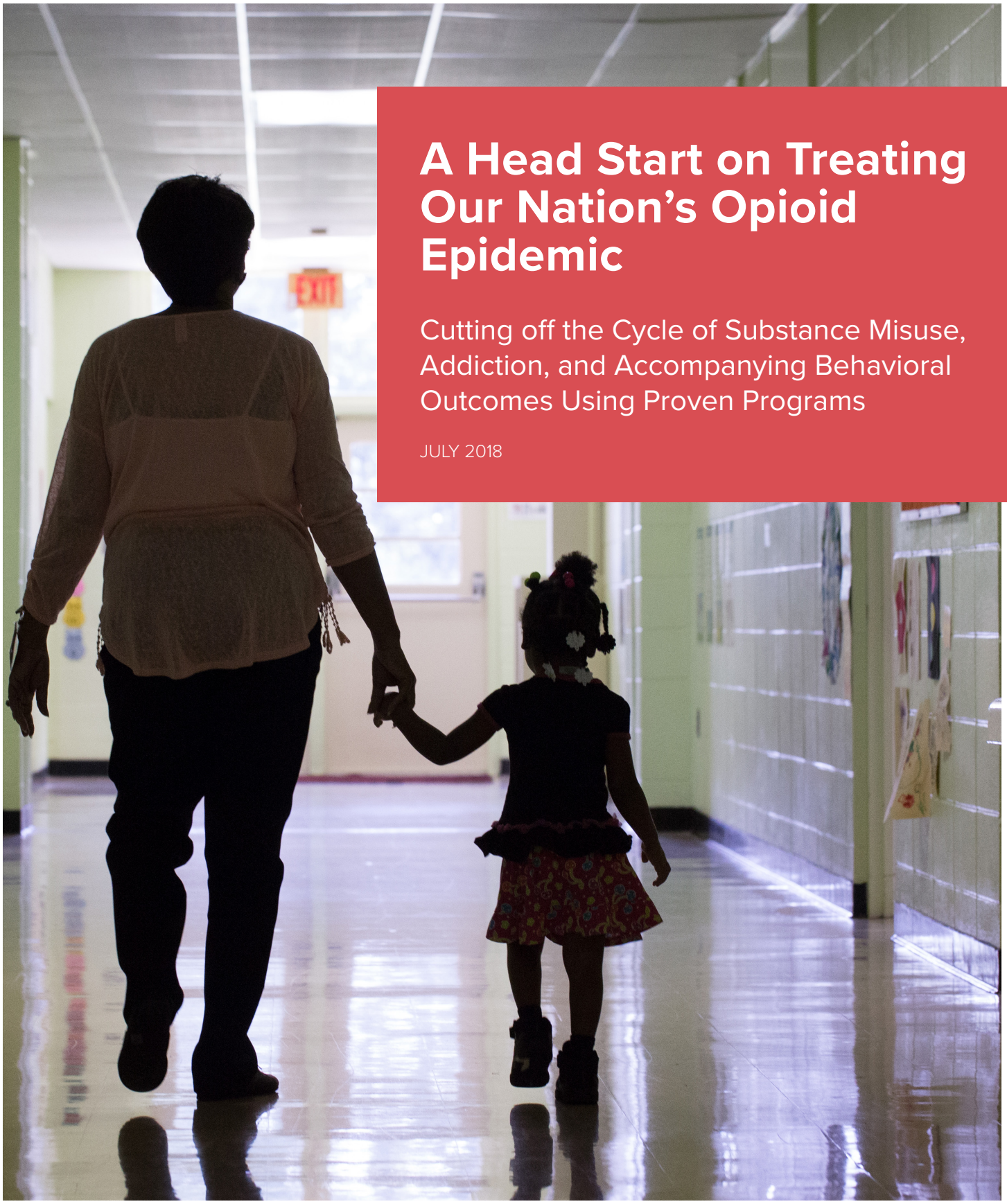
NATIONAL HEAD START ASSOCIATION

Our mission is to coalesce, inspire and support the Head Start field as a leader in early childhood development and education.



A Head Start on Treating Our Nation's Opioid Epidemic

Cutting off the Cycle of Substance Misuse, Addiction, and Accompanying Behavioral Outcomes Using Proven Programs

JULY 2018

Executive Summary

The United States faces a critical point in the opioid epidemic. Opioid death rates continue to rise across the country, taking over one hundred lives each day. However, the impact of the epidemic extends far beyond death rates to the families, households, and communities that are experiencing the scourge of substance misuse and addiction on a daily basis. Most often overlooked amidst the urgency to address the epidemic, however, are the smallest victims of this crisis–infants and children.

As the opioid epidemic worsens, the prevalence of neonatal abstinence syndrome (NAS) has also ticked upward. For children born with NAS, their earliest moments are met with withdrawal, tremors, irritability and even seizures for up to six months after being born. From 2000 to 2012, NAS cases increased 400%, and the Director of the National Institute for Drug Abuse testified before the United States Senate in May of 2018 that 1 in 5 newborns in West Virginia tested positive for opiates. The research on NAS is clear: significant poor behavioral and health outcomes can appear as these children progress through early childhood. Children who are born with NAS are found to need to repeat grades often or require more special education services and may have impaired attention spans, increased hyperactivity, among other deficits.

However, it is not just NAS that contributes to an unstable foundation for children growing up amidst the opioid epidemic. For the 8.7 million children currently living in homes where there is active substance abuse or misuse, their environment alone will play a significant role in negative health, behavioral, and academic outcomes. These children are often at risk for removal from their home and placement in the child welfare system or may be at an increased risk of being exposed to abusive behavior. For a child, the instability and disruptive parenting that can all too often go hand-in-hand with substance misuse can be traumatic and have lasting effects.

The foundational Kaiser and CDC led Adverse Childhood Experiences (ACEs) study found that traumatic early childhood experiences can have an impact on behavior and health throughout life. The study found that these health effects, some found 5, 10, even 20 years later, ranged from increased risk of heart disease, cancer, stroke, depression and behaviors like increased risks of smoking, alcoholism, and drug use. ACEs have been given the moniker “toxic stress” to denote that the effects are deep and long lasting.

Accordingly, in recent years there has been a renewed focus on programs that have the potential to mitigate the effects of this toxic stress caused by substance misuse in the family. The *President’s Commission on Combating Addiction and the Opioid Crisis* and the Bipartisan Policy Center have written that comprehensive family-centered approaches are likely to have the best outcomes for both children and parents given that more parents will have access to drug screening and treatment, allowing more children to remain with their parents and out of the child welfare system.

The federal Head Start program has provided millions of children and their parents exactly these kinds of holistic, family-centered approaches to early childhood education for more than 50 years. The Head Start model emphasizes a multigenerational approach with comprehensive services for America’s most vulnerable children birth to age 5 and their families. Services include health screenings, treatment and preventative care, mental health consultation, coordination with local community systems, and direct family engagement. Each Head Start and Early Head Start program is led by a local agency that is attuned to the specific needs of the local community to ensure that local needs are met with local solutions–there is no one-size-fits-all approach.

As the need has increased, Head Start programs across the country have used their limited existing resources to develop new and innovative models that are specifically targeted toward early childhood trauma related to opioid and substance misuse. One of these models was able to show that, following completion of their program, 68% of 3 year olds were on-age level developmentally, and 100% of the children had significant improvement in their drug-impacted symptoms with 53% showing resolution. The parents of these children also showed improvement, as 88% of mothers who became pregnant while their child was enrolled gave birth to full-term, drug-free infants. Another Head Start model had equally compelling data showing children by the end of the program had a 46.3% improvement in total protective factors, which are skills or coping strategies to help mitigate the effects of harmful ACEs and toxic stress.

8.7M

children currently live in homes where there is active substance abuse or misuse

Most often overlooked amidst the urgency to address the epidemic, however, are the smallest victims of the crisis–infants and children.

Executive Summary (cont'd)

While the Head Start community has generally focused on the opioid epidemic at the local program level, in April 2018 a working group of Head Start and Early Head Start program leaders from around the country assembled to discuss existing models, best practices, outcomes data, and resource requirements for these models. The working group agreed on the following key principles:

1. There are insufficient resources available to address the staggering and increasing needs in their local communities.

2. Head Start eligibility requirements can be an impediment to drug-impacted children who could benefit from services by enrolling in a local program.

3. Local collaboration with government agencies and organizations providing wrap-around services is critical to success because the collaborations build capacity and increase services available to children and their parents.

4. Training and technical assistance (in trauma-informed care) for more educators and staff is desperately needed.

5. Additional classroom staffing is required to support teachers due to significant behavioral and health challenges facing this population of trauma exposed children. More dedicated mental health professionals will be required to work directly with children.

Recommendations

Using these agreed upon principles, the working group proposed the following recommendations. In the absence of additional resources, the Department of Health and Human Services (HHS) Office of Head Start (OHS) should provide more technical assistance in trauma-informed care and classroom strategies tailored for teachers managing children facing significant psychological and behavioral challenges due to trauma. Second, OHS should issue guidance to existing Head Start programs to add administrative flexibilities to explore new and innovative models with their local agencies and organizations with a focus on measurable reductions in negative behavioral outcomes in children exposed to trauma.

Those administrative reforms provide a starting place. **However, to make a difference and build the specialized training, capacity, and staff required to serve this population of vulnerable children**, **Congress should appropriate dedicated funding that can be used for the following purposes**:

1. **Flexible Resources**: Provide existing Head Start programs new resources, including increased staff capacity, to implement multi-tiered positive behavioral interventions, supports, or other trauma-informed models of support for child and family.

2. **Referral Capacity**: Improve program capacity to identify, refer, and provide services to children in need of trauma support or behavioral health services.

3. **Training**: Provide extensive professional development to all Head Start program personnel with a focus on how to prevent, identify, and mitigate the effects of trauma.

4. **Building the Evidence Base**: Increase capacity and infrastructure support for data input and analysis to track pre-post evaluation of resiliency, social-emotional wellness, or behavioral concerns.

Using proven methods and resources already working on the front lines of the epidemic is critical to successfully addressing this crisis for the nation's trauma-impacted children. As an established vehicle of change for entire families, the prevention and intervention provided by Head Start to communities across the country make Head Start programs an essential element in the country's efforts to mitigate the devastating effects that the opioid epidemic has on children, their families, and their communities. By increasing Head Start's capacity to implement proven, comprehensive, community-based solutions to improve the mental, behavioral and physical health in lives of tens of thousands of children in urgent need, the administration and lawmakers can make a meaningful difference now.

Acknowledgements

A special thanks to the Head Start practitioners and experts from across the country who not only are committed to this critical work in local communities every day but who also contributed their time to informing this report and the National Head Start Association's work. Specifically, a sincere thank you to James Anderson, CEO of the Family Resource Agency in Tennessee, and all those who served on the National Head Start Opioid and Substance Misuse Working group, including:

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About NHSA

NATIONAL HEAD START ASSOCIATION

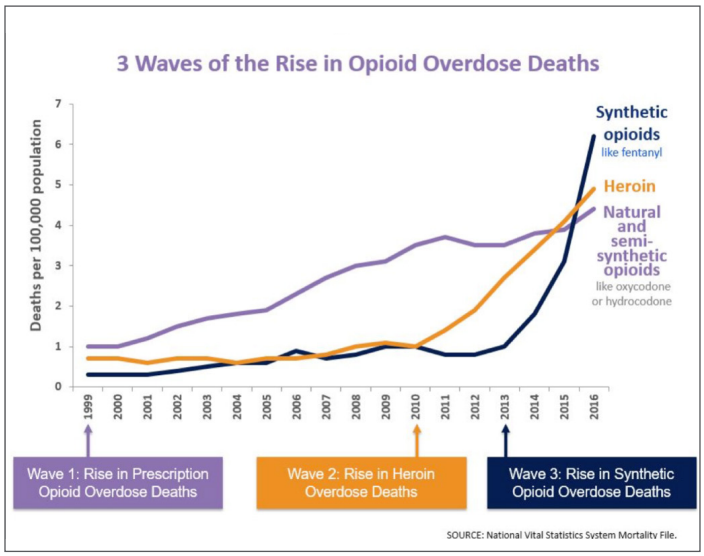
The National Head Start Association (NHSA) is a non-profit organization committed to the belief that every child, regardless of circumstances at birth, has the ability to succeed in life.

NHSA is the voice for more than 1 million children, 200,000 staff and 1,600 Head Start grantees in the United States. Since 1974, NHSA has worked diligently for policy changes that ensure all at-risk children have access to the Head Start model of support for the whole child, the family and the community. NHSA's vision is to lead - to be the untiring voice that will not be quiet until every vulnerable child is served with the Head Start model of support for the whole child, the family and community - and to advocate - to work diligently for policy and institutional changes that ensure all vulnerable children and families have what they need to succeed. NHSA's mission is to coalesce, inspire, and support the Head Start field as a leader in early childhood development and education.

State of the Epidemic

Today, according to the Centers for Disease Control and Prevention (CDC), 115 Americans will likely die from an opioid overdose.[1] Many more will have a near fatal overdose event, and still more will become addicted to prescription opiate painkillers, synthetic opioids, or illicit drugs such as heroin. Like a deadly tsunami that crept up on America from 1999-2016, more than 350,000 people have died from an overdose involving opioids as illustrated in Figure 1. Recognizing this, the Trump Administration and the Congress have made tackling the opioid epidemic a top priority. On October 26, 2017, the Department of Health and Human Services (HHS) Acting Secretary Eric Hargan declared the opioid crisis a public health emergency under section 319 of the Public Health Service Act to address the growing opioid crisis. This declaration has been extended twice by the current HHS Secretary Alex Azar and remains in effect through October 26, 2018 unless it is renewed again.

Figure 1



Understanding the Impact from Birth to Adulthood

The significant toll this public health crisis has taken on adults and adolescents should not, however, overshadow the severe, long-lasting impact it also has on children and infants. Opioid use during pregnancy has a strong association with neonatal complications.[2] Neonatal abstinence syndrome (NAS), where an infant is exposed to drugs in utero and suffers from withdrawal upon being born, is generally associated with symptoms for a newborn including tremors, seizures, diarrhea, vomiting, excessive crying, poor feeding, breathing problems, sleeping problems, inability to thrive, and low birthweight. From 2000 to 2012, the number of infants in the United States born with NAS grew 400% according to the CDC.[3] In some of the states with the highest burden of opioid abuse, the rate of growth in NAS cases is even higher. For example, the Director of the National Institute for Drug Abuse recently testified before the Senate Appropriations Committee that in West Virginia 1 in 5 newborns tested positive for opiates.[4] These infants require more intensive care after birth, stay in the hospital at least 3.5 times longer than a non-NAS patient, and cost 3 times more than a non NAS-affected infant.[5]

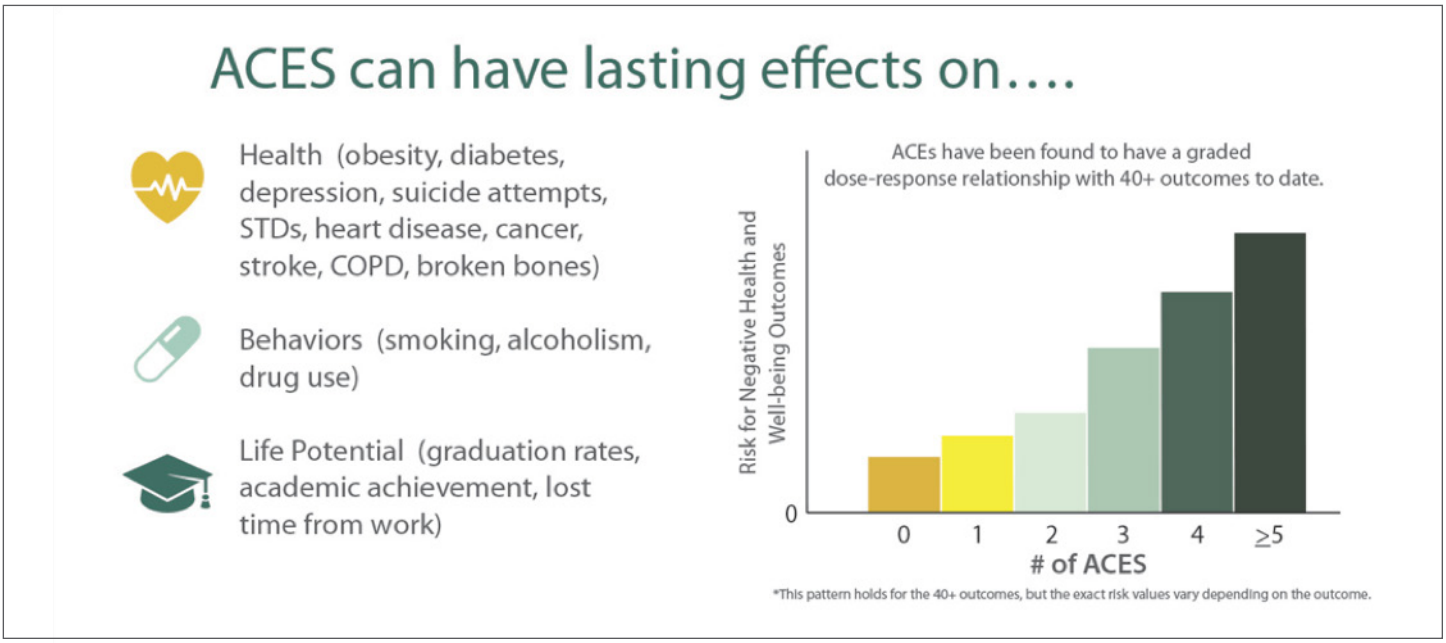
In recent years, research has emerged that has uncovered the behavioral and health outcomes of children treated for NAS as infants. The findings demonstrate that NAS is a strong indicator of significant poor behavioral and health outcomes as children progress through early childhood. For instance, one set of researchers found that 65% of children between the ages of 3 and 6 who were exposed to heroin prenatally had repeated one or more grades in school and/or needed special education services.[6] Other research has found prenatal exposure is linked to short attention span and hyperactivity among toddlers and impaired verbal and performance skills, motor weakness and perceptual abilities throughout childhood.[7] Even medications for opioid dependence during gestation were found to have a particular association with significant increases in hyperactivity, impulsivity, and attention disorder among children ages 5 and 6.[8] This research is likely just the tip of the iceberg. More is presently underway and will need to be completed in the coming years to assess the short and long-term impacts on this new large population of impacted children.

In addition to NAS, a child's home environment has a significant role in their health, behavioral and academic outcomes. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 8.7 million children in America live in homes where there is a substance use disorder.[9] Children living in these homes are often in unstable environments with the potential for exposure to abusive behavior from one or more parents and an increased risk of removal from his or her family into foster care (or into a family member's home) who may not be equipped to care for them. Many studies have found that children who live in homes with substance abuse have higher levels of anxiety and depression than their peers throughout their childhood.[10] In addition, academic performance appears to also be impacted by the presence of opioid abuse in the home, as some research shows impairment in quantitative and auditory memory cognitive functioning.[11]

Understanding the Impact from Birth to Adulthood (cont'd)

Nearly 20 years ago, researchers sought to understand these associations between childhood exposures to adverse events and the social, emotional, health, and eventual mortality consequences later in that child's life. A groundbreaking study conducted jointly by CDC and Kaiser, known as the Adverse Childhood Experiences Study (ACEs), suggests that certain adverse experiences such as childhood abuse, neglect or household challenges, including substance misuse within household, parental mental illness, separation or divorce, or an incarcerated household member, will increase the risk of health problems as the number of a child's ACEs increases.[12] Numerous studies since have demonstrated that an increased number of ACEs has significant effects on an individual's health (see Figure 2).

Figure 2 [23]



The health effects of ACEs can include substance misuse, depression, illicit drug use, ischemic heart disease, liver disease, risk for intimate partner violence, multiple sexual partners, early initiation of smoking, suicide attempts, early initiation of sexual activity, and adolescent pregnancy. Dr. Jack Shonkoff, on behalf of the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, has dubbed ACEs as "toxic stress" because of their dramatic ability to negatively impact the lives of children and ultimately adults.[13] Early academic deficits caused by ACEs come at the foundation of the learning process, which if not addressed, can lead to consistent below-average achievement.[14]

Consistent with this research, children who have been removed from their parents or who are in foster care have higher levels of behavioral and emotional problems between the ages of 6 and 12 and are more likely to have been expelled from school between the ages of 12 and 17. Likewise, children born into the opioid epidemic have often experienced some level of neglect, abuse, or substance abuse in their household leading to removal from the home. Therefore, as the opioid crisis has intensified, the burden on the child welfare system has increased significantly. Between 2011 and 2015, Ohio's foster care population increased 60%, Massachusetts by 19%, and North Dakota by 27%.[15] Additionally, children in the child welfare system were found to be more likely to have health issues than those living with parents, even those in high-risk settings. This combination of multiple ACEs and childhood trauma sets the stage for a whole generation of children in need of immediate assistance and early assistance to buffer the effects of this toxic stress before it has significant lifelong consequences.

Uniquely Positioned to Break the Cycle of Childhood Trauma: Head Start

The *President's Commission on Combating Addiction and the Opioid Crisis* released its final report on November 1, 2017. The report noted that any federal response must prioritize "comprehensive family-centered approaches and should ensure families have access to drug screening, substance use treatment, and parental support."[16]

This focus on intervention in the lives of families is critical to breaking the negative cycle that occurs when children who are exposed to multiple ACEs become adults with substance abuse problems themselves. There are multiple points of potential intervention with regards to families caught in the grips of substance abuse, whether it be preconception care, follow up from birth with a NAS patient, or eventually child care. A recent review of family-based intervention programs explored factors that impact a program's potential effectiveness and found the following predictors of success: (1) opportunities for positive parent-child interactions, (2) supportive peer-to-peer relationships, (3) power of knowledge, and (4) engaging families using strategies that are responsive to their socioeconomic needs and offering services that match the client-lived experience.[17]

One program emphasizing all of those predictors of success is Head Start. First launched in 1965 with the idea of providing comprehensive health, nutrition, and education services to children in poverty, today Head Start is a federal program housed in HHS's Administration for Children and Families (ACF) with an annual budget of around $9.8 billion, funding nearly 1,700 grantees that serve 1 million children and families. While Head Start is generally thought of as a school readiness program, it is significantly more. The Head Start model emphasizes a multigenerational approach with comprehensive services for America's most vulnerable children from birth to age 5 and their families. Services often include health screenings, treatment and preventative care, mental health consultation, coordination with local community systems, and direct family engagement. These whole family and child models developed over decades have been built on evidence-based practices and are continuously evolving to meet the needs of local communities. Because of this local focus there are no two Head Start programs exactly alike. Resource availability, geographic differences and other population variations in local communities encourage Head Start programs to work with building blocks of many existing innovative models and ideas, but one model certainly does not fit all.

Whole Family–Real Outcomes

One innovative Early Head Start program working collaboratively with local child welfare is the SafeStart Program in Allentown, Pennsylvania. SafeStart is a therapeutic Early Head Start program designed as an answer for children 0-3 who have been abused and are drug impacted. All children in the SafeStart program have experienced the ill effects and traumatic impacts that occur in families misusing substances such as developmental delay, neglect, inconsistent caregiving, homelessness and out of home placements. Children are referred to SafeStart by child welfare, the collaborating partner. Goals of the program include remediation of the impacts of prenatal exposure (NAS) or neglect from substance-misusing parents and ensuring healthy and family child development.

Like all Head Start or Early Head Start programs, SafeStart is a holistic model of support for the whole child and family. However, what makes SafeStart different from many Head Start and Early Head Start Programs is that in addition to the therapeutic center-based care, it provides services including home visiting, child/adult mental health, experiential parenting education, and addiction counseling. A developmental assessment is conducted on each child, including screening for emotional and behavioral needs, with results shared with the parents and collaborators. This helps develop the best comprehensive treatment and plan of care for each child. In the classroom, a low child-to-teacher ratio is maintained to address the increased needs of these vulnerable children.

Children are able to receive specialized therapies–such as occupational, physical, sensory, speech/language and feeding therapies—to remediate the effects of trauma from NAS and substance misuse in the home.

Data on outcomes confirms that SafeStart's model demonstrates an ability to improve the trajectory of these significantly at-risk children. Specifically, after completing SafeStart, 68% of 3 year olds were on-age developmentally, and 100% of the children had significant improvement in their drug-impacted symptoms with 53% showing resolution. Additionally, SafeStart improves family stability through its whole-family approach and integration with local community partners; as an effect, 91% of children achieved a stable permanent home and caregiver. Mothers of children in SafeStart also showed signs of significant improvement. Of the women who became pregnant while their substance impacted child was enrolled in SafeStart, 88% gave birth to full term, drug free, and healthy second children.

Given the staggering increase in costs to the state for foster care and Medicaid, the economic savings achieved from SafeStart are significant. It is estimated more than $120,000 is saved every year when foster care is avoided and children are able to stay in stable home environments and child welfare cases are closed. Thus far, it is estimated that SafeStart has netted nearly $1.5 million in foster care savings and over $9.5 million in child welfare involvement alone by stabilizing 106 families locally.

Overwhelming Crisis Requires a Full Court Press–a Focus on Trauma-related Services

Like Pennsylvania, the opioid epidemic has taken thousands of lives and impacted countless families in Ohio. According to the CDC, Ohio's rate of opioid-related deaths has risen from 5.8 per 100,000 residents in 2009 to 23.2 in 2015–a staggering 400% increase and nearly three times the national average. The Public School Children Services Association of Ohio conducted a survey and found that 70% of children in custody (out-of-home care) under the age of 1 had one or more parents who used opiates, including heroin. They also found that children are staying longer in foster care with a 19% increase in the median days in temporary custody. Given the historically high relapse rates observed with opioids (between 40-60%), these longer stretches in custodial care fit the timeline and pattern associated with treatment and relapse.[18] Recognizing the overwhelming need, the Butler County Educational Service Center has refined a unique Head Start program based on the Therapeutic Interagency Preschool Program or TIP Model. Currently operating in two Ohio counties and the Cincinnati Children's Hospital, the TIP model is deeply integrated with its local child and family welfare agency. In short, TIP seeks to be a supportive and integrated educational, mental health, and child-focused intervention that seeks to protect children while promoting healthy social interactions which are central to facilitating school readiness for preschoolers who have experienced significant trauma. TIP uses a trauma-focused approach with year-round preschool classes that are designed to be a safe supportive environment, where self-regulation, connections, and problem-solving are developed and practiced. Critical to the program is a low teacher-to-child ratio of 1 to 4 (typically 3 teachers in a single classroom) which means staff can provide personalized skill building and support. Teachers are informed and provided regular updates regarding the children and families' history and experience and how these may affect child behavior, choices, and reactions.

Close integration with early childhood mental health counseling is critical to TIP's success, as enrolled students are provided with on-site supportive therapies (developing self-regulation, peer negotiation, conflict management skills, and increasing frustration tolerance), grief therapy (dealing with losses related to multiple placements, separation from loved ones, loss of self-esteem/confidence, & loss of innocence), skill building (relaxation & self-soothing techniques, communication skills, safety skills, & independent thinking), and intensive trauma-focused interventions (feeling identification, positive memory, intrusive thinking, gradual exposure to traumatic events, trauma narrative). Like all Head Start programs, TIP focuses on the whole family as well by providing opportunities and activities for caregivers to participate in the child's learning experience at a variety of settings including in the home, classroom, building, and community. Frequent visits to the home are made to discuss progress, concerns, strengths, how to implement strategies in the home, identify parent goals, and to provide linkages to community resources.

Overwhelming Crisis Requires a Full Court Press–a Focus on Trauma-related Services (cont'd)

TIP has demonstrated measurable outcomes by working to build children's protective factors in the classroom and home. To measure and assess this, TIP uses the Devereux Early Childhood Assessment (DECA). DECA is a standardized strength-based assessment and planning system for promoting resilience in children ages 3 through 5. DECA includes three scales for reliably measuring attachment, self-control, initiative and a behavioral concerns scale. DECA scores can be used to identify children low on protective factors and screen children who are at risk for behavioral issues before they become disabling. Additionally, educators review the DECA ratings for the class to see the number of students with similar needs, set priorities for planning, and implement program changes.[19] DECA can be read and administered to evaluate progress at the end of a program year to determine whether a program is achieving its targeted goals of increasing student protective factors and decreasing behavioral concerns.[20]

Using DECA outcome data from the 2017-2018 program year, children showed significant improvements in all areas of measurement. The first area is initiative, which measures the child's ability to use independent thought and action to meet his or her needs and was found to be 24.4% improved from the start of the year. Self-regulation, which assesses a child's ability to experience a range of feelings and express them using the words and actions considered appropriate, was 36.6% improved. Attachment relationships are a measure of a mutual, strong, and long-lasting relationship between a child and significant adult(s) and improved by 26.8%. The behavioral concerns scale relates to underdeveloped protective factors. Children who are more likely to develop emotional and behavioral problems under similar risk conditions are described as "vulnerable," and a 21.9% improvement was seen in this category. Finally, there was a 46.3% improvement in total protective factors.

Since protective factors build resiliency and help reduce the risk of harm, support recovery, and foster social-emotional wellbeing, the TIP program may mitigate or soften the effect of multiple ACEs. Further long-term research on this population can be conducted, but the early outcomes are promising.

Figure 3

Leveraging Successful Head Start Models to Address the Epidemic—Talking to Educators

According to the Bipartisan Policy Center, "treatment programs that engage the whole family, and treatment facilities that allow parents to stay with their children, achieve better treatment outcomes."[21] Additionally, a recent USC-Brookings report stated that "the best evidence shows that a multi-faceted response to the opioid drug epidemic is warranted. This will require the Administration, states and localities to elevate the importance of interventions that remove barriers to housing, increase job training and educational opportunities, and assist families with accessing multi-generational treatment and resources."[22]

As demonstrated previously, Head Start programs are delivering these multi-faceted integrated services already at the local level. In April of 2018, a working group of Head Start and Early Head Start programs from around the country assembled to discuss existing models, best practices, how those models are executed, collaboration with local agencies and organizations, outcome data and resource requirements for these models.

The working group agreed with a number of key baseline principles. First and foremost, there are insufficient resources to address the growing needs among the parent and child population in their communities affected by the opioid epidemic. The number of NAS infants and children exposed to early childhood trauma related to a substance misusing parent has skyrocketed. They also noted that there was an acute need to provide significantly more assistance through wrap-around services to the parents and/or caregivers to ensure the child remained in a safe stable environment.

However, the working group noted that unlike previous substance abuse crises like the crack cocaine epidemic of the 1980's, where the children primarily came from urban low-income areas, the opioid epidemic is affecting children who often do not meet income criteria to qualify for Head Start programs. Multiple participants noted that only after a child was removed from his or her home into foster care or declared legally homeless, could they then qualify for Head Start.

Most participants stressed the critical importance of collaboration with local government agencies and organizations to provide wrap-around services. In one instance, a Head Start program worked in partnership with Children's Hospital of Cincinnati to embed two Head Start classrooms on site. In this model, therapists from the Children's Hospital are able to work one-on-one with the child for individual work, but enrollment is limited as children must be Medicaid eligible to participate. In another Head Start setting, the local public health agency was the primary referral source for identifying children who should be placed in the program. There was agreement that leveraging existing local agencies and organizations informally or formally via a memoranda of understanding (MOU) was a significant means of increasing program capacity and improving cost savings within Head Start programs.

Additional common themes emerged. As previously mentioned, the SafeStart and TIP programs conducted a validated pre-post assessment to determine progress from an academic and resiliency perspective. Many others did as well. The most frequently cited assessment for resiliency and behavioral screening was the DECA, however other tools were noted such as the Ages & Stages Questionnaires®: Social-Emotional, Second Edition and PROMIS® (Patient-Reported Outcomes Measurement Information System).

Additionally, the working group participants agreed that there were significant training needs that were unfulfilled. First, they concluded that more educators needed more frequent and up-to-date training in trauma-informed care techniques, classroom strategies, and methods for promoting resiliency. There was also a need for new training and resources for educators and program administrators to understand the signs of addiction in families, work with families who have one or more victims of substance misuse, and understand the impacts on those families especially the children. Additional training is needed in order to help mitigate atypical behaviors in the classroom (angry outbursts and/or aggression, increased activity level, decreased attention/concentration, increased distress), as these behaviors are more common in trauma exposed children. Finally, there was an expressed need for how to deal with the impacts of addiction and trauma within the Head Start staff themselves. Since these staff members come from the same communities as these parents and children, working group members stressed that the epidemic was taking a personal toll on their staff and they needed resources on how to cope.

Overall, the working group expressed that additional staff was critical to meet the demands of the growing number of children in their programs with significant behavioral and health challenges due to the opioid crisis. Many suggested that a third staff person in the classroom would provide a safe, stable, and supportive environment for all of the children, as an additional person could more effectively handle one or more children with distracting behavioral outbursts or distress. One staff person would be able to refocus these students while the remainder of the class would able to continue the lesson.

Working group participants also strongly agreed that they needed more dedicated resources for mental health services for both children and their families. All of the models surveyed had either a direct or indirect (via local agency or organization) relationship with at least one mental health professional to provide services and support for affected children and adults. The working group agreed that there was a need for full time on-site mental health professionals to work in or between classrooms depending on the Head Start program geography and/or design. Additionally, some expressed a need for professionals with specialization in play therapy and family therapy, and several expressed an interest in using desensitization therapies if resources permitted.

Delivering Policy Solutions to Meet the Needs of American Families During the Opioid Crisis–Working group Recommendations

To best address the needs of the children and families in need the Office of Head Start (OHS) can take several initial steps to begin to stem the tide. First, without utilizing any additional resources, OHS can administratively place priorities on the technical assistance it provides to its programs. Specifically, OHS can provide more technical assistance in trauma-informed care and classroom strategies tailored for teachers managing students facing significant psychological and behavioral challenges due to trauma. Second, OHS can issue guidance to existing Head Start programs to add administrative flexibilities to explore new and innovative models with their local agencies and organizations with a focus on measurable reductions in negative behavioral outcomes in children exposed to trauma.

Beyond those two administrative reforms, additional resources will be required to provide the specialized training, capacity and staff required to adequately serve this population of most at risk families. To accomplish this, Congress should appropriate dedicated funding that can be used for the following purposes:

1. **Flexible Resources:** Provide existing Head Start programs new resources, including increased staff capacity, to implement multi-tiered positive behavioral interventions, supports, or other trauma-informed models of support for child and family.

2. **Referral Capacity:** Improve program capacity to identify, refer, and provide services to children in need of trauma support or behavioral health services.

3. **Training:** Provide extensive professional development to all Head Start program personnel with a focus on how to prevent, identify, and mitigate the effects of trauma.

4. **The Evidence Base:** Increase capacity and infrastructure support for data input and analysis to track pre-post evaluation of resiliency, social-emotional wellness, or behavioral concerns.

The location of the Head Start or Early Head Start program and its relative per-capita opioid and NAS burden (as determined CDC's National Health Statistics Data) should be a significant factor (greater than 30%) in assigning points as a demonstration of need as part of the Funding Opportunity Announcement (FOA) scoring process.

The estimated yearly operating costs for supplementing existing Head Start programs may range from $125,000 to $500,000 depending on the size, scope and needs of local Head Start agencies. Most programs that apply for funding will likely require several new mental health professionals (i.e. school psychologists, licensed social workers), speech language pathologists, multiple assistant teachers, and significant professional development. If OHS were to receive an appropriation for $200,000,000 targeted toward this purpose and the average award was $275,000, OHS could make just over 700 awards.

Cutting off the Cycle of Trauma, One Child at a Time

Drafting, releasing, and ultimately awarding funds under this groundbreaking FOA will be a significant step in the process of working toward improving the lives of these children and their families. Stopping there is not sufficient. With added flexibilities and technical assistance in FY 2018 to give Head Start programs an initial needed boost to manage the impact in the highest burden areas, increased appropriations will be necessary in FY 2019 to accommodate an expansion of services to the more than 57,000 Head Start classrooms.

Ultimately, the opioid epidemic continues to expand. Through increased federal, state, and local focus however, there is a real hope of a turning point where a coordinated effort is starting to stem the tide of this destructive force. Critical to resolving this crisis will be using proven methods and resources already working on the front lines of the epidemic. As one of the front-line providers serving over one million children and their families every day, Head Start can play a crucial part in reducing the impact of toxic stress created by trauma caused by substance misuse in the family. Head Start providers are already stretched thin, and additional resources will be required to ensure children and their families are able to receive the services they need. By increasing these providers' capacity to implement uniquely-positioned, proven, comprehensive, and community-based solutions to improve the mental, behavioral and physical health in the lives of tens of thousands of children in urgent need today, we know Head Start can make a difference– it just has to be given the opportunity.

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