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Factors Associated With Service Referrals and Uptake in Early Head Start

The Importance of Care Setting

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Secondary analysis of the Early Head Start Family and Child Experiences Survey 2018 data set (Baby FACES 2018) explored links between family risk events and referral-making and referral uptake among families receiving Early Head Start (EHS) services. Referrals to both behavioral health and entitlement programs were considered. Results showed that referrals to behavioral health programs were much more likely to be given to families receiving care from home-based care than center-based care, and that referrals were slightly more likely to be given to families who did not have any family risk events. Several factors also moderated the relationship between family risk and referrals, including perceived closeness of the parent/caregiver-EHS staff relationship, family conflict, and caregiver depression. There were no observed effects for referrals to entitlement programs. Caregiver depression weakened the link between family risk and service uptake for entitlement programs. **Key words:** *early childhood, Early Head Start, family risk, referral, service uptake*

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EARLY CHILDHOOD (0-3 years) has been identified by researchers, policymakers, and practitioners as a critical period of growth and development in a child's life, with a growing recognition that events during this time set the stage for physical and mental health outcomes later in life (Shonkoff, 2016). Previous research, including the seminal Adverse Childhood Experiences (ACEs) study (Felitti et al., 1998), has demonstrated that exposure to potentially traumatic events and other significant negative experiences in childhood contributes to poorer outcomes later in life. In infancy and early childhood, potentially traumatic events can have impacts, including increases in stress hormone levels which can in turn lead to slower development of language, cognitive, and social

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skills (Shonkoff et al., 2012). Early intervention for both parents/caregivers (Birur et al., 2017) and young children (Hahn et al., 2016) after a potentially traumatic experience has been shown to be an effective strategy in reducing trauma reactions. Particularly with parents of young children, an important part of the posttrauma exposure response is to provide services to promote positive parenting behaviors (Johnson et al., 2018).

Since its inception in 1995, Early Head Start (EHS) has served low-income children aged 0 to 3 years and their families through center-based, home-based, and family childcare settings. The EHS model includes a whole child, trauma-informed approach, recognizing that these individual and environmental factors, including both the ability of a caregiver and child to access resources, play a major role in overall child and family development and the ability to rebound from adversity (Bartlett & Smith, 2019; Vogel et al., 2011).

Evidence shows that the children and families served by EHS are more likely than their peers to have experienced a potentially traumatic event. Within the United States, nearly 8% of infants and toddlers have already had two or more adverse experiences (Keating et al., 2021). Studies in early care and education settings, including EHS, reveal a higher incidence of childhood trauma among both primary caregivers and children. It is estimated that as many as 60% to 85% of EHS and Head Start children have experienced trauma, many of them with multiple exposures to potentially traumatic events (Blodgett, 2014; Saint Gilles & Carlson, 2015), compared with the general population of young children, with an estimated rate of trauma exposure around 20% (Keating et al., 2021). An EHS parent/caregiver with multiple traumatic events in their history is more likely to have a child in EHS that has experienced at least one trauma (Blodgett, 2014). This places EHS, whose mandate includes referring families to programs and other sources of support to address the needs of both parent/caregiver and child, at a key juncture to intervene on behalf of young children exposed to potentially traumatic events.

Because EHS focuses on the needs of low-income families, children enrolled in EHS are more likely to be living with families reporting high levels of financial insecurity (Vogel et al., 2011). The referrals provided can include both clinical services that might help address behavioral health needs that result from trauma, as well as entitlement programs that can provide material assistance to families. Access to these services is linked to better long-term outcomes for young children (Shonkoff, 2016).

RESOURCE REFERRALS FOR EHS FAMILIES

EHS supports families in building protective factors and resiliency by providing early care and education, caregiver support and education, home visiting, developmental screening, and referrals to community services. There are following two models for providing EHS services: home-based and center-based (U. S. Department of Health and Human Services, n.d.). Center-based care primarily involves classroom-based services provided at group care settings, although there is more variability associated with the model. Home-based care involves Head Start services provided primarily within a family home with Head Start workers visiting the home at least 46 times per year and the families attending some events at a Head Start group care setting.

As a core component of EHS, referral-making and service connection are viewed as critical to family success, especially given that the program primarily enrolls families with a wide range of needs. Because not all EHS programs can develop in-house capacity to address the range of needs of families with trauma or other emergent needs, most employ a community referral strategy to help fill the gaps and connect families to critical supports (Bartlett & Smith, 2019).

Studies have not yet addressed the relationship between family trauma and referral-making or referral uptake within an EHS setting, nor how EHS program type may affect referrals. It is possible that given the

lower family to staff ratio of children served in home-based care that EHS workers are better able to connect with families and provide referrals to services. Vogel and colleagues (2006) noted that in a survey of EHS centers, representatives from nearly half stated that they did not believe that they had any children in their care who needed referrals and had not yet received one.

Because limited research exists on referrals within the EHS context (Baggett et al., 2007; Summers & Wall, 2008), this analysis seeks to add knowledge to the field related to referral patterns and moderators of the referral processes. The EHS referral process can be an important link in identifying risk and guiding families to services that may help a family build protective factors. Understanding referral patterns and moderators of the referral process could illuminate opportunities for improvement across an array of EHS implementation areas.

The present research addresses two primary research questions. (1) How well do elevated family risk profiles predict being referred to services by EHS staff and subsequently connecting to those services? (2) What factors influence the links between family risk and referrals, and the rate of referral and service receipt?

DATA AND METHODS

Data were from the EHS Family and Child Experiences Survey of 2018 (Baby FACES 2018; Vogel et al., 2020). The data were obtained through an agreement with the Interuniversity Consortium for Political and Social Research. Baby FACES 2018 was a continuation of previous data collection efforts to understand the experiences of Head Start families undertaken from 2009 to 2012. Data were collected from a nationally representative, cross-sectional sample of EHS participants, with questionnaires administered to parents/caregivers of children, their EHS teachers or home visitors, and for center-based programs, program directors. In all, caregivers of 2,495 participants

were surveyed. Of these, 2,160 participated in center-based EHS programs and 335 in home-based programs. The average age of the participating children was 26.2 months. A total of 2,139 EHS staff members, who provided care to the children in the sample, were also surveyed. Because the two models of EHS have significant differences in program requirements and service delivery, the present study considered the center-based and home-based EHS programs both separately and combined.

Survey participants were chosen using a multistage sampling procedure, which resulted in a representative sample of EHS grantees in the United States, excluding programs in Alaska and Hawaii, and programs that were funded through Region XI (focusing on American Indian/Alaska Native children) and Region XII (focusing on children of seasonal/migrant workers). Demographic information about the sample can be found in Table 1.

MEASURES

Outcome variables

The Baby FACES data set included questions of whether the respondent had been referred to one or several available resources within a community. There were two broad groups of resources assessed, behavioral health resources (e.g., substance use treatment, domestic violence services) and entitlement programs (e.g., TANF, SNAP). There were also questions concerning whether the parent/caregiver had then received benefits from the entitlement programs—though not for behavioral health resources. These service uptake questions were also considered. For these analyses, the researchers used a binary indicator of whether any referrals had been made. When the number of referrals made was modeled as a continuous variable, the results did not vary substantially.

Primary predictor variable

The researchers created a Family Risk Index from questions present in the Baby

Table 1. Sample Demographics

Characteristics of EHS Families	<i>n</i>	%
EHS placement		
Center-based	2,160	86.6
Home-based	335	13.4
Child's sex		
Male	1,313	52.6
Female	1,175	47.2
Parent/caregiver respondent age in years		
0-17	28	1.3
18-19	50	2.4
20-24	394	18.9
25-29	599	28.7
30-34	502	24.1
>35	511	24.5
Caregiver race/ethnicity		
Hispanic	822	39.7
Black/non-Hispanic	583	28.2
White/non-Hispanic	557	26.9
American Indian/Alaska Native	24	1.2
Multiracial	60	2.9
Other	24	1.2
Caregiver education		
Less than high school	444	21.4
High school diploma or GED	646	31.1
Vocational/technical	81	3.9
Some college	493	23.8
College degree	410	19.7
Caregiver born in United States		
Yes	1,555	74.7
Family risk events		
None	1,824	73.1
1	573	23.0
≥2	98	3.9

Note. EHS = Early Head Start.

FACES survey, borrowing heavily from the ACEs framework (Felitti et al., 1998). Although the Baby FACES data set did not directly use the ACEs framework, a subset of following eight questions from the survey correspond with categories of trauma found in ACEs: child abuse/neglect, child protective services involvement, intimate partner violence, parent/caregiver leaving the family, parent/caregiver death, parent/caregiver substance abuse, parent caregiver mental health concerns, and parent/caregiver incarceration. As part of the survey form, parent/caregivers were asked about several experiences that they may have had within the lifetime of their child. For example, if the child was not living with both biological parents, the custodial caregiver was asked why this was the case. In some cases, the respondent indicated that the noncustodial parent was incarcerated or had experienced a substance use problem. In addition, staff were asked whether they had addressed specific issues during face-to-face encounters with the child's caregiver, including issues such as domestic violence or alcohol/drug use. In this way, we were able to identify evidence of several family stressors that may have been present in the life of the caregiver and child in EHS services. Because most of the questions were asked within the context of the lifetime of the child, and because the children served by EHS are up to 3 years of age, the likely time frame for experiencing those events was within that range. The Family Risk Index included a total of eight potential events scored as yes/no for occurrence with possible scores ranging from 0 (no events) to 8. Risk exposure was also analyzed as a binary variable (no risk events vs. one or more events), but no substantive differences were found from what is reported later.

Potential moderator variables

To test what factors might moderate the relationship between family stress and the referrals to and receipt of services, we investigated several other measures included within the Baby FACES protocol.

Family environment

- *Confusion, Hubbub and Order Scale* (CHAOS; Matheny et al., 1995): The 15-item scale is completed by parents/caregivers and provides a rating of the level of disorganization and chaos present in the home. Items are rated on a 4-point Likert scale. Within the full sample, the scale had an internal consistency of 0.77 by Cronbach's alpha.
- *Family Conflict Subscale of the Family Environment Scale* (FCS; Moos & Moos, 2002): The FCS of the larger Family Environment Scale provides a rating of perceived conflict and anger expressed within the child's family and is completed by the child's caregiver. The larger scale contains 90 total true-false items, of which the Family Conflict Scale comprises nine items with a Cronbach's alpha of 0.56.
- *Parenting Stress Index—short form* (PSI; Abidin, 2012): This scale requests that caregivers rate their own experiences of stress in relation to their role as a caregiver for the specific child being assessed as part of the study. The 36-item short form was used, and caregivers answer questions on a 5-point Likert scale, which had a Cronbach's alpha of 0.95.

For all three scales, higher scores were indicative of higher levels of stress and conflict.

Parent mental health symptoms measure

- *Center for Epidemiological Studies Depression Scale-Revised* (Eaton et al., 2004): Caregivers, primarily mothers, were asked to rate their own experiences of depressive symptoms. Caregivers rated 20 questions on a Likert-type scale from 0 to 4, and higher scores were indicative of higher levels of depression. Internal consistency was high for the measure (Cronbach's alpha = 0.91)

Parent-EHS staff relationship measures

- *Support scale of the Cocaring Relationship Questionnaire-Adapted* (CRQ;

Lang et al., 2017): This 12-item measure, on which the items are scored on a Likert-type scale from 0 to 6, is administered separately to teachers and parents to assess whether they have a well-formed relationship around their shared responsibilities with a specific child. This instrument was administered to parent/caregivers of children who were receiving center-based Head Start services, and within the parent/caregiver sample had high internal consistency (0.79 by Cronbach's alpha).

- *Working Alliance Inventory* (WAI; Tracey & Kokotovic, 1989), which was completed by parent/caregivers receiving home-based services and measured the strength of the relationship between the caregiver and the EHS home visitor. The scale contains 12 items scored on a 5-point Likert scale, and had a Cronbach's alpha of 0.88 for the full scale.

For both scales, higher scores indicated a closer working relationship between parent/caregiver and EHS staff.

Analysis

Measures had been previously scored within the original data set. Sample sizes for each measure varied, based on missing data. The primary methods for analysis included chi-square and binary logistic regression. For the second research question, the researchers used a moderator framework (Baron & Kenny, 1986), conducting a series of analyses to determine whether any of the included measures altered the relationship between the Family Risk Index and the likelihood of a respondent family receiving a referral for services or the likelihood of a respondent family receiving services. In the moderator framework, both the primary independent variable (family risk events), the potential moderator, and the interaction term of those two variables were entered into a single regression. A moderator effect was present if the interaction term loaded significantly into the regression.

The Baby FACES data set also contained an indicator of whether the family was served in a home-based or center-based setting. All analyses were run first with the full sample, and then separately within each subgroup. Unless noted, the results presented are for the full sample, and the same patterns were observed in both subgroups.

RESULTS

Preliminary descriptive analyses

Of the families surveyed, 26.9% reported at least one of the eight family risk events. Overall, only 7.8% families received any referrals to behavioral health programs. However, the type of program in which the family was enrolled made a significant difference. Families who were receiving services through center-based EHS programs were much less likely (3.7%) to receive a referral to any behavioral health programs than were those receiving home visit-based services (34.0%; $\chi^2 = 371.95$; $p < .001$). However, family risk events were actually more prevalent among those in center-based care (27.9% families) compared with those in home-visit care (20.6%; $\chi^2 = 7.80$; $p < .01$). Participants in each of the two service models did not differ in the rates at which they received referrals to entitlement programs (57.0% families enrolled in center-based care vs. 57.6% for those served in home-based care; $\chi^2 = 0.39$; n.s.).

Those enrolled in center-based care reported somewhat lower levels of family conflict on the CHAOS (mean = 9.95) than

those in home-based care (mean = 11.97; $t[2,055] = 5.36$; $p < .001$). Similarly, those in center-based care (mean = 1.41) rated themselves as experiencing less conflict on the Family Environment Scale than those in home-based services (mean = 1.53; $t[1,325] = 4.35$; $p < .001$). Finally, those in center-based care (mean = 13.57) reported feeling less of a connection to EHS staff than those in home-based care (mean = 14.23; $t[2,024] = 4.001$; $p < .001$) on the CRQ. There were no other observed differences between the two groups on variables of interest.

A logistic regression, controlling for these three factors found that whether the child was served in a home-based or a center-based program continued to significantly predict whether the family would be referred to behavioral health services and explained the majority of the variance accounted for by the variables in the equation (see Table 2).

Are EHS families with family risk events being referred to services by EHS staff and then receiving services?

Respondents who had at least one family risk event (6.0%) were significantly *less* likely to receive a referral to any behavioral health program than those who had no risk events (8.4%; $\chi^2 = 4.21$; $p < .05$). At the same time, families with at least one risk event (73.0%) were *more* likely to receive a referral to entitlement services than those with no identified risk events (51.3%; $\chi^2 = 94.87$; $p < .001$).

This pattern held in both center-based and home-based EHS programs. Among families

Table 2. Preliminary Regression Analyses, Predicting Referral to Behavioral Health Service^a

Variable	B	SE	Wald	p	-2LL
EHS model (1 = center-based)	-2.112	0.196	116.22	<.001	128.72
CHAOS	0.038	0.015	6.28	<.05	6.16
Cocaring relationship	0.141	0.059	5.63	<.05	6.96
Constant	-3.135	0.903	12.07	<.001	N/A

Note. -2LL = change in -2log likelihood; CHAOS = Confusion, Hubbub and Order Scale; EHS = Early Head Start; N/A, not applicable.

^aFamily Environment Scale did not significantly predict referral in this model.

receiving center-based care, 2.5% of those who had a risk event received a referral to a behavioral health service compared with 4.2% of those who had no risk events ($\chi^2 = 3.43$; $p = .064$). Those with a risk event (72.8%) in center-based care were more likely to receive a referral to an entitlement program than those who had no risk events (51.0%; $\chi^2 = 84.17$; $p < .001$). In home-based care, respondents with one or more family risk events (36.2%) were slightly more likely to have received a referral to behavioral health services than those with no risk events (33.5%; $\chi^2 = 0.18$; n.s.). Referrals to entitlement programs were higher among those who had a risk event (75.4%) than those who did not (53.0%; $\chi^2 = 11.21$; $p < .001$).

Families who had at least one risk event were more likely (90.9%) to have received services from an entitlement program than those who had zero risk events (69.0%; $\chi^2 = 125.01$; $p < .001$). The Baby FACES data set did not report on receipt of services from behavioral health resources.

What factors influence the rate of referral and connection to services?

In addition to the effect of program type, several other variables moderated the link between family risk events and referrals to services. In the moderator analyses summarized in Table 3, the researchers found that greater levels of family conflict (as measured by both the CHAOS and the FCS) predicted a stronger link between family risk events and referral to behavioral health resources.

A significant effect was also present for both the CRQ and WAI. Parents/caregivers who rated that they felt more supported by EHS workers, were less likely to have family risk events associated with a referral to behavioral health services.

There were no significant moderator findings for referrals to entitlement programs.

For receipt of services from entitlement programs, there was a marginally significant moderator effect involving the parent/caregiver’s level of depressive symptoms, as measured by the CES-D. Although family

Table 3. Moderator Analyses, Predicting Referral to Behavioral Health Services

Variable	B	SE	Wald	p
FRI	-0.913	0.320	8.13	<.01
CHAOS	0.038	0.015	6.55	<.05
FRI*CHAOS	0.047	0.020	5.56	<.05
Constant	-2.737	0.193	N/A	N/A
FRI	-1.792	0.659	7.40	<.01
FCS	-0.025	0.259	0.01	n.s.
FRI*FCS	1.174	0.407	8.32	<.01
Constant	-2.117	0.385	N/A	N/A
FRI	1.042	0.568	3.37	.07
CRQ	0.195	0.056	12.03	<.001
FRI*CRQ	-0.092	0.042	4.91	<.05
Constant	-5.062	0.806	N/A	N/A
FRI	6.169	2.44	6.38	<.05
WAI	0.028	0.023	1.51	n.s.
FRI*WAI	-0.109	0.044	6.27	<.05
Constant	-2.062	1.277	N/A	N/A

Note. CHAOS = Confusion, Hubbub and Order Scale; CRQ = Cocaring Relationship Questionnaire (Support Scale); FCS = Family Conflict Scale; FRI = Family Risk Index; N/A, not applicable; WAI = Working Alliance Index.

risk events were generally associated with receiving more entitlement program services, the link somewhat weakened at higher levels of caregiver reported depression (interaction term $B = -0.025$; Wald = 3.37; $p = .067$). This was the only noted moderator effect on receipt of services.

DISCUSSION

Using the national Baby FACES 2018 data set, the current study examined whether the experience of family risk events was associated with referral to and uptake of behavioral health and entitlement program services in EHS settings. It also investigated whether this association was moderated by various parent/caregiver, family, and EHS characteristics (e.g., EHS model, relationship between parent and EHS staff).

The prevalence of experiencing family risk events was lower among participants in the current study than found previously in the literature (27% in current study compared with 60%–85% for EHS and Head Start children in previous studies; Blodgett, 2014; Saint Gilles & Carlson, 2015). This difference could in part be due to different ways of assessing trauma. The available data lacked a previously benchmarked standardized assessment of trauma exposure, and so the researchers developed a measure of family risk events pulling together items in the Baby FACES survey that were similar to those found in the ACEs framework (Felitti et al., 1998). However, the rate found in the current study was higher than that found for children in the general population. This highlights the importance of having trauma-informed EHS programs with staff who are knowledgeable about both the outward and more subtle signs of trauma for both the child and the family and of ways to provide a supportive environment for both.

Surprisingly, respondents who had experienced a family risk event were less likely to receive referrals for behavioral health services though they were more likely to receive referrals to and subsequently be receiving

services from entitlement programs. Perhaps EHS staff prioritized referrals to entitlement services, as they provided basic resources such as food and housing security which must be met first before someone might benefit from behavioral health services. But given that risk events led to lower levels of referral to behavioral health services, there is clearly a barrier either to EHS staff members being able to identify parents/caregivers who have experienced significant risk events or to being able to comfortably approach and refer those who are in need due to potential trauma. There may be discomfort around how to even start such a conversation around referral. Innovations that promote collaboration and communication between parent-caregivers and EHS staff have proven effective in increasing monitoring for potential developmental concerns among children served by EHS (Taylor et al., 2022). Perhaps similar programs could be created around monitoring behavioral health needs of both children and parent-caregivers.

In addition, the type of program from which EHS participants received services mattered greatly, with significantly more referrals (by a factor of nearly 10) being made in home-based care than in center-based care. This was surprising, as both groups experienced family risk events, although they reported different levels of family conflict, with those in home-based EHS care reporting higher levels of conflict. Those receiving home-based care also reported a stronger co-caring relationship with EHS staff. However, even controlling for these variables, program type remained a strong predictor of referral. It is also possible that the relative lack of referrals in center-based care represents unmet need among these families, and this is the most troubling implication of these findings. Vogel and colleagues (2006) found that nearly half of EHS center administrators believed that they had no children in their care who were in need of further referrals, which suggests a systematic underestimation of need in this population by EHS staff. EHS stands as one of the best-positioned intervention points

to address potential trauma and other adverse events early in a child's life, and by doing so to prevent a suite of negative and socially costly outcomes associated with them. Beardslee and colleagues (2010) also found that after developing a specific training curriculum for center-based EHS staff, they were more responsive to and better able to refer families to services for depression. Future research may want to assess what specific characteristics of home- versus center-based care may be associated with providing referrals, especially to those who have experienced family risk events.

Staff training for EHS programs could potentially be revised to address these issues, though future policy discussions may wish to address whether responsive services can be scaled in a large-group setting, such as an EHS program center, or whether hybrid programs, which incorporate elements of both center-based care and home visitation are a better model for serving children (Love et al., 2005).

EHS programs can be an important entry point for receiving needed services whether they are for behavioral health needs or for material needs (e.g., TANF, SNAP). Perhaps physically visiting the home and having fewer children in the home setting may make it easier for staff to assess the needs of the parent and family, leading to a higher likelihood of providing referrals. It is possible that families who were enrolled in center-based care did not receive as many referrals as they were more likely to already have connected with behavioral health services; however, this information was not available in the current data set.

Several factors appeared to modify the relationship between experiencing adverse events and the receipt of referrals to both behavioral health services and entitlement programs at the individual family level. The presence of caregiver depressive symptoms and family conflict were both associated with a stronger relationship between family risk events and receiving referrals. This may reflect that the effects of depression and family conflict might show themselves in ob-

vious ways in the behavior of the children who receive Head Start services or of their caregivers. These may be immediately noticeable to staff, though responses to trauma do not always manifest in outward symptoms or conflict (e.g., withdrawn presentations). If EHS staff members are only referring those with outwardly obvious presentations of trauma, it is possible that this is creating an unintentional pocket of unmet need.

Although most moderator variables included in these analyses predicted a stronger link between family risk events and referrals to behavioral health services, results indicated that when parents/caregivers felt closer to and more supported by EHS staff, experiencing a higher level of family risk events was less likely to lead to referral. One possibility is that those families who felt a stronger relationship with the EHS staff were already engaging in support-seeking behaviors in other venues and had engaged services for their own behavioral health independently. However, it may be the case that while EHS staff might develop stronger relationships with some caregivers, they may feel hesitancy or experience compassion fatigue with these families when presented with evidence of potentially traumatic family risk events and be more averse to becoming involved in a difficult situation. One possibility is that EHS workers may have their own personal difficulties with which they may be coping. In a 2012 survey of Pennsylvania, Head Start workers found that they were more likely to experience both physical and behavioral health troubles than workers in other fields (Whitaker et al., 2013). If EHS workers are consumed by their own emotional needs, they may not be able to engage in often difficult and emotionally laden conversations to benefit others.

Finally, parental depression increased the likelihood that having family risk events present in participants' lives would result in a referral to behavioral health resources; this effect was not seen with referrals to entitlement services. Experiencing family risk events was generally associated with receiving more

entitlement program services; however, higher levels of caregiver depression weakened this association such that caregivers who reported experiencing family risk events and reported elevated symptoms of depression were less likely to receive services even if referred. This finding is similar to other studies noting that depression can disrupt the uptake of needed services (Xue et al., 2020).

The current study uses a rigorous nationally representative data set to explore important questions around the role of EHS programs in connecting participants to needed services, particularly for those families who have experienced trauma and family risk events. Limitations of the current study include the cross-sectional nature of the data and reliance on retrospective reporting, lack of data on uptake of behavioral health services, and lack of a standardized measure of family risk events making comparison with other stud-

ies more difficult. However, despite these limitations, our study sheds light on the potential role for EHS programs to connect participants to needed services, how family experiences of traumatic events may be associated with referral patterns, and various familial and program-based factors that may influence these associations. These include whether a program is home- or center-based and parental depression. Future research should continue to explore differences between home- and center-based EHS programs related to staff's ability to identify need and make appropriate referrals and training in trauma-informed approaches, as this may help address existing pockets of unmet need in the community. The role of familial and program-related factors that may influence whether staff provide needed referrals and families receive services should be highlighted and assessed within EHS programs.

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