



**Connecticut's Early Childhood Trauma Collaborative
Trauma Training Needs Assessment Report
Connecticut Association for Infant Mental Health (CT-AIMH)
Executive Summary**

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Introduction:

Much attention, research, and scientific advances over the last 30 years have been focused on understanding the effects of trauma on young children.¹ Scientists have used the latest technology and imaging to study the damaging effects of abuse, neglect, witnessing violence, and long-term exposure to stress on early childhood brain development. Despite this evidence a gap remains between what is known and what is done to prevent or mitigate the effects of trauma. A commitment to closing this gap between research and practice requires having an early childhood workforce that understands young children and trauma, that has the necessary skills to engage with these young children and their families and that can screen and refer when appropriate.

The early childhood workforce in Connecticut that engages very young children and their families include those working in child care, in home visiting programs, in early intervention, in primary health care settings and in child welfare. The Connecticut Early Childhood Alliance estimates that there are 111,815 infants and toddlers in Connecticut. Of those, 27% are in licensed childcare centers, 9.2% are served by Birth to Three Systems, and 44.5% are enrolled in HUSKY.² These are the children most vulnerable and at risk for experiencing trauma. Thus those in the workforce serving these children are in strategic places to employ strategies to prevent or reduce the effects of trauma on young children and their families.

Overview:

The Early Childhood Trauma Collaborative (ECTC), a 5-year initiative awarded to the Child Health and Development Institute (CHDI) by SAMHSA as part of the National Child Traumatic Stress Network, is working to expand trauma-specific services for children age birth to seven in Connecticut. One of the goals of ECTC is to provide training to a range of professionals who serve young children in order to improve their knowledge about childhood trauma and ability to identify and refer children to trauma-focused assessment or

¹ Center on the Developing Child (2007). *The Impact of Early Adversity on Child Development* (InBrief). Retrieved from www.developingchild.harvard.edu.

² Connecticut Early Childhood Alliance. Retrieved from http://www.earlychildhoodalliance.com/sources_and_methodology.

treatment when indicated. To meet this goal CHDI engaged the Connecticut Association for Infant Mental Health (CT-AIMH) to conduct a survey of the relevant workforce to determine the training needs around trauma as experienced by very young children. The purpose of the survey was to:

- Assess the types of trauma training available
- Understand how and where individuals working with children birth to age 6 are trained on the topic of trauma
- Develop recommendations for embedding trauma topics into the early childhood workforce through future trainings or initiatives.

In preparation for this work, CT-AIMH contracted with Lorentson Consulting to conduct a comprehensive statewide needs assessment in line with the tenets of participatory evaluation. The Connecticut Early Childhood Funder Collaborative, a project of the Connecticut Council for Philanthropy made this report possible.

Needs assessment activities were completed from March to July 2017 and were designed to gain a better understanding of how individuals working with children birth to age 6 in a variety of settings understand trauma and to assess the types of trauma training available. From these data recommendations are made for embedding trauma understanding into the early childhood workforce through future training.

The needs assessment addressed the following questions:

Q1: *What training does the infant and early childhood workforce (working with children 0-6 and their families), need to increase their ability to address the needs of children and families who have experienced or are experiencing trauma?*

Q2: *How can training providers address the needs of individuals working with children 0-6 and their families to increase their ability to address the needs of children and families who have experienced trauma?*

Target Audience:

The needs assessment targeted the providers of care to young children 0-6 and their families and individuals who provide training to this early childhood workforce, often on behalf of the employing organizations. Professionals and paraprofessionals from many disciplines make up the early childhood workforce: early interventionists, teachers, social workers, clinicians, pediatricians, nurses and medical and behavior professionals, child care providers, home visitors, and family resource center (FRC) staff. To embed trauma understanding into the early childhood workforce, it seemed important to understand how providers working with young children currently learn about trauma, how much exposure they have had to layers of understanding trauma's impact on children and families, and which trauma topics need additional support. This survey was designed to examine the experiences of both the workforce and the existing trainers of the workforce.

Trauma definition used in the survey:

Trauma describes experiences or situations that threaten or cause harm to an individual's emotional or physical well being. For young children and infants, trauma can result from events that threaten their safety and well being or the safety and well being of their parents or caregivers. These events can include intentional violence (physical/sexual abuse or domestic violence), exposure to natural disasters, accidents or war, or experiences such as premature birth, homelessness, serious injury, death of a loved one, medical procedures or

living with a parent who is unable to properly care for the child. Information about trauma was topically segmented for this survey so that specific questions could be addressed about layers of knowledge (see Table 1 for the list of topics queried). This definition was included in the introductory statements on the on-line survey.

Data Collection Methods and Activities:

Data collection methods included two on-line survey instruments, one designed for the early childhood workforce (290 respondents) and one for trauma training providers (52 respondents). In addition, qualitative semi-structured interviews were conducted with 15 key training providers.

Limitations:

Some sectors of the workforce are underrepresented in the workforce survey. They may have self-selected out of the survey because they already receive enough trauma training. For example, Birth to Three providers, Child First and the Higher Education workforce did not participate in the workforce survey in significant numbers. On the other hand, other potential respondents might not have thought they needed to participate in the survey because they have not received any trauma training and do not see the need. Where the workforce survey appeared to be most useful was in suggesting where the next steps should be in deepening trauma training.

Results:

The two surveys and 15 interviews resulted in the following information:

A. Why Trauma Training is Needed

Children are experiencing trauma:

- Most respondents to the workforce survey estimated that 26% to 100% of children in their programs had experienced trauma.

The workforce expressed the need for more training on trauma

- All individuals working with infants and toddlers expressed a need for trauma training.
- Overall, the majority (93%) of those surveyed reported that they want training on trauma, regardless if they have received any training in the past (See Table 1).
- The need for additional trauma training is widespread and not limited geographically (requested in all counties in CT) or by workforce role (requested by all segments of the early childhood workforce).
- Each segment of the workforce identified interest in somewhat different trauma topics, based upon their role.
- Across all of these topics, fewer than 25% of childcare providers and FRC staffs had received trainings while nearly half of home visitors had been trained more specifically.

Segment of the workforce identified as having the greatest need for trauma training:

- Pediatricians
- Individuals involved in early care and education

The importance of training for them was attributed to the frequency and consistency of time these individuals spend with young children, coupled with the importance of the early years of development.

B. What Trauma Training Topics are Needed

Topic 1: Introduction to trauma, definition and types:

- Overall, the majority (75%) of respondents reported that they had received introductory trauma training.
- More than 90% overall indicated an interest in receiving training even if they have been previously trained on the topic.
- Training about the definition of and types of trauma were identified by most workforce participants as their primary training need, including 60% of child care providers, 84% of home visitors, and the majority of individuals working with medical organizations (69%) and individuals working with state level agencies (82%).
- Nearly one-third (32%) of center or family-based childcare providers reported not having received training
- Roughly one-in-eight (12.3%) home visitors reported not having received training.

Topic 2: Impact of trauma on Child Development, including brain development:

- Training about the impact of trauma on child development was identified as a primary training need by the majority of FRC staffs (68%) and home visitors (84%).
- Roughly half (53.3%) of center or family-based childcare providers reported not having received training on the impact of trauma on child development.
- Only one-in-eight (12.7%) of home visitors reported not having received this training.

Topic 3: Impact of trauma on parents and parenting:

- Roughly half (48%) of survey participants indicated they had not received training on this topic, yet nearly all (95%) indicated an interest in receiving more training.
- Childcare providers are the least informed on this topic; two-thirds (67%) reported not having received training.
- One-fourth (24%) of home visitors reported not having training on this topic.

Topic 4: Screening and referring for trauma:

- Approximately half of the respondents say they use surveillance or monitoring to identify children who have experienced trauma, although very few (19%) use trauma screening measures of children or their families.
- In general, when respondents said they used screening tools, the instruments they identified were not trauma screens.
- The majority of the workforce reported that they do not screen or refer for trauma because of a lack of trained staff to screen and refer, a lack of education regarding the importance of screening and referring, and a perceived lack of access to qualified service providers.
- Three-fourths (76.6%) of center or family-based childcare providers reported not having received training but would be interested in training on this topic.
- Nearly half (46.2%) of home visitors reported not having received training but would be interested in training on this topic.

Topic 5: Impact of Transgenerational Trauma on Family Functioning:

- 82% of center or family-based childcare providers reported not having received training but would be interested.
- 63% of home visitors reported not having received training but would be interested.

Topic 6: Relationship between Mental Health, Homelessness and Trauma:

- 81% of center or family-based childcare providers reported not having received training but would be interested.
- 73% of home visitors reported not having received training but would be interested.

Topic 7: Impact of Culture on Trauma:

- 81% of center or family-based childcare providers reported not having received training but would be interested.
- 59% of home visitors reported not having received training but would be interested.

Topic 8: Helping Families Dealing with Trauma to Develop Reflective Capacity:

- Responses from staff of the Department of Children and Families expressed interest in trainings related to helping families dealing with trauma to develop reflective capacity (91%).
- 80% of center or family-based childcare providers reported not having received training but would be interested.
- 63% of home visitors reported not having received training but would be interested.

C. How Training Providers are currently addressing the training need

Training Providers that were surveyed were most likely to provide training on the definition of and types of trauma and the impact of trauma on child development. Over 80% of trauma training providers expressed an interest in receiving enhancements, or more training themselves on each trauma-related topic.

Need to enhance current trainings or curriculum:

Those who provide trauma training and were interviewed in the qualitative portion of the survey reported that:

- They offer limited sessions to limited audiences
- Some do not offer trauma training themselves, but do refer their staff to outside trainings or conferences
- Many do not offer training on some of the trauma topics at all
- They see the need for a system-wide approach to identify their needs, enhance current offerings, and/or to develop audience-specific curriculum to be used by skilled trainers.

The majority of trainers emphasized the need for trainings to be formatted:

- As participatory
- To involve case studies/presentations
- To provide the training participants an opportunity to reflect on the issues presented and to apply the issues presented to the young children and families that they work with.
- As audience-specific
- Align curriculum with CT-AIMH Competencies for Endorsement•

Preferred Format:

- A series of half-day face-to-face trainings and online, but both with case studies.

Delivery:

- Almost half (43%) of the 15 surveyed offer trauma trainings internally, primarily to staff employed within their particular program or registered for their courses.

- Only 2 of the 15 training providers who were surveyed offer 7 out of 8 of the trauma-related topics, Child First (internally) and CT-AIMH (externally). See Table 2.
- The workforce identified that they receive the majority of their trauma training from CT-AIMH, early childhood conferences, or through DCF.
- Two programs reported that they are collaborating to develop an online introduction to trauma training for home visitors.

The results of the surveys suggest the following training needs:

Outcome #1

Increase availability of trauma trainings.

Recommendation #1:

As revealed in these survey data, provision of the vast majority of training is only to a specific audience, either limited by geographic or regional boundaries, by funding, or it restricts participation to those in programs through which training is provided.

How:

Educate policy makers, lawmakers and funders on the importance of training the early childhood workforce on the various trauma topics. This is essential to ensure that funding is allocated to the development and continued provision of statewide trauma training for the entire early childhood workforce.

Outcome #2:

There is limited access to trauma trainings.

Recommendation #2:

There is not equal access to training for everyone in the early childhood workforce. Especially noted was a gap in availability of trauma training for early care and education programs. To increase access to trauma trainings, it would be imperative to develop a training structure and process that ensures the provision of trauma training for all. One idea would be the development of a fully funded single trauma training hub. This training hub could house an online trauma training clearinghouse, where all of the currently offered trauma trainings for the early childhood workforce could be listed and easily accessed.

How:

This training hub could be offered through a current website (i.e. CHDI or CT-AIMH) training page. It could list current trainings and offer links to other training courses. It could also house a cross discipline trauma-training academy from which individuals and programs could have access to a trauma training curricula or training modules (i.e. newly developed HV trauma training module).

Outcome #3:

There is a lack of developmentally appropriate training.

Recommendation #3:

Very little training on any trauma topic is available for the infant and toddler workforce as most training available is targeted toward the preschool age level or older. Ensure the availability of trauma training that is developmentally informed and addresses the

specific issues of infant and early childhood trauma, especially how it may affect early relationships.

How:

Develop trainings with the recommended essential elements listed in the final recommendation.

Outcome #4:

There is a lack of knowledge on types of trauma screening tools, appropriate use of trauma screening tools, and where to refer when a need is determined.

Recommendation #4:

Provide training on screening for trauma, types of screening tools that are available, who should use them, and where to refer after a need is determined.

How:

Create an easy to understand handout on types of trauma screening, who should administer them, and where to refer if a need is determined. Also add this handout to the existing trauma training online module for home visitors.

Outcome #5:

Due to the time spent with children and/or frequency of interactions, trauma training is essential for the early care and education workforce and for pediatricians.

Recommendation #5:

Reach the audiences that are not getting trauma training on particular topics, and those with the highest need.

How:

For the programs that only offer internal trainings, in order to enhance their current trauma training offerings, they can review the proposed training structure and competencies listed below to identify gaps, and add to current trainings. For those that do not have a current training structure in place, they could develop both face-to-face and online training formats be according to the proposed training structure and competencies listed below, or access currently developed trainings through the newly developed training hub.

Outcome #6:

Offer audience-specific trauma training.

Recommendation #6:

Identify which trauma topics are appropriate for which segments of the workforce, and define who fits in each segment. Those working in promotion should receive training on Introduction to Trauma: definition and types, and the impact of trauma on child development, including brain development.

Those working in prevention, intervention and treatment should receive training on all trauma topics listed in this trauma training survey, plus a few more, as listed in the final recommendation.

How:

Ensure that the final recommendations are followed before any trauma training is delivered.

Promotion includes those in education (teachers, childcare providers, administrators), early intervention (case managers, speech therapists, occupational therapists, physical therapists, early intervention, administrators), home visitors, child welfare (judges, attorneys, child protection workers, social workers, supervisors, administrators) and medical/health care (nurses, pediatricians, dieticians, physicians) .

Prevention includes licensed mental health clinicians, and those in education; early intervention, home visitors, child welfare and medical/health care who receive reflective supervision.

Intervention and treatment includes licensed mental health clinicians, or other licensed clinical professionals.

D. Essential elements for future trauma trainings

Final Recommendation:

Based upon the data collected from the Trauma Training Needs Assessment, and the expertise from staff and members of CT-AIMH the following structure is recommended to deliver trauma training:

1. Offer universal trauma training for promotion, prevention, intervention, and treatment staff:

- Offered by IMH-Endorsed® professionals or skilled trainers with a background in the infant and early childhood field, relevant experience for the audience they are training and expertise in the particular trauma topic they are offering.
- Include core knowledge on theoretical foundations about trauma, trauma-informed practice and child development to provide trauma-informed, developmentally sensitive services to young children and their families (definition, types, signs and symptoms, trauma triggers, and how trauma affects prenatal and child development, the attachment relationship, brain development, and behavior).
- Include competencies in working with others to reduce risk factors and increase protective factors associated with trauma and early childhood adversity (collaborating, relationship building, empathy).

2. Offer trauma training for prevention staff:

- Include all of the above-mentioned items from #1.
- Include core knowledge on theoretical foundations about trauma, trauma-informed practice and child development to provide trauma-informed, developmentally sensitive services to young children and their families (above and family relationships, cultural responsiveness, emotional regulation, homelessness, two-gen, emotional and physical abuse, neglect, and violence).
- Include core values and attitudes needed to provide trauma informed, developmentally sensitive services to young children and their families

(importance of role, include parents/caregivers as partners, relationship-focused practice, recovery and healing from trauma).

- Include direct service skills and abilities needed to practice trauma informed care with young children and their families (observe, establish relationships, screening, referrals, sensitivity, safety, offer techniques to families)
- Include communication skills needed to provide effective trauma informed, developmentally sensitive services to young children and their families (listen, develop trusting, honest relationships that promote safety for all).
- Opportunity to participate in reflective supervision/consultation experience

3. Offer audience-specific trauma training for intervention and treatment staff:

- Include all of the above-mentioned items from #1 and #2.
- Include clinical training on working with young children and families that have experienced trauma, have unresolved trauma, grief or loss (assessment and diagnostic tools, treatment and practices, Infant or Child Parent Psychotherapy)
- Include development of reflective supervision/consultation skills.
- Include leadership skills needed in management; advocacy, policy and systems change to sustain trauma informed and developmentally appropriate services for infants, young children and their families.

4. Offer training in conjunction with Reflective Supervision/ Consultation (RS/C):

Some trainers also identified that they provide training on vicarious trauma and self care (Table 2). To ensure greater provider resilience and less burnout, RS/C is recommended for those working with children and families that have experienced trauma. RS/C goes beyond clinical supervision to shared exploration of the parallel process, i.e., attention to all of the relationships, including that between practitioner and parent, between parent and infant/toddler, and between practitioner and supervisor. It is critical to understand how each of these relationships affects the others. Of additional importance, by attending to the emotional content of the work and how reactions to the content affect the work, reflective supervision/consultation relates to professional and personal development within one's discipline. Finally, there is emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor/consultant (<https://www.ct-aimh.org/endorsement/reflective-supervision.shtml>). Through the use of the CT-AIMH Endorsement Registry (www.ct-aimh.org), ensure that RS/C is provided to the early childhood workforce with competent IMH-Endorsed individuals, who understand the effects of early childhood and family trauma.

Next steps:

Develop a statewide multi-disciplinary planning group to bring this report and recommendations to the next level, by creating a strategic plan, and working together to implement that plan.

Tables

Table 1:

Topics	#	Have received training, but want more	Have not received training, and want training	Total wanting trauma training
Intro. To Trauma: Definition of and Types of Trauma	288	75%	18%	93%
Impact of Trauma on Child Development including Brain Development	263	65%	27%	92%
Impact of Trauma on Parents and Parenting	254	52%	43%	95%
Screening and Referring for Trauma	272	38%	51%	89%
Impact of Transgenerational Trauma on Family Functioning	251	29%	62%	91%
Relationship between Mental Health, Homelessness and Trauma	249	28%	67%	95%
Impact of Culture on Trauma	246	33%	62%	95%
Helping Families Dealing with Trauma to Develop Reflective Capacity	244	30%	64%	94%

Table 2:

Topics	# Providers interviewed (of 15) that offer this training	Mainly offer training internally	Offered internally, but also offered externally upon request	Offered externally
Intro. To Trauma: Definition of and Types of Trauma	14	6	6	2
Impact of Trauma on Child Development including Brain Development	9	5	3	1
Impact of Trauma on Parents and Parenting	3	2		1
Impact of Transgenerational Trauma on Family Functioning	4	2	1	1
Relationship between Mental Health, Homelessness and Trauma	2	1	1	
Impact of Culture on Trauma	1		1	1
Screening and Referring for Trauma	5	1	3	1
Helping Families Dealing with Trauma to Develop Reflective Capacity	3	1	1	1
Other trauma topic noted: Vicarious trauma and self care	4	1	2	1