Resilient Early Childhood System Self-Assessment

One key desired outcome of *Promising Minds* is that early educators and service providers, and families and children are **supported by a coherent system** to be resilient. We recognize, however, that becoming a coherent early childhood system of resilience is an **ongoing journey or change process** for a collective of organizations and agencies that is not linear. Rather it is a continuum where organizations move through stages; and knowledge, perspectives, attitudes and skills continue to deepen and unfold over time.

One of the challenges with systems change is identifying meaningful indicators of interim progress towards longer-term change. The **Resilient Early Childhood System Self-Assessment (RECSSA)** was designed to be a **tool** to break down the process and identify primary indicators of change to help guide organizations and communities towards deeper, systemic changes required to be trauma-informed. The RECSSA also took into consideration a **wide range of settings** including, but not limited to early care centers, family (home-based) child care, home visiting organizations, behavioral health settings, school districts, health care settings, public agencies and departments. And each of these settings may be situated within **unique local, cultural and political contexts**.

It is also important to emphasize that this is not a formal evaluation or certification assessment, nor an assessment tied to grantmaking decisions for organizations. **This is a self-assessment tool** to help community partners better understand their systems-change process and make informed strategic decisions. Its purpose is also to help organizations identify where they are on the matrix **of trauma-informed systems integration** and where they want to be.

Organization of the RECSSA Tool

- The RECSSA is organized into a framework of four domain areas: *Leadership*, *Quality Improvement* (Programs), *Infrastructure* (Organizations), and *Partnerships and Alignment* (Community).
- Within each domain there are descriptions of "Desired Outcomes" and four stages/ratings of each Desired Outcome. Each of the stages/ratings includes a full description to ensure clarity and that they are meaningful (rather than just a number rating). The following table defines the ratings:

Awareness (Key Focus: awareness and attitudes)	Organizations have become aware of how prevalent trauma is and have begun to consider that it might impact their clientele and their staff
Building (Key Focus: knowledge, application, skill development)	Organizations have begun to 1) explore principles of trauma-informed care (safety, choice, collaboration, trustworthiness and empowerment) within their environment and daily work; 2) build consensus around the principles; 3) consider the implications of adopting the principles within the organization; and 4) prepare for change
Emerging (Key Focus: change and integration)	Organizations have begun to change their organizational culture to highlight the role of trauma. At all levels of the organization, staff begin re-thinking the routines and infrastructure of the organization
Developed (Key Focus: leadership and sustainability)	Organizations have made trauma-responsive practices the organizational norm. The trauma model has become so accepted and thoroughly embedded that it no longer depends on a few leaders. The organization works with other partners to strengthen collaboration around being trauma informed

- The RECSSA is designed to be completed as a team (versus just a lead person). This ensures a more accurate representation of each outcome by considering multiple perspectives, and also increases the likelihood of creating time and space to reflect on progress as an organization and strategically consider next steps.

Resilient Early Childhood System Self-Assessment

Domain	★ Desired Outcomes ★	Awareness	Building	Emerging	Developed
Leadership	*Leadership demonstrates an understanding of the impact and prevalence of trauma in daily practice and works to create a respectful and supportive environment for staff and the community they serve.*	• Leadership understands that knowledge about trauma could potentially enhance their ability to fulfill their mission. • Leadership seeks out information/data on trauma for the population served. • Leadership supports staff attending/receiving training for trauma. • Leadership demonstrates an understanding of the importance of staff well-being.	• Leadership participates in trauma training. • Management responds to secondary trauma in staff (i.e., compassion fatigue, vicarious trauma, burnout) • Leadership prepares the organization for change and leads a process of reflection.	• Leadership begins integration of principles into staff supports: ○ Addressing staff trauma ○ Self-care ○ Supervision models ○ Staff development ○ Staff performance evaluations • Leadership begins integration of principles in org structures: ○ Environment review ○ Policies and procedures re-examined ○ Self-help and peer advocacy incorporated • Leadership actively addresses the role of the organization in creating and perpetuating inequity. • Leadership gains an understanding of a "two-lens approach" blending western science research and practice with Native Hawaiian culture values and practices.	• Leadership, including hiring of new leaders, demonstrate a commitment to trauma-informed values (safety, choice, collaboration, trustworthiness, and empowerment) and reflect communities in Hawai'i. • Leadership promotes and participates in *pilina* between supervisor/subordinate through mindfulness and/or cultural practices (e.g., walking, storytelling, cultural activities) • Leadership advocates at a macro level with funders and policymakers for systemic changes that support trauma-informed approaches.
	An equity lens is applied to all programs and policies to address bias and the impact of historical	• Leadership and staff demonstrate an understanding of historical trauma and the relationship of systemic oppression to	• Anti-bias or anti-racism training is required for all staff • Staff begin to understand their role in advancing or	• Program or assessment data is disaggregated by relevant social factors. • Concrete steps are taken to ensure staff and leadership	• All decisions are made using a racial equity lens, with the goal of creating outcomes that are no longer predictable by race

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	trauma and systemic oppression on multiple generations of families.	intergenerational trauma.	perpetuating inequities.	representation reflect the community they serve.	or identity factor. • Language, both informally and formally, reflect an embedded equity and liberation framework.
	Staff have access to meaningful leadership opportunities and are supported in trying new and innovative techniques to support keiki and their 'ohana.	• Staff input is considered by leadership when requested and only on occasion	• Staff leadership groups are formed to amplify their voice in the decision-making process. • Direct care providers/frontline staff are routinely asked to share promising practices with one another.	• Staff leadership groups are supported and given needed resources, including time for *pilina* within staff peer groups and between staff and leadership.	• Diverse representation of staff is included in all decision-making processes. • Practices and policies incentivize and reward innovation.

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Quality Improvement (Programs)	*Staff have access to needed supports, including coaching, consultation, meaningful professional development, wellness and self-care, and necessary materials and resources.*	• Most staff can define trauma • Most staff understand impact of trauma on infants and early childhood but may not yet recognize their own trauma. • Trauma is discussed in informal conversations	• Trauma training is institutionalized for all staff, incl. new staff orientation, includes understanding their own trauma and triggers. • Information on trauma is available and visible to staff and clients • Direct care providers seek out opportunities to learn new skills. • Staff drive agenda-setting for professional development opportunities that directly align with their self-care needs and early care practice.	• Staff develop and deepen trauma skills • Staff apply new knowledge about trauma to their work. • Staff begin to incorporate self-care and wellness practices to prevent burnout and address secondary trauma.	• All staff are skilled in using trauma-informed practices – whether they work with clients or staff. • Ongoing coaching and consultation is available to staff on-site and in real time. • Impact of trauma is routinely discussed and addressed in performance management (to discuss professional development and self-care needs).
	It is a norm for all high- quality early childhood programs – birth to age 5 – to support the trauma-informed process with cultural responsiveness and aloha.	• A cohesive definition of success is developed. • Key metrics are identified to measure progress and impact. • Trauma is discussed in programs supported by this organization	• Policies begin to be revised so that all programs within the organization include trauma-informed practices and use the same goals and measures of success. • Ensure that trauma-informed approaches include home grown components that are co-designed with local leaders and champions. • Org/program begins to identify internal trauma champions.	• The policy revision process is formalized with intentional focus on the inclusion of diverse stakeholders. • A centralized integrated data infrastructure is developed to include developmental screening data and childhood development data. • All clients are screened for trauma and/or a “universal precautions” approach is used. • People with lived	• Comprehensive process is formally adopted to address policies that includes specific standards. • Open data sharing utilizing the integrated data system happens routinely. • Process in place to review program fidelity over time and appropriate corrective actions are taken • Programs focus on reduction of stigma of trauma. • Community is continually

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				experience, such as historical trauma, play meaningful roles in organization (employees, consultants, board members, volunteers, etc.) • Changes to early learning environments are made. • Trauma-specific assessment and treatment models are available to those who need them.	involved to identify standards of success.
	Programs actively, appropriately, and meaningfully engage parents/families in educational and decision-making opportunities.	• Staff and leadership demonstrate an understanding of the impact of trauma on parents and caregivers from different backgrounds and how that affects relationships and intergenerational trauma.	• Staff identify information opportunities to build relationships with parents • Programs identify meaningful engagement opportunities and/or roles for parents at caregiving sites/settings (before, during or after care hours).	• Programs offer information and tools to parents/families about stress, trauma and resilience that include cultural practices and activities. • Programs actively seek and respond to feedback from parents through talk-story.	• Parents/families are actively engaged in decision-making. • Routine positive, informal and formal communication happens between staff and families due to ongoing pilina-building practices.

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Infrastructure (Organization)	*Trauma-informed organizations have made trauma-responsive practices the organizational norm and has become so accepted and embedded that it no longer depends on a few leaders.*	• Informal practices exist for all staff to meet their own needs for healing and well-being.	• Organization values and prioritizes the trauma lens. • Trauma is cited in mission statement and/or other policy documents • Organization mission statement and framework of their work is inclusive of the diverse cultures of Hawai'i. • Org begins to identify potential resources and toolkits for trauma specific treatment and to promote resilience. • Org finds ways to hire people who reflect in their attitudes and behaviors alignment with trauma-informed principles. • Org begins to review tools and processes for universal screening of trauma.	• Language is introduced throughout the org. that supports safety, choice, collaboration, trustworthiness and empowerment. • Policies in place to actively address staff trauma • Org has a ready response for crisis management that reflects resilience and trauma-informed principles and values. • Changes to workplace environments are made	• All aspects of organization have been reviewed and revised to reflect trauma-informed values and approach • Resources dedicated to trauma-informed care and practices (e.g., funding, grant writing, staffing, enhancing benefits) • The organization uses data to inform decision-making at all levels. • The business model including fiscal structures works to meet the need to address trauma. • Human resource policies support hiring staff with knowledge and expertise in trauma transforming it into a trauma-responsive workplace. • The org and staff become advocates and champions of trauma within their community.
	Strong infrastructure for data collection is in place for developmental screening (i.e., ASQ, ASQ-SE) and ACES data, including accessibility of this	• Developmental screening (i.e., ASQ, ASQ_SE) and ACES data are not collected, but early care practitioners know about this data. • Resources and capacity for	• Developmental screening and/or ACES data are administered for most children, but processes and resources for data collection vary within the program or local system,	• The program/ organization is in the process of establishing the universal collection of developmental screening and ACES data across the organization or local system annually (or in	• The program/ organization has universal processes and resources to collect developmental screening and ACES data on all children. • Data are readily available to

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	data to early care practitioners and families.	managing and utilizing data are not yet available.	or from year-to-year. • An infrastructure for managing and sharing data does not yet exist. • ·Not all early care practitioners and families have ready access to the data.	appropriate intervals). • Process for easy data accessibility and sharing are also in development.	early care practitioners and families.
	Early care practitioners/ professionals can access a sustainable and thriving network of infant and early childhood mental health (IECMH) consultants.	• Informal processes exist to access a limited number of trained IECMH consultants. • There exists a resource for mental health professionals to be specialized in infant and early childhood mental health. • Organization leadership may not be bought in to the importance of IECMH consultants.	• The organization has secured resources to provide IECMH consultation for a subset of early care practitioners/professionals or for a limited period of time. • There is a growing number of mental health professionals with an infant and early childhood mental health specialization.	• Policies are developed that actively support staff in accessing needed help from IECMH consultants and a process for support is clearly identified and communicated. • Resources are allocated to fund some IECMH consultation, but the funding is not stable • A standard level of competency for trauma-informed care in infant and early childhood mental health is established.	• Quality, onsite and real time coaching, consultation and supervision is available to staff. • Resources are available to fund reimbursement for mental health consultant FTE in early childhood programs. • Organization leaders are committed to ensuring resources of mental health consultation remain a priority.

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Partnerships and Alignment (Community)	*Early care organizations and programs work with other community and statewide partners to strengthen collaboration around being trauma-informed.*	• Early care organizations are aware of key partners in their communities. • Early care organizations actively identify gaps in services and seek out appropriate partners.	• Early care organization staff, including teachers and other direct care providers regularly communicate and collaborate with external partners.	• Community partners regularly share disaggregated data on the impacts of their services. • Community partners are embedded in the work of early care organizations with clear expectations for communication and success.	• People outside the agency (from Board to community) understand the organization's mission to be trauma-related • External agencies and community members routinely turn to the organization for expertise and leadership in trauma-informed care
	The organization/ program has or participates in an integrated early learning, health and behavioral health data system.	• Early learning, health and behavioral health data systems are separate. • Data sharing agreements do not exist between the organization and public agency partners.	• The organization and partner agencies have established data sharing agreements.	• A shared integrated data system is being developed to support data sharing practices between the organization and partner agencies.	• A robust data system that includes child-level early learning, health and behavioral health data exists. • Partner agencies and organizations have established protocols for regular and consistent data sharing. • Organizations use early learning, health, and behavioral health data to inform decision-making at all levels
	Funders and policymakers actively, appropriately and meaningfully partner with community organizations to advocate for and meet the needs of early care practitioners, keiki and their 'ohana.	• Organizations and community partners have independent visions of a trauma-informed system. • Policymakers and funders have some knowledge of trauma-informed care, but do not have a vision for a trauma-informed system.	• Organizations and community partners have shared their visions for a trauma-informed system with one another and are working to establish a shared vision.	• Organizations and community partners have communicated their shared vision with parents, other community stakeholders, funders and policymakers. • Partner organizations and their staff have organized to become advocates and champions of trauma-informed decision making at all levels. • Champions for a trauma-informed system emerge at the policy-/decision-making level.	• Advocacy occurs at a macro-level with payors and policymakers for systemic changes that support trauma-informed approaches.