Implementation and program evaluation of trauma-informed care training across state child advocacy centers: An exploratory study

Maureen C. Kenny [a],*, Alejandro Vazquez [a], Haiying Long [a], Dawn Thompson [b]

[a] Florida International University, 11200 SW 8th St, Miami, FL 33199, United States
[b] Kristi House, 15321 S Dixie Hwy, Miami, FL 33157, United States

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ABSTRACT

Awareness of Trauma-Informed Care (TIC) is essential for all professionals employed at child advocacy centers (CAC). This study evaluated the effectiveness of a training program that utilized a modified version of a TIC curriculum accessible through the National Child Traumatic Stress Network (NCTSN) among CAC workers in Florida. The workers' TIC knowledge level ($n = 203$) was examined prior to the training, immediately thereafter, and in a 12-month follow-up. Participants in general had similar levels of TIC knowledge before the training although the knowledge level was significantly affected by race/ethnicity, years of working experience, and educational degree. The results also indicated that participants' TIC knowledge significantly increased after training, with an effect size of 0.71. This increase appeared to be universal among participants. Further, the significant increase still maintained in the 12-month follow-up test. The analysis of participants' responses to two open-ended questions suggested that most participants were satisfied with the program. It is suggested that training efforts need to be conducted frequently to ensure that CAC employees get repeated exposure to the information in order to ultimately improve the services they provide to victims.

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1. Introduction

Child maltreatment, including physical and sexual abuse, has become a serious public health issue in the United States (U.S.). In 2014, there were nationally estimated 702,000 victims of child abuse and neglect (U.S. Department of Health and Human Services, Administration of Children and Families, 2016). Subsequent to report or disclosure, child victims of abuse come into contact with multiple professionals and may often be revictimized during this investigative process (Saywitz & Nathanson, 1993; Themeli & Panagiotaki, 2014). Repeated interviews may cause children to re-experience the trauma by describing it multiple times. This may have adverse effects on children's emotional well-being and intensify feelings of self-blame and guilt (Runyan, Everson, Edelsohn, Hunter, & Coulter, 1988). Staff who are not sensitive to the children's trauma may also inadvertently contribute to the children's poor outcome. Appropriately trained staff are necessary to provide assessment, treatment, and referral of victims of abuse. To this end, child advocacy centers (CAC) have been specifically designed to provide mental health services to children who have been traumatized by child abuse (Jackson, 2004) with the goal of minimizing the trauma

and breaking the cycle of abuse (Shadoin, Callins, & Nace Magnuson, 2010).

In the U.S., CACs were developed in the 1980s in response to the criticism that investigations into child sexual abuse were often not handled sensitively and resulted in "system-induced trauma" (Jackson, 2004, p. 412). For example, child victims were being interviewed in various locations with multiple authority figures and taken to court for appearances. Through the vision of one U.S. congressman, the National Children's Advocacy Center (NCAC) was established and earned a national reputation providing training, technical assistance, and support for child abuse professionals (Van Eyes & Beneke, 2012). The NCAC became the model for CACs and helped spread the goal of multidisciplinary response to child abuse. In 1987, the National Children's Alliance (NCA) was formed and developed standards and an accreditation process for CACs to ensure appropriate services for abused children (Van Eyes & Beneke, 2012). The NCA standards require ten essential program components for CAC accreditation that include improving the investigative process for children, reducing trauma to children, and providing support and treatment for victims and their families through a multidisciplinary team in a child friendly environment (Shadoin et al., 2010). While CACs were initially developed to handle sexual abuse, they have been expanded to work with victims of other forms of maltreatment (National Children's Advocacy Center, 2016). In 2015, there were over 811 CACs in the U.S. which served 311,688 children (NCA, 2016). CACs can be independent organizations, hospital based, operate within larger community

* Corresponding author.
E-mail addresses: Kennym@fiu.edu (M.C. Kenny), Avazq020@fiu.edu (A. Vazquez), Haiying.long@fiu.edu (H. Long), Dthompson@kristihouse.org (D. Thompson).

agencies, or located in the prosecutor's office (Shadoin et al., 2010). Forensic interviews take place in CACs and families can access necessary medical and therapeutic services for victims (Jones, Cross, Walsh, & Simone, 2007). It has been suggested that the use of CACs in the U.S. may affect children's reactions to legal involvement by making the process less stressful (Saywitz, Goodman, & Lyon, 2002).

The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) in the U.S. has demonstrated a link between adverse childhood experiences, including sexual abuse, and the development of poor health outcomes as adults. The consequences of sexual abuse can include emotional disorders (e.g., depression, anxiety, posttraumatic stress disorder [PTSD]), cognitive disturbances (e.g., poor concentration, dissociation), academic problems, physical problems (e.g., sexually transmitted diseases, teenage pregnancy), acting-out behaviors (e.g., prostitution, running away from home), and interpersonal difficulties (Berliner & Elliott, 2002; Kilpatrick et al., 2003; Noll, Trickett, & Putnam, 2003; Paolucci, Genuis, & Violato, 2001; Roberts et al., 2004; Tyler, 2002). Thus, intervention and treatment for victims by qualified staff are critical. To better meet the needs of these victims, Trauma Informed Care (TIC) is among the initiatives employed by agencies to promote trauma-informed awareness. Other initiatives include the implementation of Trauma-Focused Cognitive Behavioral Therapy interventions that have been found to be effective with children who have experienced a variety of traumas (Substance Abuse and Mental Health Services Administration (SAMHSA), 2016). TIC describes a trend in mental health care which seeks to understand the pervasive impact of trauma and strives to ameliorate, as opposed to exacerbate, the effects of the trauma on the victim (Brown, Baker, & Wilcox, 2012). While CACs provide safe and child-sensitive environments, the extent to which all CAC staff are trained in the effects of trauma on child victims or TIC is unknown.

Due to the nature and structure of CACs, they employ a wide variety of professions (e.g. mental health professionals, forensic interviewers, and case managers) and must work with multidisciplinary partners (e.g. law enforcement, legal staff) in order to meet accreditation standards. However, some professionals may not receive any training in the impact of trauma on children and the ways they can help to improve these children's outcomes (Ko et al., 2008). Research has highlighted the lack of trauma or sexual victimization training in graduate education for most mental health professionals (Cook & Newman, 2014; Courtois & Gold, 2009; Gere, Dass-Brailsford, & Hoshmand, 2009; Kitzrow, 2002; Priest & Nishimura, 1995). Ko et al. (2008) also report that police officers who are part of CACs often lack formal training in addressing the complexities of children who have been traumatized. Non-clinical staff, including reception area workers, support staff, and others who are instrumental in the administration of the CAC, may also not receive any exposure to trauma training. Despite this lack of awareness, all these staff members work directly or indirectly with trauma victims at the CAC. It has been argued that those who work with child victims who are not trauma-informed can potentially misunderstand the child's experience, which can damage the relationship between the worker and the child as well as impact the worker's understanding of the child's symptoms (Richardson, Coryn, Henry, Black-Pond, & Unrau, 2012).

Staff training may be a critical first step for agencies concerned with implementing TIC in their settings. Those who are working in a capacity to support children can benefit from a greater understanding of how trauma affects child development and behavior (Walkley & Cox, 2013). The implementation of behavioral practices without awareness of their potential for harm can lead to the retraumatization of clients who have been exposed to prior traumatic experiences. Trauma awareness highlights the need for practitioners to be mindful and critical of their standard practices in order to prevent retraumatization (SAMHSA, 2014). Under the NCA Standards for Accreditation, it is required that all victims' advocates who provide services to CAC clients receive no <24 h of training, including areas such as trauma informed services, the dynamics of abuse, and crisis assessment and

interventions, among other topics (NCA, 2017). The training of all staff—professional, administrative, and secretarial—is essential to transform an agency into being trauma-informed even if trauma is not the main focus of the service (Berger & Quiros, 2014). When an agency takes the step to become trauma-informed, every part of its organization, management, and service delivery system may be modified to include a basic understanding of how trauma impacts the life of families seeking services (Harris & Fallot, 2001).

1.1. Trauma informed care evaluation

According to SAMHSA, "A program, organization, or system that is trauma-informed: "*Realizes* the widespread impact of trauma and understands potential paths for recovery; *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and Seeks to actively resist *re-traumatization*" (SAMHSA, 2012, p. 4).

Research on TIC training has begun to appear in the literature and is typically conducted with those who provide direct care to victims. TIC practices have been applied and implemented in a variety of mental health settings, including inpatient care units, youth residential treatment centers, social services agencies, and child welfare services (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013; Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013; Muskett, 2014; Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014). While some CACs may be training their workers in TIC, evaluation of these programs is lacking. Collins (2008) surveyed 48 child welfare agencies and found that most focused on satisfaction with TIC training or pre/post knowledge, while less conducted follow-up or assessed those participants who may have made behavioral changes subsequent to training. Brown et al. (2012) found that there were changes in knowledge and beliefs following a foundational course in trauma training (approximately 16–18 h). Child welfare directors and trainers who participated in TIC trainings demonstrated significant improvement on posttesting on trauma-informed practices (Kramer et al., 2013). Berliner and Kolko (2016) comment that there is little downside to brief awareness training as long as it does not consume limited resources and helps professionals increase empathy and understanding toward victims.

1.2. Challenging training-to-practice issues

While training is implemented at sites, the degree to which this affects the behavior of staff is unknown. Kramer et al. (2013) found that child welfare directors and trainers who participated in TIC trainings demonstrated significant improvement in their use of trauma-informed practices when assessed at three-month follow-up. Conners-Burrow et al. (2013) found that after training in TIC, front line workers (86.6%) reported fully or partially employing strategies they had learned in the NCTSN training. However, the larger impact of the training seemed to be on indirect support services designed to build a TIC system for the child.

1.3. Child advocacy centers and TIC

The goal of CACs is to provide support and advocacy for child victims of abuse and their non-offending family members (Tavkar & Hansen, 2011) in a child-centered environment. While there are certain structural factors in place at CACs to ensure this goal is met, aspects of TIC may not be present. Ko et al. (2008) advise that one of the components of creating a trauma-informed child serving system is a knowledgeable workforce. Thus, all CAC staff would benefit from training in TIC to ensure that such an approach is present in interactions with victims and their families. Effective TIC sites focus on appropriate treatment but also employ staff who are aware of and sensitive to doing no further harm to victims (Jennings, 2004). There is a commonly recognized

need to provide training in trauma into core curricula for a variety of mental health professionals, given the likelihood that they will encounter victims of trauma (Cook & Newman, 2014; Layne et al., 2011). However, when this training does not take place, agencies must take the responsibility to ensure all their staff are knowledgeable about TIC.

Despite the need for trauma-informed care in CACs and the availability of professionals and accessible TIC trainings, to date there have been few studies describing the implementation and evaluation of NCTSN trainings. The present study was conducted in Florida, which has a large population of children (over 4 million, U.S. Census Bureau, 2015) and a high rate of child maltreatment. While other states' rates of victimization have declined from 2009 to 2013, Florida's has increased 5.7% (U.S. Department of Health and Human Services, 2015). There are 27 CACs in Florida that are poised to address the needs of the large child population and high rates of child abuse in the state (Florida Network of Children's Advocacy, 2016). In 2015, over 33,000 child victims of abuse were served at child advocacy centers in Florida (NCA, 2015).

The purpose of the present pilot study was to evaluate the effectiveness of a modified version of the NCTSN TIC training with CAC workers. To achieve this goal, we applied Kirpatrick and Kirpatrick's (2006) model for evaluating training programs which includes: (a) reaction (customer satisfaction); (b) learning (knowledge, skills, attitudes); (c) behavior change (measurement before and after, transfer of skills after training to real world); and (d) results (cost effectiveness). We sought to: (a) identify pre-training differences in knowledge of TIC among CAC workers with different functions, (b) examine changes in knowledge for CAC workers from pre- to posttesting, and (c) explore knowledge retained at one year follow-up among CAC workers.

2. Method

2.1. Participants

A total of 203 employees of 5 different CACs across the state of Florida participated in the trainings offered between August 2013 and October 2014. The CACs were accredited by the NCA. The participants represented a variety of job positions at the CAC, but for the purposes of analyses, they were grouped into 2 categories: Clinical Staff/Direct Contact (e.g., case manager, therapist, intake worker, and advocate) and Administrative (e.g., receptionist, support staff, transportation driver, law enforcement, and state attorney's office staff). Participants were grouped into these categories based on their response to the "position" question on the Trauma Informed Care Questionnaire (TICQ). Table 1 presents demographic information of the participants.

2.2. Procedure

Florida International University's Office of Research Integrity approval (#IRB-13-0207) was obtained for the use of human participants. Directors of all 27 CACs in Florida were contacted (by email and phone) about their interest in having TIC training for their staff. Sites were chosen based on their willingness and availability to host the training, and those who first responded and scheduled dates were selected. Training was limited to 5 accredited sites due to funding resources. The five CACs represented different geographic regions (north, south, east, and west) across the state (representing 19% of CACs in the state). While they were located mostly in urban settings, they also serve clients from rural areas that fall within their catchment area. All trainings were delivered by an educational trainer with a Master's degree and >13 years of experience in training on trauma and child maltreatment as well as professional experience with victims and their families. Trained in both education and multicultural education, the instructor was previously an educator in the K-12 school system for 15 years prior to providing training and outreach education at a CAC. The instructor also had extensive experience

Table 1
Demographic characteristics of the participants.

Participant demographics (N = 203)	%
Age M(SD)	37.67 (11.77)
Gender	
Male	16.9
Female	83.1
Race/ethnicity	
White/Caucasian	53.7
Hispanic/Latino	22.7
Black or African American	21.2
Asian	1.0
Other	1.5
Language	
English	92.0
Spanish	7.5
Creole	0.5
Positions	
Clinical Staff/Direct Contact	63.7
Administrative	36.3
Experience	
Years worked in CAC	
<1 year	32.7
1–5 years	27.4
5–10 years	16.7
10–20 years	20.2
>20 years	3.0
Degree	
High school diploma/equivalent	10.8
Associates AA/AS	6.4
Bachelors BA/BS	50.2
Graduate degree	32.5
Prior TIC training	
Yes	53.7
Professional development training on site	
Never/rarely	2.6
Once a year	6.2
Twice a year	10.4
More than twice a year	80.8

with the materials from NCTSN and previously delivered similar trainings to other populations.

The pretest was completed immediately prior to the beginning of the training on site and used to gain participants' basic demographic characteristics (e.g., position, education, and years of experience) and to assess the participants' knowledge of TIC. The posttest was completed at the end of the training (immediately following the end of the training on site) and designed to measure the participants' knowledge of TIC after the training using the same items from the pretest. An additional measure was used to gauge satisfaction with the training. Follow-up assessments were conducted one year after training by contacting the site directors of the training sites. The trainer contacted all the site directors by email and telephone and explained the necessity of obtaining the follow-up assessments. Directors agreed to make the assessments available at their site to all participants. It was suggested that they send out an agency wide email and let staff know where the assessments could be accessed and returned. The follow-up assessments were mailed or dropped off at the center, depending on the location. A post-age paid return envelope was provided. The follow-up assessment was used to determine the maintenance of TIC knowledge. Twenty-five participants (12% of all the participants in pre- and posttests), representing all 5 sites, responded and returned follow-ups.

2.2.1. Training

The training was guided by free materials from the National Child Traumatic Stress Network's (NCTSN) Child Welfare Trauma Training Toolkit (Child Welfare Collaborative Group, National Child Traumatic Stress Network,, & The California Social Work Education Center, 2013). The training is intended to be a two-day workshop and was modified

to be delivered in a half day due to time constraints and funding limitations. The NTCSN training includes a Comprehensive Guide, a Trainer's Guide, an outline of the resources for each individual module, Participant's Manual provided to each participant, a list of reading resources, handouts, and Powerpoint slides for each one of the modules. The instructor supplemented the material with videos from the optional activities list from the manual. While this training is intended to be used with staff in child welfare settings, it can be utilized across child-serving systems, such as juvenile justice, education and child welfare (NCTSN, 2013). CAC workers and child welfare workers share the tasks of responding to allegations of abuse and ensuring the children and their families receive medical and mental health services. The content of the training was applicable to CAC staff as adopting a trauma-informed approach in all child-serving systems provides benefits on multiple levels. Such an approach, "equips front-line workers, supervisors, and administrators with the tools and skills necessary to help children and families overcome trauma and manage their own secondary traumatic stress" (NCTSN, 2013 p. 6). The current training was developed to spread trauma-informed practice beyond the non-clinical staff to every employee level in the CAC and among its multidisciplinary team member agencies. The trainings are intended to increase awareness among workers of the effects of trauma on children; promote evidence-based screening, assessment, and treatment; and coordinate care with other agencies (Conners-Burrow et al., 2013).

The training embodies the 7 Essential Elements that include: (1) Maximize physical and psychological safety for the child, (2) Identify trauma-related needs of children, (3) Enhance child well-being and resilience, (4) Enhance family well-being and resilience, (5) Enhance the well-being and resilience of those working in the system, (6) Partner with youth and families and (7) Partner with agencies and systems that interact with children and families (Child Welfare Collaborative Group et al., 2013).

Appendix A outlines the modifications made to the training. For each of the 7 Essential Elements, the instructor utilized PowerPoint slides and information provided by the NCTSN. For the first Essential Element, she provided examples and explained the topic and implementation. For the remaining topics, the group was broken into 6 smaller groups to work on an assigned essential topic. After some time, the small group would present their findings to the larger group. The trainer would then review the concept via the PowerPoint slides provided by NCTSN and utilize any supplemental material to emphasize the Essential Elements.

2.2.2. Measures

Two measures were used to assess knowledge and satisfaction of the TIC training.

2.2.2.1. Knowledge/learning. Trauma-Informed Care Questionnaire (TICQ). The TICQ was developed for this project to specifically assess the key contents of the TIC training in the current study because no existing measure for the construct of TIC could be located nor was one available from the NCTSN training materials. This questionnaire addresses the participant learning component of Kirpatrick and Kirpatrick's (2006) model of program evaluation. The learning theory underlying the measure development was to capture components of the 7 Essential Elements (to demonstrate content validity). These Essential Elements are based on years of clinical experience by the experts on the Child Welfare Committee of the NCTSN as well as research literature on the effects of trauma on children (Sullivan, Murray, & Ake, 2016). After creation of the instrument, it was shared with two other experts in child maltreatment, who had both research and clinical experience. Based on their feedback, several items were changed for readability. The resultant questionnaire consists of an 18-item, 4-option multiple choice questionnaire. Research has shown that 4 options are plausible for a multiple choice test in terms of item discrimination and difficulty and reliability (see meta-analysis by Rodriguez, 2005). Test-retest reliability with

another sample was 0.71 (N = 59). Items include: "What are some Essential Elements of trauma-informed care?" and "What are some ways helping professionals can address the impact of trauma?". In addition, it contained questions to elicit demographic information on participants (e.g., position, years of experience, prior training). The TICQ pre-, post- and follow-up tests contained the same items.

2.2.2.2. Training reaction/satisfaction. The *Training Reaction/Satisfaction* measure is a project-developed satisfaction survey which was administered at the end of the training. Participants rated the helpfulness of the training on a 5-point Likert scale, with response options ranging from *not at all* (1) to *very helpful* (5). They also responded *yes* or *no* to the query, "Was the time adequate for this training?". This measure also contained two open-ended items about the most and least preferred components of the workshop and an open-ended question about topics on which they desired more training. This survey was created to address the participant reaction component of Kirpatrick and Kirpatrick's (2006) model of program evaluation.

3. Results

3.1. Data analysis

The data obtained from the two measures were kept separate throughout the data analysis process but used to inform different aspects of the training. The TICQ was used to measure knowledge acquisition while the Training Reaction/Satisfaction survey was used to gain information about the process and participant satisfaction with the training. For the ultimate analysis and conclusions, the data were used together to draw conclusions. The use of the two instruments was an intentional strategy to inform all the aspects of the training and reinforced the validity of the results by using multiple sources of information.

All of the data collected from the TICQ were analyzed by statistical tests in IBM SPSS Statistics (Version 24). T-tests and one-way ANOVAs were performed to examine if there were significant differences in participants' knowledge on the TICQ before and after training due to their demographic characteristics, including gender, age, race/ethnicity, language, degree, working experience, prior training experience, and the frequency of training. A dependent sample *t*-test was performed to examine participants' knowledge on the TICQ before and after training, and a repeated measure one-way ANOVA was conducted to compare participants' knowledge on the TICQ in pre-, post-, and follow-up tests. Table 2 presents means and standard deviations for the TICQ in pre-, post-, and follow–up tests.

3.2. Knowledge/learning

The results from SPSS indicated that statistically significant differences existed in participants' pretest scores based on their race/ethnicity ($F_{(4,203)} = 4.62$, $p < 0.05$, partial $\eta^2 = 0.09$), degrees, ($F_{(3,203)} = 7.67$, $p < 0.001$, partial $\eta^2 = 0.06$), and years of working experience ($F_{(4,203)} = 2.48$, $p < 0.05$, partial $\eta^2 = 0.09$). More specifically, White/Caucasian participants had higher pretest scores than Black and Hispanic, and participants with bachelor's and graduate degrees had higher scores than those with only high school diplomas. Surprisingly, participants with 10–20 years' work experience and >20 years' experience had

Table 2
Means and SD for the TICQ.

Pretest		Posttest		Follow Up	
Mean	SD	Mean	SD	Mean	SD
10.81	2.17	12.69	2.02	12.40	2.08

significantly lower scores than other groups. However, no significant difference was found in participants' pretest scores due to other factors, including participants' gender, age, language, current positions, prior training on the topic, and frequency of prior training. This suggests that participants had similar level of baseline knowledge on the TICQ, regardless of their background.

Differences in posttest TICQ scores due to participants' demographic characteristics were also compared after controlling pretest scores. Significant differences only existed among participants in terms of their prior training experience (F (1,203) = 5.40, $p < 0.05$, partial η^2 = 0.03) and the frequency of training (F (3,203) = 2.68, $p < 0.05$, partial η^2 = 0.04). More specifically, participants who experienced prior TIC training had significantly higher posttest scores than their counterparts who did not experience the same training. Participants who were trained more than twice a year had significantly higher scores than those who were only trained twice a year. This suggests that the training program was generally effective, regardless of participants' demographic background.

A dependent samples paired t-test was performed for the entire group (N = 203) and it was found that posttest TICQ scores were significantly higher than pretest scores (t (202) = 10.18, $p < 0.001$), indicating the overall effectiveness of the training for the participants. The effect size (Cohen's d) is 0.71, which is a medium but close to large magnitude of difference (Cohen, 1988). A repeated measure one-way ANOVA was further conducted to compare participants' pre-, post-, and follow-up TICQ scores. Mauchly's test of sphericity[1] showed an insignificant result ($p > 0.05$), which suggests that the assumption of sphericity was not violated despite the small sample size in the follow-up test. The results indicated that these three scores were significantly different (F (2,24) = 24.60, $p < 0.001$, partial η^2 = 0.51). Specifically, posttest scores on TICQ test were significantly higher than pretest scores ($p < 0.001$). Although follow-up scores were lower than posttest scores ($p < 0.05$), they were higher than pretest scores ($p < 0.001$). This indicates that the effectiveness of the training was maintained even after 12 months.

A closer examination of the items on which there was a significant difference between pre- and posttests reveals two domains related to knowledge and practice. The items that were significant represent two domains: (1) Characteristics of children with trauma, including such concepts as definition, common age of traumatic events, greater suffering, causes of secondary trauma, and characteristics of children who have experienced trauma; (2) Optimizing treatment of children who have experienced trauma, including essential components of TIC, how to maximize feeling of safety for children, sensitivity to child's culture, assessment of TIC, and how to implement TIC.

3.3. Training reaction/satisfaction

Written responses were coded using thematic analysis (Braun & Clarke, 2006, 2013). This type of conventional content analysis (Hsieh & Shannon, 2005) provides the advantage of not imposing preconceived categories on the participants. To ensure the validity of our identified themes, we used a consensus building process. That is, two independent reviewers (authors) read and coded all the responses for prevalent emerging themes. Using an inductive process, common responses were examined for overarching themes and frequency counts of certain responses (within themes) were conducted to reduce qualitative data. Both reviewers conducted this process independently and then discussed and resolved disagreements by repeatedly reading and comparing data within and across themes. There was considerable overlap in the identification of initial themes by the two coders, with an inter-

rater agreement that ranged from 90 to 100% for each response. Responses could include more than one theme.

Ninety-two percent of the participants reported that the training was very helpful or helpful, while 8% reported a neutral response. In the response to the query, "What did you like best about the training?", several themes emerged, including stories/videos/real life cases, interaction/group work for participants, information/strategies/handouts/tips, and presenter (engaging style). Participants indicated that stories/real life cases (n = 42) were the most valuable (e.g., children's personal stories, vignettes, video testimonials, concrete examples). Responses that fit the interactive group theme (n = 34) included: Group projects, interactive activities, varied activities/opportunities to participate, connection with others, exercises, Play Doh® and drawing groups. The information/tips theme (n = 33) contained comments about the handouts, helpful tips, and other information that was provided in the training. For presenter style (n = 16), the responses primarily included comments related to the presenter's knowledge and presence, speaking ability, and good instructional aides. There were a total of 125 responses that could be coded for this question; each response was coded separately and yielded 92% agreement.

For the question, "What did you like least about the training?", participant responses fell into the following themes: Structure, need more breaks, negative content, group interaction. The general theme of Structure (n = 17) included the following comments: Assessment exercise, too many handouts, having to do an evaluation, doing the case vignettes, and reading from handouts. The final three categories received almost an equal number of replies (n = 9, n = 8, n = 6, respectively). Several participants desired breaks during the training. Some were upset by the content of the videos or the abuse calls. Still others did not enjoy the group interaction and stated they did not like to speak in public or stand up in front of others. There was a total of 40 responses that could be coded, each response was coded separately and yielded 95% agreement. In reply to the question asking if the training was an adequate length, 82% of the participants reported that the training was an adequate length of time. When asked to explain their reply, comments primarily fell into three categories: Sufficient time (53), more time was needed (8), too much time was given to training (2). There were a total of 61 comments provided on this section and 100% agreement among coders.

In response to the question, "What topics would you like additional training on?", several themes emerged. These included: Trauma information (n = 15), self-care/secondary stress (n = 7), human trafficking (n = 3). Within the category of trauma information, participants desired more knowledge in the following areas: Protective factors, psychological abuse, posttraumatic abuse, impact on brain development, resiliency, TIC techniques, inter organization collaboration, and speaking to children about trauma. There were a total of 25 comments provided on this section and 90% agreement among coders.

4. Discussion

In this paper, we outlined the implementation of a modified version of the NCTSN trauma-informed training program with CAC workers in Florida. Designed to increase knowledge and awareness of TIC among CAC workers, the training specifically focuses on the seven Essential Elements of care, including enhancing child and family well-being and resilience, maximizing psychological safety for children and families, and partnering with agencies and systems. The results presented in this paper suggest that this is a promising approach to introducing TIC training for CAC workers from various disciplines.

Scores on the pretest evaluation demonstrate a need for implementing the training with all CAC workers. Prior training on

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[1] Mauchly's test of sphericity is used in SPSS to test the assumption of sphericity in repeated measures ANOVA, which is similar to homogeneity of variances in a between-subjects ANOVA.

TIC did not affect participants' pretest knowledge, emphasizing a need for continued awareness of TIC practices. Not surprisingly, those with high school degrees or higher displayed more knowledge than those without degrees. Length of time employed at the CAC affected knowledge scores, with participants with less years of experience having more TIC knowledge than those with more, indicating that the longer a participant had been working, the less they knew about TIC. Those more recently trained (e.g. <1 year–10 years) seemed to possess more TIC knowledge at the outset than those working > 10 years. This may be due to the growth in the field of traumatology over the last decade with various organizations providing training models and standards of education (Webb, 2003). Following the events of September 11, 2001 and the subsequent establishment of the National Child Traumatic Stress Initiative, there has been an emphasis on increasing the availability of training in trauma to individuals who interface with children. The significant change in knowledge about the key components of TIC from pre- to posttest for all participants (regardless of participants' demographic background, including position at the CAC) suggests that the training was successful in conveying the critical content.

Aside from Kramer et al. (2013) which used a 3-month follow-up, this study is an improvement over others that do not perform any follow-up and found that gains in knowledge were maintained over time in a smaller sample. While there was some drop in TIC knowledge scores over time, follow-up scores were still significantly higher than pretest scores. Additionally, the evaluation results indicate that participants were highly satisfied with the training with no one reporting it to be "unhelpful". Participants were overwhelmingly positive about the training and expressed an appreciation for the training methods used. Eighty-two percent thought the length of the training was adequate and a small group (17%) wanted more time, while very few participants indicated that less time would be better. There were some comments about the negative content of the training (which are understandable given the traumatic content) and some participants did not appreciate the group work or structure of the training. Consideration of this feedback might allow future participants to opt out of experiential activities if they report discomfort.

4.1. Evaluation

Kirpatrick and Kirpatrick's (2006) model for evaluating training programs revealed relatively positive results. In looking at Reaction (customer satisfaction), feedback from participants indicated general satisfaction with the training, including the presentation methods and presenter. The authors recognize the immeasurable effects of the expert trainer who conducted these sessions. It is unclear if the same results would be found with a less qualified trainer. The second component, Learning (knowledge, skills and attitude), appeared to occur as evidenced by the significant change in pre- to posttest knowledge of TIC scores. Behavior change, or the extent to which skills were learned or attitudes were changed, is unknown and could be explored in future studies by employing assessments of these constructs and follow-up examination of changes in reporting behavior. In order to evaluate this, a more skill-based assessment would have to be employed. With regard to measuring Results (cost effectiveness), the training was considered cost-effective, in that it was supported by a $20,000 grant for a 12-month period and there was no charge to CACs. The majority of funds were used for travel and lodging expenses for the presenter and a fraction of the budget was used for evaluation. Considering the training reached over 200 CAC workers in a one-year period, the cost is minimal. Considering the breadth of the information provided and the amount of training provided (4 h), this cost per participant (approximately $100) seems to be reasonable. Since this study addressed three of the four levels of evaluation, all four are needed to determine the most cost effective dose of the training (Sullivan et al., 2016).

4.2. Implications for practice and training

It has been recommended that TIC training begins at the point of orientation for all new staff and also be part of ongoing staff development (Hummer, Dollard, Robst, & Armstrong, 2010). Layne et al. (2011) recommend a "profession-long process of self-reflection and professional growth" (p. 249) with an emphasis on understanding trauma and its effects on victims. Multiple vehicles can assist agencies in transforming into being trauma-informed. While training and lectures are common methods, Berger and Quiros (2014) recommend continued supervision for trauma-informed practice. This allows for staff to have a place to discuss the complexity of their work and help emphasize the need for self-care. Since self-care and avoiding burnout were topics of interest with this sample, agencies may want to implement supervision or other ways to ensure staff engage in precautionary measures against burnout or secondary trauma. In addition, given the potentially high turnover in CACs due to secondary trauma (see Bonach & Heckert, 2012) and influx of new workers in into CACs' (32.7% in this sample had been employed less than one year), it would be wise to implement training annually. This study follows the recommendation of Harris and Fallot (2001) who suggest postponing intensive training for a few staff in favor of a more general introduction for the majority of workers. This general introduction would emphasize the most important TIC concepts (Berliner & Kolko, 2016). There may be varied training needs for different job positions and some aspects of training curricula and targeted skills might be best tailored to one's job function (Lang, Campbell, Shanley, Crusto, & Connell, 2016).

While the results of this study demonstrate that participants increased their knowledge and a smaller sample maintained knowledge at follow-up, these authors recommend repeated training for CAC workers. One-time trainings are often not as effective as multiple opportunities for training (Cepeda, Pashler, Vul, Wixted, & Rohrer, 2006). Prior knowledge of TIC did not affect participants' scores but those who had more professional development (>2 times per year) showed greater TIC knowledge, which may indicate training in general leads to greater awareness of the importance of being trauma-informed. It may be that previous training was not as comprehensive, or interactive or content-based as this training. Conners-Burrow et al. (2013) suggest that additional coaching, consultation, supervision, and support may need to be provided to CAC workers in order to fully commit them to change their behavior. Thus, even following training, changes in behavior may be slow to happen. Future training needs to emphasize ways in which workers can incorporate the knowledge they have gained into real-life practical settings.

This training relied on the learning theory of Dewey (1938) who proposed that people learn through experience and interaction. Kolb (1984) also recommends experiential learning in the workplace, where peers support one another's learning from experiences. Our findings show that participants generally enjoyed the more active aspects of the training (e.g., exercises, interactive activities, opportunities to participate). Thus, these authors recommend trainings that include the opportunity for interaction, case vignettes, clinical examples, and multimedia presentations. Some of our participants desired additional training on other topics related to trauma, indicating the desire for continual professional development. Those who provide direct care may be able to take the first step in becoming trauma informed in their treatment of victims and then advocate for a full trauma-informed approach at CACs.

4.3. Limitations

These results are preliminary and emphasize the need for replication with more rigorous research methods and a more nationally representative sample. Some subgroups were small and a larger sample of various professional groups would be beneficial. Understanding that knowledge acquisition does not equate to behavioral change

(Kirkpatrick, 1967), future research could examine changes in beliefs, practice, and behaviors after participation in TIC trainings as well as TIC consultation and supervision. A comparison across these methods (training vs. consultation) may be helpful as well. Another limitation of the study is that we used an instrument that was specifically developed for this project given that there were very few existent measures for the same purpose (previous research used program-developed measures too). In the future, we will consider using multiple assessments to measure the effectiveness of the training, such as participants' behavior change and how they implement TIC after training. At the same time, we will refine the instrument used in this project in the future so that it can be applied to other similar training sessions. The rate of reply to the follow-up was low, which limits the generalizability of the results, and it is possible that only those that remember the training content replied.

4.4. Lessons learned

There were challenges to implementing the training program, including scheduling of sessions and travel costs. Finding a block of time that CACs could dedicate to training was difficult with some of the sites requesting (but not receiving) a shorter training. Committing to adopting a trauma-informed approach will require support and commitment of senior administration (Muskett, 2014; Walkley & Cox, 2013). If trainers were available locally, this would reduce the need for travel and allow for greater flexibility in scheduling trainings. Thus, a "train the trainer" model could be implemented to ensure that workshops can be given in all locations on more regular basis. Although gains in knowledge were maintained at 12-month

follow-up in a smaller sample, results did indicate that prior training did not affect pretest scores on the TIC measure, indicating perhaps a loss of previous knowledge over time and the need for repeated exposure to the content. It is recommended by some learning theorists that a review of material after a few months of initial presentation is likely to lead to a high rate of memory for the material (Cepeda et al., 2006).

Attempts to collect follow-up data were difficult. Center directors were contacted but had little success getting participants to complete the follow-up assessment. At some sites, workers were no longer employed or simply did not comply with requests to complete the test. In total, only 25 follow-up surveys (12%) were completed and returned. Future research might utilize emails to send the follow up assessment via an online link on multiple occasions or perhaps employ incentives (financial or otherwise) for completion of the survey.

Declaration of interest

Acknowledgement

Appendix A. Modification of NCTSN 7 essential elements of child welfare trauma training kit

2 day NCTSN training	½ day modified training	Activities
Registration	Removed	Prior to the training
Breaks	Removed	None
Lunch	Removed	None
Welcome back	Removed	None
Module 1: introduction: the essential elements of a trauma-informed child welfare system	✔	
Module 2: child trauma and child traumatic stress	Removed medical, historical trauma and neglect. Added polyvictimization.	9-1-1 - tape played
Module 3: how does trauma affect children?	Removed variability of response, overwhelming emotion and behaviors. Added brain development.	Optional bottle exercise and independent writing activity removed
Module 4: what is the impact of trauma on the brain and body?	X Removed module	
Module 5: what is the influence of developmental stage?	✔	Optional video and independent writing activity removed.
Module 6: what is the influence of culture?	✔	Optional video removed.
Module 7: essential element 1 – maximize physical and psychological safety for children and families	✔	Large group activity: The entire group collaborated on the 1st element. Optional writing activity removed.
Module 8: essential element 2 – identify trauma-related needs of children and families	✔	Small group activity.[a] Trauma referral tool used in group.
Module 9: essential element 3 – enhance child well-being and resilience	✔	Small group activity.[a] Removed role play activity, optional video and writing activity.
Module 10: essential element 4 – enhance family well-being and resilience	✔	Small group activity.[a] Removed optional videos.
Module 11: essential element 5 – enhance the well-being and resilience of those working in the system	✔	Small group activity.[a] Removed relaxation exercise and writing activity.
Module 12: essential element 6 – partner with youth and families	✔	Small group activity.[a] Removed writing activity.
Module 13: essential element 7 – partner with agencies and systems that interact with children and families	✔	Small group activity.[a] Removed writing activity. Closing activity added from Module 14.
Module 14: summary – case culmination activity and summary activity	X Removed module	

Note. [a] For Essential Elements 2–7, the participants were divided into 6 small groups. Each group was assigned one Essential Element. The groups brainstormed how to apply and implement the Essential Element assigned to them, and presented their ideas on a flipboard to the rest of the group. The trainer provided feedback and supplemented with the slides and other resources as indicated.

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