DECEMBER 2021

EARLY CHILDHOOD WORKFORCE

SUPPORTING THE PROFESSIONALS WHO SUPPORT OUR FAMILIES

by Megan Carolan, VP of Research and Amber Posey, Policy Research Associate

THE UNDERLYING ISSUES
COMPENSATION, BURNOUT, RETENTION AND SAFETY

AVAILABLE SOLUTIONS
AT THE POLICY- AND PROGRAM-LEVEL

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Introduction

Professionals who work with children and their families play many roles, from child care provider to social worker to health professional. **While specific responsibilities and training may differ, each of these sectors contribute meaningfully to the well-being of children and families, often working with the same families in different contexts.** Each specific field faces a range of similar challenges related to burnout, compensation, safety, and retention. The COVID-19 pandemic moved many of these professions squarely into the role of "frontline worker"–but often without increasing resources to support these professionals. As policymakers, service providers, funders, and families begin to move forward from this crisis, it is essential to address long-standing issues faced by these workforces and build a resilient, productive, stellar workforce that our children deserve.

This paper will explore the challenges faced in each of these sectors of the broadly-defined "early childhood workforce," highlight commonalities, and provide possible course of action to build resilience in the workforce serving our children, particularly in light of the lingering crisis and long-term impacts of COVID-19.

Defining the Early Childhood Workforce

Who is a member of the "early childhood workforce?" Traditionally, this term has been used to refer to care and education providers (child care centers, pre-K classrooms, Head Start centers, etc.) but has not been more specifically defined. In this paper, the term is used to comprehensively refer to the broad range of professionals working with young children (up to age 8) and families across education and care, health, child welfare, and more.

It would be impossible to include all the professionals and specialists that comprise this workforce. Efforts have been made to be as inclusive as possible based on existing literature and data, while also keeping the focus on systems and sectors serving a wide range of families. Thus, while the conversation on health will discuss several professionals within this field, it would be impossible to explore each pediatric subspeciality in the same degree of detail.[1] Community-based providers are also particularly difficult to capture in the existing research literature, but that should not mean their roles are ignored; libraries, sports instructors, clergy, and more all play important roles in the development of children and the support of their families. Omissions should not be taken as exclusions of important professions, but rather limitations of research and space. Importantly, this paper will provide specific examples and figures of challenges facing professionals working with families; but the broader themes of burnout, turnover, safety, and problematic compensation are cross-cutting and likely also apply to those fields whose research literature was not robust enough for inclusion. This piece is a starting point to begin framing the needs of the early childhood workforce more collaboratively; it is not the final word.

Why address so many related fields in one brief? Traditionally, the professionals working in the early childhood sector have been discussed in their individual silos–early childhood educators discussed separately than pediatricians who are discussed separately from social workers, and there may be even further differentiations within these groups (for example, Head Start teachers versus private child care versus school-based pre-K). While these distinctions may be necessary for the sake of funding streams, regulations, and qualifications, at the end of the day this workforce all serves different needs of the same families within a community and face many similar issues. It may not seem intuitive to discuss the professional earnings of the childcare provider with an associate's degree who is barely making poverty-level wages compared to the pediatrician who finished medical school and is earning six figures. However, a review of the existing research shows that in both scenarios these professionals are under compensated compared to their adult serving peers and face high levels of burnout. Any of these factors can jeopardize the stability of this workforce, which impacts the quality of care the families they serve are receiving. By borrowing inspiration from the collective impact movement which has slowly revolutionized social services and nonprofit work, we can understand that change in the sectors is more likely when we view these challenges as inextricably interconnected rather than as separate spheres.[1]

Most research on these workforces focus on medical providers and classroom professionals. This is partly because these professionals work with all families across the board, whereas other providers such as child life specialists or social workers work with a smaller segment of the population and are thus a smaller workforce in size. This paper will draw from the best available literature to connect across themes across these sectors and identify solutions which can be incorporated and piloted in new environments. As much as possible, this brief is focused on children under the age of 8;

[1]This paper focuses on young children up to age 8, which aligns with ICS's mission and also is generally viewed as the last age of "early" elementary school. ICS also has a focus on prenatal well-being for families. These professionals are essential to helping families start life ready to flourish; however, they are beyond the scope of the current paper.

however, existing literature often focuses on professionals who serve a broader range (for example, pediatricians do not stop serving children at age 8).

A comprehensive list of all professionals working with young children and their families is impossible. This paper draws from literature on the following professions, though the implications for others in related fields are strong:

- Early childhood education/child care providers
- Teachers (early elementary teachers and special education) and assistant teachers and paraprofessionals
- Pediatric medical providers, including doctors and nurses
- Mental health professionals, including guidance counselors and private practice providers (psychologists, social workers)
- Child welfare professionals and home visitors
- Child-life specialists

Finally, in a field devoted to children, why focus on the workforce itself? Simply put, because the desired impacts for families and children are simply dreams if our systems do not have the qualified, expert workforce to make them real. Investing in the early childhood workforce is tantamount to investing in the community it serves, children. According to Professor James Heckman, Nobel Memorial Prize Laureate in Economics, funding early childhood development–including programs and the professionals that fuel those endeavors–amounts to an increase in national economic productivity.[2] Children who build healthy social skills such as attentiveness and peer engagement statistically become more capable adults with higher competencies in education, better overall health, and greater participation in positive economic outcomes. To provide children with the tools needed to access greater social skills, there must be a system of adult professionals focused on the health and development of children in all spaces from the doctor's office to child care and beyond. If these spaces and their professional teams are at the heart of childhood social development, they require financial and structural support in the form of professional advancement, substantive wages, access to quality healthcare, reasonable caseloads, and legislative support for these changes. The health of these workers, when viewed as imperative to the health of our nation's children and invested in accordingly, can lead to long-term economic progress in all industries.

Issues Facing the Workforce

Compensation

Adequate compensation is a basic tenet to a stable, well-qualified, respected workforce across fields. Compensation is not about a specific number so much as it is about a broader need to balance the cost of living with acknowledgment of the difficulty of the work and skillset needed and proportionate to the workload. In fields with significant emotional engagement with families, this equation becomes even more complex. Across sectors, low compensation, or compensation that fails to offset the physical, mental, emotional, and financial toll of working in a field, combined with the issues discussed in this paper, may lead to staff shortages in the early childhood workforce; this is already starkly the case in early childhood education (ECE) programs, where staff are reported to be leaving for high-paying service sector jobs and hiring has not rebounded to pre-pandemic levels.[3]

Quality childcare involves well-trained, committed, and caring professionals, and yet has historically taken a back seat. For years, teachers across the U.S. have expressed their need for better compensation to help close the gap on issues manifesting in the classroom like limited supplies, a

lack of competitive incentives such as raises, and a dwindling number of people entering the field. Early childhood educators frequently leave childcare centers and family home settings for positions in public schools where higher wages and benefits are offered for doing the same or similar work.[4] The same can be said for pediatric nurses leaving public school settings to receive better pay and benefits from a position within a hospital system.[5] When this is the case, professionals may stay within the field but move among employers in search of a better fit for themselves, contributing to turnover or "churn."

Income expectations in positions working with young children vary significantly. The table below highlights average base salary from a variety of child-focused professions, compared to a variety of peers in non-child focused professions, or those that serve both children and adults.

Salary is only one factor of compensation. Benefits access–sick and vacation time, health insurance, and retirement accounts–vary significantly not only by job type in the field but by employer as well, and data are difficult to find on availability by field. For example, the vast majority of child-life respondents indicated that they had access to health care benefits, including dental and vision, usually through a cost-sharing arrangement with their employers.[6] On the other hand, only between 40 and 50 percent of child care providers are offered health insurance through their employers;[7] the need for comprehensive, competitive benefits has specifically been identified by a national collaboration of experts and advocates as an important step to improving the well-being of staff and of the system overall.[8] For doctors and nurses, benefits access likely differs based on employment settings, with hospital systems the most likely to provide compared to smaller practices; similarly, child welfare professionals may find a significant difference in benefits provided by working for government agencies directly when compared to nonprofit organizations.

Median Salaries for a Selection of Child and Non-Child Focused Careers

	Profession	Median Salary	Population
EDUCATION PROFESSIONALS	Child care provider	$25,460	Child
	Teaching Assistant	$28,900	Child
	Preschool Teacher	$31,930	Child
	Kindergarten & Elementary Teacher	$60,660	Child
	Special Education Teacher	$61,500	Child
	High School Teacher	$62,870	Child
HEALTH CARE PROFESSIONALS	Child-life specialist*	$49,000	Child
	In-School Nurse (RN)**	$51,300	Child
	Certified Pediatric Nurses (CPNs)**	$71,560	Child
	Registered Nurse	$75,330	Adult/General
	Nurse Practitioner	$117,670	Adult/General
	Pediatrician	$177,130	Child
	Physicians and Surgeons	$208,000	Adult/General
PSYCHOLOGY/ SOCIAL WORK PROFESSIONALS	Social Worker	$51,760	General
	Guidance Counselor	$58,120	Child
	School Psychologist***	$74,000	Child
	Psychologist	$82,180	Adult/General

Sources: Median salaries from US Bureau of Labor Statistics Occupational Outlook Handbook, unless otherwise noted.

* Association of Child Life Professionals. (2020). 2020 salary survey.

** https://www.incrediblehealth.com/blog/pediatric-nurse-salary/

*** https://www.nasponline.org/about-school-psychology/workforce-and-salary-information

The Expectation of Selflessness

In many cases, the expectation for the child psychologist, teacher, social worker, doctor, etc. to put the health and wellness of the child over themselves is baked into the job description.

That's in part why early in the pandemic, many in these fields were viewed as heroes for going beyond their normal responsibilities. Think of a teacher providing specialized online classes where they had to get creative to engage children in a new way, with nearly no time to prepare as the shift to virtual was so sudden. However, for many professionals, this quick adjustment to meet the needs of families came at a personal expense–they spent more of their own time, money and energy creating lesson plans–which became an expectation.

Consequently, societal acceptance for burnout among teachers grows. Even when the teacher cannot maintain the same level of care for their students due to the personal toll it takes over time, the expectation for them to maintain that level persists.

Burnout

While burnout has become a mainstream term, it does have a specific definition used in the research literature, "a state of physical or emotional exhaustion that also involves a sense of reduced accomplishment and loss of personal identity."[9] Burnout has a range of physical, mental, and professional impacts; in the early childhood workforce, this could undermine many of the intended benefits for families and children. Across populations, burnout is linked to higher rates of cardiovascular diseases as well as a shorter lifespan.[10] Among physicians broadly, burnout is associated with depression, relationship difficulties, substance misuse, and even suicide.[11] Unaddressed burnout has implications for organizations and their staff as well. Burnout among physicians is linked to intent to leave their current position in the next two years; considering that the costs to replace a physician is generally two to three times their annual salary, this has significant financial implications for health care systems.[12] Burnout can also be, in some sense, contagious; turnover of one member of a care team increases the risk of other members of that team leaving, even if a replacement is hired.[13] Crucially for families, burnout and quality of care are also tied together, though it can be hard to say which causes the other. An increase in burnout symptoms is linked to an increased rate of major medical errors in the past three months.[14]

Pediatric nurses in hospital settings also experience demanding and emotionally intense work. Particularly given that many children may need long-term care for an illness in the pediatric department, nurses often have the opportunity to work closely with families and may develop a bond; however, when a child's illness is terminal or when the child passes away, this bond can lead to grief which can impact the nurse's well-being. Nurses may experience this grief in their personal life, and it also can lead to burnout at work, potentially leading to medical errors, lower quality care, and/or turnover."[15]

Consider the role of an administrator or manager in the early childcare space. These positions "that often struggle for enough funding, interact with staff and families that cope with emotionally-laden issues and constantly work to improve the quality of early care and education"[16] are naturally inclined to experience burnout. In addition to existing in an environment where stress and exhaustion are consequences of a system which is often under-funded and under-staffed, there are few policies in place to help mitigate this stress; many early childhood positions lack insurance coverage for physical and mental health services or adequate vacation hours. The same can easily be seen in the pediatric medical field–both for those in private practice and, more acutely, for those in emergency care settings–and child welfare–where individual employees may even spend a significant amount of time away from the calmer environment of an office and very literally in the field on home visits. Infant-toddler home visitors report being stressed not only about concerns for their safety but also the safety and financial stability of the families with whom they work.[17] Burnout is well-documented among child welfare case workers, with these professionals demonstrating higher rates of "compassion fatigue" and stress than do other social service providers, resulting in negative overall well-being.[18]

The need for self-care among nurses is documented in the 2021 National Academies report, *The Future of Nursing*, which lists among its goal for the field, "Nurses attend to their own self-care and help to ensure that nurse well-being is addressed in educational and employment settings through the implementation of evidence-based strategies."[19] The link between work environment, caseload, nurse well-being, and quality of care has been further exacerbated by COVID-19, as nurses experience a direct risk of infection (particularly in 2020 before vaccination was available); higher caseloads; a lack of appropriate precautions and protective equipment; and the emotional toll of working under such conditions, particularly as patients are separated from families.[20] Caseloads in particular, present a confluence of concerns; high caseloads greatly inhibit the provider's time, replacing activities linked to higher competency and thoroughness like reflective supervision, planning and professional growth with exhaustive hours that enhance professional fatigue.

Professionals can also be deeply impacted by the experiences of *others* with whom they work. "Second traumatic stress" (STS) is "the emotional duress that results when an individual hears about the firsthand trauma experiences of another person."[21] Individuals experiencing STS may demonstrate symptoms similar to Post-Traumatic Stress Disorder (PTSD), including increased negativity, a feeling of detachment, and hopelessness.[22] Much has been written about the experience of social workers and other human service professionals facing STS and similar challenges, but all providers who work with children may experience these feelings based on working with populations facing challenges or struggling emotionally. This is all the more likely as families navigate the negative emotional and financial impacts of COVID-19, and all the more profound for those who have lost loved ones. Providers from physicians to teachers are working with these families and experiencing their difficulties vicariously.

STS can also impact *organizations*, not just individual employees, "In agencies affected by STS, the organization may be very reactive or avoidant, communication and collaboration may break down, and staff and clients may feel a lack of psychological safety. Given how common trauma exposure is in child welfare, some organizations have a "stiff upper lip" ethos that discourages talking about the emotional impact of the work."[23] While this excerpt is specific to child welfare organizations, providers who work extensively with clients facing trauma–for example, physicians who work specifically with terminally ill children or child care providers working in a neighborhood where children routinely experience violence–could also be impacted.

Burnout has been an urgent concern in these fields for years; the COVID-19 pandemic has pushed it to emergency levels, increasing stress and workloads while reducing supports, all while these professionals navigate the impacts in their personal lives as well. One study across a range of health professionals (physicians, advanced practice providers, residents/fellows, and nurses) finding that 60 percent reported acute stress, and half exhibiting symptoms for depressive disorder related to the current crisis.[24] When given a list of burnout symptoms, more than half of child life specialists in October 2020 rated themselves at a moderate risk of burnout, with about 17 percent reporting a high risk.[25]

A summer 2020 study of child welfare professionals looked at "peritraumatic distress"–"physiological and/or emotional distress experienced by an individual during a traumatic event"–and found that half of child welfare professionals had mild/severe levels.[26] This may then fuel burnout, high turnover, and impact practice decisions.[27] Child welfare workers had to navigate stress caused by operational challenges due to COVID, including court closures which delayed proceedings impacting families and added to backlogged cases[28]; many also reported concern of underreported abuse/neglect due to school closures.[29]

Burnout: A Chicken-or-the-Egg Problem

Which came first–the burnout or the stressful situation? The relationship between burnout and other negative impacts identified in research is complex.

For example, literature on burnout and physicians demonstrates a link between provider errors and burnout, but cannot tell us for sure:

- Did the feeling of burnout create conditions for those errors? or
- Did the errors (and subsequent self-doubt, professional consequences, etc.) cause the feeling of burnout? or
- Did some other factor (for example, lack of sleep) contribute to both burnout and medical errors?

More specific research questions can help finetune the exact relationships. In the meantime, those concerned about the early childhood workforce should understand that burnout does not exist in a silo, and that conditions within a workplace are important to address.

Many early childhood education providers are small business owners and they found wearing the dual practitioner and administrator hat challenging. As of summer 2021, one in three providers reported experiencing at least one material hardship (such as a struggle to pay for food, housing, or utilities); this was more common among child care homes, which often operate as very small businesses.[30] As providers reported the most experiences of material hardship, they also had higher scores of emotional distress (measured on a self-reported scale for anxiety, depression, and stress). The experience of ECE providers differed significantly based on a number of factors, particularly the type of setting. Programs with strong government financial backing (state-funded pre-K, Head Start) experienced more stability in several areas of operation, compared to those at private child care centers (which may or may not take child care vouchers)[31]; those experiences differed still from home-based child care providers, whose needs are not explicitly accounted for in many existing supports for ECE providers.[32]

Safety

Safety, within the context of the workforce, applies to the physical and emotional well-being of an employee. Now, more than ever, the safety of early childhood professionals is at a high risk due to the threat of exposure to COVID-19 within the in-person work settings–especially the kind of up-close work necessary when working with young children–as well as the physical deterioration caused by prolonged periods of exhaustion and the emotional trauma of living through a pandemic. Worker safety is a basic right legally secured and enforced by Occupational Safety and Health Administration (OSHA) guidelines, but many of these protocols are designed for mitigating exposure to dangerous substances; modern caregiving work introduces new challenges. Safety measures such as the right to receive access to employee medical and exposure records, as well as the right to

receive required safety equipment such as gloves or masks to limit their risk of harm or injury while working are imperative during a pandemic[33]. These measures are not only in place to protect the physical health of professionals, but also to protect the physical health of the children they serve, as well as the level of care they can provide. Children are highly perceptive, and the environments where they spend most of their time are often the spaces which inform their internalized feelings of protection and security.[34] If a teacher is burdened by the idea they are unsafe at work, a child is likely to perceive some level of that discomfort, which can undermine their ability to trust, bond, and learn.

Safety concerns exist in the day-to-day practice of many early childhood-focused professions. One OSHA report estimates that of the 25,000 workplace assaults reported annually, three-quarters occur in health care and social service settings, with an even higher number of assaults never reported.[35] Physical assault is a particularly common concern among medical providers, particularly those in hospital and emergency care settings.[36]The most common scenario for health system violence is when a patient or loved one of a patient attacks a staff member, often rooted in fear, stress, or anger.[37] Workplace violence in pediatric specialties is currently understudied, but is considered a reality of the job among nurses in the field; in a small study, pediatric nurses shared their harrowing experiences and generally identified this violence as an expected reality that they and their colleagues had adapted to in order to prevent and avoid. Many of the nurses interviewed expressed that they were supported by colleagues after a violent encounter, but did not feel that hospital administration was active enough in improving safety and intervening.[38]

Child welfare professionals, particularly those conducting home visits, have long advocated for safety protocols. These professionals also work with families during unique periods of stress and fear, which may be heightened by suspicion of the home visitor and fear of the actions of the state (ultimately, the potential for removing a child from the home). All of this happens within the client family's home–an atmosphere outside of the control of the home visitor and where they do not have immediate resources such as colleagues or security to intervene. Exact numbers vary, but several studies find that at least a quarter of social workers (across all positions) had been physically assaulted during the course of their work, to say nothing of threats of violence and/or verbal abuse.[39] A number of violent assaults, and even murders, of social service staff on home visits have become national news. This may create a climate of fear among other practitioners as well as those considering a career on social services; it also demonstrates the risks inherent in this work which have often gone unaddressed.[40]

School safety is a common headline news topic, though many focus exclusively on students. Early childhood teachers and other staff members may be assumed to be spared from these worries, but children can unwittingly cause injuries. Once again, comprehensive data is not available to make comparisons across grades, school settings, and more. However, research literature demonstrates this is an issue of concern regardless of grade level or classroom specialty; while violence against teachers may not be exceedingly common, no teacher is immune from the risk. One study of school staff in Minnesota found that working Kindergarten through grade two actually increased the risk of "student-perpetrated violence" compared to other grades; notably, the rates were higher for non-classroom staff, including school psychologists and guidance counselors.[41] Special teachers are at an elevated risk of being injured on the job, often resulting from an attempt to restrain a student who is experiencing a breakdown in self-regulation; one study in Pennsylvania found that of all teachers assaulted on the job, special education teachers were 2.7 times more likely to be assaulted than general education teachers, in line with other research on this issue.[42] Teachers report that the frequency and severity of injuries are greater with older students based on their size and strength. There is a lack of evidence-based solutions to ensuring that both students and teachers remain physically safe during "meltdowns."[43]

Safety protocols are often not designed with regard to the mental and emotional well-being of workers. More often, the immediate physical needs of professionals are considered when it comes to safety, for example scrubs are used in medical settings to protect professionals from being exposed to biohazards and bringing them home on their clothes. The same precautions are rarely taken in instances where the mental health of the professional is threatened. Those precautions might include stress relieving exercises, employer-provided counseling, or access to mental health services through an insurance plan. This becomes apparent in the context of the EC professional workforce as it struggles with issues like low wages, burnout, and limited resources or organizational support which, when compounded, can lead to poor mental health including battles with anxiety and depression. The rise in mental health challenges during the COVID-19 pandemic have increased the numbers of early childhood professionals in need of a therapeutic outlet, most notably pediatric mental health specialists. Like the patients or parents of the patients they treat, child psychologists, therapists, and counselors have the unique experience of listening to someone who is experiencing trauma while they are also experiencing the same personal trauma. This could mean they are experiencing the loss of a loved one due to illness, the loss of their social life due to new guidelines and restrictions surrounding gatherings, or the loss of their personal time since they are experiencing unprecedented numbers of patients and caseloads as people across the nation are seeking mental health specialists now more than ever.

The sudden spread of COVID-19 beginning in spring 2020 escalated the risks faced by in-person early childhood professionals, creating additional stress for all while also introducing the risk of a contagious deadly virus. While most schools shut down within the first weeks of broad national spread, and many non-essential home visits were halted, some professions could not shift to a virtual mode. Some child welfare case workers continued in-person visits with clients, but often did not have access to personal protective equipment (PPE) which was necessary for face-to-face contact in an enclosed space.[44] Many early childhood education settings which operate outside of districts were left in limbo, with some providers ordered to close by their state governments, while others left the decision to provider/local discretion. This was a complex decision for providers to make during a time of significant anxiety and with much about the virus still unknown; research indicates operators weighed staff and child health and safety, program financial concerns, needs of families related to essential employment, child care situations of staff members, and more. Those who did remain open reported significant financial hardship from reduced enrollment and difficulty securing PPE to ensure staff and child safety.[45]

Health care providers had very different experiences depending on the settings in which they operated. As families sought to minimize contract with members outside the households, pediatric providers in primary care experienced a sharp drop in appointments, including those necessary for vaccinations, regular check-ups, and those for managing chronic conditions.[46] Hospitals halted non-essential medical procedures, which left many providers furloughed as a cost-reduction strategy based on lessened revenue.[47] At the same time, those working in emergency and critical care medicine experienced huge patients surges of COVID-19 cases in waves; while children were initially spared the full toll of the virus, children were still receiving emergency medical care for other reasons in a situation which suddenly demanded additional precautions for safety of staff and patients.[48] In some hospital settings, as non-essential procedures were paused, pediatric nurses were tasked with treating the influx of adult patients being hospitalized with COVID. Nurses reported significant emotional reactions to this shift in practice during a deadly pandemic, with some referring to the work as "traumatic."[49] Pediatric cases later rose in the summer/fall of 2021 through the spread of the more contagious Delta variant (particularly since children under 12 were not able to be vaccinated).[50] Many children's hospitals hit their capacity just by treating COVID-19 patients during this time, again forcing a shift in the usual scope of practice for pediatric nurses.

Nurses were disproportionately impacted by COVID-19, following disparities in the broader population along racial, ethnic, and socioeconomic lines.[51] As of April 2021, about 3,600 US health care workers had been killed by COVID-19; one-third were nurses, the largest of any specific health care category.[52] Deaths were more common in the early months of the pandemic, particularly on the states hardest hit by the "first wave," as much was still unknown about transmission; PPE was in short supply; and vaccination was not yet available. COVID-19 infection, hospitalization, and deaths were significantly more likely among providers of color than their white colleagues. It is essential that as the country emerges from the pandemic, ongoing emotional support is provided to all health care providers who worked under untenable circumstances and experienced both primary and secondary trauma during the peak of the crisis.

Retention

Retention plays an important role in any profession that values long-term quality care and staff commitment and is closely linked to the issues of compensation, burnout, and safety previously discussed. Retention is crucial in any profession serving children in that providing a safe and reliable service that informs the educational, psychological, and physical health of the most vulnerable population requires individuals who are highly trained and competent. That kind of expertise requires years of learning, practice, financial investment and oftentimes, passion. There are several ways in which an employer can struggle with staff retention. An organization could have difficulty finding qualified applicants for their open positions. They could also have difficulty maintaining a competent staff that can perform their jobs to the standards required of them. Additionally, they could struggle to maintain a staff due to the business not meeting the standards of a lucrative employer; for instance, their hours are too demanding, the wages aren't competitive enough within the industry, or the working environment is deemed unsafe or unfulfilling to the employee. Finally, an employer could have difficulty retaining a staff that is largely nearing retirement age. The threat of retirement is usually low on retention status as retirements are often staggered among individuals and their years of employment.

The COVID-19 pandemic has significantly compounded these existing threats to workforce stability. Suddenly, the workspace for EC professionals experienced new challenges and pressures associated with an international health crisis and magnified those challenges that already existed. Compensation did not change with the onset of the pandemic but instead work hours increased, the working environment changed and required the use of new technologies, the physical safety of employees was now threatened by a transmissible illness, and exhaustion grew in the wake of these changes leading to less job satisfaction.

Additionally, professionals in these fields are *people* as well, with their own families and personal lives. In heavily female-dominated fields, many professionals who are also parents juggled difficulties with their own families' needs, and research finds that mothers bore the brunt of this. One survey from the Center for the Study of Child Care Employment (CSCCE) identifies 60 percent of child care providers as having their own dependent children at home; one-third of these parents have children under the age of 5, and nearly half were single parents.[53] A 2015 survey of early career pediatricians found that 86 percent had children of their own.[54] The Brookings Institution reports that, "COVID-19 has also increased the pressure on working mothers, low-wage and otherwise. In a survey from May and June, one out of four women who became unemployed during the pandemic reported the job loss was due to a lack of childcare, twice the rate of men surveyed. A more recent survey shows the losses have not slowed down: between February and August, mothers of children 12 years old and younger lost 2.2 million jobs compared to 870,000 jobs lost among fathers.[55]

Staffing and retention have long been challenges in the early childhood education field which has been widely exacerbated by the pandemic–50 percent of the National Association for the Education of Young Children (NAEYC) survey respondents said it is harder to recruit qualified staff since the pandemic; eighty percent have experienced a staffing shortage at their location. Fewer professionals in classrooms means serving fewer children, having longer waitlists or keeping classrooms closed, and/or reducing hours of operation.[56]

Why do providers leave their roles? Providers across fields attribute this to a combination of low wages, a lack of benefits, and burnout. This results in significant churn within agencies, including high costs for recruiting and training new hires, and also leads to a scenario where staff may not stay long enough to develop expertise.

By the Numbers

What does high turnover look like in these professions? A few examples:

- 1/3 of all child care providers considering closing their doors or leaving their programs in spring 2021; this jumps to 55% for minority-owned businesses.
- 13% of Head Start staff who left their positions in the last program year; 14% of these report they left for higher compensation elsewhere.
- 4 to 22%: the average annual turnover rate at state child welfare agencies, pre-pandemic.
- 1.8 years: the median time a child welfare caseworker spends in their position.
- 2 to 4 years: the average length of time a home visitor stays in their position.

Sources: NAEYC, Progress & Peril; Head Start Program Information Report, 2021; Quality Improvement Center for Workforce Development, Recent Research to Build Knowledge of the Child Welfare Workforce.

The pandemic has triggered a significant shift in employment trends. Prior to February 2020, going back to summer of 2011, monthly trends across all employment sectors found that more people were leaving positions each week than were being laid off or let go. The Bureau of Labor Statistics reports that the onset of COVID-19 abruptly reversed this trend, with layoffs/discharges exceeding quits by 10.1 million in March 2020 and 7.2 million in April. This immediate contraction of positions was largely due to industry-wide changes in demand and uncertainty about the economic future given the pandemic. By May, however, the pattern had returned to normal with quits exceeding layoffs; however, those positions that were eliminated were not immediately restored.[57] What many businesses and families hoped would only be temporary layoffs became extended as the virus continued to spread well past the two-week quarantine window that was initially in effect. Different sectors were impacted differently. The "educational services" sector had a sharp downturn in employment levels between December 2019 (pre pandemic) and December 2020, while "healthcare and social services" grew nearly four times faster than the previous year-to-year period. By the time of this writing in November 2021, the economy is now experiencing what media outlets are calling "the great resignation"–marked by higher than pre-pandemic levels of resignations each month and uncharacteristically high levels of open positions. This trend has been covered in media as a rejection of low wages and poor working conditions during the pandemic, though the phenomenon is likely more complex and may also reflect professionals who delayed their resignation during the uncertainty of early pandemic days.[58] Of course, jobs and people are not interchangeable widgets, and many of the open positions may be in skills and industries that require specific credentials.

Opportunities

The issues highlighted throughout this brief are clearly large in scale and long-running historically. Addressing any one of these challenges–compensation, burnout, retention, and safety–in any one sector of the field will require close collaborations, a strong understanding of the situation, and additional financial resources to deploy. Individual practitioners may be able to improve their own situations through strategies such as negotiation, meditation, or requesting additional supports; however, this would be a drop in the bucket compared to the looming challenges in the field. At heart, these issues must be addressed at the **policy-** and **program/employer-** level to make widescale change, and to ensure that solutions are grounded in research on what is effective. These are daunting challenges. This section focuses on what is known from a variety of research across health, education, and child welfare sectors on how to best support the professionals who support families and provides actionable steps for those looking to make change to ensure a strong, stable workforce working with families.

Policy-Level Changes

Financial Support: Increasing Amounts and Flexibility: At the heart of the issues discussed in this report is often a lack of necessary financial support to fund positions at sufficiency levels of compensation, and with enough professionals to meet full need. At the federal level, just 7.48 percent of all federal funds are directed towards programs which are classified as child-serving, using a relatively broad definition.[59]

One cannot talk about the adequacy of the pediatric health workforce without looking at the complex health care delivery system. While public discussions of health care financing tend to focus on the experience of patients, the structures underpinning these systems are crucial to reliable, fair compensation for the highly qualified professionals who provide health care. These conversations can often get bogged down in complex formulas or else politicized quickly, but experts in the field are clear: the current system cannot sufficiently address the financial complexities of quality care into the future. In their 2021 report on nursing, the National Academies stress that payment systems must be redesigned to recognize the *value* of services, with an eye towards improving population health; they highlight several payment models–including accountable care organizations (ACOs), accountable health communities (AHCs), and value-based payment (VBP)–which may serve the goals of health care organizations moving forward. Of course, such widescale change in a deeply entrenched system will not be easy, but it is urgent. As the National Academies write, "Changing the ways in which the nation pays for health care will cause discomfort among some but will also stimulate those seeking innovative ways of maximizing the population's health. Payment reform represents an opportunity to consider who has access to health care and who does not, what types of services are needed to improve individual and population health, and how the nation's resources can be used most wisely to these ends."[60]

Medicaid is an important entity for the early childhood workforce in several ways: it provides health care to many of the children served by this range of professionals; it influences the cash flow of many pediatric health care providers, with significant implications for their operations; and it provides health insurance access for professionals in low-paying fields, including child care providers. Medicaid is a prominent payor for children's health care in the United States and thus has significant influence over the cash flow of pediatric providers. Pediatricians provide the majority of office visits for children enrolled in Medicaid, up to 80 percent for the population of children ages 0 to 5 using Medicaid. It is essential to families who rely on Medicaid for children's health that there is a robust network of pediatric providers who accept Medicaid insurance. Pediatric providers frequently reported that the reimbursement rates provided by Medicaid for common services are lower than

the actual costs of those services; on average, Medicaid reimbursement rates are about 66 percent of what a similar service would have received for a *Medicare* patient (as of 2017),[61] with many states reimbursing at a lower rate. Providers may opt out of Medicaid if reimbursement rates are not sufficient to cover the cost of doing business, which can impact access to care and increase wait times or travel needs for families. When states make changes to their Medicaid programs to increase repayment rates, more pediatricians participate in the program. When Medicaid reimbursement rates were raised as a component of the Affordable Care Act, the percent of private-practice pediatricians accepting at least some new Medicaid patients increased by 3 percentage points (to 77 percent) and those accepting all new Medicaid patients increased by 6 point (to 43 percent).[62] The existing Medicaid infrastructure provides robust opportunities for adjustments to foster a strong pediatric health workforce.

American Rescue Plan Act

This paper is being released in late 2021 at a unique time for many of the fields discussed within at the federal level. The American Rescue Plan (ARP) Act was passed in March 2021 with significant financial resources for state and local governments intended to invest in COVID-19 recovery efforts.

"Recovery" is broadly defined here as well beyond just health outcomes, as is appropriate for a crisis which has impacted every facet of American life. While the ARP is not specifically geared at the early childhood sector (as defined in this report), there are numerous areas where education, child care, health, and child welfare sectors may be able to secure financial support, through three broad eligible uses of funding specified in the regulations: Public Health Impacts, Addressing Negative Economic Impacts, and Premium Pay for Essential Workers.

Half of funds were available through the ARP in spring of 2021; the other half will be made available one year after the initial disbursement in spring of 2022, allowing for longer-term planning and investment in sectors impacted by COVID-19 and the ongoing crisis.

Sources: Institute for Child Success. (2021). Early childhood opportunities in ARP state & local funding; National League of Cities. (2021). ARPA local relief frequently asked questions.

Build Back Better Legislation

Federal policymakers are also currently debating historic new investments in a range of early childhood sectors through the so-called Build Back Better (BBB) agenda. The exact future of this funding is uncertain as of writing in November 2021 as budget reconciliation is ongoing.

One goal is an expansion of funding for preschool programs already administered by states through a mixed-delivery system; notably, salary parity across public and non-public settings is a key component. The agenda also takes a multi-faceted approach to child care provision: targeting funding to alleviate "child care deserts" in underserved communities (a problem exacerbated by COVID-related permanent closures); reducing parent fees to no more than seven percent of family income; investing in quality improvements; and raising salary levels of child care professionals to pay a living wage in line with public school programs.

Various phases of negotiation on these goals have also included paid family leave, which can support many of the professionals working in these fields; extending Medicaid coverage for mothers who have recently given birth, which benefits both parenting professionals as well as impacts revenue within the health care sector; and investments in preventative mental and physical health.

Sources: Guarino, A. (2021). FAQ on the Child Care and Preschool Provisions in the Build Back Better Act. First Five Years Fund.; Kaiser Family Foundation. (2021). Recent Efforts to Extend Medicaid Postpartum Coverage and What to Watch Looking Ahead.; CLASP. (2021). Build Back Better Framework is Historic Investment.

Increase Compensation

Simply put, professionals working with young children and their families are generally underpaid compared to other industries and compared to peers in similar fields. This is true in early childhood education and care, where private child care providers have average pay on par with dog walkers,[63] and where even those with specialized degrees working in state-funded programs in communities may be paid less than colleagues funded through the same source who physically work within school buildings.[64] It's also true in health care; while pediatricians earn an order of magnitude more than do early childhood educators, they are among the lowest compensated of all physician specialties. The issue of a pay gap along gender and racial/ethnic lines across all sectors is well documented, even if the causes are complex. Across all backgrounds, women earn 83 cents per dollar compared to white men. Women of color are disproportionately impacted. Latina women earn 57 cents to every dollar earned by white men, while Black women earn 64 cents to non-White male counterparts.[65] The sectors discussed in this brief are generally female dominated, which brings these economic inequalities to light at the macro level.

Increasing compensation across these fields would serve to fairly compensate professionals based on the true value of their labor, particularly given the societal importance of health child development; it would also likely reduce turnover, and the subsequent costs of turnover to employers; decreasing the utilization of public benefits among certain professionals; and improve quality of the services families received based on reduced stress and burnouts levels of professionals. "Compensation cannot be increased on the backs of clients. Parents already pay, on average, about 10 percent of their annual income for child care, significantly higher than the federal definition of affordability.[66] Families with insurance already spend $22,000 per year in premiums, to say nothing of out-of-pocket costs.[67] Long-term structural changes to the compensation structures in these fields is required, like ensuring that funding streams for early childhood ensure salary parity across all settings. Similar disparities can also be seen based on setting in pediatric health care and child welfare settings.[68] While different positions should continue to compensate for differing skillsets and workloads, often professionals are incentivized to jump from one position to another as the best opportunity for significant salary advance. Reducing this turnover can help stabilize the workforce and improve quality as expertise is developed.

Short-term, wage supplementation strategies can help quickly stem turnover and attract new members to the field; these are best used as a stepping stone to more sustainable salary restructuring, and communicated to professionals as such. These strategies can be implemented through government policies and investment as well as at the individual program or employer level. In their spring 2021 survey of child care providers, NAEYC found that nearly three-quarters saw the benefit of a wage increase even if they knew it was temporary for only a year or two. However, about half of respondents expressed concern about being cut off from public benefits they themselves utilize if compensation was increased; policymakers should consider short-term wage increases or bonuses with built in "income disregards" so families are not abruptly disqualified from benefits.

The COVID-19 crisis has brought federal and state responses meant to address the many areas of financial instability for businesses and families. While many of these relief efforts were not intended specifically for the early childhood workforce, entities that were able to access them reported they made a significant difference to maintain operations; the Paycheck Protection Program (PPP) provides an example of how a rapid response program (imperfect as it may be) could help stabilize a sector. Many child care owners reported paying operating expenses out of personal credit; by summer 2021–just one-third of those in centers and about one-quarter in family child care homes had avoided taking on debt during the pandemic.[69] Relief funds have been an important tool for repaying this debt; 40 percent of those in child care centers and 36 percent of those in family child

care homes who had taken on debt reported being able to repay debts with these funds.[70] Nearly half of child care providers reported in summer 2021 that their program would have closed without federal financial relief, including the PPP and child care relief funds. Funds were targeted to urgently ensure small businesses could continue to meet payroll and fund operating expenses, but interestingly, many child care providers reported these cash infusions allowed them to increase compensation in order to attract and retain staff during uncertain times. About 63 percent of child care providers nationally reported receiving an increase in compensation of some type, either through raises or bonuses, since the crisis began. These funds cannot sustain the field long term but helped to avoid a further disaster with additional closures and layoffs.

In addition to increasing financial support, policymakers should also consider what adjustments can be made to existing financial streams to allow for more flexibility in their use; adjustments made during this crisis should also be considered for permanent change. For example, public child care subsidies are often based on child *attendance* rather than enrollment, creating a scenario where funding is disproportionately impacted when children do not show up for the day, as was the case in the early days of the pandemic when parents may have kept children home from operating centers out of concern about transmission.[71, 72] Reimbursement rates provide an existing structure which can be tweaked to address specific needs in the field. In states that increased subsidy payment rates to support providers during the pandemic, 80 percent of those who reported receiving payments increased rates were able to increase compensation (permanently or temporarily) for staff in an effort to retain professionals.[73] Increasing rates for addressing specific gaps can also help to incentivize needed services, and meet the additional costs of those services; for example, increasing rates for those who serve infants and toddlers where there are few slots available or are operating in child care deserts can help attract providers to these audiences.[74] Of course, increasing reimbursement rates does eventually mean that fewer subsidies are available to families who need them; an expansion of total funding would still be necessary to expand the reach of programs, but adjusting reimbursement rates in line with true costs of care and certain priorities is an important step towards equity.

Preparing for Growth

Importantly, retaining employees at the current level is a necessary but insufficient step to stabilize employment in these fields. The projected growth of many early childhood professions between 2020 and 2030 exceeds the average projected growth of American jobs overall.[75] This means the number of positions available to be filled by professionals within a specific industry will expand and more people will be needed, which creates pressure to ensure people hold the necessary credentials. While the average projected growth across all industries is 8 percent, jobs predominantly focused on child well-being exceed that: social workers are projected to experience industry growth at 12 percent, and early child care educators at 18 percent. Science-based and medical-based jobs maintain the average projected growth of 8 percent; however, the subspecialties within those jobs struggle to fill the new positions. Pediatricians are in limited supply compared to their growing demand. One explanation of this unmet growth potential is a dwindling number of pediatric applicants. Enrollment and interest in pediatric subspecialties have slowed to a rate between 20 and 40 percent fewer applicants to open positions.[76] Another contributing factor to the issue is changing geographic needs. Many rural areas in particular have a greater demand for pediatricians and yet fewer eligible candidates apply to work in those areas, more often choosing metropolitan spaces that offer competitive pay and benefits along with greater access to city life. Telehealth services were heavily employed over the period of the COVID-19 pandemic in an attempt to eliminate some of the issues related to access in rural areas. In some spaces, this proved helpful to individuals who could not travel a long distance or were not willing to face exposure by way of an in-person appointment. Early research on trends in telehealth use found that "patients who utilized telehealth visits were more

likely to be white and non-Hispanic, younger, have insurance and live in a poorer community,"[77] leaving a gap in coverage for the many community members existing outside of those classifications. Of particular concern for the future of telemedicine is the continued challenges of internet accessibility in rural communities.[78]

Another subspecialty experiencing growing pains is pediatric mental health. In 2021, psychologists have reported an increase of 30 percent in the demand of services for children under the age of 13.

Projected Growth in Child Psychiatry

Sources: Jenco, M. (2019). Study: 1 in 5 children lives in county without a child psychiatrist. AAP News; SAMHSA. (2020). Qualifications of an Infant and Early Childhood Mental Health Consultant. Infant and Early Childhood Mental Health Consultation.

Many factors explain the imbalanced growth of mental health professionals for children versus adults, such as the COVID-19 pandemic which created a great mental and emotional toll on children who, unlike adults, lack the social and emotional development to process the trauma of sudden isolation from their peers, fear amongst their community, and the looming threat of sickness befalling themselves or their loved ones. While the pandemic influenced a swift growth in demand for child psychiatrists, the issue of limited supply in professionals who can fill these positions has existed for years.[79] Additionally, there is the financial and physical cost of training for this professional field. The rigor and time required to earn the credentials of a child mental health professional often match those required of a surgeon, while the salary remains well below that of a surgeon and similar professions.

Across specialties, nurses are leaving the field at a faster rate than new nurses are joining the ranks, a situation which leaves potential staffing shortages. This turnover also reduces the average length of experience of nurses currently working in a field where experience is essential to expert care; a common measurement of proficiency is based on three-to-five years of work in the same clinical area, and expertise is based on five or more years of such experience.[80] The field stands on the precipice of a staffing crisis, with the need for nurses rapidly growing at the same time that retirements will remove many experienced nurses from the field; the South and the West are projected to be most strongly impacted by the staffing shortage.[81] The nursing profession faces a multi-faceted staffing challenge; the National Academies write that the nursing field must cohesively increase the number of nursing in general' "rightsize" the distribution of nurses in clinical specialties; ensure staffing meets geographic needs; and develop a workforce with diverse experiences to both meet the cultural needs of patients and to address social determinants of health in addition to clinical skills.[82]

Identify Pipeline Strategies

Given the high turnover and significant projected growth in many of these fields, efforts must be focused on expanding these workforces to meet future needs, including focusing on the "pipeline" from higher education into the field. There is no one solution to the issue of ensuring adequate numbers of high-quality staff across these fields, and certainly the exact educational and licensing requirements of each will require its own consideration. Addressing the issues detailed in this report–low compensation compared to similarly qualified peers in other fields; safety concerns which make positions less appealing; and high burnout levels due to emotionally intense work without adequate supports–are all important steps to ensure that these professions are attractive to future workers. The conversation must go deeper, though, to consider training for these fields, including the financial costs of higher education, as well as how professionals are recruited into these academic pursuits. Additionally, ensuring high-quality, ongoing professional development to both develop skills *and* allow meaningful connection to the work is important.

Data-Driven Decision-Making

Across all sectors discussed in this paper, more quality data collection is needed regarding compensation levels, retention and turnover, professional development opportunities, workplace satisfaction, safety concerns, and work-life balance. Some questions posed in this report were nearly impossible to answer, such as which non-salary benefits were available and to which professionals, or what recent pre-pandemic turnover levels looked like in specific professions. Data on demographics of these workforces were also relatively difficult to come by, including gender, age, racial/ethnic, and geographic distributions–all of which have implications for equity not only for the workforce itself but also for the families served. When these data points were available, they were often collected as part of academic research studies; these are tremendously beneficial for the field but also risk missing large portions of the professional population based on the availability and

interests of researchers. Alternately, such data may be collected by individual employers (particularly large health care systems) to understand employee needs and frustrations, but are not able to be linked to broader trends in the field to help inform the systems-level changes that are needed.

Professional associations can, and should, take a large role in collecting these data. Membership organizations across these sectors have played a tremendous role in disseminating information, providing support, and advocating on behalf of their members, especially during the COVID-19 crisis, and can continue to do so to capture essential data and encourage best practices for strengthening this workforce. These groups including the American Academy of Pediatrics (AAP), the National Association for the Education of Young Children (NAEYC), Child Care Aware, the National Association of Social Workers (NASW), the Institute of Pediatric Nursing, and the Association of Child Life Professionals. Membership organizations can use their networks, knowledge, and reputations connect with professionals more widely rather than each individual provider or employer beginning the work on their own. These types of organizations are important bridges between those working "on the ground" in direct family service and those who make the policies that shape the working conditions. Collaborative research organizations also play a key role in leveraging access and expertise in a range of settings to help inform the field, such as the Early Childhood Data Collaborative (a partnership of six organizations housed at a nonprofit focused on early care and education)[83] and the Quality Improvement Center for Workforce Development (a collaborative project among several universities and consultants funded by a grant from the Administration for Children and Families, focused on the child welfare workforce).[84] Many of these organizations already collect data on the workforce and their challenges; public funding and additional philanthropic support could help to enhance these efforts, allowing for deeper understandings of the workforce.

Employer-Level Changes

Creating Conditions to Avoid Burnout

Burnout is a clear threat to the well-being and effectiveness of early childhood professionals in all the fields in this report. Significant research has been done on this issue in the medical and child welfare fields; many of the findings on risk factors can be applied to other professions as well. Compassion fatigue is a term often used to describe the toll of burnout on early childhood educators. It manifests as feelings of "fear, guilt, anxiety, apathy, sense of hopelessness, sleep disturbances, nightmares and intrusive thoughts, hypervigilance, short-temperedness, and a denial of problems." The end result is a reduced level of empathy for the children they serve and a lowered inability to provide quality care.

Many employers, from large hospitals to small child care centers, are already aware that staff may be experiencing burnout or feelings of being overwhelmed, and recognize that COVID-19 has added additional stress; however, they are unsure how to address the issue. One study of physicians provides a helpful framework for considering burnout across fields, highlight two specific barriers decisionmakers often raise:

> "The first is a lack of awareness regarding the economic costs of…burnout. This uncertainty is typically expressed by the question: 'In a time of limited resources and competing priorities, what's the business case to address this issue?' The second barrier is uncertainty about whether anything can be done. This view is often expressed by the fatalistic question, 'This is a national epidemic, what can we do about it?'"[85]

There is no lack of advice and employee wellness programming focused on how individuals can avoid and manage burnout; however, the causes and consequences of burnout are ultimately best addressed at the systems level. Although, experts do agree that burnout is system-level issue, generally driven by demands on individual workers and inadequate resources. While wellness programs and awareness campaigns may help certain individuals relieve their feelings of burnout, employers and systems would operate more efficiently to take responsibility for reducing burnout at the systems-level. Additionally, promoting individual solutions to address burnout (like encouraging meditation or only providing resources for information) may imply a "blame" on the individual for perceived shortcomings, which may actually keep employees from pursuing assistance.[86]

In thinking about organizational and structural reforms, there are seven "dimensions" linked to burnout and engagement in the workforce which provide insight into both prevention and mitigation, again derived from the medical world:[87]

- workload,
- efficiency,
- flexibility and/or control,
- culture and values,
- work-life integration,
- community at work, and
- meaning in work

What do these look like in practice? Again writing about the medical field, one source provides examples: One research source on reducing burnout among medical providers lists several effective organizational behaviors which can be applied to a wide range of organizations and management structures, "improving the workplace context by assuring that [staff] are asked to perform work that matches their values, are faced with manageable workloads, have decision latitude about how work is done, and receive reasonable rewards and fair responses to complaints about work processes—all within a community of respect and collegiality."[88] Specific actions that organizational leadership can take include, "keeping colleagues informed; asking colleagues' opinions about how to improve the work setting; facilitating faculty career development; and offering recognition for well-done work."[89] Small steps taken to acknowledge, care for, and decrease the stress level of staff can impact services at every level from employer to customer, as reduced stress among professionals can mean greater productivity and improved thoroughness of care. In this way, it is clear that the well-being of individual staff and the workforce as a whole is closely linked to the health of an organization.

Many of the risks for burnout in these fields are partly due to the emotionally intense nature of the work; many professionals would note that they feel drawn to and fulfilled by the work, despite the challenges. One benefit of these motivations is "compassion satisfaction" which is drawn from the positive feelings of engaging in work which benefits others. However, in many of these professions, compassion satisfaction can be eroded by a focus on what went *wrong* or the bureaucratic requirements of the job. Organizationally reinforcing compassion satisfaction can help bolster staff to navigate difficulties. The National Child Traumatic Stress Network recommends employers find ways to keep staff "tuned in" to their motivations for the work and clearly recognize the positive impact they have on families to help mitigate feelings of burnout.[90]

Organizations should also not overlook changes to their culture which may not come under the umbrella of reducing burnout or improving stress levels, but can help create an environment where self-care is the norm. These include allowing and encouraging flexible schedules to the extent possible; encouraging taking an actual lunch break rather than working through it; and setting and

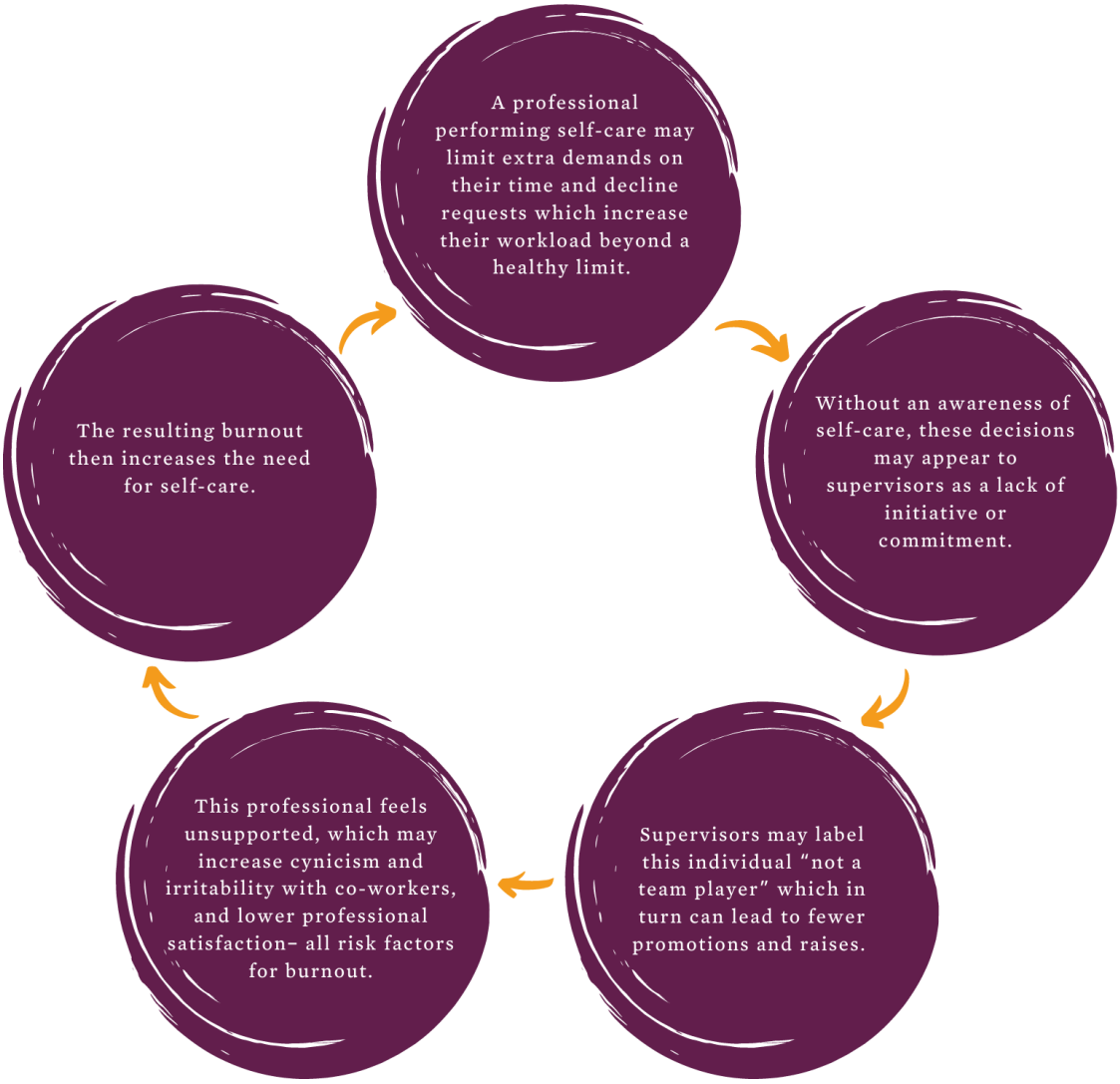
honoring boundaries between work and life. It is *not* enough to simply state these policies in an employee handbook; rather, they must be lived values. Management and organizational leadership in particular should model these practices in order to signal that employees will not be punished or judged for embracing these policies.[91] While large-scale reforms and restructuring may be necessary to address issues of burnout, employers should also consider any "low hanging fruit" opportunities which may improve job satisfaction in day-to-day work; see box on next page.[92, 93]

> Organizations should also focus on increasing "self-compassion," which is a term meaning "granting yourself permission to take care of yourself as generously as you take care of others."[94] This may uniquely resonate with members of any workforce discussed in this paper, who are broadly referred to as "caring professions." Individuals often engage in this work out of compassion, concern, or motivation for the needs of others, but may not prioritize their own, seeing it as selfish, self-indulgent, or too time-consuming. However, self-compassion is not a luxury but rather a competency which can improve professional performance as well as life satisfaction through increased resilience and motivation and lower levels of anxiety and depression.[95]

Burnout in general cannot be eradicated solely by the individual experiencing it, and this is particularly true for burnout and stress caused by COVID-19 which has impacted all aspects of life. At the individual level, developing self-care practices which work for each individual may be helpful in managing and mitigating these challenges,[96] but it is not sufficient at the systems level to stop high rates of burnout in child-serving professions. Employee wellness programs and individual skills should not be seen as an alternative to organizational reform. However, some employers may choose to offer these programs and supports as a complement to changing organizational cultures. The specifics of programs meant to prevent and counteract burnout differ by profession within the early childhood sector, as well as based on work setting. There are some similarities across fields that may be informative. A meta-analysis of individual interventions addressing physician burnout highlights four approaches well supported by research; small group curricula; stress management and self-care training; mindfulness training; and communication skills training."[97]

Employers *can* play an important role in creating a culture where self-care is valued and respected. This includes the above example of "walking the walk" in terms of setting boundaries among management staff. Employers must also create a culture where those efforts by employees are encouraged and respected–and not implicitly punished based on a "facetime" oriented culture. In many instances, the early childhood field exists in a state where the worker is systemically placed in an environment that prevents self-care which can mitigate burnout and places a monetary and professional growth tax on the individual engaging in self-care; this can create a vicious cycle if supervisors are not understanding the needs of their workforce (see graphic).

The Cycle of Burnout



Source: Mayo Clinic (2021). Job burnout: How to spot it and take action.

Burnout, stress, and other negative aspects of working in education, health, and human services must be openly discussed rather than relegated to taboo status, or only addressed when an issue has already surfaced. Organizations may also benefit from utilizing one of the research-backed assessments or tools which can help them gauge burnout in a standardized way; incorporating these for all employees may also avoid a feeling of stigma.[98] While focusing on successes and progress can be rewarding and encouraging for staff, organizations and leadership must also create space to discuss the negatives, including providing support after critical incidents or periods of difficulty, rather than just highlighting achievements.[99] Acknowledging burnout as a possible consequence of the work, and openly discussing strategy to prevent and respond to it, can help frame it as less of an individual issue; this can help reduce staff resistance to these efforts by removing stigma.[100]

Peer Support

Peer support has been essential for early childhood professionals during the pandemic, particularly in navigating rapid changes to scope of practice and location, the emotional toll of the work, and the fears for safety regarding virus transmission. From nurses to child welfare providers, professionals working in these fields identified connecting with their colleagues to share challenges as a value resource.[101] One study among child welfare professionals in select sites found that the majority of staff shared work-related stressors, positive experience, and virtual social/community activities with colleagues during the pandemic.[102] Among child life specialists, the most common source of support professionals turned to were family, followed distantly by child-life colleagues and friends at about the same rate. Nearly three times more respondents reported seeking support from their colleagues in the field than did those seeking professional help,[103] suggesting a rich opportunity for formal peer support.[104] There are benefits to turning to colleagues for support, whether within the same organization or just the field, in that many are already familiar with the challenges being faced; a preschool teacher may spend so much time explaining the logistics of a bad day to a friend who was not in the classroom that they do not really have a chance to process those feelings with them. Many professionals in the field are also sensitive to the privacy of the children and families with whom they work, both based on legal requirements in some fields and out of a sense of protecting the privacy of minors. While this is a good thing for families, it may create uncertainty about what a professional can share within the bounds of good decorum with those outside of the field. However, turning to peers for support who are also "pouring from an empty cup" in terms of their own burnout and resources may create a cycle of adding to those negative feelings or even creating a situation of secondary trauma.

While policymakers and providers can mobilize quickly to improve retention through some of the strategies presented here, it is also important in the long term to ensure they are accurately measuring, tracking, and monitoring retention. Some degree of turnover is expected in even the most supportive, highly-compensated fields, based on individual needs and preferences; the goal should not be a zero percent turnover rate. However, data on turnover rates by specific industries is difficult to obtain, a challenge which suggests that employers may not have a firm sense on the rate and reasons within their own operations; without knowing the causes and magnitude, it is difficult to respond with solutions that can address these problems. The data presented earlier on turnover among federal Head Start grantees does not answer all questions about turnover (for example, the "other" response will always be popular when management, and not individual employees, are the ones completing the form) but is notably thorough compared to other fields. Employers may conduct exit interviews and create other opportunity to understand changes that can help retain employees.

Embracing Virtual Opportunities

Many of the professions in the early childhood sector historically require face-to-face, dynamic, and responsive interactions. Historically, the focus has been on providing such interactions in person; but the sudden emergence of the pandemic introduced opportunities to adapt to virtual opportunities. While virtual work would be inappropriate to replace all engagements in these fields–you cannot supervise children in child care remotely, nor administer a throat swab over the internet–the unprecedented crisis of COVID-19 has created long-term interest in moving some tasks online, including staff meetings; trainings; and a small portion of client/patient engagement.

Child welfare agencies and staff identified that several changes to practice made during the pandemic may be beneficial to continue into the future.[105] While virtual family visits cannot, and should not, completely replace in-person home visits, many providers found they offered surprising benefits, including increased engagement in visits among some families (likely, an extra level of comfort from

not having someone in their home) and additional ways for children in foster care to connect with their biological families (for example, virtually having dinner together).[106] For both families and staff, the switch to virtual visits was often noted for reducing stress regarding virus transmission and travel time, though of course some staff members and families did not prefer the virtual visits and may have found authentic engagement more challenging.[107] Thus, there may be an opportunity to use digital tools to connect professionals with families in limited circumstances as well as allow children in foster care additional connections with their families. Telemedicine was also rapidly introduced in a number of medical fields during this time. Well-child visits are considered an important touchpoint for both families and physicians, and much value of this visit would be lost by switching to a virtual session. However, for medical providers managing chronic pediatric health conditions, telehealth appointments may prove to be more convenient and still effective.[108] Previous to the pandemic, some providers who wanted to offer telehealth were unable to access insurance reimbursement for these visits;[109] removing these barriers to coverage post-pandemic creates an opportunity for innovation for providers to best serve families.

Across all early childhood fields–but particularly in health care and foster care, where state and federal laws may govern privacy expectations–must develop guidance on the appropriate uses of virtual technology in better reaching families.[110] Notably, in some fields, a switch to remote work was identified as a major supportive factor during the pandemic which improved employee well-being: in a survey of child welfare providers, "the majority of staff expressed a desire for remote work/work-from-home options to continue in the future, even if in a limited capacity (e.g., one to two days a week). For example, staff shared how the 'opportunity to work remotely has made a significant impact on my overall satisfaction with my job and work-related duties.'"[111] Many of the fields in this report traditionally did not offer much remote work flexibility, generally operating with in-person work. The pandemic has shown that many of these services can utilize virtual connection for at least some degree of work, whether that's face-to-face with families or to improve flexibility among staff for meetings, training, supervision, and communities of practice for peer support.[112, 113] As discussed below, professional development offered virtually may allow professionals to explore a wider range of interests for their own practice, improving quality as well as job satisfaction.

Professional Development

Professional development (PD) also provides an opportunity for creating meaning and satisfaction within the everyday experiences of service providers, which can help avoid burnout as well as provide meaningful paths to advancement which support retention. Research among child welfare providers finds that staff who feel they have opportunities to increase their professional competencies–especially those utilizing evidence-based practices–experience secondary traumatic stress at a lower rate.[114] Ensuring providers receive meaningful opportunities for PD may help improve "compassion satisfaction" which is defined as the positive emotions experienced from helping someone. Broadly, creating opportunities for staff to connect with their motivation for the work and focus on victories (and not just challenges) in the work can help to foster this, which provides a protective factor against burnout.[115] Many child-serving professionals detailed in this report must navigate complex bureaucracies with heavy burdens on record keeping both for their own work as well as possible government requirements. When providers become bogged down in the paperwork aspect of their job and are less connected to the direct work about which they are passionate, they may be detached and stressed.[116] Quality, accessible professional development can help keep this spark lit. This requires employers to go farther than just sharing PD opportunities, but to also ensure that professionals receive adequate paid time to engage in these trainings and avoid a financial burden that would make them untenable.

Professional development is an important resource not only to ensure high-quality service delivery but also to invest in the professionalization of these fields and potentially provide opportunities that can reduce burnout and/or isolation among professionals. A catalog of courses is not sufficient to meet professional development needs; high-quality, engaging, research-informed PD must be made available and easily accessible at low/no cost; across geographic locations, or virtually; with cultural and linguistic considerations for both providers and the families they serve. Administrators and program directors must avoid the temptation to schedule classes on self-care or burnout which focus on individual level strategies only. While these sessions may provide useful techniques to some professionals, they can never be sufficient to address the system-wide and cross-sector challenges within these fields.

Professional development may also help to address some of the very issues which contribute to stress in the field. For example, some studies find that early childhood teacher stress is associated with what teachers report as behavioral challenges in the classroom;[117] high-quality professional development which can help teachers improve their confidence and strategies for managing such behaviors can, downstream, reduce stress and contribute to retention. Endorsements, certifications, and other credentials can help facilitate professionals developing skills that allow them to flourish, without the time and financial commitment of acquiring another degree. For example, Alliance for the Advancement of Infant Mental Health has developed competency guidelines for professionals working on infant mental health issues in a range of positions. Professionals can complete coursework to demonstrate these competencies to receive Endorsement®, which both helps individual professionals in their skills and abilities–potentially reducing their risk of burnout–while also improving the quality of care specific to the very youngest children.[118] Responding to the need voiced by home visitors for support in addressing sensitive topics, the Maryland's Home Visitor Training and Certificate Program helps participants build their competencies for navigating challenging conversations which are often a part of the job in home visiting; building confidence in these abilities is important in reducing stress for visitors.[119] Districts, agencies, and others in the field may benefit from such cross-sector professional development opportunities and also avoid the cost and effort of developing their own.

The fast-moving impacts of COVID-19 forced many fields to switch to virtual practice and learning where available; while this was a daunting challenge for many organizations and providers due to the speed of the change, the lessons learned can help inform more accessible and meaningful PD into the future. One caution with virtual PD is ensuring that practitioners engage high-quality interactions with coaches and other attendees that serve to build up their skills and confidence. Research suggests that professional development may sometimes cause immediate *negative* impacts for teachers; this so called "implementation dip" results from teachers realizing during PD that they may have previously overestimated their skills.[120] Virtual PD should include robust opportunities to connect, receive supportive feedback, and express emotion or else face a higher risk of emotional exhaustion.[121]

Safety Considerations

The child-serving professions discussed here have long experienced issues related to safety and security; these have been significantly compounded by COVID-19 and the need for often up-close work with children. Safety issues are particularly prominent among child welfare professionals, especially those making home visits which necessarily requires entering an environment over which the provider has no control.[122] Researchers stress that safety protocols should be central for any child welfare organizations, and the use and effectiveness of these practices should be discussed as part of PD.[123] See the sidebar box for a discussion of surveying to develop safety protocols.

To provide support to clinicians facing burnout and secondary trauma, a supervisor must be trained in what these symptoms and conditions look like and how to respond.[124] Organizations should also develop protocols for how to handle "critical incidents" which may be uniquely stressful for staff,[125] including the death of a client/patient/student, a violet incident, or national disaster. Staff perhaps themselves have experienced firsthand difficulties from these incidents as well as helping clients/patients/students process their own experience, creating multiple opportunities for secondary trauma. This can include both group opportunities to process experiences and responses as well as more individualized "debriefing" with those professionals who are most closely impacted.[126] "Reflective supervision" is an important technique which can both support high-quality work and mitigate or prevent burnout; it has been studied and utilized in a range of fields impacting children and families. One resource for child welfare professionals stresses that organizations should train all supervisors in these techniques "which encourage looking at the personal impact of client-worker relationships and promote the exploration of perceptions and emotions that may be affecting worker effectiveness and impeding case progress."[127]

The Survey Says...

All of the fields addressed in this report could benefit from gauging the experiences and feelings of their professionals as it relates to safety. This could be done on a regular (annual) basis through a survey of staff members. The exact questions to be asked will vary by field, but include issues such as:

- Do early education/child care providers feel safe in their classrooms? Have their employers adequately developed and trained staff on policies for violence, fire, natural disaster, and other situations?
- Do medical providers feel adequately protected by patient or family violence? Do they have resources to call if a situation is escalated? Does this experience differ by location in which they practice? Has COVID-19 changed this experience?
- Do child welfare professionals feel comfortable with protocols in place to record their whereabouts for home visits? If a professional feels unsafe in a situation, do they have access to immediate resources to secure the situation? Are there available options for mitigating those dangers long term (for example, asking to move visits from a home to a neutral location), and do providers feel comfortable requesting those adjustments?

Working with children in any field introduces the potential for unexpected surprises. After the dramatic and fast-moving changes due to the COVID-19 pandemic, many fields in the early childhood sector are increasing their focus on planning for emergencies and contingencies. In many fields, emergency plans were previously focused on time-limited weather- or geographic-specific issues such as snowstorm, hurricanes, or widespread power outages;[128] those plans were not well-suited to the prolonged impacts of a pandemic which was impacting the entire country simultaneously. Officials in several of these fields have expressed the intention to revisit emergency planning for a more resilient future.

Conclusion

Children and families do not magically experience improved outcomes just by simple investments in health, education, and welfare; these impacts are only achieved if they are served by a dedicated and talented workforce well-suited to meet their needs. To be delivered on the promise of early childhood investment, the workforce requires competitive compensation in line with their peers and in line with the value of their work; long-term investment to retain talented staff, including professional development and support for the emotionally intense nature of the work; and a commitment to ensuring their physical and mental safety on the job.

While much is similar in the challenges of these fields, the daily experiences of employees can differ significantly across these professions, and even within them depending on their exact role. The nuances of each sector in terms of training and education requirement; funding sources; compensation structures; and work environments must all be taken into account. To this end, it is *essential* that the voices of professionals on the ground steer conversations on reform and long-term sustainability in their respective careers. This brief has sought to identify themes which connect among a variety of professions across the education, health, and child welfare sectors, believing that there is much to be gained by unifying the experiences of professionals working with young children. However, it must be taken as a starting point to identify these trends and advocate for systems-level change.

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