Connecticut's Early Childhood Trauma Collaborative
Trauma Training Needs Assessment Report

December 2017

By

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Overview: The Connecticut Association for Infant Mental Health, Inc. (CT-AIMH) and their Early Childhood Trauma Collaborative partners are striving to increase the competency and capacity of the workforce serving infants and young children and their families to address the needs of children and families experiencing, or who have experienced trauma. In preparation for this work Lorentson Consulting was contracted to conduct a comprehensive statewide needs assessment in line with the tenets of participatory evaluation.

Needs assessment activities were completed from March to July 2017 and were designed to gain a better understanding of how individuals working with children birth to age 6 in a variety of settings understand trauma, assess the types of trauma training available and develop recommendations for embedding trauma understanding into the early childhood workforce through future training. Data collection activities were developed and data collected to initiate the needs assessment process.

Needs Assessment Questions: The needs assessment addressed the following questions:
Q1: *What training does the infant and early childhood workforce working with young children (0-6) and their families, need to increase their ability to address the needs of children and families who have experienced or are experiencing trauma?*
Q2*: How can training providers address the needs of individuals working with children 0-6 and their families to increase their ability to address the needs of children and families who have experienced trauma?*

Target Audience: The needs assessment target audience is the providers of care to young children 0-6 and their families and the organizations who provide training to this early childhood workforce. Those in the early childhood workforce are well positioned to support children and families who have experienced or are experiencing trauma if provided the necessary skills and knowledge to provide this trauma-informed care. To embed trauma understanding into the workforce, we first need to understand how providers working with young children currently learn about and understand trauma and where additional support is needed.

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

Data Collection Methods and Activities: Data collection methods included qualitative semi-structured interviews with 15 key training providers and the use of two on-line survey instruments, one for the early childhood workforce and one for trauma training providers.

Conclusions and Recommendations: Data collection provided conclusions and recommendations for the consideration of the CT AIMH and their Early Childhood Trauma Collaborative partners. Conclusions are presented below by needs assessment question.

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

Results from qualitative interviews were supported by the results of on-line surveys and indicate overwhelmingly that there is a high need for and interest in the provision of trauma-related training for the early childhood workforce. Results show that family child care providers, center-based child care providers, private childcare providers and Family Resource Centers are less likely to have

received trauma-related training and are more likely to express interest in receiving such training than other segments of the early childhood workforce (Table 3).

Early childhood workforce respondents were most likely to have received introductory training related to trauma (75%) or the impact of trauma on early childhood development (65%) and far less likely (40% or less) to receive training on any other trauma-related topics (Table 3). The majority of respondents had received less than one day of training with most trainings provided through either CT-AIMH, the Connecticut Department of Children and Families or early childhood conferences. Respondents were typically satisfied with the trainings they had received.

Approximately half of respondents use surveillance or monitoring to identify children who have experienced trauma with very few (19%) screening children for trauma (Table 20). Respondents estimate from 26% to 100% of children in their programs had experienced trauma and express a high level of interest in enhancing skills and knowledge to better address the needs of these children and their families.

Respondents indicated that their organizations were most likely to monitor and refer children for trauma (approximately 60%) and least likely to offer training or education for parents related to trauma (approximately 23%). At least 5% of respondents stated that they did not address trauma in their programs. Approximately half of respondents participated in some sort of follow-up within their organizations to provide support in addressing trauma (Table 13). There were no clearly identifiable differences between the responses of supervisors and direct care workers.

Respondents identified the Edinburgh Postnatal Depression Scale (approximately 20%) as the tool most frequently used, although at least 6% of respondents used each of the other tools listed (Table 14).

The most common barriers to successful screening and referring for trauma identified by respondents were a lack of trained staff and a lack of education regarding the importance of screening and referring. Other common barriers included language challenges, lack of access to qualified providers and lack of funding. (Table 17)

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

Results from qualitative interviews were again supported by the results of on-line surveys and provided further information identifying the high need for and interest in the provision of widely available trauma-related training for the early childhood workforce. Results of the training provider survey and the interviews with training providers indicate that the vast majority of training provided is provided for a limited audience with that audience limited either by geographic or regional boundaries or by participation in a particular program through which training is provided.

Participants identified a high need for training for the infant and toddler workforce, for ECE providers that do not receive state or federal funding and for family resource centers in particular. Participants stated that there is almost no trauma training available for these audiences. In addition, interviews indicate that even when training is available limitations on the availability of substitute teachers and funding to support the use of existing substitute teachers prevent ECE educators from attending the few available trainings offered.

Results from the training provider survey and interviews with training providers support the results of the workforce survey. Providers were most likely to provide training on topics including the definition of and types of trauma and the impact of trauma on child development and were far less likely to provide training on additional topics, with less than one fifth of respondents provided training related

to reflective supervision, mental health, culture or transgenerational trauma. Over 80% of providers expressed an interest in receiving enhancements or additional trainings on each topic listed.

The majority of training providers offered training linked to the Infant Mental Health Competencies® either formally or informally for one day in length or less. The majority of providers developed their own training materials, provided trainings upon request, and perceived the trainings to be useful to the workforce. The majority of providers used workshop evaluations to obtain feedback on the training although there were no comprehensive evaluations of impact conducted. Providers who provided training internally to their own organizations generally followed up with participants through reflective supervision or ongoing staff evaluations while trainers providing training to external organizations typically stated that no follow up was completed.

Providers generally described successful trainings as completed over a period of time with each day or half day of training building upon the other, as highly participatory in nature and as providing participants an opportunity to reflect upon material learned and to apply material to their own work. They also emphasized the need for trainings to use a variety of formats and to be targeted specifically to the needs of the organization for which the training is requested.

Providers outlined a number of recommendations for the consideration of CT-AIMH and their Early Childhood Trauma Collaborative partners. Specific recommendations are outlined within this report.

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The CT-AIMH Professional Development Advisory Committee
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Introduction

The Connecticut Association for Infant Mental Health (CT-AIMH) and their Early Childhood Trauma Collaborative partners are striving to increase the competency and capacity of the workforce serving infants and young children and their families to address the needs of children and families experiencing, or who have experienced trauma. In preparation for this work Lorentson Consulting was contracted to conduct a comprehensive statewide needs assessment in line with the tenets of participatory evaluation.

Needs assessment activities were designed to provide insight into the current amount and types of training that providers working with young children are attending, as their own understanding about trauma might impact their work with young children and families who have experienced or are experiencing trauma. The needs assessment also uncovered the types and formats of trainings currently available to address the trauma needs of the early childhood workforce, and the types of additional trainings required by the early childhood workforce to assist them to meet the needs of children and families who have experienced or are experiencing trauma. This report summarizes evaluation activities completed during Spring 2017, offers results of each activity and develops recommendations for embedding trauma into the early childhood workforce through current and future training programs. The report is designed to support the future SAMSHA funded trauma trainings by identifying topics, workforce segments and geographic areas that are currently participating in adequate training and identifying areas in which additional training is needed.

Importance of Trauma-Informed Care in Early Childhood

Numerous studies have identified the importance of trauma-informed care to the healthy development of a young child (Child Trends, 2017[i], Statman-Well, 2015[ii]). According to Child Trends, more than two thirds of children experience a traumatic event, with young children from 0-5 being more likely to experience trauma than their older peers. Children who experience trauma are more likely to suffer long-term consequences such as impairments in physical or mental health and developmental delays and have a greater risk of ongoing delays and poorer outcomes in education, career and social connections.

Trauma has been identified as impacting the development of a young child's brain, affecting both attachment and cognitive and emotional development. Children living with trauma exhibit a stress response to normal, on-going events (Wolpow et al[iii]) leading to impulsive and reactive behavior and an inability to complete higher-order tasks. In addition, these children often have difficulty connecting with peers and experience ongoing social and learning challenges. Early trauma can undermine the development of skills in language and communication, social and emotional regulation, building relationships and play.

Children need to begin school in kindergarten ready to learn and with the social and emotional ability to succeed in both academics and life. The ability of a child to learn is dependent upon their having the appropriate developmental, social and academic skills to be successful. The ability of children who have been impacted by trauma to succeed and thrive is dependent upon the ability of the caregivers in their lives to not only identify the challenges they face but be educated in the best ways to provide the needed supports and services to address these challenges.

Prior to the development of a comprehensive training program for the early childhood workforce in Connecticut, it is critical to understand the current status of trauma knowledge and skills, the types and formats of evidence-based trainings currently available, and to identify where gaps in knowledge or training exist. This knowledge can be then used to develop new trainings to address these gaps or to enhance existing trainings. The needs assessment developed and implemented by Lorentson

Consulting on behalf of the Connecticut Association for Infant Mental Health was designed to obtain this key information. Results are summarized within this report.

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Needs Assessment Summary

Overview: Needs assessment activities were completed from March to July 2017 and were designed to gain a better understanding of how individuals working with children birth to age 6 in a variety of settings are trained on the topic of trauma, assess the types of trauma training available, and develop recommendations for embedding trauma understanding into the early childhood workforce through future training or initiatives. Data collection activities were developed and data collected to initiate the needs assessment process.

Needs Assessment Questions: The needs assessment addressed the following questions:

Q1: What training does the infant and early childhood workforce working with young children (0-5) and their families, need to increase their ability to address the needs of children and families who have experienced or are experiencing trauma? Sub questions:

a) What is the percentage of children or families currently served that have experienced or are experiencing trauma?
b) How do providers identify individuals who have experienced or are experiencing trauma (screening)?
c) How do providers understand and meet the needs of these children and families (treatment or referral)?
d) What types of trainings have providers received to support their ability to work with children and families who have experienced or are experiencing trauma?
e) What strategies are in place to ensure that follow-up services are in place to address the needs of children and families who have experienced or are experiencing trauma, after they are identified?
f) What are the obstacles faced by providers that hinder their ability to address the needs of children and families who have experienced or are experiencing trauma?
g) What organizational strategies and organizational supports are being implemented to provide support for the providers who are working with children and families who have experienced or are experiencing trauma?
h) How competent do providers feel they are in addressing and meeting the needs of children and families who have experienced or are experiencing trauma?
i) What types of trainings are needed to enhance the ability of providers to provide trauma-informed care to the families and children they serve?
j) How can trauma training providers better address the needs of providers working with children and families who have experienced trauma?
k) How do the needs of the workforce differ by workforce segment?

Q2: How can training providers address the needs of individuals working with children 0-5 and their families to increase their ability to address the needs of children and families who have experienced trauma? Sub questions:

a) What are the different types and formats of quality, or evidence-based trainings that are currently available to providers to provide information about trauma or trauma informed practice with young children (0-5)?
b) What learning objectives do trainings utilized by providers address?
c) How did the learning objectives addressed by trainings meet the needs of providers?
d) Who is the target and actual audience of existing trainings?

e) What types of curricula are being used in existing trainings?
f) How are the qualifications of the training providers determined for existing trainings? What is the approximate length and frequency of each type of training?
g) How do training providers determine what content to include in the trauma training for each particular audience considering the content such as prevention, intervention, diagnosis or treatment?
h) How does the workforce understand the usefulness of these trainings? Does the workforce identify these trainings as meeting their needs?
i) How are participant evaluations used to inform the trainers of changes that need to be made in content or delivery?
j) What additional trainings or enhancements to current trainings are needed to ensure that the needs of the workforce are met?
k) How is follow-up with the workforce provided to assess the degree to which they feel competent or supported in their work (i.e. Reflective Supervision)?
l) In addition to existing trainings, what types and formats of potential trainings are perceived to be most beneficial for providers?
m) How do the needs of the workforce differ by workforce segment?

Target Audience: The needs assessment target audience is the providers of care to young children 0-6 and their families and the organizations who provide training to this early childhood workforce.

Data Collection Methods and Activities: Data collection methods included qualitative semi-structured interviews with 15 key training providers and the use of two on-line survey instruments, one for the early childhood workforce and one for trauma training providers.

Methodology: The collection of high quality needs assessment data from a diverse group of stakeholders throughout Connecticut requires the identification of key target audiences, the development of strategies to reach each audience, and the collection of data using instruments and data collection methods designed to meet the needs of each audience. This report summarizes strategies used to identify and reach appropriate audiences and design appropriate tools and the results of data collection activities. The needs assessment activities included:

A. Fifteen semi-structured interviews with key providers of trauma training;
B. Development and on-line administration of the *"Connecticut's Early Childhood Trauma Collaborative Workforce Training Survey 2017";*
C. Development and on-line administration of the "*Connecticut's Early Childhood Trauma Collaborative Trauma Training Provider Survey 2017"*.

Instrumentation and Data Collection: The instrument development and data collection process is discussed below for each component of the methodology including interview and survey development and administration.

A. Interviews

Semi-structured interview questions for Connecticut trauma training providers were developed, linked to needs assessment goals and objectives and were designed to identify the types and formats of evidence-based trainings currently available to providers, the learning objectives provided by these trainings, the target and actual audience of these trainings, the curricula used in trainings, the usefulness of these trainings to providers, follow-up to trainings provided to providers and provider expectations and needs for support or enhancement of trainings (from CT-AIMH). It was expected that these interviews would include 15 representatives from key training providers throughout Connecticut. Participants for these interviews were selected by CT-AIMH in partnership with the CT-AIMH Professional Development Advisory Committee that included stakeholders from the Connecticut Early Childhood Trauma Collaborative.

All interview questions were reviewed by CT-AIMH prior to completion of the initial interview. Interviews were conducted in June and July 2017. Each interview with a training provider lasted approximately 30 minutes. Notes were taken throughout the process.

B. Connecticut's Early Childhood Trauma Collaborative Workforce Training Survey 2017

Connecticut's Early Childhood Trauma Collaborative Workforce Training Survey 2017 was developed during Spring 2017. Survey items were drafted to assess workforce understanding of key evaluation questions. The draft survey was shared with early childhood experts through the CT-AIMH Professional Development Advisory Committee (a state-wide group) and revised as needed.

Survey validity is maximized when the survey addresses all key concepts related to the issue being addressed and when the conceptual framework is reviewed by a panel of experts to ensure that no key concept is missed. Survey development for CT-AIMH activities was completed in line with these criteria. Survey validity is expected to be sufficient.

Reliability is maximized by the development of questions using nationally accepted standards and developed at a literacy level appropriate to the literacy level of the target population. Survey items were developed using these guidelines and were reviewed by the CT-AIMH Professional Development Advisory Committee prior to administration. Survey reliability is expected to be sufficient.

The workforce survey was incorporated into Survey Monkey and administered online during May and June 2017 through a variety of venues including:

- Incorporation into the CT-AIMH website
- On-line distribution to key stakeholder groups throughout Connecticut

Survey distribution ended on June 10, 2017.

C. Connecticut's Early Childhood Trauma Collaborative Training Provider Survey 2017

Connecticut's Early Childhood Trauma Collaborative Training Provider Survey was developed during May 2017. Survey items were drafted to obtain training provider perspectives on key evaluation questions.

Survey development procedures were similar to those used for the development of the Workforce Survey and are not repeated here.

The survey was administered to providers of trauma training throughout Connecticut. Training providers and administration venues were selected by CT-AIMH in partnership with CT-AIMH Professional Development Advisory Committee, which included stakeholders from the Connecticut Early Childhood Trauma Collaborative. Survey distribution ended on June 25, 2017.

Data Analysis: Conceptual analysis of responses was used to analyze interview results. Survey results were analyzed using SPSS, Statistical Package for the Social Sciences. Frequencies, means, and totals were obtained as appropriate.

Results

Results are described for each data collection method used.

A. Interviews

"We are just getting to the surface level at this point—just general introduction to trauma—no way are we deep enough. We need to go deeper. Next year we want to really understand the long-term adverse impacts of trauma and come to some realization about how as a community we can work together to address this—we can't fix the entire lives of everyone but what can we do?"
-A Training Provider

"We do mostly training at the intersection of trauma and early childhood development. How trauma impacts development in the first five years. We do train parents also in how to decrease their own trauma symptoms—to cope and regulate for the benefit of the child."
-A Training Provider

"I think in the field right now we need to be able to start thinking and put a different lens on what we are putting our ECE classrooms through. It is so much more complex now. I would like more training for paraprofessionals, teaching assistants, teachers—how do we collect information to understand the kids and think about what is happening with them, what their strengths are, not what is wrong with them."
-A Training Provider

"We talk about how trauma impacts parents and children but we don't get into the specifics of it. We need a lot more information on it. Often the situation comes to a head before it is recognized."
-A Training Provider

In June 2017, efforts were made to complete fifteen **(15) semi-structured interviews** with representatives from programs providing training to the early childhood workforce. These programs included Birth to Three, Child First, CT-AIMH, Department of Children and Families, Eastern CT State University, EdAdvance, EASTCONN, Office for Early Childhood, Parents as Teachers, United Community and Family Services, United Way, University of Connecticut, Yale Child Study Center and Wheeler Clinic. Fifteen interviews were completed providing a response rate of 100%. Key findings from interviews with providers are summarized in textual form and in table form in Table 1. Results frequently differed by the type of provider and are discussed separately as appropriate.

***Trauma-Related Training Topics*:**
Trauma training providers who described themselves as regional in nature generally described teaching a small number of trauma trainings to a limited audience of less than 100 individuals each year with the majority of trainings limited to a specific region or community. These providers described providing trainings to ECE programs, Birth to Three consultants, home visitors, clinicians, DCF staff and EHS staff. Of the respondents interviewed, five (5) described covering these topics somewhat in depth while ten (10) described discussing trauma briefly as part of trainings primarily directed at other material. For example, trainings provided on topics such as referring children to services, screening with the ASQ or ASQ-SE, emotional development or working with parents occasionally mentioned trauma within the context of the training although trauma was not the focus of the training.
Topics taught by regional respondents were limited and generally included an overview of trauma and the impact of trauma on child development. A few regional training providers described trainings that include at least a preliminary overview of the impact of trauma on parenting, the development of a trauma-informed program for children and the signs and symptoms of trauma in children. One training provider stated that their organization offered occasional trainings addressing the importance of self-care for providers to address the impact of secondary trauma. Another regional provider stated that they did intensive trainings on the topic of infant mental health in early care settings and homelessness and the traumatic impact of homelessness on infants, toddlers and young families. Another respondent described their program as providing trainings "*only on our own referral services*" which do not address

trauma directly. However, that individual described a need for staff training to ensure that referral services adequately meet the needs of children and families impacted by trauma.

Non-higher education organizations that described their trainings as statewide provided a greater range of trauma trainings at a more in-depth level. These individuals described providing trainings primarily to staff or programs involved with or funded by their organization or based on the requirements of specific funding sources. Training topics were varied and intensive and included transgenerational trauma, approaches to thinking about both acute and chronic trauma, understanding infants and toddlers, challenges of unresolved loss and trauma, integrating a trauma lens into infant mental health, reflective supervision, signs and symptoms of trauma and working with parents and children with trauma experience.

Organizations who were part of the higher educational system describe providing intensive training on a diverse number of topics to specific categories of individuals each year primarily including psychiatrists, psychologists, home visitors, preservice early childhood education teachers, preservice social workers and social workers with additional presentations provided to early childhood organizations, state agencies and schools upon request on an approximately monthly basis. One higher educational organization stated that they did not provide training but did develop videotapes that were distributed statewide for use in trainings and professional development sessions. This organization is currently developing one module on trauma-informed care for use by home visitors and has developed one series of videotapes addressing early childhood mental health. Another organization stated that intensive training was provided to preservice educators emphasizing toxic stress and its impact on children and families. In this case, although trauma itself was not the focus of the education, the prevention of trauma created by toxic stress was a core component of all educational activities.

***Types and Formats of Trainings Provided*:**
The majority of providers described the use of a variety of formats to provide training including primarily half to full day sessions, upon request, to individuals who were not employees of the organization or at particularly scheduled times for employees of or students within their own organization. Some regional individuals stated that they worked with community groups of providers to identify community needs for trauma-related trainings and considered the group work as one way to educate providers on trauma-related needs and concerns. Trainers had also provided trainings through café conversations, conferences, videotapes, expert panels and Q and A sessions. A number of individuals described the use of work sessions subsequent to the trainings to allow participants to examine the implications of what was learned in relation to the needs of the local community. There were a few statewide providers who stated they had provided multi-day trainings although there was no training program described of more than eight days in length. 14 of the 15 training providers targeted the training content to the needs of the audience while the remaining provider developed a variety of trainings and allowed individuals to select the trainings of interest to them.

Specific learning objectives addressed by trainings varied by topic. Examples of objectives include understanding the importance of attachment and relationship, disruption and repair, the impact of trauma on child development and parenting, the impact of trauma on social emotional development, signs and symptoms of trauma, transgenerational trauma and the role of toxic stress in trauma. Additional objectives varied by audience and included the role of early care providers in the development of an infant for an early care audience, the impact of toxic stress on child development, appropriate treatment methodologies for clinicians, and working with parents and families with diverse experiences including trauma for parent educators.

Some regional trainers described developing their own material for trainings by delving into trauma research and incorporating research based information into the training presentation while others involved trainers from national Infant Mental Health organization or other "*experts*" in the field as presenters in the training process. Sources of research-based information included the work of Harvard and Duke universities and the use of specific models such as the Pyramid Model and the Attachment, Regulation and Competency Model (ARC). Individuals typically described the development of training

materials based on "*national research*" and generally linked to specific IMH Competencies®. Statewide training organizations stated that they used all evidence-based material or material developed by experts in the organization or within the state. Evidence-based material included cognitive behavioral therapy (CBT), the trauma tool kit created by the National Center for Traumatic Stress Network, and Child First and all were typically linked to specific IMH competencies®.

Participants described the qualifications of trainers as dependent upon both the topic being addressed and the target audience. Qualifications described by participants included Endorsement in Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health ®, clinician experience, Child First experience, early childhood certification and experience, content-specific qualifications and experience in the Crisis Counseling Assistance and Training Program (CCP) model of intervention.

***Strategies Used to Identify Training Content for Audience*:** The majority of individuals described targeting training content to the needs of each individual audience. Strategies used to adapt trainings to the needs of the audience include examining what outcomes are desired, what needs exist and current experience and knowledge of the audience prior to the development and implementation of the training. Trainers also typically emphasized the importance of incorporating reflection into training activities, allowing providers to select specific training materials, providing on site coaching, providing an opportunity for participants to apply what was learned to their specific setting, and using a series of trainings provided over time to allow relationships between participants and between participants and the trainer to develop.

One statewide individual stated that they developed and marketed trainings in general and participants selected the trainings based on interest and need. This organization did not generally adapt a training to a specific audience.

***Usefulness of Trainings*:** All participants described trainings provided by their organizations as "*incredibly helpful"*. Trainings were described as opening up new areas of work for early childhood educators in particular and providing an "*entirely new perspective*" on children. Home visitors and clinicians were described as more comfortable initially with trauma work than early childhood educators but as still benefitting from additional trainings. A number of individuals described the need for trauma training for early childhood care providers and educators as critical and attributed this importance as resulting from a perception that trauma awareness and appropriate behavior is not the role of early childhood care givers and educators.

Trainings were described as particularly critical to support the ability of the early childhood workforce to understand the needs of the families and children with whom they work. A number of participants emphasized that although the response to trainings was highly positive, there was limited information to know whether changes in the workplace occurred as a result of the training.

The majority of respondents described the use of some form of training feedback to ensure that trainings are meeting the needs of the target audience. In most cases feedback was described as a post-workshop evaluation form although in one case the training provider described the use of pre-post assessments. Higher education organizations described the use of quizzes, examinations and reflection activities when providing education to preservice teachers. There were no comprehensive evaluations of change and practice conducted although one agency stated they had administered follow-up surveys requesting information as to how a training had changed the participants practice. All feedback received was described as being used to revise and improve trainings on an on-going basis.

***Strategies Used to Follow-Up with Participants After Training*:**
The use of follow-up was described as dependent upon the audience to whom the training was presented. In cases in which the audience was the workforce of the organization providing the training or when training was provided as part of a professional development or early childhood model, follow-up was typically provided in the form of reflective supervision or ongoing staff evaluation or endorsement

activities. A number of individuals described the need for staff to obtain Level I or II IMH-Endorsement ® as part of the follow-up process.
However, in cases when the training was presented to an audience not affiliated with the training organization, there was typically no follow up provided by the training organization in regional settings. In this case, most trainers describe encouraging the incorporation of trauma-related information into employee evaluation and ongoing reflective supervision processes when possible. A few statewide agencies described situations in which long-term follow up was completed if requested by the participating organization.

***Additional Trainings or Enhancements Desired*:**
Participants desired a wide range of trainings or enhancements to current trainings. Participants identified a need for trainings on topics, including working with families dealing with transgenerational trauma including transgenerational poverty; the development of trauma-informed preschools; incorporation of art, music or creative therapy into the classroom for all children; self-care for the early childhood workforce; training in the identification of signs and symptoms of trauma in parents and children; referring and screening for trauma; Circle of Security for families, strategies to support and encourage early childhood relationships; on-line trainings to provide access to rural areas; and strategies to encourage healthy development in children. A number of respondents emphasized the need for qualified service providers and for one organization to serve as a center for cross-sector trauma training and to ensure that training could be provided to all members of the early childhood workforce, not just to individuals funded by or involved with particular programs. Respondents frequently emphasized the importance of each segment of the workforce having the appropriate skills and knowledge to work with children and families with trauma experience at the level to which appropriate to that individual's role within the workforce.

The majority of respondents emphasized the need for trainings to be participatory, to involve case presentations, and to provide the audience an opportunity to reflect on the issues presented and to apply the issues to the young children and families that they work with. Formats desired included the incorporation of trauma training into conferences, a series of half-day trainings or on-line trainings and the use of case studies. Full-day trainings were described as "*challenging"* for participants to attend and therefore less successful than other formats. A number of individuals requested the formation of a "*help-line*" to allow the workforce to call someone with a question and receive guidance. Another individual described a need for the development of a cross discipline trauma-training academy in which individuals from different program areas could have access to training on trauma and young children and families. A number of individuals stated that there is very little training on any topic available for the infant and toddler workforce and most training available is targeted toward the preschool age level or older. Other participants described a large gap in the availability of trauma training for early care and education programs which was attributed to both a lack of offerings and an inability of early care and education programs to financially support staff attendance at required trainings. The development and implementation of trauma trainings targeted to individuals working with infants and toddlers, to pediatricians and to individuals involved in early care and education were identified as critical for the majority of respondents. The importance of this training was attributed to the frequency and consistency of time these individuals spend with young children.

For an overview of results in tabular form see Table 1.

B. Early Childhood Workforce Survey

Demographic Information

Two hundred and ninety (290) individuals completed the survey. Demographic data is provided for the 290 respondents who completed the demographic questions. Programs served children from 0-6 in Fairfield County (18%), Hartford County (24%), Litchfield County (7%), Middlesex Count (10%), New Haven County (32%), New London County (12%), Torrand County (3%) and Windham County (8%). Ten percent of respondents served children on a "statewide" basis.

Similar diversity was seen across the urban-rural continuum. The majority of programs (174) were located in urban areas, 59% were found in rural areas and 91 were located in suburban communities. Forty-two respondents were based in statewide programs.

Almost all programs (85%) worked with children aged 0-3 and slightly fewer (77%) worked with children from 3-6 years of age.

Workforce respondents worked in programs serving military families (39%), tribal families (13%), immigrant families (73%) families who experience housing instability (83%), children currently in foster care (73%), children who have previously been in foster care (69%), children being raised by non-parent family members (74%) and "other" populations. The majority of "other" populations described were special needs populations. All comments are in the Appendix.

Three quarters of respondents represented center or family based providers including 63% center based providers, 5% Early Head Start, 10% family-based childcare providers and 3% Head Start programs. Other types of Center-based programs included Early Head Start, School Readiness, Even Start and programs funded by a variety of sources.

In addition, 8% of respondents represented Family Resource Centers, 29% home visiting programs, 1% higher education, 6% medical providers and 13% statewide agencies. Medical providers consisted of ten clinical providers, one individual from a health center and four outpatient clinics. Statewide programs included 26 individuals from the Department of Children and Families (DCF), 2 individuals from the Office of Early Childhood (OEC), 2 individuals from Early Interventionist/Part C, 1 individual from ECCP and 1 individual from Child First. Other statewide agencies described included the Child Guidance Clinic, CTAIMH, federal programs and initiatives, Intensive Family Preservation, RESCs, and public schools.

Types of Training Received

Respondents provided the types of trauma-related training they had received over the course of their career in a number of trauma-related topic areas. Results are summarized in Table 2.
Results indicate a high interest in trainings in each topic. Additionally, at least half of respondents had not received training in 5 out of 8 topic areas and expressed interest in receiving this training.

One hundred and sixteen participants (116) indicated that they had received additional training addressing the impact of trauma on children aged 0-6.

A between group comparison was conducted to identify groups of participants who would be interested in additional training. Results are presented in Table 3.

In addition to the aggregate data provided in Table 3, data from respondents involved with the Department of Children and Families was analyzed separately. Twenty-six DCF staff responded to the survey. These individuals expressed interest in topics as follows:

- Introduction to Trauma (84%)
- Screening and Referring for Trauma (64%)
- Impact of Trauma on Child Development (87%)
- Impact of Trauma on Parents and Parenting (84%)
- Impact of Transgenerational Trauma on Family Functioning (82%)
- Relationship between Mental Health, Homelessness and Trauma (87%)
- Impact of Culture on Trauma (83%)
- Helping Families with Trauma to Develop Reflective Capacity (91%)

The majority of respondents in each type of program expressed interest in additional training in each topic area. Childcare providers and Family Resource staff were less likely to have received training in the majority of topic areas and expressed a high amount of interest in receipt of such training.

Perspectives on Training Received

Participants who had received training on each topic provided their perspectives on that training. Results are shared by topic in Table 4.

Definition of and Types of Trauma: Of the 234 individuals (82% of respondents) who had received training on this topic, the majority (43%) had received between 2 and 5 days of training while 27% had participated in "other" trainings. Almost one fifth (20%) had received one day of training and 11% had received less than four hours of training. The majority of training recipients were "satisfied" or "very satisfied" (90%) with training received.

Respondents had received training at conferences (54%), through college courses (12%), at off-site workshops (50%), through on-site coaching (16%) and through webinars (22%). Eight percent of respondents had participated in "other" trainings. Training providers are summarized in Table 4.

Individuals were most likely to receive training on this topic from CT-AIMH (51%), Department of Children and Families (32%) and conferences (38%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (6 individuals), Central Connecticut State University (8 individuals), Eastern Connecticut State University (4 individuals), Southern Connecticut State University (6 individuals), University of Connecticut (13 individuals), University of Saint Joseph (4 individuals), Western Connecticut State University (1 individual) and Yale University (10 individuals).

Of individuals who had received trainings at conferences, 112 had attended the CT-AIMH conference, 39 had attended the Together We Will conference and 38 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Screening and Referring for Trauma: Of the 132 individuals (49% of respondents) who had received training on this topic, the majority (38%) had received between 2 and 5 days of training, 29% had received one day of training and 22% had received less than four hours of training. Eleven percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (93%) with training received.

Respondents had received training at conferences (23%), through college courses (5%), at off-site workshops (21%), through on-site coaching (11%) and through webinars (7%). Three percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 5.

Individuals were most likely to receive training on this topic from CT-AIMH (25%), Department of Children and Families (25%) and conferences (25%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (2 individuals), Central Connecticut State University (2 individuals), Eastern Connecticut State University (1 individual), Southern Connecticut State University (0 individuals), University of Connecticut (4 individuals), University of Saint Joseph (1 individual), Western Connecticut State University (0 individuals) and Yale University (4 individuals).

Of individuals who had received trainings at conferences, 38 had attended the CT-AIMH conference, 9 had attended the Together We Will conference and 23 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Impact of Trauma on Child Development, including Brain Development: Of the 191 individuals (73% of respondents) who had received training on this topic, the majority (50%) had received between 2 and 5 days of training, 18% had received one day of training and 13% had received less than four hours of training. One fifth had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (91%) with training received.

Respondents had received training at conferences (39%), through college courses (11%), at off-site workshops (36%), through on-site coaching (10%) and through webinars (11%). Four percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 6.

Individuals were again most likely to receive training on this topic from CT-AIMH (47%), Department of Children and Families (23%) and conferences (32%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (4 individuals), Central Connecticut State University (2 individuals), Eastern Connecticut State University (3 individuals), Southern Connecticut State University (4 individuals), University of Connecticut (12 individuals), University of Saint Joseph (3 individuals), Western Connecticut State University (0 individuals) and Yale University (5 individuals).

Of individuals who had received trainings at conferences, 75 had attended the Connecticut Association for Infant Mental Health conference, 15 had attended the Together We Will conference and 23 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Impact of Trauma on Parents and Parenting: Of the 142 individuals (55% of respondents) who had received training on this topic, the majority (50%) had received between 2 and 5 days of training, 24% had received one day of training and 15% had received less than four hours of training. Fifteen percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (94.1%) with training received.

Respondents had received training at conferences (27%), through college courses (5%), at off-site workshops (23%), through on-site coaching (7%) and through webinars (6%). Three percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 7.

Individuals were again most likely to receive training on this topic from CT-AIMH (42%), Department of Children and Families (22%) and conferences (23%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (3 individuals), Central Connecticut State University (2 individuals), Eastern Connecticut State University (3 individuals), Southern Connecticut State University (2 individuals), University of Connecticut (6 individuals), University of Saint Joseph (1 individuals), Western Connecticut State University (0 individuals) and Yale University (3 individuals).

Of individuals who had received trainings at conferences, 54 had attended the Connecticut Association for Infant Mental Health conference, 7 had attended the Together We Will conference and 14 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Impact of Transgenerational Trauma on Family Functioning: Of the 81 individuals (32% of respondents) who had received training on this topic, the majority (43%) had received between 2 and 5 days of training, 19% had received one day of training and 28% had received less than four hours of training. Ten percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (91.1%) with training received.

Respondents had received training at conferences (14%), through college courses (4%), at off-site workshops (11%), through on-site coaching (4%) and through webinars (2%). Three percent of respondents had participated in "other" trainings.
Training providers are summarized in Table 8.

Individuals were most commonly recipients of trainings on this topic from CT-AIMH (40%), Department of Children and Families (19%) and conferences (19%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (1 individual), Central Connecticut State University (1 individual), Eastern Connecticut State University (1 individual), Southern Connecticut State University (2 individuals), University of Connecticut (2 individuals), University of Saint Joseph (3 individuals), Western Connecticut State University (1 individual) and Yale University (2 individuals).

Of individuals who had received trainings at conferences, 22 had attended the Connecticut Association for Infant Mental Health conference, 2 had attended the Together We Will conference and 7 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Relationship between Mental Health, Homelessness and Trauma: Of the 74 individuals (30% of respondents) who had received training on this topic, One fifth (21%) had received between 2 and 5 days of training, 43% had received one day of training and 29% had received less than four hours of training. Eight percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (91.7%) with training received.

Respondents had received training at conferences (14%), through college courses (3%), at off-site workshops (10%), through on-site coaching (2%) and through webinars (6%). One percent of respondents had participated in "other" trainings.
Training providers are summarized in Table 9.

Individuals received training on this topic primarily from CT-AIMH (20%), Department of Children and Families (24%) and conferences (34%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (1 individual), Central Connecticut State University (1 individual), Eastern Connecticut State University (2 individuals), Southern Connecticut State University (1 individual), University of Connecticut (3 individuals), University of Saint Joseph (2 individuals), Western Connecticut State University (0 individuals) and Yale University (2 individuals).

Of individuals who had received trainings at conferences, 17 had attended the Connecticut Association for Infant Mental Health conference, 4 had attended the Together We Will conference and 5 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Impact of Culture on Trauma: Of the 79 individuals (31% of respondents) who had received training on this topic, One fifth (22%) had received between 2 and 5 days of training, 42% had received one day of training and 22% had received less than four hours of training. Fourteen percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (94.3%) with training received.

Respondents had received training at conferences (16%), through college courses (5%), at off-site workshops (11%), through on-site coaching (3%) and through webinars (3%). Three percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 10.

Individuals were most likely to receive training on this topic from CT-AIMH (38%), Department of Children and Families (18%) and conferences (30%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (3 individuals), Central Connecticut State University (3 individuals), Eastern Connecticut State University (3 individuals), Southern Connecticut State University (2 individuals), University of Connecticut (3 individuals), University of Saint Joseph (1 individual), Western Connecticut State University (0 individuals) and Yale University (2 individuals).

Of individuals who had received trainings at conferences, 25had attended the Connecticut Association for Infant Mental Health conference, 6 had attended the Together We Will conference and 4 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Helping Families Dealing with Trauma to Develop Reflective Capacity: Of the 79 individuals (31% of respondents) who had received training on this topic, the majority (43%) had received between 2 and 5 days of training, 30% had received one day of training and 9% had received less than four hours of training. Eighteen percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (94.6%) with training received.

Respondents had received training at conferences (12%), through college courses (3%), at off-site workshops (12%), through on-site coaching (4%) and through webinars (2%). Three percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 11.

Individuals were most likely to receive training on this topic from CT-AIMH (46%), Child First (24%), Colleges and Universities (11%) and conferences (15%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (1 individual), Central Connecticut State University (1 individual), Eastern Connecticut State University (2 individuals), Southern Connecticut State University (1 individual), University of Connecticut (2 individuals), University of Saint Joseph (2 individuals), Western Connecticut State University (0 individuals) and Yale University (2 individuals).

Of individuals who had received trainings at conferences, 29 had attended the Connecticut Association for Infant Mental Health conference and 2 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Additional Training Related to Trauma: Of the 116 individuals (48% of respondents) who had received additional training related to trauma, the majority (50%) had received between 2 and 5 days of training, 7% had received one day of training and13% had received less than four hours of training. Nineteen percent had participated in "other" trainings. The majority of training recipients were "satisfied" or "very satisfied" (92.0%) with training received.

Respondents had received training at conferences (21%), through college courses (6%), at off-site workshops (19%), through on-site coaching (8%) and through webinars (6%). Four percent of respondents had participated in "other" trainings.

Training providers are summarized in Table 12.

Individuals were most likely to receive training on additional topics from CT-AIMH (37%), Department of Children and Families (26%) and conferences (25%).

Of the individuals who had taken a class from a university, participants received training as follows: community colleges (1 individual), Central Connecticut State University (2 individuals), Eastern Connecticut State University (2 individuals), Southern Connecticut State University (2 individuals), University of Connecticut (5 individuals), University of Saint Joseph (23 individuals), Western Connecticut State University (0 individuals) and Yale University (3 individuals).

Of individuals who had received trainings at conferences, 47 had attended the Connecticut Association for Infant Mental Health conference, 7 had attended the Together We Will conference and 9 had attended "other" conferences.

A number of comments regarding training received were provided by participants and can be found in the Appendix.

Organizational Structures and Processes

Survey respondents served in supervisory positions (126 individuals or 43%) and as direct care workers (115 individuals or 40%).

Supervisor Responses: Of the 126 individuals serving in supervisory positions, 46 were administrators or directors of programs, 8 percent were coordinators and 55 individuals had "other" titles.

Individuals serving in supervisory positions estimated stated that their program served children from 0-6 years old who were experiencing trauma as follows: None=1%, 1-25% of children experience trauma (28%), 26-50% of children experience trauma (23%), 51-75 percent of children experience trauma (18%) and 76-99% of children experience trauma (21%). Seven percent of respondents stated that all children served by their program have experienced trauma.

Respondents stated that their programs or institutions addressed trauma through a variety of venues. Results are summarized in Table 13.

Supervisors stated that their organizations were most likely to train staff to understand and identify the signs and symptoms of trauma (59%), to monitor children for behavior that was indicative of trauma (62%) and to refer children for trauma when indicated (60%). All other strategies are located in the Appendix.

Individuals who stated that their programs screen for trauma identified the types of trauma tools used. Responses are in Table 14.

Supervisors were most likely to identify the Edinburg Postnatal Depression Scale and the Parenting Index as tools most commonly used to screen for trauma. Other tools used and additional comments are provided in the Appendix.

Direct Care Worker Responses: Of the 115 individuals serving in direct care positions, 9 were behavioral/mental health clinicians, 2 were behavior/mental health consultants, 11 were classroom teachers or assistant teachers, 10 were clinicians, 9 were Early Interventionist Part C, 1 was a health consultant, 11 were home visitors, 2 were nurses, 14 were parent educators, 1 was a physical therapist, 1 was a physician, 4 were special education teachers, 4 were speech therapists, 15 were social workers and 19 individuals had "other" titles.

Individuals serving in direct care positions estimated stated that their program served children from 0-6 years old who were experiencing trauma as follows: None=3%, 1-25% of children experience trauma=33%, 26-50% of children experience trauma (17%), 51-75 percent of children experience trauma (12%) and 76-99% of children experience trauma (20%). Five percent of respondents stated that all children served by their program have experienced trauma.

Respondents stated that their programs or institutions addressed trauma through a variety of venues. Results are summarized in Table 15.

The direct service workforce was most likely to train staff to understand and identify the signs and symptoms of trauma and to ask parents/caregivers about trauma in their children's lives. Almost half of individuals participated in reflective supervision and only 23% offered education or training for parents on trauma. Very few individual staff screened children for trauma using a validated tool although the majority of supervisors stated that their programs screen children with such tools. All other strategies are located in the Appendix.

Individuals who stated that their programs screen for trauma identified the types of trauma tools used. Responses are in Table 16.

Like the supervising staff, direct service staff was most likely to use the Parenting Stress Index and the Edinburgh Postnatal Depression scale when screening for trauma. Other tools used and additional comments are provided in the Appendix.

Barriers to Successful Screening and Connecting Families to Trauma Services

All respondents identified potential barriers that they faced that make it difficult to screen and connect families to trauma-related services. Results are summarized in Table 17.A lack of trained staff was the most common barrier to an organization's ability to screen and refer children to trauma. (Table 17)

C. Early Childhood Training Provider Survey

Demographic Information

Fifty-two (52) trauma-training providers completed the survey. Institutions provided training for the early childhood workforce in Fairfield County (14%), Hartford County (23%), Litchfield County (4%), Middlesex Count (10%), New Haven County (39%), New London County (10%), Tolland County (2%) and Windham County (2%). Twenty one percent of respondents provided training on a "statewide" basis.

Similar diversity was seen across the urban-rural continuum. The majority of training providers (60%) were located in urban areas, 12% were found in rural areas and 20% were located in suburban communities. Twenty seven percent of respondents were located in statewide programs.

Almost all organizations provided training for the early childhood workforce working with children aged 0-3 (87%) and slightly fewer provided training for programs (73%) working with children from three to less than six years of age.

Organizations used curricula to provide educational opportunities related to trauma to the early childhood workforce including curricula specific to their agency (27%), nationally recognized curricula (44%), evidence-based curricula (64%) and Connecticut developed or recognized curricula (50%). Other curricula used are provided in the Appendix.

Respondents provided training for programs serving military families (44%), tribal families (31%), immigrant families (85%) families who experience housing instability (92%), children currently in foster care (87%), children who have previously been in foster care (85%), children being raised by non-parent family members (85%) and "other" populations (31%). All comments are in the Appendix.

Nineteen percent of respondents represented Center or family based providers including 3 Center based providers, 1 Early Head Start, 1 family-based childcare provider and 4 Head Start programs. Other types of Center-based programs included School Readiness and child development programs.

In addition, 8% of respondent represented All Our Kin, 6% represented higher education, 21% were from home visiting programs, 4% were medical providers, 4% were from Regional Education Service Centers (RESCs), and 8% represented statewide agencies working with young children. Medical providers consisted of 1 clinical providers and 1 individual from an outpatient clinic. Statewide programs included 2 individuals from the Department of Children and Families (DCF), 1 individual from the Office of Early Childhood (OEC) and 1 individual from Early Interventionist/Part C.

Almost half (49%) of respondents worked in a supervisory capacity while the remainder worked directly with the early childhood workforce. Of the administrative respondents, 9 were "Administrators or Directors", 10 were Coordinators and 6 individuals were faculty or professors. Individuals providing training directly to the workforce included 6 behavioral/mental health clinicians, 3 behavioral/mental health consultants, 6 clinicians, 2 early interventionists, 4 educational consultants, 2 home visitors, 6 individuals within the early childhood workforce who also provide training, 3 parent educators, 2 physical therapists, 5 social workers and 8 trainers. Other positions provided are described in the Appendix.

Types of Training Provided

Respondents described the types of trauma-related training they provide to the early childhood workforce in a number of trauma-related topic areas. Results are summarized in Tables 18-19.
Results indicate a high interest in trainings in receiving additional trainings or enhancements on each topic. The majority of respondents had not provided trainings on the majority of topics listed. The only topics offered by at least 50% of providers were "Definition of and Types of Trauma" and "Impact of

Trauma on Child Development". Eleven participants indicated that they provided some form of additional training addressing the impact of trauma on children aged 0-6 while 21 respondents did not.

A between group comparison was conducted to identify groups of participants who would be interested in providing additional training. Results are presented in Table 19.

The majority of respondents in each type of organization expressed interest in providing additional training in each topic area.

Perspectives on Training Provided

Participants who had provided training on each topic provided their perspectives on that training. Results are shared by topic below.

Definition of and Types of Trauma: Twenty five providers stated that they provided trainings on this topic. These respondents described a variety of learning objectives on this topic (Appendix).

Offerings provided to the early childhood workforce included college courses (3), conferences (9), off site trainings or workshops (12), in house trainings or workshops (17), coaching (7), professional learning communities (3), partnering with a mentor (0) and on-line learning (4). Other responses are provided in the Appendix.

Of the 16 individuals who provided training on this topic, the majority (50%) provided less than four hours, 19% provided one day of training, 19% provided 2-5 days and 2 individuals provided one semester of training on this topic.

Trainings were provided to Center-Based Early Care and Education programs (8 respondents), Family Resource Centers (2), Head Start or Early Head Start Programs (8), Home-Based Early Care and Education Programs (8), Medical Care or Clinical Providers (6) and Statewide agency staff (5). Other audiences to whom trainings are provided are listed in the Appendix.

Trainings were provided as requested (63%), every week (5%), every month (16%), once a quarter (11%) and once a year (5%).

A variety of strategies were used to follow up with participants after training provision including none (3), incorporation into staff evaluations (6) and ongoing reflective supervision (12). Two respondents did not know the type of follow up provided. Other comments are in the Appendix.

The majority of respondents (70%) stated offerings provided were evaluated, 25% stated that they were not and 5% did not know. Comments are in the Appendix.

Offerings were described as prevention focused (10), intervention-focused (13), diagnosis-focused (5) and treatment-focused (10).

The majority of training recipients were "satisfied" or "very satisfied" (76%) with training received.

University participants represented a Connecticut Community College (2), Central Connecticut State University (1), University of Saint Joseph (1), Yale University (1) and Connecticut College (1).

Screening and Referring for Trauma: Thirteen providers stated that they provided training on this topic. All objectives are provided in the Appendix.

Offerings provided to the early childhood workforce included college courses (1), conferences (2), off site trainings or workshops (5), in house trainings or workshops (7), coaching (3), professional learning communities (4 and on-line learning (3). There were no other responses.

Of the 6 individuals who provided training on this topic, the majority (50%) provided less than four hours, 2 provided one day of training and 1 individual provided between 2 and 5 days of training. Other comments are provided in the Appendix.

Trainings were provided to Center-Based Early Care and Education programs (2), Family Resource Centers (1), Head Start or Early Head Start Programs (4), Home-Based Early Care and Education Programs (2), and Statewide agency staff (4). Other audiences to whom trainings are provided are listed in the Appendix.

Trainings were provided as requested (63%), every month (25%) and once a quarter (13%).
A variety of strategies were used to follow up with participants after training provision including none (2), incorporation into staff evaluations (4) and ongoing reflective supervision (5). Comments are in the Appendix.

Forty five percent of respondents evaluated offerings while 45% did not. One individual did not know if offerings were available. Comments are again in the Appendix.

Offerings were described as prevention focused (5), intervention-focused (9), diagnosis-focused (3) and treatment-focused (4).

Almost half (44%) of respondents were dissatisfied with trainings provided while the remainder were satisfied or very satisfied.

University participants represented Connecticut Community College (1), Connecticut College and the University of Hartford (1 individual from each).

Impact of Trauma on Child Development, including Brain Development: Twenty providers responded that they offered trainings on this topic. These providers shared learning objectives that are provided in the Appendix.

Offerings provided to the early childhood workforce included college courses (1), conferences (7), off site trainings or workshops (8), in house trainings or workshops (9), coaching (5), professional learning communities (1), partnering with a mentor (1) and on-line learning (2). There were no other responses.

The majority of training providers (63%) provided less than four hours, 25% provided one day of training and 1 individual provided between 2 and 5 days of training. Two comments stated that training varied and one individual provided training over two semesters.

Trainings were provided to Center-Based Early Care and Education programs (3), Head Start or Early Head Start Programs (4), Home-Based Early Care and Education Programs (2), Medical Care or Clinical providers (2) and Statewide agency staff (3). Other audiences for whom trainings are provided included DCF SW and Pre-service Early Childhood Teachers.

All trainings were provided as requested.
A variety of strategies were used to follow up with participants after training provision including none (2), incorporation into staff evaluations (3) and ongoing reflective supervision (5). One individual did not know. One individual stated that support was provided to supervisors who work with staff.

The majority of respondents (64%) evaluated offerings while 18% did not. The remainder did not know. Comments are in the Appendix. A limited number of comments identified surveys, discussions and clinical supervision as being used for evaluation.

Offerings were described as prevention focused (6), intervention-focused (9), diagnosis-focused (2) and treatment-focused (5).

The majority (87%) of respondents were satisfied or very satisfied with offerings provided.

University participants were from the University of Connecticut (2) and the University of Saint Joseph (1).

Impact of Trauma on Parents and Parenting: Twelve providers responded that they offered trainings on this topic. These providers shared learning objectives on this topic that are provided in the Appendix.

Offerings provided to the early childhood workforce included college courses (1), conferences (2), off site trainings or workshops (1), in house trainings or workshops (5), coaching (2), professional learning communities (1) and on-line learning (1). There were no other responses.

All respondents provided training of less than four hours. One individual stated that training times varied and one individual provided training over two semesters.

Trainings were provided to Center-Based Early Care and Education programs (1), Head Start or Early Head Start Programs (2), Medical Care or Clinical providers (1) and statewide agency staff (1). Other audiences to whom trainings were provided described by participants included parents and caregivers.

The majority (67%) of trainers provided trainings upon request and one organization provided trainings once a quarter.

A variety of strategies were used to follow up with participants after training provision including none (1), incorporation into staff evaluations (2) and ongoing reflective supervision (2). One individual stated that follow-up support was provided to programs as needed and one individual stated that follow-up was completed with clinical supervision. The majority of respondents (75%) evaluated offerings while the remainder did not.

Offerings were described as prevention focused (4), intervention-focused (3), diagnosis-focused (1) and treatment-focused (1).

All respondents were satisfied with offerings provided.

University participants represented only the University of Connecticut (2).

Impact of Transgenerational Trauma on Family Functioning*:* Three providers responded that they offered trainings on this topic. There were no specific learning objectives provided.

Offerings provided to the early childhood workforce included conferences (2), off site trainings or workshops (2), in house trainings or workshops (2), coaching (2), professional learning communities (1), partnering with a mentor (0) and on-line learning (1). There were no other responses.

All respondents provided training of one day in length.

Trainings were provided only to Medical Care or Clinical providers (2) upon request. One comment stated that during the training the topic is implied but is not specifically elaborated on.

Strategies used to follow up with participants after training provision included incorporation into staff evaluations (1) and ongoing reflective supervision (2). One respondent evaluated offerings while one did not.
Offerings were described as prevention focused (2), intervention-focused (2), diagnosis-focused (1) and treatment-focused (2).

All respondents were satisfied with offerings provided.

One respondent identified their organization as the University of Saint Joseph.

Relationship between Mental Health, Homelessness and Trauma: Six providers responded that they offered trainings on this topic. Learning objectives provided are in the Appendix.

Offerings provided to the early childhood workforce included college courses (1), conferences (3), off site trainings or workshops (3), in house trainings or workshops (4), coaching (1), professional learning communities (2), partnering with a mentor (0) and on-line learning (1). There were no other responses.

All respondents provided training of less than one hour. One provider stated that the time allotted varies.

Trainings were provided to Center-Based Early Care and Education programs (3), Family Resource Centers 2), Head Start or Early Head Start (3), Home-Based Early Care and Education Programs (2), Medical Care or Clinical providers (2) and Statewide Agency Staff. Three respondents provided trainings upon request and one individual stated that trainings were provided once a year. One respondent stated that training is ongoing and is provided in any format and for varied audiences while one individual commented that training is provided twice per year and folded into courses.

A variety of strategies were used to follow up with participants after training provision including none (3), incorporation into staff evaluations (1) and ongoing reflective supervision (3). Three respondents stated that they evaluated offerings while one did not

Offerings were described as prevention focused (4), intervention-focused (4), diagnosis-focused (2) and treatment-focused (3). One individual stated that offerings were not deep in evidence-based treatment or screening instrument to fidelity but touched on all of these areas.

All respondents were satisfied with offerings provided.

University respondents included only the University of Connecticut.

Impact of Culture on Trauma: Five providers responded that they offered trainings on this topic. Learning objectives provided are in the Appendix.

Offerings provided to the early childhood workforce included conferences (2), off site trainings or workshops (2), in house trainings or workshops (3), coaching (2), professional learning communities (1), partnering with a mentor (0) and on-line learning (1). One individual stated that presenters were typically brought in to discuss the topic.

One individual stated that training was provided for less than four hours while one respondent stated trainings were typically one day in length.

Trainings were provided to Home-Based Early Care and Education Programs (1) and Medical Care or Clinical providers (2).

A variety of strategies were used to follow up with participants after training provision including incorporation into staff evaluations (1) and ongoing reflective supervision (2).

Two respondents stated that they evaluated offerings while one did not.

Offerings were described as prevention focused (3), intervention-focused (2), diagnosis-focused (2) and treatment-focused (2).

Two respondents were satisfied with offerings provided while one individual was dissatisfied.

University participants represented the University of Connecticut and the University of Saint Joseph. One individual from University of Bridgeport stated that they presented "Reflective Practice in Child Care" at their annual conference.

Helping Families Dealing with Trauma to Develop Reflective Capacity: Six providers responded that they offered trainings on this topic. Learning objectives provided are in the Appendix.

Offerings provided to the early childhood workforce included conferences (2), off site trainings or workshops (4), in house trainings or workshops (4), coaching (4), professional learning communities (1), partnering with a mentor (0) and on-line learning (1). One individual stated that the topic was presented in a session in CT-AIMH training and that pre-conference sessions have been completed.

All individuals stated that training was provided for less than four hours.

Trainings were provided to Center-Based Early Care and Education programs (3), Family Resource Centers (1), Head Start or Early Head Start (3), Home-Based Early Care and Education Programs (2), Medical Care or Clinical providers (3) and Statewide agency staff. All trainings were provided upon request.

A variety of strategies were used to follow up with participants after training provision including none (2), incorporation into staff evaluations (2) and ongoing reflective supervision (1). One respondent stated that the CT-AIMH series includes an opportunity to sign up for subsidized reflective supervision.

Two respondents stated that they evaluated offerings while two did not.

Offerings were described as prevention focused (3), intervention-focused (4), diagnosis-focused (2) and treatment-focused (3).

All respondents were satisfied with offerings provided.

University respondents represented the University of Saint Joseph.

Reflective Supervision: Four providers responded that they offered trainings on this topic. Learning objectives provided are in the Appendix.

Offerings provided to the early childhood workforce included conferences (1), off site trainings or workshops (2), in house trainings or workshops (3), coaching (3), professional learning communities (1), partnering with a mentor (0) and on-line learning (1).

One responded stated that training was provided for less than four hours and one indivudal stated that training was two to five days in length.

Trainings were provided to Center-Based Early Care and Education programs (1), Head Start or Early Head Start (2), Home-Based Early Care and Education Programs (2) and Medical Care or Clinical providers (2). All trainings were provided upon request.

A variety of strategies were used to follow up with participants after training provision including incorporation into staff evaluations (2) and ongoing reflective supervision (3). All respondents stated that offerings were evaluated.

Offerings were described as prevention focused (2), intervention-focused (3), diagnosis-focused (1) and treatment-focused (2).

Two respondents were satisfied with offerings provided while one individual was dissatisfied.

A number of comments were provided which are included in the Appendix.

Additional Training Related to Trauma: Eleven providers responded that they offered some form of additional training related to trauma. Learning objectives provided are in the Appendix.

Offerings provided to the early childhood workforce occurred at conferences (4), off site trainings or workshops (6), in house trainings or workshops (7), coaching (5), professional learning communities (2), partnering with a mentor (0) and on-line learning (2).

The majority of respondents stated that trainings were less than 4 hours in length (88%). One individual provided one day of training.

Trainings were provided upon request only to Center-Based Early Care and Education programs (4), Family Resource Centers (1), Head Start or Early Head Start (7), Home-Based Early Care and Education Programs (2), Medical Care or Clinical providers (1) and state agency staff.

Strategies used to follow up with participants after training provision included none (1), incorporation into staff evaluations (4) and ongoing reflective supervision (3). Two individuals did not know. The majority of respondents (78%) stated that they evaluated offerings while two did not. One respondent stated that workshops were evaluated and reported on as much as possible and results were presented at national meetings.

Offerings were described as prevention focused (2), intervention-focused (7), diagnosis-focused (1) and treatment-focused (3).

One third of respondents were dissatisfied with offerings provided and the remainder were satisfied.

Characteristics of the Early Childhood Workforce

Respondents stated that programs they served addressed trauma through a variety of venues. Results are summarized in Table 20.

Respondents most frequently stated that early childhood programs for whom they provided training most frequently monitored children for behavior and trained staff to understand and identify the signs and symptoms of trauma.(Table 20)

All other strategies are located in the Appendix.

Individuals who stated that their programs screen for trauma identified the types of trauma tools used. Responses are in Table 21.
Trainers stated that programs for which they provided training was most likely to either not screen for trauma or to only use the Edinburg Postnatal Depression Scale. (Table 21)

Individuals provided comments and additional information. All comments are provided in the Appendix.

Barriers to Successful Screening and Connecting Families to Trauma Services

All respondents identified potential barriers that they faced that make it difficult for programs to screen and connect families to trauma-related services. Results are summarized in Table 22.

A lack of time for programs to screen and refer was identified as the most common barrier to an organization's ability to screen and refer children to trauma, with lack of funding as the next most common reason. (Table 22)

Data Strengths and Limitations

This report summarizes data collection efforts developed and implemented to present the results of a needs assessment for development and implementation of trauma training activities for the early childhood workforce.

The data collection effort has the following strengths:

- Diversified data collection strategies including interviews and two on-line surveys with broad representation throughout Connecticut;
- Excellent participation of representatives from each stakeholder group, from all Connecticut counties, and from urban, suburban and rural areas throughout Connecticut; and
- The use of quality interview and survey tools reviewed by a variety of early childhood professionals prior to administration.

However, as with any research study, data collection and use of data has some limitations, including:

- Surveys and interviews were not completed in languages other than English;
- Interviews with all training providers in Connecticut were not conducted; and
- Comprehensive reliability and validity assessment of data collection instruments was not completed.

Conclusions and Recommendations

Conclusions and Recommendations: Data collection provided conclusions and recommendations for the consideration of the CT AIMH and their Early Childhood Trauma Collaborative partners. Conclusions are presented below by needs assessment question.

Q1: *What training does the infant and early childhood workforce working with young children (0-5) and their families, need to increase their ability to address the needs of children and families who have experienced or are experiencing trauma?*

Results from qualitative interviews were supported by the results of on-line surveys and indicate overwhelmingly that there is a high need for and interest in the provision of trauma-related training for the early childhood workforce. Results show that family child care providers, center-based child care providers, private childcare providers and family resource centers are less likely to have received trauma-related training and are more likely to express interest in receiving such training than other segments of the early childhood workforce.

Early childhood workforce respondents were most likely to have received introductory training related to trauma (75%) or the impact of trauma on early childhood development (65%) and far less likely (40% or less) to receive training on any other trauma-related topics. The majority of respondents who had received training had received less than one day of training with most trainings provided through CT-AIMH, the Connecticut Department of Children and Families or early childhood conferences. Respondents were typically satisfied with the trainings they had received.

Approximately half of respondents use surveillance or monitoring to identify children who have experienced trauma with very few (19%) screening children for trauma. Respondents typically estimated that between 26% to 100% of children in their programs had experienced trauma and expressed a high level of interest in enhancing their skills and knowledge to better address the needs of these children.

Respondent organizations were most likely to monitor and refer children for trauma (approximately 60%) and least likely to offer training or education for parents related to trauma (approximately 23%). At least 5% of respondents stated that they did not address trauma in their programs. Approximately half of respondents stated that their organizations provided some sort of follow-up to staff to provide support in

addressing trauma. There were no clearly identifiable differences between the responses of supervisors and direct care workers.

Respondents identified the Edinburgh Postnatal Depression Scale (approximately 20%) as the tool most likely to be used to screen for trauma although at least 6% of respondents used each of the other tools listed.

The most common barriers to successful screening and referring to trauma identified by respondents were a lack of trained staff and a lack of education regarding the importance of screening and referring. Other common barriers included language challenges, lack of access to qualified providers and lack of funding.

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

Results from qualitative interviews were again supported by the results of on-line surveys and provide further information identifying the high need for and interest in the provision of trauma-related training for the early childhood workforce. Results of the training provider survey and the interviews with training providers indicate that the vast majority of training provided is provided for a limited audience with that audience limited either by geographic or regional boundaries or by participation in programs through which training is provided.

Participants identified a particularly high need for training for the infant and toddler workforce, for ECE providers that do not receive state or federal funding and for family resource centers. Participants stated that there is almost no trauma training available for these audiences. In addition, interviews indicate that even when training is available, limitations on the availability of substitute teachers prevent ECE educators from attending.

Results from the training provider survey and interviews with training providers support the results of the workforce survey. Providers were most likely to provide training on topics including the definition of and types of trauma and the impact of trauma on child development and were far less likely to provide training on additional topics, with less than one fifth of respondents provided training related to reflective supervision, mental health, culture or transgenerational trauma. Over 80% of providers expressed an interest in receiving enhancements or additional trainings on each topic listed.

The majority of training providers provided training linked to the IMH Competencies ® either formally or informally with most trainings being of one day in length or less. The majority of providers developed their own training materials, provided trainings upon request, and perceived the trainings to be useful to the workforce. The majority of providers used workshop evaluations to obtain feedback on the training although there were no comprehensive evaluations of impact conducted. Providers who provided training internally to their own organizations generally followed up with participants through reflective supervision or ongoing staff evaluations while trainers providing training to external organizations typically stated that no follow up was completed.

Participants generally described successful trainings as completed over a period of time with each day or half day of training building upon the other, as highly participatory in nature and as providing participants an opportunity to reflect upon material learned and to apply material to their own work. Participants emphasized the need for trainings to use a variety of formats and to be targeted specifically to the needs of the organization to which training is requested.

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

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

- Offered by IMH-Endorsed® professionals or skilled trainers with a background in the infant and early childhood field, relevant experience for the audience they are training and expertise in the particular trauma topic they are offering.
- Ensure that trainings occur over a period of time and are not limited to one day or less, incorporate reflection on the issues, include case studies, provide an opportunity for participants to apply learning to their own work experience and are participatory in nature
- Include core knowledge on theoretical foundations about trauma, trauma-informed practice and child development to provide trauma-informed, developmentally sensitive services to young children and their families (definition, types, signs and symptoms, trauma triggers, and how trauma affects prenatal and child development, the attachment relationship, brain development, and behavior).
- Include competencies in working with others to reduce risk factors and increase protective factors associated with trauma and early childhood adversity (collaborating, relationship building, empathy).

2. Offer trauma training for prevention staff:

- Include all of the above-mentioned items from #1.
- Include core knowledge on theoretical foundations about trauma, trauma-informed practice and child development to provide trauma-informed, developmentally sensitive services to young children and their families (above and family relationships, cultural responsiveness, emotional regulation, homelessness, two-gen, emotional and physical abuse, neglect, and violence).
- Include core values and attitudes needed to provide trauma informed, developmentally sensitive services to young children and their families (importance of role, include parents/caregivers as partners, relationship-focused practice, recovery and healing from trauma).
- Include direct service skills and abilities needed to practice trauma informed care with young children and their families (observe, establish relationships, screening, referrals, sensitivity, safety, offer techniques to families)
- Include communication skills needed to provide effective trauma informed, developmentally sensitive services to young children and their families (listen, develop trusting, honest relationships that promote safety for all).
- Opportunity to participate in reflective supervision/consultation experience

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

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

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

Some trainers also identified that they provide training on vicarious trauma and self care (Table 2). To ensure greater provider resilience and less burnout, RS/C is recommended for those working with children and families that have experienced trauma. RS/C goes beyond clinical supervision to shared exploration of the parallel process, i.e., attention to all of the relationships, including that between practitioner and parent, between parent and infant/toddler, and between practitioner and supervisor. It is critical to understand how each of these relationships affects the others. Of additional importance, by

attending to the emotional content of the work and how reactions to the content affect the work, reflective supervision/consultation relates to professional and personal development within one's discipline. Finally, there is emphasis on the supervisor/consultant's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor/ consultant (https://www.ct-aimh.org/endorsement/reflective-supervision.shtml). Through the use of the CT-AIMH Endorsement Registry (www.ct-aimh.org), ensure that RS/C is provided to the early childhood workforce with competent IMH-Endorsed individuals, who understand the effects of early childhood and family trauma.

Next steps:

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

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[1] Child Trends 5. 2016. Five Ways Trauma-Informed Care Supports Children's Development. https://www.childtrends.org/child-trends-5/5-ways-trauma-informed-care-supports-childrens-development/.

[1] Statman-Well, K. 2015. Creating Trauma Sensitive Classrooms Preschool Through Grade 3. www.naeyc.org/yc. May 2015.

[1] Wolpow, R., M.M. Johnson, R. Hertel & S.O. Kincaid, 2009. *The Heart of Learning and Teaching: Compassion, Resilience and Academic Success.* Olympia, WA: State Office of Superintendent of Public Instruction, Compassionate Schools. www.k12wa.us/compassionate schools/pubdocs/The Heart of Learning and Teaching.pdf

Tables

A. Interview Responses

Table 1: Perceptions from Training Providers who Provide Trauma Training to the EC Workforce

	Non-Higher Education Statewide Institutions (OEC, DCF, CT-AIMH, Head Start, B23, Child First, PAT, United Way)	Regional Entities (RESCs, UCFS, Wheeler Clinic)	Higher Education (UCONN, Yale Child Study Center)
Topics of Training	• Introductory information incorporated into staff training • Causes, impacts and symptoms of trauma including domestic violence • Separation and reconciliation • Incorporation of a trauma lens into mental health • Intensive training on trauma topics including child parent psychotherapy, attachment, child development, transgenerational trauma, reflective functioning • Reflective supervision • Homelessness and Trauma • Vicarious trauma • Pyramid model • Development of a curricula to develop a trauma-informed ECE program underway • Socio-emotional development trainings including limited trauma discussions • How to refer to Birth to Three and Help Me Grow (Child Development Infoline)	Preliminary information on: • Secondary trauma • Introduction to trauma • Working with vulnerable families • Impact of trauma on child development • Impact of trauma on parents • Infant mental health in ECE settings • Homelessness and trauma • Screening • Socio-emotional • How to address challenging behaviors • Impact of mental health on communities	• Intensive information on definition of trauma, approaches to acute and chronic trauma, signs and symptoms, impact of trauma on families, multi-generational trauma • Parent child trauma • Videotapes related to trauma-informed care and early childhood mental health • In utero trauma • How trauma may impact diagnoses of child or parent • Toxic stress
Audience	• Individuals Funded or Employed by each Program including care givers, clinicians, home visitors, DCF staff, parent educators and ECE programs • Target audience delineated by the funding source including DCF and Head Start staff, early care and education programs in communities, and home visitors.	• ECE programs and home visitors within the region. • Department of Children and Families • Internal staff	• Internal and external staff • Social Workers, Clinical Psychologists, Psychiatrists, home visiting staff • Upon request with local school systems • Preschool clinical service • DCF • Upon request • Preservice ECE educators or preservice social workers
Frequency	• Variable including incorporation into 5 day introductory training, intensive one day workshops, three hour trainings, 8 day programs and one full year educational program	• Once or twice a year or upon request	• Approximately 100 people per year • Schools once a month • Upon request • Semester long courses

	Non-Higher Education Statewide Institutions (OEC, DCF, CT-AIMH, Head Start, B23, Child First, PAT, United Way)	Regional Entities (RESCs, UCFS, Wheeler Clinic)	Higher Education (UCONN, Yale Child Study Center)
Format	• Variable including on-line and in person formats, workshops, conferences, professional learning communities and coaching • Communities of practice	• Short term 3 hour to 1 day • Guest speakers • Conferences • Café conversations or group discussions • Emphasis on practice	• Part day to two day • Semester courses on toxic stress • Some lecture, some video, some interactive and skill • Small group •
Curricula Used	• Generally developed by the funding organization or by experts within Connecticut • National Center for Traumatic Stress Network trauma tool	• Developed by presenter	• Evidence-based trauma focused CBT • No specific curricula • Developed by university faculty
Competencies Addressed	• IMH competencies in a formal or less formal way • B23 competencies	• Linked to IMH competencies formally/informally	• Linked to IMH competencies formally/informally
Strategies Used to Decide on Content for Audience	• Typically determined by needs of program and desired outcome in partnership with program staff • Determined by funding source • Generally interactive in some fashion	• Typically determined by needs of program and desired outcome in partnership with program staff • Generally interactive in some fashion	• Trainings developed and then selected by audience • Determined by needs of program and desired outcome in partnership with program staff • Interactive • Upon request
Follow-Up Process	• One day workshops typically have no follow-up although workshop evaluations are given • If training provided internally by an organization to staff or funded entities, reflective supervision or other long-term follow up often used	• Workshop evaluations but no follow-up if external training • Internal trainings may use reflective supervision • No assessments of change or practice	• Workshop evaluations but no follow-up if external training • Internal trainings may use reflective supervision as follow up • No independent assessments of change and practice
Need for Enhancement or Additional Training for Organization	• Access to training in Child Parent Psychotherapy (CPP) • Executive functioning in home visiting • Use of technology in training • Effective use of assessments • Information on what we don't know—educators are not clinicians and do not know what they need to learn about • How to identify signs and symptoms so referrals can be made appropriately • Strategies to address trauma • On-line trainings • Looking at children's behavior through a trauma-informed lens	• Self-care for staff • Developing a trauma-informed ECE program • Training for ECE administrators in to maximize resources • How to integrate children into programs including traumatized kids • Infants/toddlers • Circle of Security • Strategies to address trauma • Understanding importance of a child or infant's needs •	• Supporting early childhood relationships • Supporting healthy development of children • Helping child care providers to understand children's behaviors • Identification of things we do that traumatize kids like multiple placements, multiple teachers or caregivers • Training for parents • Referring children

	Non-Higher Education Statewide Institutions (OEC, DCF, CT-AIMH, Head Start, B23, Child First, PAT, United Way)	Regional Entities (RESCs, UCFS, Wheeler Clinic)	Higher Education (UCONN, Yale Child Study Center)
Perceived Needs of EC Workforce in Connecticut	• Continuum of home visiting—bring together services/providers. • Care coordination of services • A place to pull it all together. One organization to provide trauma training to all workforce segments • A means to make services available to all children and families, bring this to scale so needs of all children get met • Awareness training then deeper level • Biggest gaps are ECE programs that do not receive state or federal funding including home-based providers and programs targeting infants and toddlers • Access to training for ECE programs • Qualified providers for care • Follow up after training—multi day • Understanding that "little" things may cause trauma like multiple placements in foster care or constantly changing staff • Coaching works well	• Cross discipline trauma training academy • Training using series of half day workshops—develop relationships • Coaching best! • Development of trauma informed preschools • Infants and toddlers • Teachers in early care and education settings	• Participatory learning—case presentations, videos, engage audiences where they are—use case examples • Access to trainings for ECE programs • Training for the ECE workforce and pediatricians • Training for all groups to be able to work with children appropriately as dependent upon their role in early childhood workforce

B. Early Childhood Workforce Survey Responses

Table 2: Training Received by Topic
Percent Response and Number of Responses

Topic	#	Yes - not interested in additional training	Yes – and interested in additional training	No--not interested in receiving such training	No – but interested in receiving this training
Definition of and Types of Trauma	288	7%	75%	0%	18%
Impact of Trauma on Child Development including Brain Development	263	8%	65%	0%	27%
Impact of Trauma on Parents and Parenting	254	4%	52%	2%	43%
Impact of Transgenerational Trauma on Family Functioning	251	3%	29%	6%	62%
Relationship between Mental Health, Homelessness and Trauma	249	2%	28%	4%	67%
Impact of Culture on Trauma	246	3%	33%	2%	62%
Screening and Referring for Trauma	272	9%	38%	2%	51%
Helping Families Dealing with Trauma to Develop Reflective Capacity	244	3%	30%	4%	64%

Table 3: Trauma Training Received: Sorted by Stakeholder Group
Percent Interested in receiving more training

Note: Yes=Individual **has received training** and interested in receiving more training
Not=Individual **has not received training** but is interested in receiving training
Highlighted yellow=over 50% surveyed have not received training on this topic

	Child Care Provider N=74			FRC N=23			Home Visitor N=82			Higher Ed N=2			Medical N=16			Statewide N=39		
Topic	**Yes**	**Not**	**Total**	**Yes**	**Not**	**Total**	**Yes**	**Not**	**Total**	**Yes**	**Not**	**Total**	**Yes**	**Not**	**Total**	**Yes**	**Not**	**Total**
Definition of and Types of Trauma	60%	35%	95%	65%	34%	99%	84%	7%	91%	50%	50%	100%	69%	19%	88%	82%	3%	85%
Screening and Referring for Trauma	20%	75%	95%	36%	59%	95%	41%	45%	86%	50%	50%	100%	53%	27%	80%	53%	18%	71%
Impact of Trauma on Child Development including Brain Development	42%	55%	97%	68%	27%	95%	84%	10%	94%	100%	0%	100%	57%	21%	78%	81%	3%	84%
Impact of Trauma on Parents and Parenting	28%	67%	95%	48%	52%	100%	67%	24%	91%	0	100%	100%	64%	29%	93%	66%	23%	89%
Impact of Trans generational Trauma on Family Functioning	12%	82%	94%	14%	81%	95%	39%	52%	91%	0	100%	100%	57%	29%	86%	37%	46%	83%
Relationship between Mental Health, Homeless-ness and Trauma	15%	77%	92%	24%	76%	100%	35%	65%	100%	0	100%	100%	36%	57%	93%	31%	51%	82%
Impact of Culture on Trauma	19%	79%	98%	21%	74%	95%	45%	52%	97%	0	100%	100%	29%	71%	100%	46%	37%	83%
Helping Families Dealing with Trauma to Develop Reflective Capacity	13%	80%	93%	26%	68%	94%	41%	54%	95%	0	100%	100%	36%	57%	93%	40%	49%	89%

Table 4: Provided Training on *Introduction to Trauma: The Definition of and Types of Trauma*
Percent Response and Frequency
N=234

Provider	Percent Received	Frequency
Child First	15%	36
Colleges or Universities	19%	44
Conferences	38%	89
CT-AIMH	51%	119
Connecticut Women's Consortium	14%	33
Department of Children and Families	32%	74
Department of Mental Health and Addiction Services	4%	10
Early Childhood Consultation Partnership	14%	33
Early Interventionist Part C	7%	17
Head Start/Early Head Start	18%	41
Nurturing Families Network	5%	12
Office of Early Childhood	9%	20
Parents as Teachers	7%	16
Regional Education Service Centers	3%	6

Table 5: Provided Training on *Screening and Referral for Trauma*
Percent Response and Frequency
N=132

Provider	Percent Received	Frequency
Child First	14%	19
Colleges or Universities	9%	12
Conferences	25%	33
CT-AIMH	25%	33
Connecticut Women's Consortium	7%	9
Department of Children and Families	25%	33
Department of Mental Health and Addiction Services	2%	3
Early Childhood Consultation Partnership	8%	11
Early Interventionist Part C	4%	5
Head Start/Early Head Start	11%	15
Nurturing Families Network	5%	7
Office of Early Childhood	6%	8
Parents as Teachers	5%	6
Regional Education Service Centers	2%	3

Table 6: Provided Training on *The Impact of Trauma on Child Development including Brain Development*
Percent Response and Frequency
N=191

Provider	Percent Received	Frequency
Child First	13%	24
Colleges or Universities	18%	35
Conferences	22%	42
CT-AIMH	47%	89
Connecticut Women's Consortium	9%	17
Department of Children and Families	23%	44
Department of Mental Health and Addiction Services	2%	4
Early Childhood Consultation Partnership	6%	11
Early Interventionist Part C	3%	5
Head Start/Early Head Start	12%	23
Nurturing Families Network	5%	9
Office of Early Childhood	5%	9
Parents as Teachers	6%	11
Regional Education Service Centers	4%	7

Table 7: Provided Training on *The Impact of Trauma on Parents and Parenting*
Percent Response and Frequency
N=142

Provider	Percent Received	Frequency
Child First	9%	19
Colleges or Universities	9%	13
Conferences	23%	32
CT-AIMH	42%	59
Connecticut Women's Consortium	8%	12
Department of Children and Families	22%	31
Department of Mental Health and Addiction Services	6%	9
Early Childhood Consultation Partnership	2%	3
Early Interventionist Part C	2%	3
Head Start/Early Head Start	8%	12
Nurturing Families Network	5%	7
Office of Early Childhood	4%	5
Parents as Teachers	6%	8
Regional Education Service Centers	3%	4

Table 8: Provided Training on *The Impact of Transgenerational Trauma on Family Functioning*
Percent Response and Frequency
N=81

Provider	Percent Received	Frequency
Child First	12%	11
Colleges or Universities	12%	10
Conferences	19%	15
CT-AIMH	40%	32
Connecticut Women's Consortium	6%	5
Department of Children and Families	19%	15
Department of Mental Health and Addiction Services	5%	4
Early Childhood Consultation Partnership	2%	2
Early Interventionist Part C	1%	1
Head Start/Early Head Start	6%	5
Nurturing Families Network	0%	0
Office of Early Childhood	0%	0
Parents as Teachers	1%	1
Regional Education Service Centers	1%	1

Table 9: Provided Training on *The Relationship Btwn Mental Health, Homelessness and Trauma*
Percent Response and Frequency
N=74

Provider	Percent Received	Frequency
Child First	14%	7
Colleges or Universities	14%	10
Conferences	34%	25
CT-AIMH	20%	15
Connecticut Women's Consortium	8%	6
Department of Children and Families	24%	18
Department of Mental Health and Addiction Services	11%	8
Early Childhood Consultation Partnership	1%	1
Early Interventionist Part C	3%	2
Head Start/Early Head Start	11%	8
Nurturing Families Network	5%	4
Office of Early Childhood	3%	2
Parents as Teachers	4%	3
Regional Education Service Centers	1%	1

Table 10: Provided Training on *The Impact of Culture on Trauma*
Percent Response and Frequency
N=79

Provider	Percent Received	Frequency
Child First	18%	16
Colleges or Universities	18%	14
Conferences	30%	24
CT-AIMH	38%	30
Connecticut Women's Consortium	8%	6
Department of Children and Families	18%	14
Department of Mental Health and Addiction Services	3%	2
Early Childhood Consultation Partnership	3%	2
Early Interventionist Part C	1%	1
Head Start/Early Head Start	9%	7
Nurturing Families Network	5%	4
Office of Early Childhood	1%	1
Parents as Teachers	4%	3
Regional Education Service Centers	0%	0

Table 11: Provided Training on *Helping Families Dealing with Trauma to Develop Reflective Capacity*
Percent Response and Frequency
N=79

Provider	Percent Received	Frequency
Child First	24%	19
Colleges or Universities	11%	9
Conferences	15%	12
CT-AIMH	46%	36
Connecticut Women's Consortium	3%	2
Department of Children and Families	9%	7
Department of Mental Health and Addiction Services	3%	2
Early Childhood Consultation Partnership	1%	1
Early Interventionist Part C	3%	2
Head Start/Early Head Start	3%	2
Nurturing Families Network	1%	1
Office of Early Childhood	1%	1
Parents as Teachers	1%	1
Regional Education Service Centers	0%	0

Table 12: Providers of Additional Trauma Training
Percent Response and Frequency

Provider	Percent Received	Frequency
Child First	13%	15
Colleges or Universities	16%	19
Conferences	25%	29
CT-AIMH	37%	43
Connecticut Women's Consortium	7%	8
Department of Children and Families	26%	30
Department of Mental Health and Addiction Services	3%	3
Early Childhood Consultation Partnership	5%	6
Early Interventionist Part C	4%	5
Head Start/Early Head Start	13%	15
Nurturing Families Network	4%	5
Office of Early Childhood	3%	4
Parents as Teachers	3%	3
Regional Education Service Centers	3%	3

Table 13: Organizational Strategies to Address Trauma
Percent Response and Frequency
N=126

Strategy	Percent Received	Frequency
Train staff to understand and identify the signs and symptoms of trauma	59%	74
Offer education or training for parents on trauma and the impact of trauma	23%	29
Have policies or guidelines that address issues related to trauma	33%	41
Ask parents/caregivers about trauma in their lives	55%	69
As parents/caregivers about trauma in their child(rens) lives	56%	70
Screen children for trauma using a validated screening tool	24%	30
Monitor children for behavior that may be indicative of trauma	62%	78
Refer children for trauma when indicated	60%	75
Use Reflective Supervision to support staff working with trauma	44%	55
Have regular team meetings in which trauma and self-care are discussed	43%	54
Use outside consultants with expertise in trauma who provide education and consultation when needed	53%	67
We do not currently address trauma in my program	8%	10
I do not know	3%	4
Other	11%	14

Table 14: Tools Used to Screen for Trauma-Direct Care Responses
Percent Response and Frequency
N=126

Tool	Percent	N
Adverse Childhood Experiences (ACEs)	13%	16
Edinburgh Postnatal Depression Scale (EDPS)	21%	27
Parenting Stress Index	14%	18
Traumatic Events Screening Inventory for Children (TESI-C)	6%	8
Traumatic Events Screening Inventory Parent Report (TESI-PR)	9%	11
Other	10%	12

Table 15: Individual Strategies to Address Trauma
Percent Response and Frequency
N=115

Strategy	Percent Received	Frequency
Train staff to understand and identify the signs and symptoms of trauma	64%	74
Offer education or training for parents on trauma and the impact of trauma	23%	27
Receive training to help me feel competent in identifying trauma	43%	50
Use policies or guidelines developed by your program to address issues related to trauma	28%	32
Ask parents/caregivers about trauma in their lives	50%	58
Ask parents/caregivers about trauma in their child (children's) lives	57%	65
Screen children for trauma using a validated screening tool	19%	22
Monitor children for behavior that may be indicative of trauma	52%	60
Refer children for trauma when indicated	47%	54
Participate in Reflective Supervision	49%	56
Attend regular team meetings in which trauma and self-care are discussed	26%	30
Use outside consultants with expertise in trauma who provide education and consultation when needed	30%	35
I do not currently address trauma in my program	5%	6
I do not know	3%	3
Other	3%	4

Table 16: Tools Used to Screen for Trauma –Supervisor Responses
Percent Response and Frequency
N=115

Tool	Percent Response	Frequency
Adverse Childhood Experiences (ACEs)	11%	13
Edinburgh Postnatal Depression Scale (EDPS)	19%	22
Parenting Stress Index	20%	23
Traumatic Events Screening Inventory for Children (TESI-C)	8%	9
Traumatic Events Screening Inventory Parent Report (TESI-PR)	9%	10
Other	18%	21

Table 17: Barriers to Successful Screening and Referring for Trauma-Workforce Responses
Percent Response and Frequency
N=290

Barrier	Percent Received	Frequency
Lack of education regarding the importance of screening and referring	30%	86
Lack of time to screen and refer	19%	55
Lack of funding to screen and refer	26%	75
Lack of trained staff to screen and refer	42%	122
Lack of information regarding quality service providers	21%	61
Lack of access to qualified service providers	29%	84
Lack of quality service providers serving the 0-6 population	26%	76
Language challenges	26%	76
Challenges building a trusting relationship with the family	18%	51

C. Early Childhood Trainer Survey Responses

Table 18: Training Provided by Respondents
Percent Response and Number of Responses

Topic	N	Yes - not interested in enhancements	Yes - interested in enhancements	No--not interested in providing training	No - interested in providing training
Definition of and Types of Trauma	50	6%	44%	8%	42%
Screening and Referring for Trauma	44	7%	23%	14%	57%
Impact of Trauma on Child Development	41	2%	46%	12%	39%
Impact of Trauma on Parents and Parenting	38	3%	29%	13%	55%
Impact of Transgenerational Trauma on Family Functioning	34	0%	9%	21%	71%
Impact of Culture on Trauma	32	0%	16%	22%	63%
Relationship between Mental Health, Homelessness and Trauma	32	3%	16%	19%	63%
Helping Families Dealing with Trauma to Develop Reflective Capacity	32	0%	19%	22%	59%
Use of Reflective Supervision	32	0%	13%	25%	63%

Table 19: Training Interest by Stakeholder Group
Number of Respondents Expressing Interest
Note: Yes=Agency has provided training but interested in more
Not=Agency has not provided training and is interested in providing

	All Our Kin N=4		Child Care Provider N=10		Home Visitor N=3		Higher Ed N=3		Medical N=2		RESCs N=2		Statewide N=4		
Topic	**Yes**	**Not**	**Yes**	**Not**	**Yes**	**Not**	**Yes**	**Not**	**Yes**	**Not**	**Yes**	**Not**	**Yes**	**Not**	Total Yes
Introduction to Trauma	2	2	4	4	2	8	1	1	2		1	1	0	3	12
Screening and Referring for Trauma	0	2	1	7	1	6	1	1	0	2	2	0	0	3	5
Impact of Trauma on Child Development	0	2	2	6	1	5	2	1	1	0	2		1	2	9
Impact of Trauma on Parents and Parenting	0	2	2	3	0	6	2	1	1	0	0	2	0	3	5
Impact of Transgenerational Trauma on Family Functioning	0	2	0	4	0	6	0	1	1	0	0	2	0	3	1
Relationship between Mental Health, Homelessness and Trauma	0	2	1	3	1	4	0	1	0	1	1	1	0	2	3
Impact of Culture on Trauma	1	1	0	4	0	5	0	1	1	0	0	2	0	2	2
Helping Families Dealing with Trauma to Develop Reflective Capacity	0	2	0	4	0	5	0	1	1	0	0	2	0	2	1
Use of Reflective Supervision	0	2	0	4	0	5	0	1	1	0	1	1	0	2	2
Totals	**3**	**17**	**10**	**39**	**5**	**50**	**6**	**9**	**8**	**3**	**7**	**11**	**1**	**22**	

Table 20: Strategies to Address Trauma
Frequency of Response
Note: Missing data prevents the calculation of percentage of response

Strategy	Frequency
Train staff to understand and identify the signs and symptoms of trauma	17
Offer education or training for parents on trauma and the impact of trauma	10
Have policies or guidelines that address issues related to trauma	10
Ask parents/caregivers about trauma in their lives	11
As parents/caregivers about trauma in their child(rens) lives	13
Screen children for trauma using a validated screening tool	6
Monitor children for behavior that may be indicative of trauma	18
Refer children for trauma when indicated	16
Use Reflective Supervision to support staff working with trauma	13
Have regular team meetings in which trauma and self-care are discussed	13
Use outside consultants with expertise in trauma who provide education and consultation when needed	12
Programs/institutions I work with do not currently address trauma	0
I do not know	4

Table 21: Tools Used to Screen for Trauma-Trainer Responses
Frequency of Response
Note: Missing data prevents the calculation of percentage of response

Tool	N
None: Programs do not screen for trauma.	11
Adverse Childhood Experiences (ACEs)	4
Edinburgh Postnatal Depression Scale (EDPS)	14
Parenting Stress Index	5
Traumatic Events Screening Inventory for Children (TESI-C)	2
Traumatic Events Screening Inventory Parent Report (TESI-PR)	3
I do not know	5

Table 22: Barriers to Successful Screening and Referring for Trauma-Trainer Responses
Frequency
Note: Missing data prevents the calculation of percentage of response

Barrier	Frequency
Lack of education regarding the importance of screening and referring	12
Lack of time to screen and refer	17
Lack of funding to screen and refer	14
Lack of trained staff to screen and refer	12
Lack of information regarding quality service providers	10
Lack of access to qualified service providers	11
Lack of quality service providers serving the 0-6 population	8
Language challenges	12
Challenges building a trusting relationship with the family	13