# FIRST:ECE TRAUMA INFORMED CARE

## *ADMINISTRATOR'S LEARNING COLLABORATIVE*

2024-2026

### Program Overview

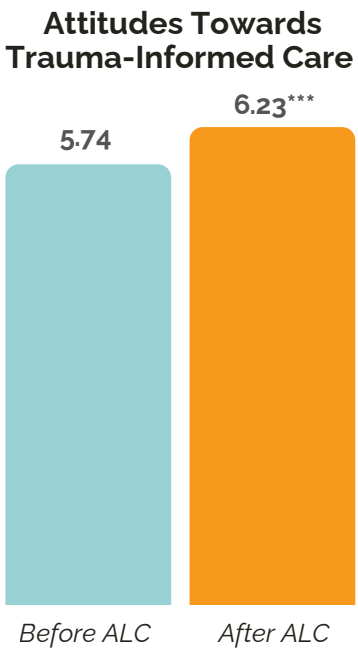
In July 2024, the FIRST:ECE team launched our inaugural Administrator's Learning Collaborative (ALC). This collaborative is a platform for administrator training and a community of practice where administrators learn from each other, apply new organizational change strategies (based on the EPIS framework), and work together to improve trauma-informed (TI) organizational practices over a school year. Key content was drawn from the FIRST:ECE Administrator's Toolkit, based on the National Child Traumatic Stress Network framework for TI schools, with a specific initial focus on three domains: a trauma-informed approach to staff wellness, trauma education and awareness for staff, and a domain of the collaborative member's choice. The ALC activities were designed with a strong emphasis on creating connections within and across school teams and supporting the well-being of the administrator. Participants engaged in a 2-day kick-off, 4 additional 1-day trainings, and alternating 'cluster' and whole-group virtual 1- hour meetings monthly.

### Participants

A total of 53 participants have joined the Learning Collaborative (27 in the first 2024-2025 cohort and 26 in the second 2025-2026 cohort), and 44 completed all data collection components. Educators were from 14 early childhood education (ECE) programs, including private and public ECE agencies. Most educators reported their role as a director or administrator (59%), and others held a range of leadership roles. The majority also said they had 10 or more years of experience in the field (66%).

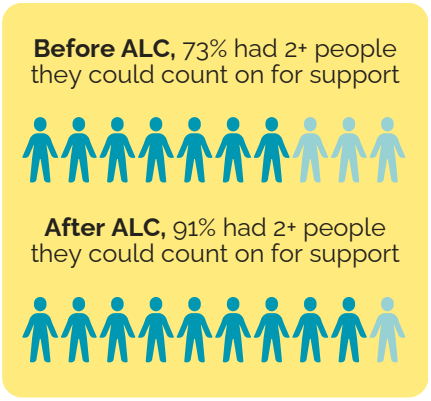
### Improving Attitudes Related to Trauma-Informed Care

Using a validated measure called the ARTIC (Attitudes Related to Trauma-Informed Care)[1], participants were asked to consider various perspectives and determine which they most closely resonated with. For example, one question, positioned at one end of the spectrum, states, "children could act better if they wanted to," translating to a score of 1. A contrary statement, "children are doing the best they can with the skills they have," yielded a score of 7. As shown in the graph to the right, participants' initial scores suggested their beliefs were already fairly consistent with trauma-informed principles before the training. After completing the Administrator's Learning Collaborative, **paired t-test results indicated statistically significant positive gains ($p<0.001$), with scores nearing the measure's ceiling (7.0).** These findings suggest participants' attitudes toward trauma-informed care principles and strategies became even more favorable following participation.



## Increasing Support & Fostering Wellness

Participants were asked how many colleagues in their field were available to offer assistance or support related to their work. They were also asked to identify how often those individuals were available to provide such support. A scale, adapted from the MOS Measures of Social Support tool[2], revealed that after participating in the ALC, the number of educators who reported having two or more people that they could confide in or lean on for work-related issues increased by 15% and was statistically significant (p=0.026). **Furthermore, only 59% of participants reported at baseline that someone was available to them most or all of the time when they needed support, compared to 84% after completing the collaborative, a statistically significant change (p=0.020).**




## Program Practices Post-Collaborative

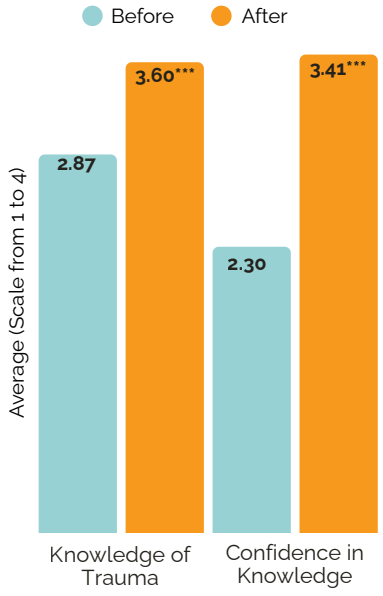
Questions related to the implementation of trauma-informed care practices within the participant's organization were derived from the NCTSN TIOA tool.[3] One sub-scale measured training and education practices that support the implementation of a trauma-informed program. Items included questions such as whether all staff receive training on the impact of trauma on youth and families before beginning employment. Before participating in the ALC, educators reported that those policies relating to training and education were at expectedly lower levels of implementation. Following participation, scores moved to the midpoint of the scale—an expected progression given that participants are still in the early stages of implementation. **This shift represented a statistically significant change (pre mean= 2.53 (SD=1.12), post mean=3.40 (SD=0.91), p<0.001) and a 34% increase after completing the program.**

Another sub-scale measured secondary trauma and wellness supports, with questions prompting administrators to reflect on whether their program regularly teaches caregivers skills to manage stress. Before participation, scores indicated limited implementation, while post-participation results reflected a movement toward the midpoint—again, an anticipated improvement for programs in early implementation. **This represented a statistically significant change (pre mean=2.61 (SD=0.94), post mean=3.53 (SD=0.78), p<0.001) and a 35% increase.**

## Knowledge of Trauma & Trauma-Informed Care

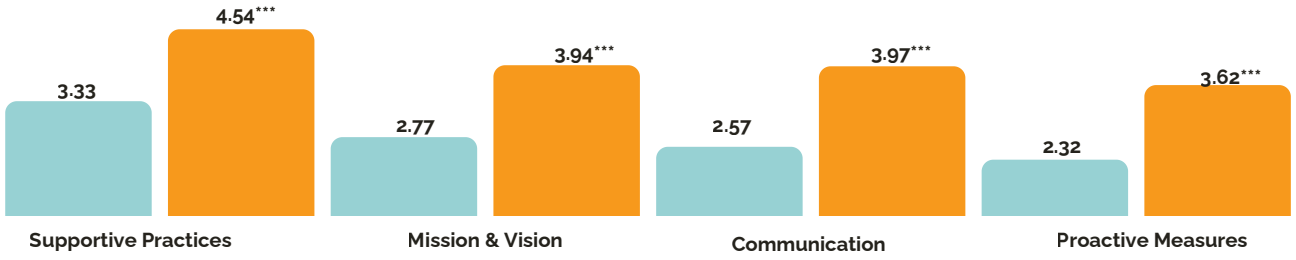
Participants were asked to consider several statements related to their knowledge of trauma and some of the trauma-related concepts covered in the program. Responses to these questions were used to develop two knowledge scales and determine an average overall level of understanding.

- The trauma **knowledge scale showed a statistically significant increase** (p<0.001) after completing the collaborative.
- An additional scale was derived from the School Implementation Leadership Scale (SILS)[4], which measures educators' confidence in their knowledge of trauma-informed care in early care and education. This **confidence in knowledge scale also revealed statistically significant positive changes** (p<0.001) after program completion.



## Leading Change

Questions from the School Implementation Leadership Scale (SILS)[4] also asked educators to consider their level of implementation of trauma-informed care practices before and after participating in the ALC. Four sub-scales were created and measured on a 5-point scale in which 1 was 'not at all,' and 5 was 'to a very great extent'. As shown in the table below, **administrators reported *significant increases*** in the extent to which they took specific steps to support the implementation of trauma-informed care practices in their programs. The highest scores were related to 'Supportive Practices,' in which participants considered the ways in which they support their school community to foster trauma-informed strategies for the children in their care. The greatest increase (by 60%) after participating was seen in the proactive measures scale, in which administrators reported on their plans to facilitate and establish clear standards and expectations to support the implementation of TI-care in their program.




## Program Satisfaction

Participants were asked to consider a series of questions designed to elicit feedback about the learning collaborative itself and determine overall satisfaction. Responses showed high levels of satisfaction as the majority of participants either agreed or strongly agreed that the learning collaborative: (1) introduced them to new ideas and information (98%), (2) incorporated various teaching techniques (100%), (3) increased their knowledge of childhood trauma (95%) and TI care (90%), (4) would recommend the learning collaborative to others (98%), and (5) believed it was a good fit for their needs (98%).

## Focus Groups

Two focus groups were conducted following the completion of the FIRST:ECE inaugural 2024-2025 ALC. Rapid coding and thematic analysis revealed saturated perceptions that the collaborative fostered systemic change and cultural shifts through structured support and community. Results further informed changes for the 2025-2026 cohort. An additional two focus groups were conducted in June 2026, with administrators and site leaders who participated in the 2025-2026 FIRST ECE Administrators Learning Collaborative (ALC). Discussions covered overall experience, most and least helpful components, facilitators and barriers to participation, knowledge gained, and suggestions for improvement. Five prominent themes emerged from these focus groups, detailed on the next page.



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| **Adults First** | The most consistent theme was a reframing of where trauma-informed work begins. Participants entered expecting to focus on children and families and left describing a sequence of self, then staff, then children and families. Several credited the collaborative with helping them recognize that staff cannot regulate children while dysregulated themselves. |
| **A Professional Network rather than Training** | Participants described the cross-site relationships as one of the most valuable outcomes, especially learning how other centers solved shared problems, comparing approaches across large and small districts. Several noted the relief of discovering their challenges were not unique to their program. |
| **Sustained Contact Changes Implementation** | Both groups noted the year-long structure as compared with typical one-day professional development. Monthly contact was described as initially feeling like accountability, and later, as a priority. This is exemplified by one program, which had staff attend the previous year's ALC, that had already scheduled standing monthly internal calls to sustain work after the collaborative ends. |
| **Concrete, Transferable Tools** | Participants named the toolkit, SMARTIE goals, the implementation stages framework, the staff survey, self-regulation and self-care practices, and "start with the why" as things they were actively using. Several described applying these to their personal life. |
| **Facilitation Modeled Through Content** | Participants described facilitators as listening closely, following up across sessions, supplying targeted resources, redirecting ideas without judgment, and extending support to site staff and parent meetings. The attention to participants' own comfort and care was repeatedly noted and used as evidence that the team practiced what it taught. |

## Professional Quality of Life & Perceived Stress

The Professional Quality of Life (ProQOL)[5] and Perceived Stress Scale (PSS) tools[6] were administered to all interested staff across 7 participating locations from cohort 1 (2024-2025). A total of 795 staff members completed the surveys about 1 year apart, from pre to post. Most had 10 or more years of experience working in an early care setting (40%) and had also worked at their current agency for 10 or more years (29%).

The ProQOL's 30 questions yield 3 scales measuring compassion satisfaction/fatigue, burnout, and secondary traumatic stress. The additional PSS yields a scale score measuring stress. All four scales produce cut scores to determine high, low, and moderate levels of each domain. Preliminary results showed small but statistically significant decreases at post on the PSS ($p=0.005$), increases in compassion satisfaction ($p=0.057$), and decreases in burnout ($p=0.092$) and secondary traumatic stress ($p=0.014$).


**References**

[1] ARTIC Attitudes Related to Trauma-Informed Care Scale. (2016). ARTIC-10 Education. Traumatic Stress Institute of Klingberg Family Centers, in partnership with Dr. Courtney N. Baker, Tulane University. www.traumaticstressinstittute.org

[2] Sherbourne CD and Stewart AL. The MOS Social Support Survey. Soc Sci Med, 1991;32(6):705-714. PMID: 2035047

[3] Halladay Goldman, J., Purbeck Trunzo, C., and Agosti, J. (2019). NCTSN Trauma-Informed Organizational Assessment. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

[4] Lyon, A. R., Corbin, C. M., Brown, E. C., Ehrhart, M. G., Locke, J., Davis, C., Picozzi, E., Aarons, G. A., & Cook, C. R. (2022). Leading the charge in the education sector: development and validation of the School Implementation Leadership Scale (SILS). Implementation Science 17(48). https://doi.org/10.1186/s13012-022-01222-7

[5] Stamm, B. H. (2009). Professional quality of life: Compassion satisfaction and fatigue subscales, Version 5 (ProQOL) [Measurement instrument]. Center for Victims of Torture. Available from ProQOL

[6] Cohen, S., Kamarck, T., & Mermelstein, R. (1983). Perceived Stress Scale [Database record]. APA PsycTests. https://doi.org/10.1037/t02889-000


*$p = 0.05^{*}$, $p = 0.01^{**}$, and $p < 0.001^{***}$*