

INTRODUCING TRAUMA-INFORMED CARE IN AN ACUTE INPATIENT
PSYCHIATRIC UNIT: A QUALITY IMPROVEMENT PROJECT

by

Evan Robert Thompson

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of the requirements for the degree

of

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ABSTRACT

Traumatic experiences are common in society and are associated with an increased risk of development of adverse physical and psychological outcomes extending throughout the lifespan. Individuals accessing mental health services, such as inpatient hospitalization, are likely to have experienced interpersonal trauma at some point during their lives. Mental health professionals are well suited to provide supportive and effective trauma-informed care (TIC) to patients with trauma histories. TIC seeks to actively resist patient re-traumatization and caregiver secondary traumatic stress. An evidenced-based trauma-informed care training was presented to mental health professionals working on a psychiatric inpatient unit. The project involved a single group pre-post test design with a 1-month follow-up assessment. Staff attitudes towards trauma-informed care were evaluated by a psychometrically validated tool (ARTIC-35). Sums of the items on the ARTIC-35 for each participant were divided by the number of items, means and standard deviations for aggregate average scores for each time point were obtained, and percent change for participant average scores between time points were calculated. Additionally, participants were asked to share if they had incorporated trauma-informed care into their work with patients and if they experienced any barriers to implementing TIC since the training. Immediately following the training, ARTIC-35 scores increased on average by 11%, demonstrating that attitudes related to trauma-informed care improved as a result of the training. One month following the training, all six participants maintained their score on the ARTIC-35, representing a 12% increase from pre-training scores and 0.61% from immediately following training. Further, all participants indicated at the 1-month follow-up assessment that they changed their practice to incorporate trauma-informed care into their work with patients. A 1-hour TIC in-service training demonstrated the ability to improve psychiatric healthcare professional's attitudes toward trauma-informed care. Healthcare organizations serving patients with traumatic histories should consider TIC training for all personnel.

CHAPTER ONE

INTRODUCTION

Trauma exposure is highly ubiquitous and it is associated with an increased risk of adverse outcomes in the domains of mental and physical health, as well as risks for police arrest, incarceration, low achievement in academics, and homelessness (Abram et al., 2004; Felitti et al., 1998; Hopper, Bassuk, & Olivet, 2010; Messina & Grella, 2006; Shonkoff et al., 2012). The Adverse Childhood Experiences (ACE) study, published in 1998, was the first study to demonstrate a graded relationship between number of categories of adverse childhood exposures and adult health risk behaviors and disease. Felitti et al. (1998) investigated the ACE categories of childhood physical, sexual, and emotional abuse, childhood physical and emotional neglect, witnessing domestic violence as a child, and living with a substance abusing, mentally ill, or incarcerated household member as a child. Recent studies that build on the seminal work of Felitti et al (1998), have included additional ACE categories, such as sibling and peer victimization, property crimes, and parental death as a child (Shonkoff et al., 2012).

Central findings of Felitti et al.'s (1998) original ACEs study revealed that ACEs are common, appear in clusters, and a dose response relationship between ACE score and negative health outcomes exists. Of the 17,000 individuals surveyed in the original study, 64% had one ACE or more; individuals who experienced one ACE were 90% more likely to experience a second ACE and 60% more likely to experience three or more ACEs (Felitti et al., 1998). Additionally, there was a dose response relationship between ACE score and negative health outcomes in areas of physical, psychological, and social

domains (Felitti et al., 1998). Trauma experienced early in life increases incident and odds ratios of an individual experiencing chronic illness, such as ischemic heart disease, chronic obstructive pulmonary disease (COPD), and diabetes; mental illness and addiction, such as anxiety disorders, mood disorders, substance use disorders, and impulse control disorders; and social impairment, such as increased work absenteeism and financial problems (Felitti et al., 1998; Shonkoff et al., 2012). Further, recent research has demonstrated that chronic illness in individuals who experience trauma appear earlier in life, which results in an increase in disease burden and decrease in quality of life (Bellis et al., 2015). Although Felitti et al. (1998) included a retrospective design that surveyed mostly middle aged adults, more recent prospective studies have demonstrated that ACEs are associated with early mortality (Liming & Grube, 2018). In extreme instances, individuals who have experienced six or more ACEs die nearly 20 years earlier than an individual with no ACEs (Liming & Grube, 2018).

Advances in neuroscience have identified that ACEs occurring at critical developmental periods can disrupt brain architecture in children, leading to direct impacts on short- and long-term health (Bremner, 2002; Heim & Nemeroff, 2002). Structural and functional alterations take place when a developing brain is exposed to significant childhood trauma (Bremner, 2002). Suppression of neural pathway development and integration between different parts of the brain, such as the cerebral cortex and limbic system, as a result of early trauma exposure, can lead to maladaptive responses to experiences and emotions, as well as impairment in mood and behavioral regulation (Bremner, 2002; Heim & Nemeroff, 2002). Additionally, individuals with

histories of traumatic experiences are more likely to adopt extreme coping strategies, such as alcohol and substance use and self-harm (Muskett, 2014).

Trauma experienced early on in life, including child abuse, neglect, household stress, and disrupted attachment, can provide the subtext for the narrative of many individual's pathways to mental illness and substance abuse. Indeed, individuals with histories of early developmental trauma make up the largest proportion of people who access public mental health, forensic health, and drug and alcohol services (Muskett, 2014). Thus, in an attempt to better meet the needs of individuals with trauma histories who are presenting to health care systems, the necessity to provide trauma-informed care (TIC) is essential. Mental health care providers at all levels are well positioned to provide supportive and effective TIC.

Conventional mental healthcare focuses on attending to the signs and symptoms of morbidity that can be easily identified. TIC provides opportunities for healthcare professionals and healthcare systems to intervene underneath the surface. Just as in the case of an iceberg, much of an individual's experience with trauma is unseen (Appendix A). TIC provides context and understanding of how trauma may be predictive of early morbidity and mortality.

One of the ways TIC may assist caregivers to respond to trauma is resilience building. Resilience transforms potential toxic stress into tolerable stress (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014b). TIC promotes the development of strong and stable relationships with caregivers, self-regulation skills, and connection with the community (SAMHSA, 2014b). Further, TIC is a

multidimensional recovery oriented approach to healthcare based on the principles of respecting patients and ensuring physical and interpersonal safety (SAMHSA, 2014b). TIC is centered on the practices of realizing the widespread impact of trauma throughout an individual's lifespan, recognizing the signs and symptoms of trauma, responding by fully integrating trauma knowledge into practices and procedures, and seeking to actively resist distress and the re-traumatization of patients and caregivers (SAMHSA, 2014a).

One of the key tenets of TIC is the recognition that caregivers who work in settings with high incidence of trauma-related events may experience secondary traumatic stress and associated compassion fatigue, decreased professional quality of life and increased work absenteeism (Hubbard, Beeber, & Eves, 2017; SAMHSA, 2014b). Failure to identify secondary traumatic stress and address underlying causes may compromise the healthcare professional's ability to obtain work-life balance and provide quality care to patients (Hubbard, Beeber, & Eves, 2017). Various studies have identified brief TIC in-services and training programs effective at increasing caregiver awareness of the pervasive impacts of trauma in healthcare settings, improving attitudes towards TIC practice, and building caregiver resilience (Muskett, 2014; Purtle, 2018).

Problem Statement

Currently, there is no trauma-informed care training offered to healthcare staff at the designated psychiatric inpatient unit located in a rural western state. According to the director of psychiatric services at the designated psychiatric inpatient unit, healthcare staff, such as nurses, psychiatric technicians, social workers, and psychiatrists, have stated trauma-informed care (TIC) has become a "buzzword" and its operationalization on the

unit is often vague and varied. The director went on to further state, healthcare workers on the unit recognize complex trauma histories contribute to the mental health issues often seen on the unit and are interested in how they can better serve patients. In other words, staff want to provide the best patient centered, trauma-informed care for patients who have experienced traumatic events throughout their lifespan, but are unsure on how to do so. Few studies have examined the maintenance of training effects of TIC trainings over time with mental health professionals (Niimura, Nakanishi, Okumura, Kawano, & Nishida, 2019). Further, there are limited studies that use standardized instruments to assess mental health professional's attitudes towards TIC within healthcare settings (Niimura et al., 2019).

The gap in healthcare worker knowledge and improvement in attitudes related to TIC at a psychiatric inpatient unit located in a rural western state can be lessened with a TIC in-service, utilizing evidence-based practice research and clinical practice guidelines. This scholarly project focuses on the delivery of an evidence-based trauma-informed care training that will be provided to interdisciplinary healthcare staff, including nurses, psychiatric technicians, social workers, recreational therapists, nurse practitioners, physician assistants, and psychiatrists.

Purpose Statement

The aim of this scholarly project is to deliver an evidence-based TIC training to mental health professionals working on a psychiatric inpatient unit to improve attitudes related to trauma and trauma-informed practices. Further, a standardized instrument will measure attitudes towards TIC implementation and adoption.

Clinical Question

(P) In mental healthcare professionals working on an acute psychiatric inpatient unit, (I) does implementing a TIC in-service, (O) improve attitudes related to trauma-informed-care (T) when evaluated immediately after and one month after the in-service training?

CHAPTER TWO

REVIEW OF THE LITERATURE

The TIC literature was reviewed by conducting a search of Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, ERIC, PsycINFO, and SocINDEX to capture relevant evidence-based literature on TIC interventions at the organization level that included a staff-training component. The literature review focused on peer reviewed outcome evaluations and excluded studies that included trauma-informed programming/interventions, direct services, and clinical care. The literature review aims were to identify characteristics of trauma-informed organizational interventions and evaluation designs, effects of trauma-informed organizational intervention on staff and client outcomes, and evaluation of temporal effects of trauma-informed organizational intervention on staff outcomes. The results of the literature review are outlined below by the following categories: development of trauma-informed curriculum and role of TIC in inpatient psychiatric settings.

Development of Trauma-Informed Curriculum

The movement toward organizational adoption of trauma-informed practice has grown significantly in recent years (Becker-Blease, 2017). While most literature involving implementation of TIC and trauma-informed policies are in mental health, substance abuse, and child welfare service sectors, enthusiasm for trauma-informed practice has spread to diverse fields, such as social policy, intellectual disability, obesity prevention, and children's sports (Bowen & Murshid, 2016; D'Andrea, Bergholz,

Fortunato, & Spinazzola, 2013; Keesler, 2014; Mason et al., 2016; Raja et al., 2015). As a result, publication of literature involving trauma-informed practice has grown significantly. In 2010, there were seven articles published that mentioned “trauma-informed” in the title, abstract, or key words; in 2016, 127 articles were published (Purtle, 2018).

The growing prevalence of organizational adoption of trauma-informed practice and its increasing relevance in peer-reviewed literature reflects widespread consensus surrounding the efficacy and importance of trauma-informed approaches to care. Organizational commitment to becoming trauma-informed starts with staff trainings. Nearly all trauma-informed care trainings described in contemporary peer reviewed literature included information about the prevalence and negative outcomes associated with trauma exposure and principles of TIC. The overarching goals of trauma-informed care trainings described in the literature were to increase staff knowledge, improve attitudes, and change behavior.

Characteristics of Trauma-Informed Organizational Interventions

The most common evaluation design utilized in TIC trainings is single group, pretest/posttest designs (Blair et al., 2017; Goetz & Taylor-Trujillo, 2012; Greenwald et al., 2008; Niimura et al., 2019). Other evaluation designs have included randomized control designs (Crale, Underwood, Parks-Savage, & Maclin, 2013) and quasi-experimental design (Borckardt et al., 2011). Intervention sites for TIC trainings are diverse, but are concentrated in child welfare agencies, psychiatric hospitals, and general medical hospitals. In a majority of studies, the training curriculum was developed by the

authors of the study or by the institution they were affiliated with. The most commonly used evidence-based trauma-informed training curriculum was Risking Connection and The National Child Traumatic Stress Network's trauma-informed training. Training lengths ranged from 1 or 2 hours to several days training.

Several studies included initiatives, in addition to staff training, to further promote organizational change. Borckardt et al. (2011) included changes to unit rules, language, and physical environment consistent with trauma-informed practices, as well as, involved patients in treatment planning. Lang, Campbell, Shanley, Crusto, and Connell (2016) included creation of a core team and subcommittee to guide trauma-informed system change, development of "trauma champions" who organized in-service monthly trainings about trauma, a wellness program to promote staff self-care, and revision of agency policies for alignment with trauma-informed practices. Blair et al. (2017) included changes to physical environment, creation of a formal review process for all seclusion and restraint events, and a checklist for staff to inform seclusion and restraint decisions.

Staff knowledge, attitudes, and behaviors relating to trauma-informed practice represent common themes in outcomes assessment. Self-report instruments varied widely. Few studies have utilized standardized and psychometrically valid instruments to assess attitudes towards TIC within healthcare settings (Niimura et al., 2019). Rather, a majority of studies have used outcome assessment tools developed by the evaluator of the study. The inconsistent use of assessment tools with validated psychometric properties limits the strength of trauma-informed organizational staff training effects.

Core Concepts of TIC

The Substance Abuse and Mental Health Service Administration (SAMHSA) has played an integral role in establishing consensus surrounding the concept of trauma. SAMHSA's conceptual framework on trauma and TIC is widely utilized by practitioners and researchers to support individuals who have experienced trauma. According to SAMHSA (2014a), "individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (p. 7). SAMHSA's concept of trauma is represented by the Diagnostic Statistical Manual of Mental Disorders (DSM-5) due to the inclusion of exposure to a traumatic or stressful event, which is required for all conditions classified as trauma or stressor related disorders.

SAMHSA (2014b) has recognized that the understanding of trauma alone is not sufficient in the quest to improve outcomes for trauma survivors. Rather, it is crucial for the healthcare provider to understand the context in which trauma is addressed and treatments are deployed. SAMHSA's trauma-informed approach is guided by four assumptions and six key principles. The four assumptions, referred to as the four R's, are realizes, recognizes, responds, and resists re-traumatization (SAMHSA, 2104a). According to SAMHSA (2014a), organizations or systems that are trauma-informed realize the widespread impact of trauma and understands potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and respond by fully integrating knowledge about trauma into

policies, procedures, and practices, and seeks to actively resist re-traumatization. Further, SAMHSA (2014a) identifies six key principles fundamental to trauma-informed care as follows: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues.

Practice Guidelines

SAMHSA's treatment improvement protocol entitled, "Trauma-Informed Care in Behavioral Health Services" is widely accepted by healthcare organizations and mental health practitioners as best practice guidelines for trauma-informed care within behavioral health services. The treatment improvement protocol is divided into two parts, a practical guide for the provision of behavioral health services (Part 1) and an implementation guide for behavioral health program administrators (Part 2). Part 1 is designed for behavioral service providers and focuses on evidenced based trauma-informed interventions, treatment principles, screening and assessment, and trauma specific services. Part 2 is designated for behavioral health administrators and focuses on building trauma-informed organizations and workforces (SAMHSA, 2014b).

The Substance Abuse and Mental Health Service Administration TIC practice guidelines also emphasize the importance of recognizing secondary traumatization and provides strategies on ways to prevent it. SAMHSA (2014b) utilizes a risks and protective factors model for understanding of secondary traumatic stress in behavioral health professionals. Risk factors, such as a prior history of personal history of trauma, high caseloads of clients with trauma related disorders, and being new to the psychiatric field with little clinical experiences, contribute to the development of secondary traumatic

stress (SAMHSA, 2014b). Protective factors, such as the lack of prior personal trauma, more clinical experience working with individuals with trauma related disorders, having specialized training in TIC, and use of positive personal coping styles, may lessen the impact of secondary traumatic stress on behavioral health professionals (SAMHSA, 2014b).

SAMHSA (2014b) describes ways behavioral health professionals and healthcare organizations can recognize the emotional, cognitive, and behavioral signs of secondary traumatic stress. Validated self-assessment tools, such as the Professional Quality of Life Scale, may provide a resource behavioral health professionals to evaluate their stress levels and identify potential signs of secondary traumatic stress (SAMHSA, 2014b). SAHHS (2014b) also describes ways for behavioral health organizations to address secondary traumatization of behavioral health professionals to dissipate acute stress and prevent long term after effects, such as development of compassion fatigue and increased work absenteeism.

Role of Trauma-Informed Care in Inpatient Psychiatric Settings

Effects of Trauma-Informed Organizational Intervention on Staff Outcomes

The effects of trauma-informed organizational interventions on staff outcomes have primarily focused on evaluating staff attitudes, knowledge, and behavior. A majority of studies evaluating these domains have found statistically significant improvement in one or more outcomes via pre/post training evaluation. Mean differences in pre-test and post-test scores generally were statistically significant but effect sizes varied based on the duration of the training. Of the trainings that included initiatives in

addition to staff training, only one study did not implement all intervention components concurrently. Borckardt et al. (2011) used a cluster-randomized design, where different units at a pediatric psychiatric hospital received components of the trauma-informed training in different order, to evaluate each component of the study independently. Borckardt et al. (2011) found no statistically significant difference in staff attitudes related to trauma-informed care.

Evaluation of Temporal Effects of TIC on Staff Outcomes

Temporal effects of trauma-informed organizational interventions on staff outcomes were generally measured 1 month after the training was completed. A majority of studies demonstrated significant improvement in staff knowledge, attitudes, and behaviors were maintained over time. For example, Niimura et al. (2019) (n= 65) found mean scores of the Attitudes Related to Trauma-Informed Care scale increased significantly immediately after the training and were retained after 3 months. Further, at the 3-month follow-up, participants claimed to have implemented trauma-informed practice daily in their clinical setting (Niimura et al., 2019).

Effects of Trauma-Informed Organizational Intervention on Client Outcomes

Few studies evaluating the effects of trauma-informed organizational interventions on client outcomes within psychiatric inpatient settings have been published. Of the few that were found, the results were mixed. A majority of the studies evaluating trauma-informed organizational interventions within psychiatric settings evaluated effects on incidence of seclusion and restraint or patient perceptions of care. Blair et al. (2017) (n= 11,913) found significant reduction in the incidence of seclusion at

a psychiatric hospital (9.2 per 100 admissions vs. 4.4 per 100 admissions, $p < 0.01$) two years after implementation of a TIC training intervention. In a cluster randomized control trial, Borckardt et al. (2011) ($n=340$ staff and 446 patients) observed a significant reduction of 82.3% ($p=0.008$) in the rate of seclusion and restraint but found no statistically significant improvement in client perception of staff's trauma sensitivity after implementation of a trauma-informed intervention for healthcare staff at a psychiatric hospital.

Theoretical Framework

The theoretical framework utilized in this scholarly project is Rosswurm and Larrabee's Model for Evidence-Based Practice change. Developed in 1999, Rosswurm and Larrabee's Model for Evidence-Based Practice change guides nurses and healthcare professionals with systematic processes supporting integration of evidence-based literature into practice. Further, the model was designed to follow a series of steps to help practitioners identify need for change in practice, link problem interventions and outcomes, appraise and synthesize the best evidence, design practice change and translate the best evidence into practice, and integrate and maintain change (Rosswurm & Larrabee, 1999).

The first step in Rosswurm and Larrabee's Model for Evidence-Based Practice change is to assess the need for change in practice. This is accomplished through identification and engagement of stakeholders in the practice site, collection of pertinent internal data surrounding the clinical problem, and comparing internal and external data (Rosswurm & Larrabee, 1999). This project was initiated by the director of psychiatric

services at the designated healthcare system voicing concern about the lack of TIC on the inpatient unit and identifying the need for an evidenced based TIC training for the healthcare professionals working on the unit. Stakeholders, such as the nurse manager, assistant nurse manager, charge nurses, and nurse working groups on the unit were engaged early on and they expressed enthusiasm for integration of trauma-informed practices into the adult and adolescent inpatient psychiatric unit. Unfortunately, the site hasn't collected internal data on staff attitudes, knowledge, or behaviors surrounding trauma-informed practice. Stakeholders at the clinical practice site have acknowledged the need to address this gap in patient care practices. Informal interviews of staff at the clinical practice site reveal that trauma-informed care has become a "buzzword" and its operationalization is often vague and varied.

The next step in the theoretical framework is to link problem interventions and outcomes. This is accomplished through the use of standardized classification systems and language, identification of potential interventions and activities, and selection of outcome indicators (Rosswurm & Larrabee, 1999). A single definition of trauma-informed care and associated principles do not exist in the literature, creating challenges in the evaluation of specific interventions (Purtle, 2018). The use of specific language and classification systems to identify interventions as trauma-informed will allow translation methods and outcomes to be replicated and applied to a body of evidence (Purtle, 2018). As demonstrated in the literature review, trauma-informed learning interventions and activities, as well as outcome indicators, vary widely. This project will

utilize evidence-based research from peer-reviewed literature and a psychometrically validated outcome evaluation tool to link problem interventions and outcomes.

The third step of the theoretical framework involves synthesizing best evidence. This is accomplished through an extensive search of the literature related to major variables of the clinical problem and associated target intervention (Rosswurm & Larrabee, 1999). In this project, relevant evidence-based literature on TIC interventions at the organization level that included a staff-training component were reviewed. Critical review of the literature is also key to synthesizing the best evidence. Selection of literature was limited to articles published in peer-reviewed journals with specific exclusion criteria.

The fourth and fifth steps to the model are designing the practice change and implementing and evaluating change in practice, respectively. Designing the practice change is accomplished by clearly defining the proposed change, identification of the needed resources, planning of the intervention process, and defining outcomes. Implementation and evaluation of the practice change are accomplished by conducting the study and evaluating the process and outcomes (Rosswurm & Larrabee, 1999).

In this project, the proposed change is to improve staff attitudes related to TIC. Stakeholders of the psychiatric unit, including the director of psychiatric services at the designated healthcare organization, nursing manager, assistant nursing manager, and social work manager were identified and engaged early on in the planning of the intervention. Stakeholders provided guidance and needed resources for the project. Key

outcomes were identified as TIC knowledge attainment and attitudes of TIC and these will be measured pre-in-service, post-in-service, and one-month post in-service.

The last step to the model is integration and maintenance of the change in practice. This is accomplished by communicating recommended changes to stakeholders, presentation of change in practice to staff via in-service education, integration of change into standards of practice, and monitoring of process and outcome data (Rosswurm & Larrabee, 1999). Stakeholders were briefed on the results of the study and were provided recommendations on changes to practice.

CHAPTER THREE

METHODS FOR PROJECT IMPLEMENTATION

Project Design

The project involved a pre-post design with a 1-month follow-up assessment. Interdisciplinary healthcare staff members employed by a large healthcare organization, including nurses, psychiatrists, nurse practitioners, physician assistants, social workers, certified nursing assistants, recreational therapists, and dieticians were invited to the one-hour training approximately one month before the in-service via an email announcement sent to all employees in the organization who work on the psychiatric inpatient unit. Healthcare staff who signed up for the training by responding via email were asked to complete the ARTIC-35 scale one week prior to the training date. Participants of the project completed the ARTIC-35 scale immediately after the training and 1 month after the training. Additionally, at the 1-month follow-up assessment, participants were asked if they incorporated TIC into their practice; if yes, what trauma-informed care they delivered; and any received barriers to TIC implementation.

Ethical Considerations

The project was approved by the Montana State University's Institutional Review Board (IRB) and Providence Health and Services IRB. Attendees of the in-service were informed of the purpose of the quality improvement scholarly project as well as risks and benefits to participation. Attendees engaged in the in-service on a voluntary basis and

were paid their usual hourly rate while attending the in-service, per the permission of the Director of Psychiatric Services.

Evidence-Based Trauma-Informed Care Training

The content of the training was based on current evidence-based literature surrounding TIC. The training included information on the psychological and physiological effects of trauma, core concepts of TIC, strategies to avoid re-traumatization and foster a culture of safety, best practice guidelines, strategies to recognize secondary traumatic stress, strategies to reduce the impacts of secondary traumatic stress, and strategies to promote self-care of behavioral healthcare workers.

Measures

Participant demographic characteristics, including sex, age, job category, and years in the psychiatric field were collected at the beginning of the training. The Attitudes Related to Trauma-Informed Care scale-35 (ARTIC-35) was administered 1 week before the training, post-training, and 1-month follow-up via pencil and paper method. The ARTIC-35 includes five core subscales: underlying causes of problem behavior and symptoms, responses to problem behavior and symptoms, on the job behavior, self-efficacy at work, and reactions to the work. The five subscales evaluate attitudes towards TIC implementation. Mean scores of overall items were calculated as the primary outcome. ARTIC-35 mean scores range from 1-7, with higher scores indicating more favorable attitudes towards trauma-informed care. The ARTIC-35 has demonstrated good internal consistency, 0.91, and good test-retest reliability, 0.75 (Baker

et al., 2016). Permission to use the ARTIC-35 scale was granted by the Traumatic Stress Institute, authors of the scale.

Statistical Analysis

Given the scope of this Doctor of Nursing Practice project and the small sample size, descriptive statistics were used to describe participant characteristics and changes in ARTIC-35 scores over time. Data from participant responses to the ARTIC-35 scale were entered into EXCEL for Mac 2020. For each data set, the following analyses were conducted: (i) the sum of the items on the ARTIC-35 for each participant divided by the number of items (i.e., 35), (ii) mean and standard deviation for average scores for each time point obtained, and (iii) and percent change for participant average scores between time points were calculated. Participant characteristics including sex, age, job category, and years in the psychiatric field are summarized in a demographic table.

CHAPTER FOUR

RESULTS

Participant Characteristics

A total of six mental health professionals, three registered nurses and three social workers, participated in the TIC training. All of the participants identified their gender as female. Thirty-three percent of participants were between the ages of 30-39 years and 67% of the participants were between the ages of 40-49 years. Mean years worked in the psychiatric field was 12.5 (SD= 7.2). The details of participant characteristics are displayed in Table 1.

Table 1. Participant demographics.

Demographic characteristics	n	%
Age in years (30-39)	2	33
Age in years (40-49)	4	67
Female	6	100
Social Worker	3	50
Registered Nurse	3	50
Years worked in psychiatric field, mean (SD)	12.5	7.2

SD, standard deviation.

Outcomes of Training Program

Data were collected at three points: (1) one week prior to the training; (2) immediately post training; and 1 month post-training. Of the six mental health professionals who participated in the TIC training, group ARTIC-35 mean scores increased from 5.9 (SD= 0.37) at pre-training to 6.57 (SD = 0.35) immediately after the

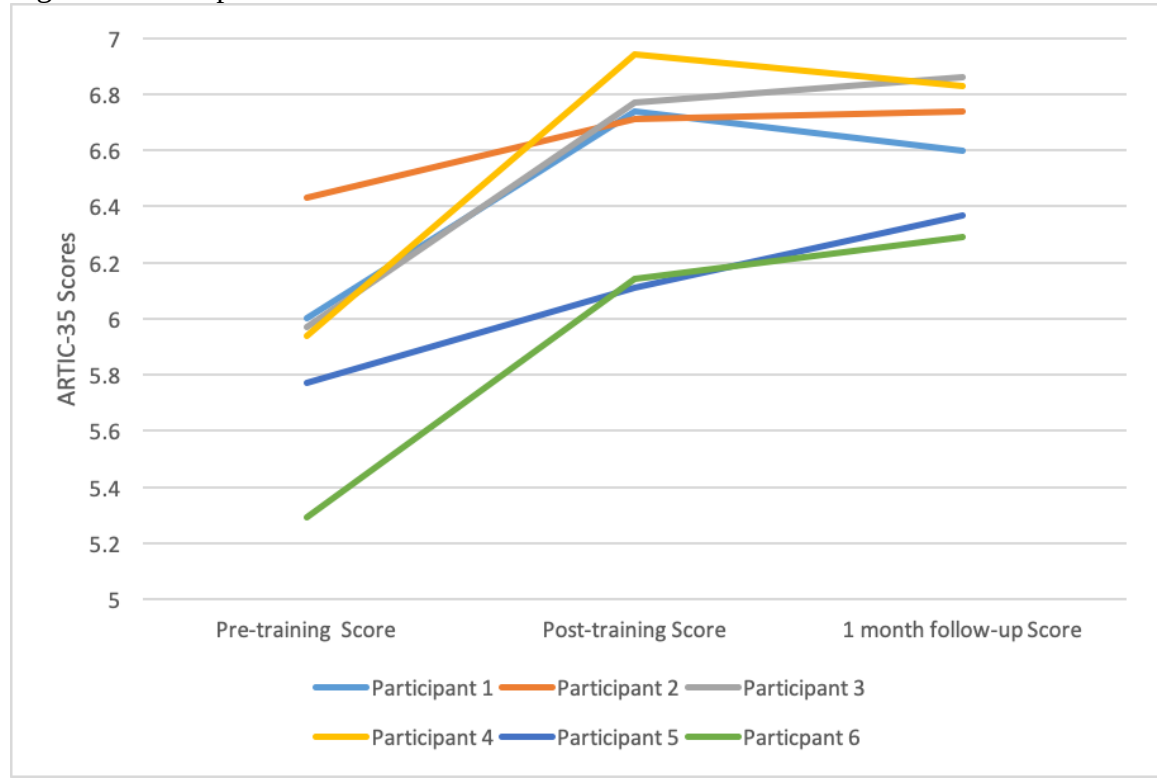
training, and 6.61 (SD= 0.24) at the 1-month follow-up assessment. Every participant's pre-training ARTIC-35 score increased from pre-training to post-training and pre-training to 1-month follow-up assessment. Four participants' ARTIC-35 scores increased slightly from post-training to 1-month follow-up. Two participants' ARTIC-35 scores slightly decreased from post-training to 1-month follow-up.

Table 2. Attitudes Related to Trauma-Informed Care (ARTIC) over time.

Training cohort	Pre-training score	Post-training score	1-month follow-up score	Percent Change		
				Pre-training-Post-training	Pre-training vs. 1-month follow-up	Post-training vs. 1-month follow-up
Participant 1	6	6.74	6.6	12.33	10	-2.01
Participant 2	6.43	6.71	6.74	4.35	4.82	0.45
Participant 3	5.97	6.77	6.86	13.4	14.91	1.33
Participant 4	5.94	6.94	6.83	16.84	14.98	-1.59
Participant 5	5.77	6.11	6.37	5.89	10.39	4.26
Participant 6	5.29	6.14	6.29	16.07	18.9	2.44
Mean (SD) Score	5.9 (0.37)	6.57 (0.35)	6.61 (0.24)			

SD, standard deviation

Figure 1. Participant ARTIC-35 mean scores over time.



ARTIC-35, Attitudes Related to Trauma-Informed Care

Clinical Practice and Barriers to TIC

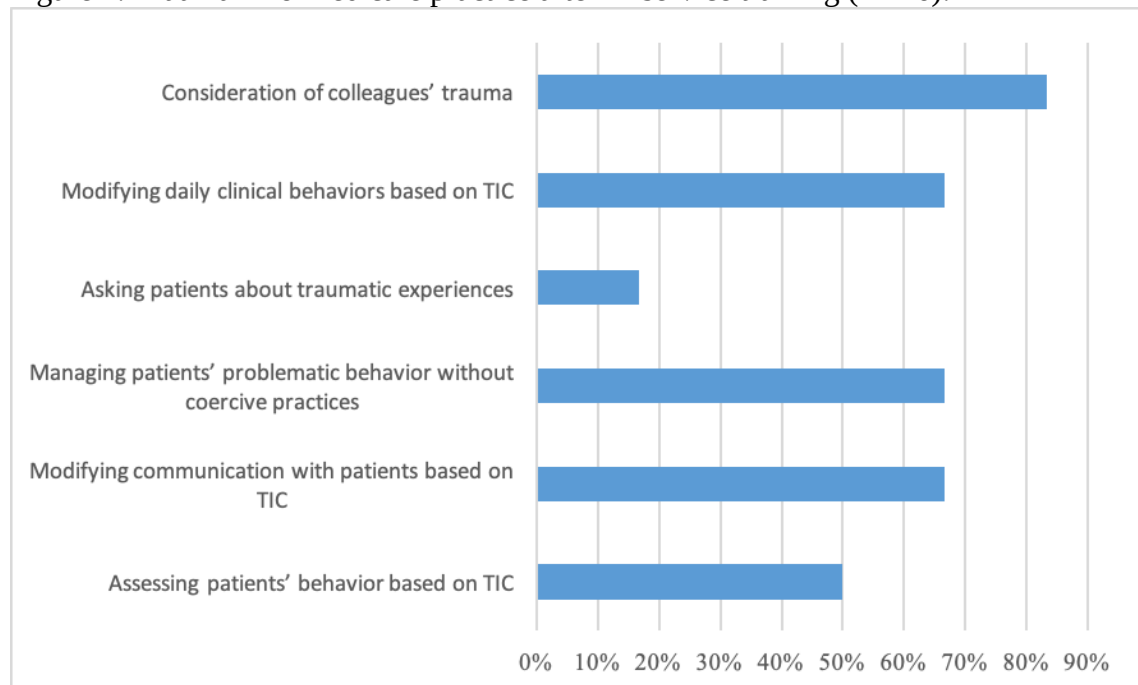
Participants of the trauma-informed care training were asked at the 1-month follow-up assessment if since attending the training, have they at any time changed their practice to incorporate trauma-informed care into their work. Of the six participants who participated in the 1-month follow-up assessment, all six reported they had incorporated trauma-informed care into their work with patients. The most frequently reported clinical practice was “consideration of colleagues’ trauma” (83.33%). The second most common responses were “modifying communication with patients based on TIC” (66.67%), “managing patients’ problematic behavior without coercive practices” (66.67 %), and “modifying daily clinical behaviors based on TIC” (66.67 %).

Table 3. Trauma-informed care practice after in-service training (N = 6).

Practice items +	n	%
Assessing patients' behavior based on TIC	3	50
Modifying communication with patients based on TIC	4	66.67
Managing patients' problematic behavior without coercive practices	4	66.67
Modifying physical environment (e.g. pamphlets, posters, and interview rooms in hospital) based on TIC	0	0
Asking patients about traumatic experiences	1	16.67
Sharing information on TIC with colleagues	0	0
Modifying daily clinical behaviors based on TIC	4	66.67
Consideration of colleagues' trauma	5	83.33
Other	0	0

+ Multiple answers were possible. TIC, Trauma-informed care

Figure 2. Trauma-informed care practice after in-service training (N = 6).



Participants of the trauma-informed care training were asked at the 1-month follow-up assessment if, since attending the training, have they experienced any barriers to implementing TIC. Only two out of the six participants indicated they had experienced implementation barriers. One of the participants felt they have “limited

skills and/or experience with TIC” and one participant indicated they “lack opportunities to try TIC in clinical settings.”

Table 4. Trauma-informed care implementation difficulties among participants (N = 6).

Barriers +	n	%
Limited skills and/or experience with TIC	1	16.67
Difficulties in sharing information regarding TIC with colleagues	0	0
Correcting patient behavior based on TIC can be a time consuming process	0	0
Time constraint and/or staff shortages	0	0
Lack of opportunities to try TIC in clinical settings	1	16.67
Other	0	0

+ Multiple answers were possible. TIC, Trauma-informed care

CHAPTER FIVE

DISCUSSION

In this scholarly project, a TIC training was developed from peer reviewed and evidence based literature, then implemented via a two hour training for mental health professionals currently working on an acute psychiatric inpatient unit. Attitudes related to trauma-informed care were measured via a standardized measure at multiple time points, including pre-training, immediately post-training, and 1 month follow up. Prior to the TIC training, all six participants scored above a 5 on the ARTIC-35, with scores ranging from 5.29 to 6.43, meaning all participants generally had favorable attitudes toward TIC. Participant differences in attitudes toward TIC prior to the training, despite working on the same inpatient psychiatric unit, may be explained by a host of factors, such as differences in life experiences or differences in experience caring for individuals who've experienced trauma.

Immediately following the training, ARTIC-35 scores increased on average by 11.32%. Percent change in ARTIC-35 scores, pre-training to post training, ranged from 4.35% to 16.07%. Variation in percent change among participants may be due to differences in prior exposure to TIC education. Increase in participant ARTIC-35 scores demonstrates that attitudes related to trauma informed care may have improved as a result of the training. One month following the training, participant's ARTIC-35 scores slightly increased, representing a 12% increase from pre-training scores and 0.71% increase from post-training scores. Further, all of the participants reported changing their practice to incorporate trauma informed care into their work with patients at the 1 month follow up

assessment. However, attitudes toward TIC did not vary much from immediately following the training to the one-month follow up assessment. This may be due to already having very favorable attitudes toward trauma informed care after the training or perhaps more time and experience was needed practicing TIC for attitudes to increase further.

Consistent with previous literature, the trauma-informed care training increased participant favorable attitudes toward TIC (Lotzin et al., 2018; Niimura et al., 2019; Palfrey et al., 2018; Williams & Smith, 2017). This scholarly project added to the small number of studies that have utilized a standardized measure with multiple assessment time points. As suggested by Lotzin et al. (2018) and Niimura et al. (2019), the results of the scholarly project indicate effects of the TIC training were retained over time. Further, consistent with previous studies that investigated change in clinical practice as a result of TIC trainings, the findings from this scholarly project suggest a brief TIC training may influence healthcare workers to incorporate TIC practices into their interactions with patients (Lotzin et al., 2018; Palfrey et al., 2018).

While this scholarly project solely measured attitudes related to trauma-informed care, other studies have measured how TIC training affects confidence, awareness, and knowledge related to TIC (Lotzin et al., 2017; Palfrey et al., 2018). Lotzin et al. (2018) found trauma knowledge, attitudes toward trauma inquiry, and confidence in trauma inquiry were significantly higher in for healthcare professionals who participated in 1-day TIC training (intervention group) compared to healthcare professionals who didn't (control). As a result, frequency of asking patients about exposure to traumatic events were significantly higher in the intervention group compared to control group (Lotzin et

al., 2018). Palfrey et al. (2018) found a significant increase in healthcare professional self-rated confidence, awareness, and attitude towards trauma-informed practice after attending a 4-day TIC workshop.

Limitations

This scholarly project was subject to several limitations. The project was only offered one time at one hospital located in Montana, and therefore the findings may not be generalizable to other regions. The small sample size ($n = 6$) and lack of diversity among participants should also be considered when appraising generalizability. The pre-test post-test design lacked a control group, further limiting generalizability of the findings. Furthermore, selection bias may have occurred in this project, as all participants participated voluntarily and presumably had a high interest in TIC. All participants' ARTIC-35 scores were favorable prior to the training. Participants of this project volunteered and may have been ready for attitude change before attending the training. Future studies should evaluate organizational implementation of TIC. Although participants were asked at the 1 month follow up if they changed their practice since the TIC training to incorporate TIC into their work with patients, no objective measures of clinical care were measured in this study. Future studies should evaluate the impact of TIC training on clinical practice.

Implications for Practice

This scholarly project demonstrates that a brief TIC in-service training may be associated with improving psychiatric healthcare professionals attitudes towards TIC.

Although participants in this scholarly project had considerable experience in the psychiatric profession, they showed favorable changes in their attitudes towards TIC immediately after the training and this favorable change was sustained 1 month post-training. Further, all of the participants indicated they had changed their practice to incorporate trauma-informed care into their work with patients at the one month follow up assessment.

Healthcare organizations should consider incorporating TIC training into staff orientation training for newly hired staff, as well as, continuing education for healthcare professionals throughout their employment. As demonstrated in this scholarly project, a TIC training may encourage healthcare professionals to modify their daily clinical practices by assessing patients' behavior based on TIC, modifying communication with patients based on TIC, managing patients' problematic behavior without coercive practices, and considering their colleague's trauma. These changes in healthcare professional clinical behavior may improve the delivery of supportive and effective TIC and decrease the occurrence of patient re-traumatization in healthcare facilities.

Influence on DNP Practice

Several essentials of doctoral education for advanced nursing practice outlined by the American Association of Colleges of Nursing (AACN) (2006) influenced this project. From its inception, the scholarly project was informed by scientific underpinnings of the interactions between human health and the environment. While developing the TIC training curriculum, special consideration was given to the interactions between physical, social, emotional, and developmental environments of individuals experiencing trauma.

Current nursing science with knowledge of biophysical and psychosocial health was integrated to curate training content to improve psychiatric healthcare professionals attitudes towards TIC (AACN, 2006).

The scholarly project utilized knowledge of organizational and systems leadership for quality improvement and systems thinking (AACN, 2006). The TIC training content was created, implemented, and evaluated to meet the current and future needs of patients hospitalized on an acute inpatient psychiatric unit. Rosswurm and Larrabee's model for evidence based practice change provided structure and guidance for the quality improvement project. First, the need for change in practice was assessed by identifying and engaging stakeholders at the practice site. Once the clinical problem was identified, problem interventions and intended outcomes were linked. For this scholarly project, the problem intervention was a TIC training and the intended outcome was improvement in healthcare profession's attitudes related to TIC.

Finally, the scholarly project was informed by nursing clinical scholarship and analytical methods for evidenced-based practice (AACN, 2006). This involved the translation of evidence surrounding TIC into practice, as well as the dissemination of new knowledge into practice (AACN, 2006). To accomplish this, analytic methods were used to critically appraise existing TIC literature to determine and implement best evidence for practice (AACN, 2006). Next, a TIC training was designed, implemented, and evaluated. Outcomes of this scholarly project will guide further improvements to clinical practice and practice environment at the designated psychiatric inpatient unit.

Future clinical practice will be informed by the methodical approach taken in this scholarly project. From initial conceptualization of the scholarly project to final outcome evaluation, a stepwise approach guided by Rosswurm and Larrabee's theoretical model was taken. Key steps involved in creating evidence based practice change, such as assessing need for change, synthesizing available evidence-based literature, and linking problem interventions and outcomes will be utilized for various clinical problems. Montana State University's Doctor of Nursing Practice program has provided this writer with the foundation for future leadership in the analysis of complex practice and organizational issues, as well as the ability to function in an expert consultative role among intraprofession and interdisciplinary healthcare teams.

Conclusion

Trauma is prevalent and has significant impact on physical and psychological health outcomes extending throughout the lifespan. Individuals accessing mental health services, such as inpatient hospitalization, are likely to have experienced interpersonal trauma at some point during their lives. Mental health professionals are well positioned to provide supportive and effective trauma-informed care (TIC) to patients with trauma histories. TIC trainings can help psychiatric health care professionals improve their delivery of clinical care by realizing the widespread impact of trauma and understanding potential paths to recovery; recognizing the signs and symptoms of trauma of their patients and co-workers; respond fully by integrating knowledge of TIC into their practice; and actively resisting re-traumatization. A 1-hour TIC in-service training demonstrated the ability to improve psychiatric healthcare professional's attitudes toward

trauma-informed care. Healthcare organizations serving patients with traumatic histories should consider TIC training for all personnel.

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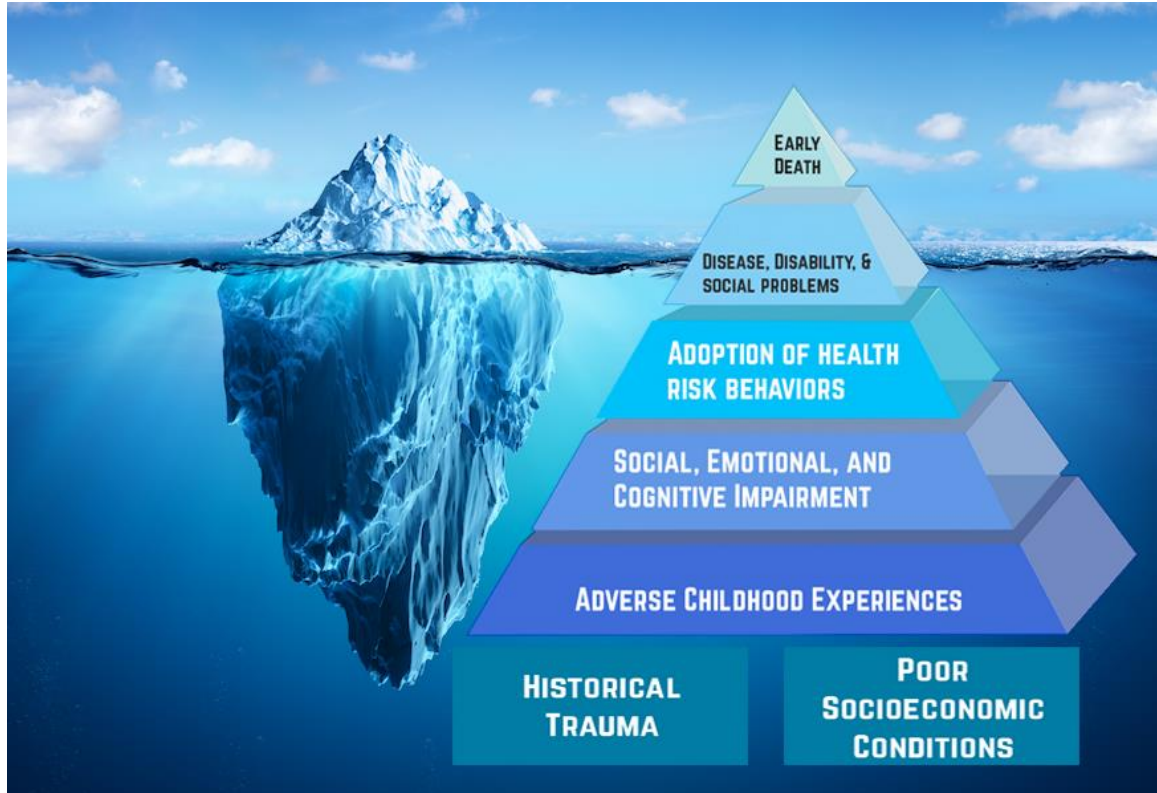
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APPENDICES

APPENDIX A

ICEBERG MODEL



APPENDIX B

REVIEW OF THE EVIDENCE

Author (year)	Study Design, Population, Setting, Follow-Up	Intervention	Outcomes and Measures	Results
Blair et al. (2017)	Study design: Single group pretest/posttest, N= 11,913 Population/setting: Patients admitted to a psychiatric hospital Follow-up: 2 years	Two-day Risking Connection training, 8-hour crisis intervention course	Seclusion and restraint events	Significant reduction in rate of seclusion events (9.2 per 100 admissions vs. 4.4 per 100 admissions)
Borckardt et al. (2011)	Study design: Randomized control trial N= 340 staff, 446 patients Population/setting: staff and patients at a pediatric psychiatric hospital Follow-up: 3.5 years	Trauma-informed training, changes to the unit rules and language, changes to physical environment, and involvement of patients in treatment planning	Seclusion/restraint event, trauma sensitivity rating among patients and staff	Significant reduction in rate of seclusion events (82.3%), no significant change in patient or staff trauma sensitivity rating
Goetz & Taylor-Trujillo (2012)	Study design: Single group pre-test/post-test Population/setting: staff and patients at a	Two-day trauma-informed care training	Staff outcomes: staff injuries and staff perception of safety Patient outcomes: seclusion hours, restraint hours, and	Staff outcomes: staff injuries reduced by 48% in first year post implementation, staff perception of safety improved in half of measured areas in first year

	psychiatric hospital Follow-up: 1, 2, 3 years		number of aggressive patient incidents	post implementation. Patient outcomes: seclusion hours, restraint hours, and aggressive patient incidence reduced by roughly 50% in first year post implementation.
Greenwald et al. (2012)	Study design: Single group pretest/post-test N= 48 Population/setting: Residential psychiatric hospital Follow-up: 1 year	Nineteen-day TIC training over 9 months	Rating of problem severity, measured by self-report scale, number of days in inpatient treatment, discharge to lower level of care	Significant decrease (34%) in rating of problem severity, significant reduction (39%) in days of treatment, and significant reduction (33%) in discharge to higher level of care
Lotzin et al. (2017)	Study design: Randomized control trial N= 148 Population/setting: Substance use disorder providers working in outpatient clinics	One-day TIC training and short refresher session at 3-month follow-up	Frequency of asking patients about trauma exposure; knowledge of traumatic stress; attitudes toward trauma inquiry; and confidence in trauma inquiry and response	Increases in frequency of asking patients about exposure to traumatic events were significantly higher in intervention group compared to control group and increase was retained at 6-month follow-up. Trauma knowledge, attitudes toward trauma inquiry, and confidence in trauma inquiry were significantly higher in intervention group

				compared to control group at 3- and 6-month follow-up.
Palfrey et al. (2018)	Study design: Single group pre-test/post-test design N= 121 Population/setting: Nursing, medical, and allied health professional working in a mental health setting in Australia	Four day-long TIC workshops were conducted between July 2013- 2015	Five-item measure of self-rated confidence, awareness and attitude towards trauma-informed practice; six-item checklist of perceived barriers to working with clients affected by trauma; three qualitative questions on post training questionnaire (most important clinical aspects of training, intended changes to clinical practice, participant further training needs)	Significant increase in mean scores for self-rated confidence, awareness, and attitude towards trauma-informed practice.
Niimura et al. (2019)	Study design: Single group pretest/post-test with 3-month follow-up N= 65 Population/s etting:	3.5 hour TIC training with 1-hour group discussion	Attitudes Related to Trauma-Informed Care (ARTIC) scale, participant behavioral changes in clinical	ARTIC mean scores significantly increased at post training and 3-month follow-up assessment, 48% of participants reported to implement TIC

	Mental health professionals working in psychiatric hospitals in Japan		practice, and barriers to TIC	practice at 3-month follow-up.
Williams & Smith (2017)	Study design: Single group quality assurance project with 12-month follow-up N= 271 Population/setting: Clinicians and managers from public mental health and drug and alcohol services in Western Australia	1-day TIC training for clinicians and half day training for managers	On-line self-report questionnaire examining the impact of the training on participants' values, attitudes and knowledge in relation to TIC; the extent to which participants had been able to implement the principles of TIC into their clinical practice; the extent to which participants had been able to bring about changes in practice in their workplaces as a result of training; the extent to which participants supported the development of a Statewide strategy to embed the	Training had “high level of positive impact awareness, knowledge and attitudes towards TIC for both clinicians and managers. 37% of respondents to the 12-month survey indicated they had “significantly or very significantly” implemented TIC in their practice setting 12 months post-training.

			principles of TIC into services, and factors that helped or hindered implementation	
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TIC, trauma-informed care

APPENDIX C

SUBJECT CONSENT FORM FOR PARTICIPATION

**SUBJECT CONSENT FORM FOR PARTICIPATION IN HUMAN RESEARCH AT
MONTANA STATE UNIVERSITY**

Project Title: Introducing Trauma-Informed Care in an Acute Inpatient Psychiatric Unit: A Quality Improvement Project.

You are being asked to participate in an educational project to understand if training on trauma-informed care and practices is effective at improving healthcare worker attitudes related to trauma-informed care and practices in an acute inpatient psychiatric unit.

Rationale of research: This project may help us to obtain a better understanding of the effectiveness of this particular trauma-informed care educational program. Your participation may also help us to better understand the need for this type of training for healthcare workers.

Procedures involved: Participation is voluntary. If you agree to participate you will be asked to complete a questionnaire one week before the in-service education, after the in-service education, and one month after the in-service education. Participation is voluntary and you can choose to not answer any questions you do not want to answer and/or leave the in-service training at any time. The participation or non-participation will not affect the employee's employment standing.

Risks and Benefits: There are minimal risks associated with participating in this educational project. Due to the sensitized nature of the content, it may make participants feel uncomfortable or evoke participant's emotions surrounding trauma experienced by patients, co-workers, or themselves. Licensed Clinical Social Workers employed through Providence Health and Services will be on-site and will be available to debrief with participants of the training if needed. The benefits associated with participation in this project are the possibility of improved knowledge and understanding of trauma-informed care and practices in psychiatric settings.

Source of funding: None

Confidentiality: Your responses will in no way be tied to your personal demographic information. All possible attempts to maintain your privacy will be completed. Your participation is at no cost to you as the participant.

Please feel free to contact me with any questions you may have:

Evan Thompson, RN, BSN

Evan.thompson@msu.montana.edu

If you have additional questions about the rights of human subjects you can contact the Chair of the Institutional Review Board, Mark Quinn, (406) 994-4707 [mquinn@montana.edu].

AUTHORIZATION: I have read the above and understand the discomforts, inconvenience and risk of this study. I, _____ (*name of subject*), agree to participate in this research. I understand that I may later refuse to participate and that I may withdraw from the study at any time. I have received a copy of this consent form for my own records.

Signed: _____

Investigator: _____

Date: _____

APPENDIX D

PARTICIPANT DEMOGRAPHIC INFORMATION

Participant Demographic Information

Age: 18-29 _____ 30-39 _____ 40-49 _____ 50-59 _____ 60- 69 _____ 70 + _____

Sex: _____

Profession: _____

Years worked in the Profession: _____

APPENDIX E

TRAUMA-INFORMED CARE PRACTICE AFTER TRAINING

Since attending the in-service, have you at any time changed your practice to incorporate trauma-informed care into your work with patients?

_____ Yes

_____ No

If yes to the above, please indicate the trauma-informed care you delivered.

_____ Assessing patients' behavior based on TIC

_____ Modifying communication with patients based on TIC

_____ Managing patients' problematic behavior without coercive practices

_____ Modifying physical environment (e.g. pamphlets, posters) based on TIC

_____ Asking patients about traumatic experiences

_____ Sharing information on TIC with colleagues

_____ Modifying daily clinical behaviors based on TIC

_____ Consideration of colleagues' trauma

_____ Other, please describe:

APPENDIX F

BARRIERS TO TRAUMA-INFORMED CARE PRACTICE

Since attending the in-service, have there been any barriers to implementing TIC?

_____ Yes

_____ No

If yes, please indicate barriers to implementing TIC?

_____ Limited skills and/or experience with TIC

_____ Difficulties in sharing information regarding TIC with colleagues

_____ Correcting patient behavior based on TIC can be a time consuming process

_____ Time constraint and/or staff shortages

_____ Lack of opportunities to try TIC in clinical settings

_____ Other, please describe:

APPENDIX G

MONTANA STATE UNIVERSITY IRB APPROVAL



INSTITUTIONAL REVIEW BOARD
For the Protection of Human Subjects
FWA 00000165

2155 Analysis Drive
 c/o Microbiology & Immunology
 Montana State University
 Bozeman, MT 59718
 Telephone: 406-994-4706
 FAX: 406-994-4303
 E-mail: cherylj@montana.edu

Chair: Mark Quinn
 406-994-4707
 mquinn@montana.edu
 Administrator:
 Cheryl Johnson
 406-994-4706
 cherylj@montana.edu

MEMORANDUM

TO: Evan Thompson and Julie Alexander-Ruff

FROM: Mark Quinn *Mark Quinn CJ*
 Chair, Institutional Review Board for the Protection of Human Subjects

DATE: December 13, 2019

RE: "Introducing Trauma-Informed Care in an Acute Inpatient Psychiatric Unit: A Quality Improvement Project"
 [ET121319-EX]

The above research, described in your submission of December 12, 2019, is exempt from the requirement of review by the Institutional Review Board in accordance with the Code of Federal regulations, Part 46, section 101. The specific paragraph which applies to your research is:

- ☐ (b) (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
- ☒ (b) (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation; and (iii) the information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by section 16.111(a)(7).
- ☐ (b) (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
- ☐ (b) (4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available, or if the information is recorded by the investigator in such a manner that the subjects cannot be identified, directly or through identifiers linked to the subjects.
- ☐ (b) (5) Research and demonstration projects, which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.
- ☐ (b) (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed, or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the FDA, or approved by the EPA, or the Food Safety and Inspection Service of the USDA.

Although review by the Institutional Review Board is not required for the above research, the Committee will be glad to review it. If you wish a review and committee approval, please submit 3 copies of the usual application form and it will be processed by expedited review.

APPENDIX H

PROVIDENCE IRB DETERMINATION



PROJECT DETERMINATION

Date: 30 January, 2020

To: Evan Thompson

From: Andrew McKelvey, CIP, Social/Behavioral IRB Analyst

Project Title: INTRODUCING TRAUMA-INFORMED CARE IN AN ACUTE INPATIENT PSYCHIATRIC UNIT: A QUALITY IMPROVEMENT PROJECT

This represents the IRB determination for the above referenced project. The IRB has determined that this project, as submitted, does not meet the definition of human subjects' research and does not require IRB review as defined in the federal regulations. The determination is based upon the information submitted only, revisions must be submitted to the IRB prior to implementation.

This determination does not exempt you from following hospital policies and procedures as they relate to conduct of this project. It is your responsibility to ensure compliance with those policies.

If you have questions related to this determination please contact Andrew McKelvey at 206-215-6277 or via email at andrew.mckelvey@swedish.org.

If you have questions related to QI/PI/EBP review, please contact us at:
PSJHIRBDetermination@providence.org

Project Leads/Student Faculty-Advisors/Providence Sponsors must comply with all the following

- Conduct your project in accordance with the information submitted to and reviewed by the IRB.
- All revisions to this project must be submitted to the IRB prior to implementation.
- Students **cannot** directly access any Protected Health Information (PHI) through Epic or any other database, this must be completed by the Providence Sponsor.
- All PHI and confidential PSJH information must remain on a PSJH campus and on a PSJH secure computer.
 - PHI and confidential PSJH information must not be recorded on personal computers or other electronic devices including USBs, smartphone (including taking pictures of data), emailing information to a personal e-mail account.
 - Paper copies of PHI cannot leave the PSJH facility.
- Project results that leave PSJH for inclusion in a poster/paper presentation/publication must be in aggregate (summary statistics) form only and/or be de-identified. There must be no way to link the data to a patient, either alone or in combination with other information.
- Failure to comply with PSJH integrity, compliance, privacy and security standards and requirements will result in appropriate corrective action.
- This project may be audited.

APPENDIX I

PROVIDENCE ADMINISTRATIVE APPROVAL OF RESEARCH PROPOSAL

Providence Montana
Recommendation for Administrative Approval of Research Proposal

Study Title: Trauma Informed Care in NBMI

Researcher: Evan Thompson, RN, BSN, DNP Candidate

Date Submitted for Review: 1-09-2020

To assure alignment with organizational goals and processes, the Nursing Research Council reviews research requests and makes a recommendation to Administration, who must give approval before any study can be initiated. The following guidelines are considered:

Criteria	Met?
The study has been developed/guided by an experienced researcher.	Yes, working with faculty
The research question is compatible with mission, values, and ethical standards of Providence St. Patrick Hospital.	Yes
Proper confidentiality and privacy measures, including HIPAA are ensured.	Yes
Recruitment plans do not impose on patients or study subjects unduly, and are respectful, fair, non-soliciting, non-interfering, and non-coercive.	True
The proposed study does not interfere with Providence St. Patrick Hospital internal projects or initiatives.	True
Impact on department where study is conducted (cost, staffing, patient impact, etc.)	Student has discussed with manager
Impact to other departments	NA
Study drug or device: see addendum if needed	NA
The Nursing Research Council will identify a contact person from the hospital for each external research study.	NA
Permission is required to name Providence St. Patrick Hospital in any dissemination activities (posters, presentations, publications.)	Agreed
Additional Safety Concerns?	None identified

Administrative Decision

Recommendation to Administration: ☒ Approve ☐ Do Not Approve

Date: 1-16-2020

Staff:

Wynette C. Ph.D. MHI, RN, PC, FAAN

Response from Administration:

Date: 1/20/20

Executive:

C. Bensen MSN RN DNP