KNOWLEDGE, ATTITUDES AND PRACTICES OF TRAUMA INFORMED PRACTICE:

A SURVEY OF HEALTH CARE PROFESSIONALS AND SUPPORT STAFF AT ALEXANDER STREET COMMUNITY

NURS 344: Synthesis Project

Nora Abdoh, Elena Bernardi, Alexa McCarthy
Faculty Advisor: Elsie Tan, UBC School of Nursing
10/02/2017

Introduction

Trauma informed practice (TIP) seeks to acknowledge the past experiences of individuals in a way that supports healing, and avoids retraumatization (Isobel & Edwards 2016). Specifically, Trauma-informed practice, or TIP, refers to “a frame of reference and set of operational processes adopted in behavioural health care services that incorporates evidence about the prevalence and impact of traumatic events across the lifespan” (Power, & Associates, 2011, p.10). As more evidence surfaces regarding the significance of trauma on physical and psychological well-being (Hanson & Lang, 2016), the idea of practicing through a trauma informed lens has become particularly important. The use of TIP recognizes that trauma is defined by the individual, and values the subjectivity of trauma as an integral aspect in the healing process (Power, & Associates, 2011, p 10). It is important to understand that the details of one’s past are not needed to demonstrate TIP as it’s principles can be applied to all individuals regardless of history or experience. Moreover, TIP ensures safety and respect are given to all clients regardless of their specific histories. Browne, Varcoe, Lavoie, Smye & Wong (2016) demonstrate this concept in their research focused on enhancing health care equity with Indigenous populations, by stressing [TIP] “is not about eliciting trauma histories, but it is about creating a safe environment and obtaining an understanding of the effects of historical and ongoing trauma, violence and discrimination”. Recognizing the prevalence of traumatic experiences helps illustrate the widespread impact of trauma and the understanding that trauma can impact those who have experienced it first hand, as well as service providers involved in their care (Reeves, 2015).

The Alexander Street Community (ASC) is a project that provides 100 units of low-barrier permanent housing and 39 units of clinically supported transitional housing for individuals living with concurrent physical and mental health issues, substance dependencies and other challenges (Portland Hotel Society, 2017). The staff at ASC is comprised of various professional disciplines, including: clinical staff (a medical doctor, a social worker, a registered nurse, licensed practical nurses) and support staff (mental health workers, and project manager).

As part of its curriculum, the University of British Columbia (UBC) School of Nursing implements a community synthesis project as part of the graduation requirement for all fourth year nursing students. The synthesis projects involve students working with program leaders from local community organizations to synthesize knowledge acquired throughout the program and engage in real-life, quality improvement healthcare issues. In fulfillment of their community synthesis project, three UBC nursing students designed and implemented a Knowledge, Attitudes, and Practices (KAP) survey to quantify the role of Trauma Informed Practice at ASC. This KAP project was requested by the ASC Clinical Coordinator with the goal of using the information collected from the survey to gain a greater understanding of the current level of knowledge of Trauma Informed Practice within the Alexander Street site.

Methods

Survey development

In late November 2016, the project was introduced to the staff at ASC during a scheduled staff meeting. The majority of communication with staff continued through the Clinical Coordinator until early February 2017 during which time a literature review with

the search terms *trauma informed practice,* and *trauma informed care* were used to obtain a comprehensive description of Trauma Informed Practice. Common themes and inquiries found within the literature were used to inform the survey questions.

After the survey was drafted, the questions were reviewed and edited by the Clinical Coordinator. The original survey (and paper format) consisted of 36 questions, with 2 styles of questions. First the participants were asked to comment on 3 open-ended questions in a fill-in-the-blank format, which were followed by 4 yes or no questions with the option to add comments. The last 23 items were to be rated on a 5 point likert scale (strongly disagree, disagree, neutral, agree, and strongly agree). The last six used a 5 point likert scale (never, seldom, sometimes, often, and always). A third party (Flexible Learning Coordinator) at UBC configured the survey into an online format using UBC fluidsurveys. Due to an error in the software, the online survey inadvertently left out 4 likert questions (#11-14) in the knowledge assessment section, giving a total of 32 questions to answer.

Survey distribution

The survey was ready for distribution on January 11 2017 at which point the Clinical Coordinator emailed the survey link to clinical staff at Alexander Street Community. Similarly, the Clinical Coordinator arranged for the link to be posted on the building log for support staff to access. All staff were encouraged to complete the survey and given verbal and email reminders before the deadline. Nearing the completion of the survey in early February, the UBC students went to Alexander Street Community in an effort to encourage more staff to complete the survey. The students timed their two visits to maximize opportunity to interact with staff working different schedules (i.e.

weekday vs weekday/ day vs night). The students engaged with staff members in person and administered the survey using paper versions that were then collected anonymously in a manila envelope. The students also provided participants with the fluidsurveys link if they preferred to complete the survey online. The survey was accessible from January 11 2017 to February 5 2017 (26 days) during which eighteen online entries were recorded. Of those 18 entries, 6 were excluded due to being incomplete attempts (no data) while one was excluded as it was a 'Test' version completed by the students. Of the remaining online surveys, 10 were fully completed and included in the final analysis. Additionally, one partially completed online survey was also included in the analysis. Furthermore, six surveys were collected in person at Alexander Street Community. A total of 17 survey entries were available for analysis.

Data analysis

For each closed ended question (likert or yes/no), the frequency of each response was determined in relation to the number of participants who answered the question. In other words, the distribution of responses is represented as percentages reflecting how many people chose that particular response. This method was used to determine how each response was answered as a group. In an effort to see the how the participants individually responded to the survey, 'values' were assigned to the responses. Each participant would therefore achieve a score, which was compared to an 'idealized' response. For example, with the exception of #17, a response of strongly agree (or always) scored the maximum score of 5; a agree (or often) scored a 4; a neutral (or sometimes) scored a 3; a disagree (or seldom) scored a 2; and a strongly disagree (or never) scored a 1. The participant's score was then compared to the

maximum possible points they could have achieved (i.e. depending on the number of questions they answered). According to this method, a higher score or percentage reflects a more comprehensive understanding of trauma informed practice. To determine whether a difference in scoring existed between the professional disciplines, the answers from questions 1 to 3 were used to group the data into three categories comparing the clinical staff, mental health workers, and other(s).

Results

The first 7 questions of the survey were for the purpose of assessing the participant's role at Alexander Street Community (ASC), the duration of their current position, their previous work experience in the downtown eastside and their previous level of engagement with trauma informed practice education. From this information, it was determined that 1 medical doctor, 1 RN/clinical coordinator, 3 LPN's, 1 social worker/case manager, 8 mental health workers and 3 "other" individuals participated in the survey. The "other" participants identified themselves as chief physician, project manager and home support worker.

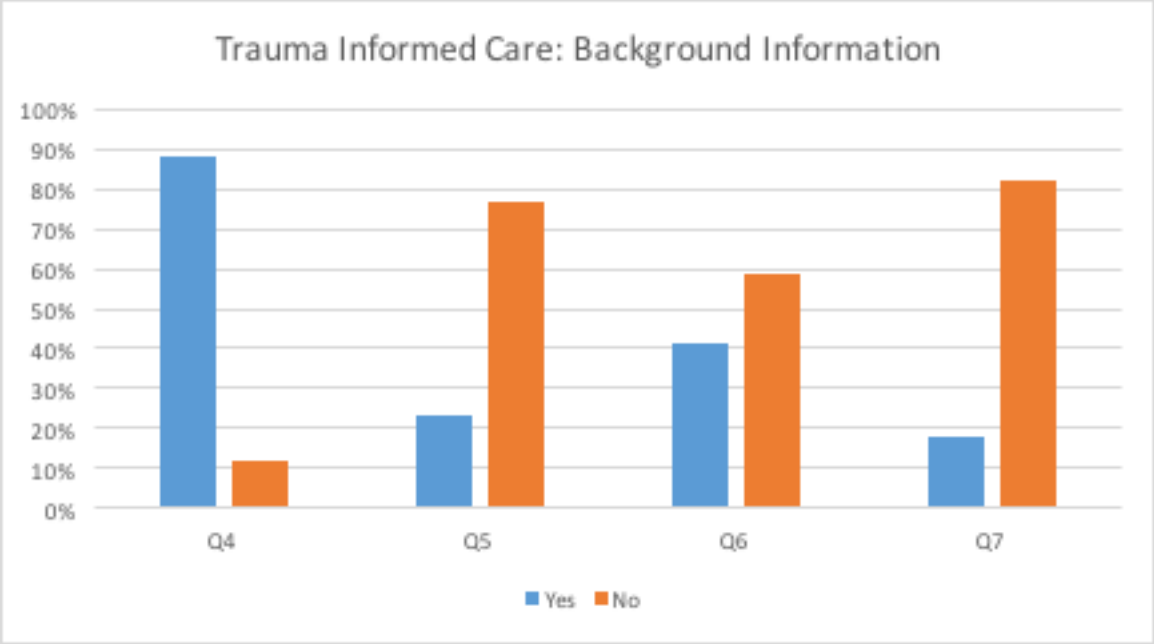
Of all ASC staff, the duration of their current positions ranged from having only completed a few shifts at ASC to having been in the current position for 2.5 years with an average duration of 14.5 months working at ASC. Previous work experiences in the DTES were extensive and included 5 individuals who have worked within the Portland Hotel Society (PHS) from 2.5 years to over 10 years. Other areas of past work and volunteer experience include outreach work, Insite, Raincity Housing, and Coast Mental Health. Only two respondents indicated that do they do not have previous work experience working in the DTES. Six respondents indicated that they have had formal

training on TIP, but only 3 respondents noted their participation in the in house TIP session provided at ASC.

Table 1.0: Percent Distribution of Trauma Informed Practice 'Previous Experience' Assessment Questions 4-7

Question		Total	Yes	No
Q4	Prior to working at Alexander Street Community, did you have experience working in the downtown eastside community, or with individuals that live in marginalized situations, have physical and mental health conditions, or substance dependencies?	17	88%	12%
Q5	During your post secondary education (certifications, undergraduate, graduate, etc.), was Trauma Informed Practice (TIP) addressed?	17	24%	76%
Q6	Have you received any training related to Trauma Informed Practice (TIP) that was not provided through a post secondary education program (e.g, through an employer or other community group)?	17	41%	59%
Q7	Did you participate in the most recent Trauma Informed Practice (TIP) training session held at Alexander Street Community on December 7 2016?	17	18%	82%

Figure 1.0: Percent Distribution of Trauma Informed Practice 'Previous Experience' Assessment Questions 4-7

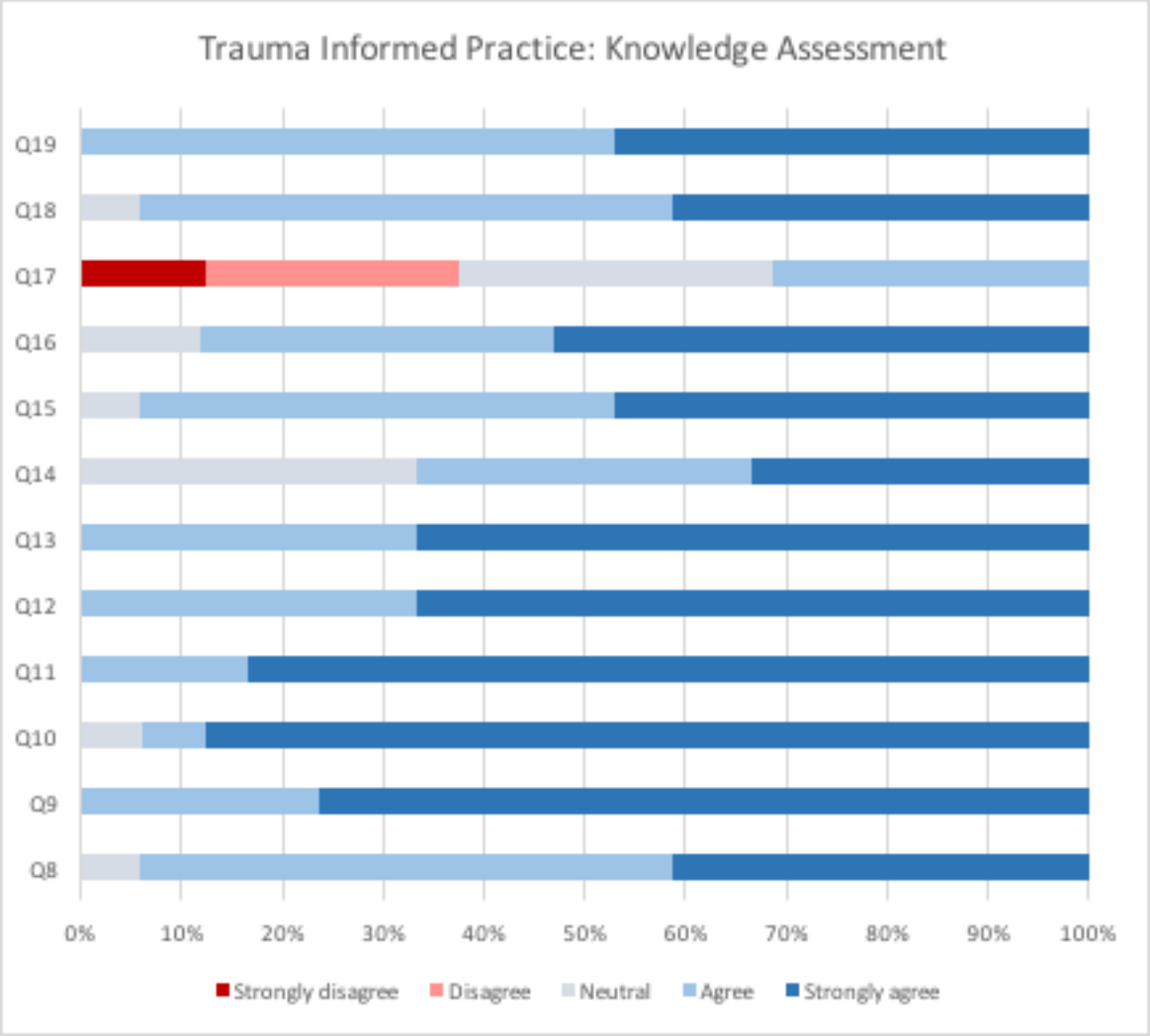


In analyzing the collected data, the results have been categorized based upon their category of assessment, either knowledge, attitudes or practices. The first likert style questions assessed knowledge of trauma informed practice and were represented by statements such as “exposure to trauma is common” and “trauma affects physical, emotional, and mental well-being”. Answers in agreement with these statements were associated with a greater understanding of the concept of TIP, since these statements represented facts outlined in our literature review.

Table 2.0: Percent Distribution of Trauma Informed Practice 'Knowledge' Assessment Questions 8-19

Question		Total	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Q8	Exposure to trauma is common.	17	0%	0%	6%	53%	41%	100%
Q9	Trauma affects physical, emotional, and mental well-being.	17	0%	0%	0%	24%	76%	100%
Q10	Trauma can have lifelong effects that may span generations.	16	0%	0%	6%	6%	88%	100%
Q11	Substance use issues can be indicative of past traumatic experiences or adverse childhood events (ACE).	6	0%	0%	0%	17%	83%	100%
Q12	There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE).	6	0%	0%	0%	33%	67%	100%
Q13	Distrusting behaviour is indicative of past traumatic experiences or adverse childhood events (ACE).	6	0%	0%	0%	33%	67%	100%
Q14	Trauma Informed Practice (TIP) requires providers to recognize, understand, and respond to the effects of trauma.	6	0%	0%	33%	33%	33%	100%
Q15	Trauma Informed Practice (TIP) aims to create safe environments that promote healing and recovery from trauma exposure.	17	0%	0%	6%	47%	47%	100%
Q16	Trauma Informed Practice (TIP) includes understanding the physical, psychological and emotional safety of both the client and the provider.	17	0%	0%	12%	35%	53%	100%
Q17	When using Trauma Informed Practice (TIP), you must know specific details of a client's history of trauma.	16	13%	25%	31%	31%	0%	100%
Q18	Re-traumatization can occur unintentionally.	17	0%	0%	6%	53%	41%	100%
Q19	Re-traumatization can occur in both community and institutional settings.	17	0%	0%	0%	53%	47%	100%

Figure 2.0: Percent Distribution of Trauma Informed Practice 'Knowledge' Assessment Questions 8-19

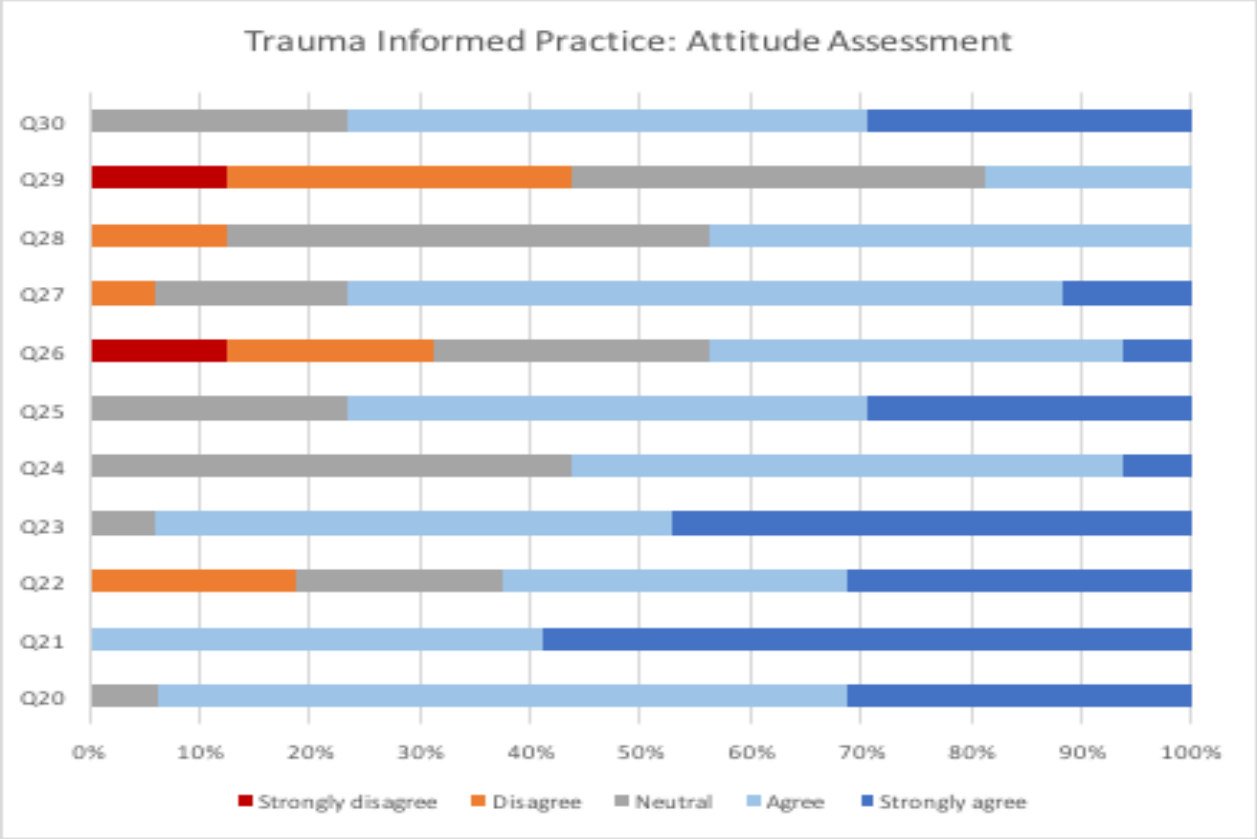


Overall, respondents showed an overall understanding of knowledge of TIP as they agreed or strongly agreed with the majority of questions. Figure 2.0 indicates that the largest variation in responses occurred for Q17 which stated “when using Trauma Informed Practice (TIP) you must know specific details client’s history of trauma”. Thirteen percent of respondents indicated they strongly disagree with this statement, 25% disagreed, 31% agreed, and 31% remained neutral.

Table 3.0: Percent Distribution of Trauma Informed Practice 'Attitude' Assessment Questions 20-30

Question		Total	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Q20	Recovery from trauma is possible.	16	0%	0%	6%	63%	31%	100%
Q21	Paths to healing/recovery from trauma are different for everyone.	17	0%	0%	0%	41%	59%	100%
Q22	People are experts in their own healing/recovery from trauma.	16	0%	19%	19%	31%	31%	100%
Q23	Informed choice is essential to healing/recovery from trauma.	17	0%	0%	6%	47%	47%	100%
Q24	Trauma Informed Practice (TIP) shares many similarities to harm reduction.	16	0%	0%	44%	50%	6%	100%
Q25	Trauma Informed Practice (TIP) is essential to working effectively with people who live in Vancouver's Downtown Eastside.	17	0%	0%	24%	47%	29%	100%
Q26	I have a comprehensive understanding of Trauma Informed Practice (TIP).	16	13%	19%	25%	38%	6%	100%
Q27	I believe in and support the principles of Trauma Informed Practice (TIP).	17	0%	6%	18%	65%	12%	100%
Q28	I share my expertise and collaborate effectively with colleagues regarding the use of Trauma Informed Practice (TIP).	16	0%	13%	44%	44%	0%	100%
Q29	I have all the resources I need to engage in Trauma Informed Practice (TIP).	16	13%	31%	38%	19%	0%	100%
Q30	I would like to receive more training on Trauma Informed Practice (TIP).	17	0%	0%	24%	47%	29%	100%

Figure 3.0: Percent Distribution of Trauma Informed Practice 'Attitude' Assessment Questions 20-30



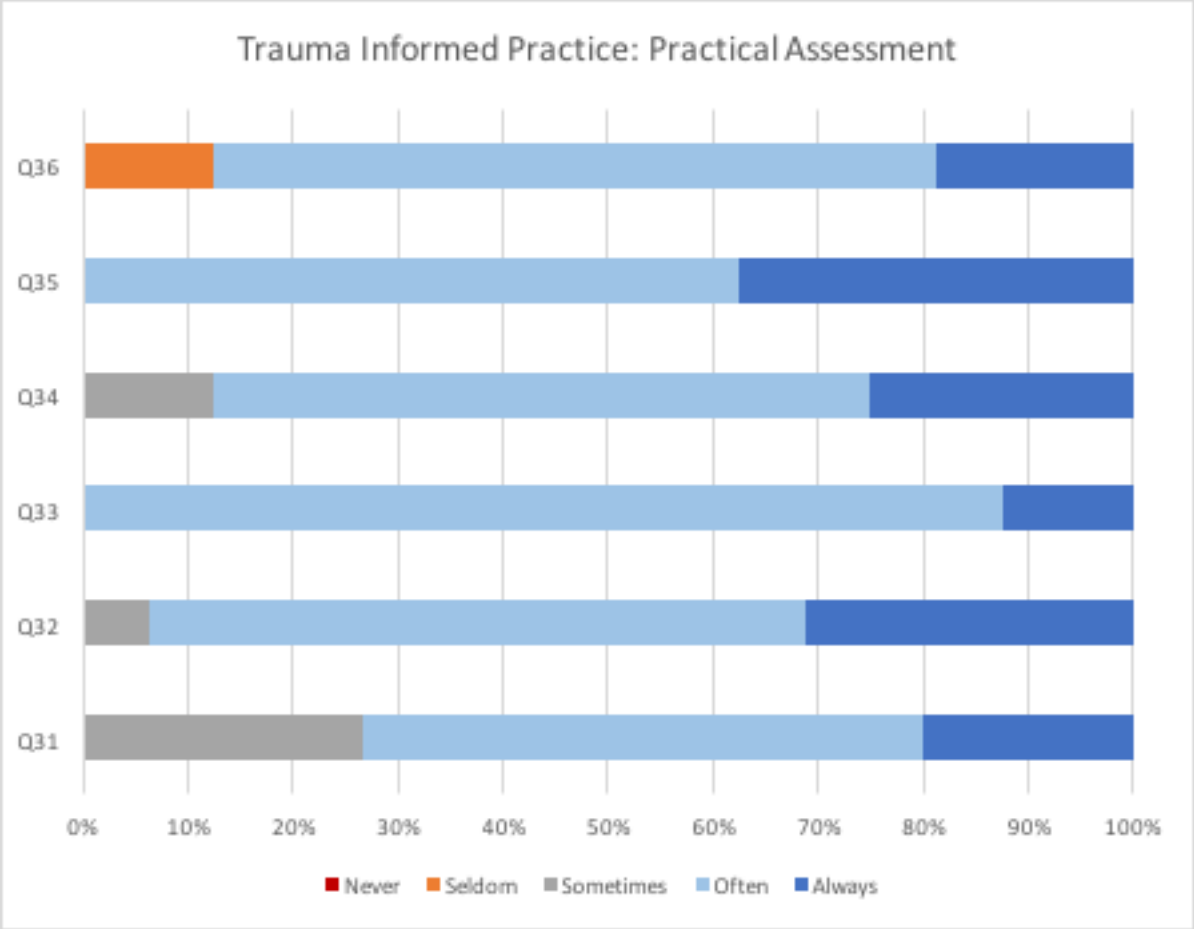
The attitude assessment portion of the questionnaire elicited a diverse set of responses with participants typically feeling neutral, in agreement, or strong agreement with the questions, indicating positive attitudes about trauma informed practice. The statements with the largest distribution of responses were Q22, Q26, Q28 and Q29. Nineteen percent of participants indicated that they disagreed with Q22: “people are experts in their own healing/recovery from trauma”; whereas, 19% felt neutral to this statement, 31% agreed, and 31% strongly agreed. The statement “I have a comprehensive understanding of Trauma Informed Practice” (Q26), demonstrated the largest variation of responses for the entire survey. Nineteen percent of the participants disagreed, 13% strongly disagreed, 25% felt neutral, 44% agreed, and 6% strongly

agreed to Q26. Q28 showed that 44% of participants agreed that they shared and collaborated with colleagues regarding TIP, while 44% felt neutral and 13% disagreed. Q29 stated: “I have all the resources I need to engage in Trauma Informed Practice”. This question also elicited a diverse set of responses, with 31% disagreeing, 13% strongly disagreeing, 38% feeling neutral, and 19% agreeing with this statement. In Q30, a high proportion of participants indicated they felt neutral (24%) about receiving more training on TIP, while 47% agreed and 29% strongly agreed to wanting more training.

Table 4.0: Percent Distribution of Trauma Informed Practice 'Practical' Assessment Questions 31-36.

Question		Total	Never	Seldom	Sometimes	Often	Always	Total
Q31	I maintain transparency in all interactions with clients.	15	0%	0%	27%	53%	20%	100%
Q32	I offer clients choices, and respect their decisions.	16	0%	0%	6%	63%	31%	100%
Q33	I help client and peers to recognize their own strengths.	16	0%	0%	0%	88%	13%	100%
Q34	I inform all clients of my actions before I perform them.	16	0%	0%	13%	63%	25%	100%
Q35	My interaction with each client is unique and tailored to their specific needs.	16	0%	0%	0%	63%	38%	100%
Q36	I practice self-care (taking care of my own needs and well-being).	16	0%	13%	0%	69%	19%	100%

Figure 4.0: Percent Distribution of Trauma Informed Practice 'Practical' Assessment Questions 31-36.

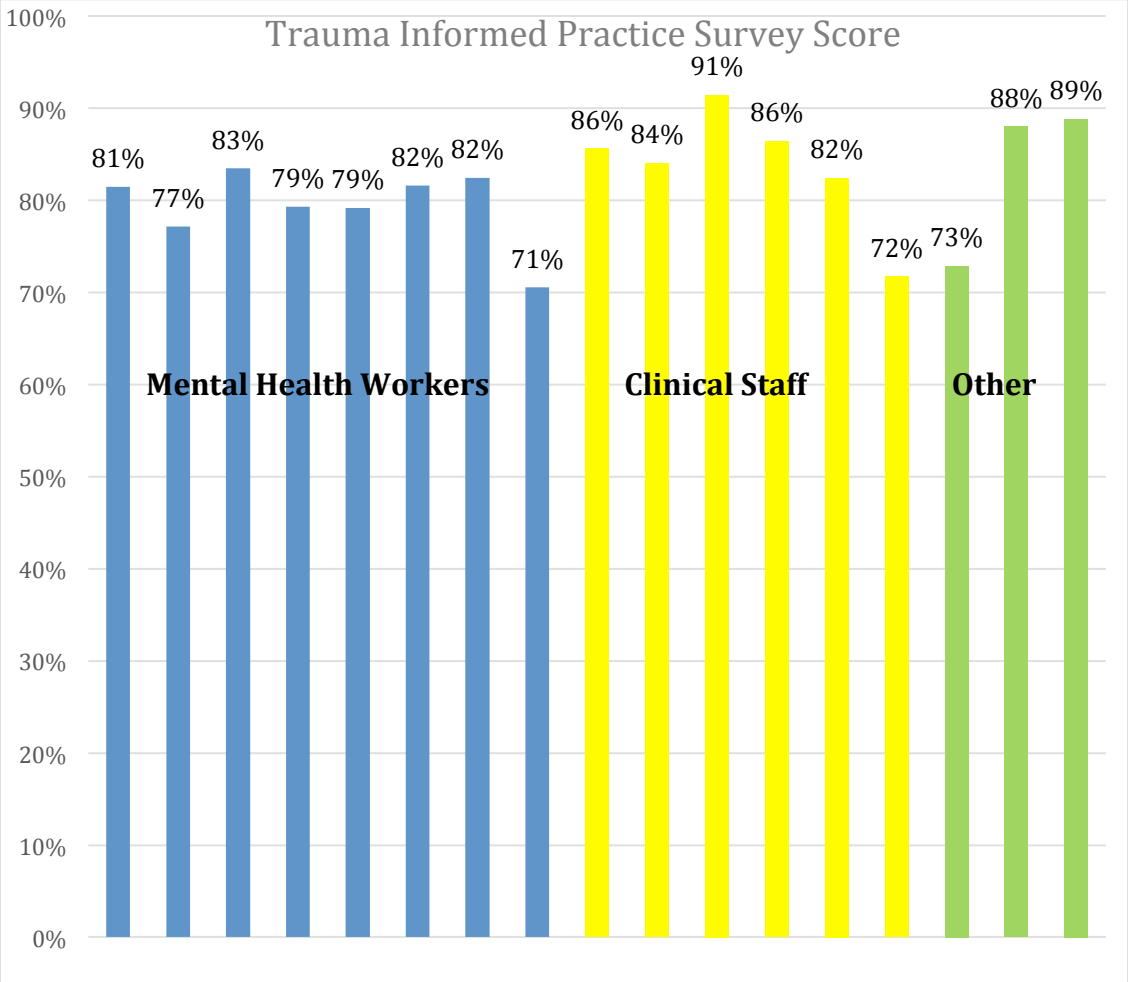


The results of the practical assessment section indicated that participants either often or always utilized the practice described in the question. In Q34 and Q36 however, variances did occur. In Q34 participants “sometimes” informed clients before an action is performed (13%). Question 36 relates to the practice of self-care. Sixty-nine percent of participants indicated that they often practice self-care, 19% always practice self-care, and 13% seldom practice self-care.

Neutral Questions

Q14, Q24, and Q31 appeared to induce high neutral response rates. Q14 queried if TIP requires providers to "recognize understand, and respond to the effects of trauma". While 33% percent of respondents agreed and 33% strongly agreed to this statement in Q14, 33% remained neutral. Q24, which stated "trauma informed practice shares many similarities to harm reduction" elicited a neutral response rate of 44% and an agree response rate of 50%. When responding to Q31 "I maintain transparency in all interactions with clients", 27% felt neutral and 53% reported that they often do this, while 20% stated they always maintain transparency.

Figure 4.1: Overall Knowledge, Attitudes and Practice Survey Score



Discussion

Data Collection

Multiple strategies were required to obtain the 17 completed surveys, including an online survey deployed in early January, which elicited 4 responses over approximately one month. Reminder emails were sent to clinical staff via the Clinical Coordinator to encourage more staff to complete the survey. The UBC students also went to Alexander Street Community to engage with front line workers and clinical staff in an effort to engage more participants. In total, 15 hours were spent at ASC connecting with staff at during various days and shifts. Providing paper surveys elicited an additional 6 responses. During the time spent at ASC, incentives (cookies/coffee) were used in an effort to engage with staff. Although the significance of the survey and its role as a potential means of quality improvement, mixed responses were received from potential participants. Although some staff expressed interest in the project and were keen to participate others were hesitant to participate. The anonymity of the survey was potentially compromised by issuing and collecting the survey in person and this may have deterred some from completing. An attempt was made to mitigate this complication by providing cards with a link to the online survey. In retrospect, it would have been beneficial to obtain the staffing schedule/ staffing list to maximize the potential of connecting with everyone working at ASC.

Knowledge Assessment

The results of the knowledge assessment section indicated that overall, the staff had a comprehensive understanding of the underlying principles of TIP. However, there is a gap in knowledge related to question 17, which addressed the need to elicit a

person's trauma history in order to practice TIP. The intention of this question was that TIP can be used without eliciting trauma histories. However, mixed responses were received over this question, for example one participant said: "I feel that it is important to know some specifics as you can learn things that could be triggers, but sometimes hearing extensive specifics can trigger the worker also and re-traumatize victims, so I feel this is a very loaded question that requires more conversation on both sides."

Attitude Assessment

The results of the attitude assessment indicated a positive outlook towards the use of trauma informed practice and its principles. Specifically, 94% of participants agreed or strongly agreed that recovery from trauma is possible (Q20). At the end of the survey in the comments section it was noted by one participant that perhaps the question could have been worded differently or the idea of recovery could have been better described, saying "I agree that [recovery] is possible for some, but that recovery looks different depending on the person and that for some the answer would likely be never recovering from the trauma". Q22 stated "people are experts in their own healing/recovery from trauma" also received mixed results, with 19% of participants disagreeing, 19% responding neutrally, 31% agreeing and 31% strongly agreeing. This idea of clients being experts in their own healing is central to the principles of trauma informed practice so the lack of agreement of this statement may indicate a need for further education. Q26 included a wide range of responses, with 32% of participants indicating that they do not have a comprehensive understanding of TIP, further indicating not only a need for education but also recognition that their understanding could be improved. Q28 represented a broad take on the communication and sharing of

TIP, stating “I share my expertise and collaborate effectively with colleagues regarding the use of Trauma Informed Practice (TIP)”. Although 44% did agree with this statement, the remainder of participants either disagreed or were neutral on the subject, indicating the need for elaboration on the benefits of intra and interprofessional communication in the use of TIP. Nearly half (44%) of participants indicated through their responses to Q29 that they do not “have all the resources [they] need to engage in Trauma Informed Practice (TIP)”. In future research, it would be beneficial to allow for an open ended and written response, allowing the participants to specify what type of further resources would allow for increased engagement in TIP.

Practical Assessment

The practical assessment included in the questionnaire exemplifies how participants implement practices informed by TIP. Overall responses showed that participants are utilizing TIP when working with clients. For example all 16 participants answered that interactions with clients are often or always “unique and tailored to [the client’s] specific needs” (Q35). All participants stated that they often or always “help clients and peers to recognize their own strengths” (Q33). In their study of health care inequity, Browne, et al. (2016) highlight the saliency of tailoring care to individual and community needs. This knowledge is congruent with our survey results, which as shown above, indicate a strong agreement with the value and need of acknowledging clients as individuals with unique strengths and experiences.

There were two questions that were inconsistent with the overall impression from this section. For example, of the 16 participants who answered Q34, 13% reported that they sometimes inform clients of all actions before performing them. It is difficult to

interpret this result as more information is needed about the scenarios in which they sometimes did not inform a client about an action being performed. In Q36, the majority of participants noted they often or always practice self-care; however, 13% indicated that they seldom participate in self-care. Given that research suggests service providers can experience secondary trauma , it is imperative that all employees participate in self-care; therefore, further inquiry and education is needed on this topic.

Indeterminate Results

Two questions elicited high neutral response rates that prompted further investigation. Q24 evaluated whether participants felt that TIP and harm reduction shared similar principles, and 44% felt neutral to this statement. When composing questions for the survey there was discussion of providing a definition of harm reduction for this question. Ultimately it was concluded that by not providing a definition for this question, it also assessed participants knowledge of the term ‘harm reduction’ as it relates to TIP. This has made interpretation difficult due to the inability to decipher if the neutral responses are due to unfamiliarity with the term “harm reduction’ or truly feeling neutral on the subject and its similarities to TIP.

Q31 assessed the attitudes about TIP, specifically whether participants maintained transparency in all their interactions with clients. Twenty-seven percent of participants indicated they sometimes maintain transparency. Moreover, one survey participant wrote “define transparency” over this question. During interpretation and analysis of results it was concluded that this term might have been too vague, and further explanation could have been provided. As a result, it is difficult to determine whether this question prompted participants to interpret and answer the question

differently than what was intended which may call the validity of the responses into question.

Future Research

Although a thorough assessment of knowledge, attitudes and practice of TIP was performed in this project, future research exploring the actual application of the practice is needed. Self-reports of attitudes and practice among ASC staff were used in this study, but assessing the viewpoints of clients receiving care via client engagement is also worthy of investigation. Exploring the relationship between the perceived delivery of TIP by staff and the interpretation of care received by the client would allow for data encompassing both sides of care.

TIP Education

As illustrated in the data, familiarity with the term trauma informed practice is not always necessary in order for one to demonstrate the principles of the concept. Education on the importance of TIP may occur formally or may be a set of values developed through first hand experience dealing with victims of trauma and its subsequent repercussions. Formal education programs that seek to inform those delivering care about the principles of TIP can be instrumental in giving a name to the values and ensuring their consistent presence in all client interactions. Hall and McKenna (2015) conducted exploratory research with healthcare providers that evaluated the effectiveness of TIP education package modules on understanding, knowledge and perceived use of the practice. Pre and post education questionnaires determined that the means of teaching was effective in delivering the principles of TIP and ultimately increasing the perceived use of the practice in delivery of care (McKenna,

2015). This research speaks to the importance of ongoing education on the topic and the need for the integration of TIP workshops and education into orientation and new job training. In reference to our own research completed with the staff at Alexander Street Community, it was unable to be determined whether or not participation in the TIP workshop on December 7th resulted in a greater understanding of the practice. Although the data indicated that the majority of staff are interested receiving more training, most participants did not attend the last TIP session offered through Alexander Street Community. It was concluded that another training session may prove beneficial if it were offered through a means that is accessible to all staff (such as a flexible learning online format).

Conclusion

Trauma Informed Practice supports the healing and recovery of clients, by engaging in respectful practices and promoting a culture of safety (Abt Associates, 2014). TIP is an important and essential practice when working with all populations, and especially relevant when serving communities such as Alexander Street Community in Vancouver's downtown eastside. UBC nursing students pursued a project in partnership with ASC to design and implement a Knowledge, Attitudes, and Practices (KAP) survey evaluate the level of TIP knowledge among the staff working at ASC. Through this survey, it was determined the staff had a relatively comprehensive understanding of the principles of TIP. Despite some uncertainty around the term "trauma informed practice" it was often implemented within professional practice. In the future, additional training sessions accessible to all staff that highlight the role and practical application of TIP are

recommended. Lastly, assessing outcomes of TIP implementation via self reports in addition to client perspectives on care received can further inform future quality improvement projects.

References

Abt Associates. (2014). *Participant Survey Scales Cross-site Evaluation of the National Training Initiative on Trauma-Informed Care (TIC) for Community-Based Providers from Diverse Service Systems.* Rutgers' School of Criminal Justice. Cambridge: Abt Associates.

Arthur, E., Seymour A., Dartnall, M., Beltgens, P., Poole, N., Smylie, D., North, N., Schmidt, R.

(2013). Trauma-Informed practice guidelines. *Provincial Mental Health and Substance Use Planning Council.*

Baker, C.N., Brown, S.M., Wilcox, P.D., Overstreet, S., Arora, P. (2016). Development and psychometric evaluation of the attitudes related to trauma-informed care (ARTIC) Scale. *School Mental Health, 8*(1), 61-76.

Bowen, E.A., Murshid, N.S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health, 2,* 223-229.

Browne, A., Varcoe, Colleen, Lavoie, J., Smye, V., Wong, S., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*(544), 1-17.

Green, B., Saunders, P., Power, E., Dass-Brailsford, P., Bhat Schelbert, K., Giller, E., Mete, M. (2016). Trauma-Informed Medical Care: Patient Response to a Primary Care Provider Communication Training. *Journal of Loss and Trauma, 21*(2), 147-159.

Hall. A., McKenna, B., Dearie, V., Maguire, T., Charleston, R., Furness, T. (2016). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: A pilot study. *BMC Nursing, 15*(21).DOI 10.1186/s12912-016-0141-y

Hanson, R., & Lang, J. (2016). A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families. *Child Maltreatment, 21*(2), 95-100.

Hopper, E., Bassuk, E.L., Olivet, J. (2010). Shelter from the storm: Trauma informed care in homelessness service settings. *The Open Health Services and Policy Journal, 3,* 80-100.

Isobel, S., & Edwards, C. (2016). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, 1-7.

Kassam-Adams, N., Rzucidlo, S., Campbell, M., Good, G., Bonifacio, E., Slouf, K., Schneider, S., McKenna, C., Hanson, C.A., Grather D. (2014). Nurses' views and current practice of trauma-informed pediatric nursing care. *Journal of Pediatric Nursing,30* (3), 478-484.

PHS Community Services Society. (2017). *Portland Hotel Society*. Retrieved February 9, 2017, from Alexander Street Community: https://www.phs.ca/index.php/project/alexander-street-community/#

Power, E., & Associates. (2011). Trauma-responsive systems implementation advisor. Retrieved from: http://www.traumainformedcare.com/TIC_PDF/Sec_02-TReSIA-About_TIC.pdf

Prestidge, J. (2014). Using trauma-informed care to provide therapeutic support to homeless people with complex needs: A transatlantic search for an approach to engage the “non-engaging”. *Housing, Care, and Support, 4,* 208-214.

Reeves, E. (2015). A synthesis of the literature on Trauma-informed care. *Issues in Mental Health Nursing, 36,* 698-709.

Appendix 1:

Knowledge, Attitudes, Practices Trauma Informed Practice Survey

The University of British Columbia School of Nursing implements a community synthesis project for all fourth year nursing students. Students work with program leaders from local community organizations to create new projects. We are three nursing students, working with Alexander Street Community on a project related to Trauma Informed Care. For the purpose of this survey, we define Trauma Informed Care as a conceptual framework, and the implementation of it as Trauma Informed Practice (TIP). For simplicity, we will use the single term “Trauma Informed Practice” (TIP) to encompass both the conceptual framework and practical component.

The purpose of the survey is to determine the knowledge, attitudes, and practices surrounding Trauma Informed Practice. Our goal is to use the information collected from the survey to gain a greater understanding of the role of Trauma Informed Practice within your project site, and use that understanding to create recommendations for quality improvement within the Alexander Street organization. Survey questions were informed by common themes and inquiries within the academic literature, including other Trauma Informed Practice surveys.

This survey is voluntary and will be distributed to all staff at Alexander Street Community. Anonymity of participants will be maintained, and the final results will be presented to both the project lead and staff at Alexander Street Community. Your input is greatly appreciated.

Background/ Professional Experience

1) What is your role (job title) at Alexander Street Community?

Blank comment box

2) If applicable, what is your professional designation?

Blank comment box

3) How long have you been working in your current role at Alexander Street Community?

Blank comment box

4) Prior to working at Alexander Street Community, did you have experience working in the downtown eastside community, or with individuals that live in marginalized situations, have physical and mental health conditions, or substance dependencies? If yes, please explain.

Yes or No

Blank comment box

5) During your post secondary education (certifications, undergraduate, graduate, etc.), was Trauma Informed Practice (TIP) addressed? If yes, please comment on the duration and context of the teaching.

Yes or No

Blank comment box

6) Have you received any training related to Trauma Informed Practice (TIP) that was not provided through a post secondary education program (e.g, through an employer or other community group)? If yes, please comment on the duration and context of the teaching.

Yes or No

Blank comment box

7) Did you participate in the most recent Trauma Informed Practice (TIP) training session held at Alexander Street Community on December 7 2016? If yes, please provide any comments you had regarding the information provided in this session.

Yes or No

Blank comment box

Knowledge Assessment

8) Exposure to trauma is common.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

9) Trauma affects physical, emotional, and mental well-being.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

10) Trauma can have lifelong effects that may span generations.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

11) Substance use issues can be indicative of past traumatic experiences or adverse childhood events (ACE).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

12) There is a connection between mental health issues and past traumatic experiences or adverse childhood events (ACE).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

13) Distrusting behaviour can be indicative of past traumatic experiences or adverse childhood events (ACE).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

14) Trauma Informed Practice (TIP) requires providers to recognize, understand, and respond to the effects of trauma.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

15) Trauma Informed Practice (TIP) aims to create safe environments that promote healing and recovery from trauma exposure.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

16) Trauma Informed Practice (TIP) includes understanding the physical, psychological and emotional safety of both the client and the provider.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

17) When using Trauma Informed Practice (TIP), you must know specific details of a client's history of trauma.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

18) Re-traumatization can occur unintentionally.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

19) Re-traumatization can occur in both community and institutional settings.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Attitude Assessment

20) Recovery from trauma is possible.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

21) Paths to healing/recovery from trauma are different for everyone.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

22) People are experts in their own healing/recovery from trauma.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

23) Informed choice is essential to healing/recovery from trauma.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

24) Trauma Informed Practice (TIP) shares many similarities to harm reduction.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

25) Trauma Informed Practice (TIP) is essential to working effectively with people who live in Vancouver's Downtown Eastside.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

26) I have a comprehensive understanding of Trauma Informed Practice (TIP).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

27) I believe in and support the principles of Trauma Informed Practice (TIP).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

28) I share my expertise and collaborate effectively with colleagues regarding the use of Trauma Informed Practice (TIP).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

29) I have all the resources I need to engage in Trauma Informed Practice (TIP).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

30) I would like to receive more training on Trauma Informed Practice (TIP).

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Practical Assessment

31) I maintain transparency in all interactions with clients.

Never	Seldom	Sometimes	Often	Always

32) I offer clients choices, and respect their decisions.

Never	Seldom	Sometimes	Often	Always

33) I help client and peers to recognize their own strengths.

Never	Seldom	Sometimes	Often	Always

34) I inform all clients of my actions before I perform them.

Never	Seldom	Sometimes	Often	Always

35) My interaction with each client is unique and tailored to their specific needs.

Never	Seldom	Sometimes	Often	Always

36) I practice self-care (taking care of my own needs and well-being).

Never	Seldom	Sometimes	Often	Always

Comments

Please provide any additional comments related to Trauma Informed Practice or further comments or suggestions regarding your participation in this survey.

Blank comment box

Appendix 2:

Literature Review

Baker, C., & Brown, S. M. (2015). Development and Psychometric Evaluation of the Attitudes Related to Trauma-Informed Care (ARTIC) Scale. *School Mental Health* , 61-76.

This research looked at using an ARTIC scale to evaluate school staff and their attitudes and knowledge regarding trauma informed care after a shortage of psychometrically robust instruments to evaluate TIC was found. They used a partnership-based approach to develop a direct, efficient, and cost-effective measure of TIC focused on evaluating the TIC-relevant attitudes of staff working in schools, human service systems, and other settings serving individuals with histories of trauma. The ARTIC scale seems like it would be a good tool for us to use but its not available for free. Some of the components that it measures and that we may want to work into out survey are: (a) underlying causes of problem behavior and symptoms, (b) responses to problem behavior and symptoms, (c) on-the-job behavior, (d) self-efficacy at work, and (e) reactions to the work. The supplementary subscales include (f) personal support of TIC and (g) system-wide support for TIC. These seven subscales represent much of the current thinking about important elements of TIC, both in schools and in human services and healthcare settings.

BC Centre for Excellence in Women's Health. (2013). *Trauma-Informed Practice Guide.* Vancouver: MHSU.

This practice guide was developed by the BC Centre for Excellence in Women's Health to support the translation of trauma-informed principles into practice. The goal was to enhance awareness among practitioners and organizations who deliver mental health and substance use (MHSU) services in BC, identify current efforts of trauma informed practice and to increase capacity amongst MHSU practitioners and organizations to better serve people impacted by violence and trauma and thereby improve outcomes for clients of MHSU services in BC. Insight into the implementation of TIP into practice is provided in great detail as well as information regarding the prominence of trauma specific to BC.

Bowen, E.A., Murshid, N.S. (2016). Trauma-informed social policy: A conceptual framework for policy analysis and advocacy. *American Journal of Public Health, 2,* 223-229.

Bowen et al. aimed to argue for why trauma informed care should be discussed when creating policies addressing homelessness, violence, addiction, and chronic disease at local, state, federal, and international levels. They identified the 6 core principles of TIC as: safety, trustworthiness/transparency, collaboration, empowerment, choice and intersectionality. They concluded that these principles should be a part of the creation of any type of social policy. They stated that these core principles can also be a basis for policy advocacy for health care professionals to standardize TIC in their workplaces.

Browne, A., Varcoe, Colleen, Lavoie, J., Smye, V., Wong, S., . . . Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*(544), 1-17.

Indigenous people of Canada are continually exposed to social and structural violence (Browne, et al., 2016). Browne, et al. (2016) purpose the following four key dimensions to equitable health care service for indigenous populations: culturally safe care; trauma-and-violence informed care (TVIC); contextually tailored care; and inequity responsive care. Browne, et al. (2016) subsequently purpose four approaches and ten strategies to delivering such equitable services. It is important to note that Browne et al. (2016) describe concern over the use of the word 'trauma' and it is often attributed to something in the past that results in a psychological response, and may obscure the impact of ongoing structural violence. Browne et al. (2016) define trauma as various forms of violence and inequities, leading to multiple affects both physical and psychological. They stress TVIC is not about eliciting trauma histories, but it is about creating a safe environments and obtaining an understanding of the effects of historical and ongoing trauma, violence and discrimination (Browne et al., 2016) Trauma = psychological and physical, historical and ongoing, structural violence, discrimination

Green, B., Saunders, P., Power, E., Dass-Brailsford, P., Bhat Schelbert, K., Giller, E., Mete, M. (2016). Trauma-Informed Medical Care: Patient Response to a Primary Care Provider Communication Training. *Journal of Loss and Trauma, 21*(2), 147-159.

Green et al. (2016) performed a randomized control study to collect information about the effectiveness of a modified trauma-informed care training program for primary care providers (PCP) called TI-med training (a 6 hour CME program). The study was conducted at 4 primary health sites. Data was collected from patients of the primary care providers before or after training. Patients filled out a survey with 21 items to rate on a Likert scale relating to the PCP's rapport, information, and partnership. The rapport scale did not show significant results as the PCP's had good rapport even before training. The information increased from pre to post training (but was not significant), and the partnership increased with significance after TI-med training.

Hall, A., & Mckenna, B. (2015). Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: a pilot study. *BMC Nursing* , 140-155.

This study was done as exploratory research with a mixed methods design. Mixed methods research designs attempt to use both the methodology and philosophy of quantitative and qualitative research. 23Staff completed a pre-education and post-education 18-item questionnaire derived from the content of the eight modules. For example, ED nurses were asked to rate their level of confidence to respond to patients' disclosures of trauma and understanding if their current nursing practice is trauma informed The questionnaire was completed immediately before and after ED nurses had participated in the education. Data were collected on a Likert scale where a rating of 1 represented strong disagreement and a rating of 5 represented strong.

Hanson, R., & Lang, J. (2016). A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families. *Child Maltreatment, 21*(2), 95-100.

Hanson and Lang (2016) identified six empirical studies that utilized at least one component of Trauma Informed care (TIC) in a child-serving system. Hanson and Lang (2016) also provide feedback about definitional and conceptual issues of TIC from child-serving professionals. They discuss how the detrimental effects of trauma have become well known, and many agencies have taken a trauma-informed approach; however, what 'trauma informed' means is not standard (no one definition), and there is little evidence to show whether practices are improving outcomes. Hanson and Lang (2016) identified 15 components that were commonly identified as important components of TIC, and categorized into three categories: workforce development; trauma-focused services; and organizational environment and practices. An anonymous survey was administered to child-serving professionals which asked the following three questions in relation to the 15 identified components: how important was each component to TIC; what extent had each been implemented in their agency; and how unique was each to TIC (as opposed to general best practice). Several components were not considered unique, and implementation varied amongst agencies (those most widely implemented were considered the least unique). Hanson and Lang (2016) stress the lack of evidence to support improved outcomes related to TIC, and suggest more evaluation is needed, otherwise can continue with general best practice. TIC 15 Components:
Workforce Development- training/awareness, staff proficiency, reduce secondary trauma, knowledge/skill evidence-based practice

Trauma-focused services- evidence-based screening, recording trauma history, trained/skilled providers. Organizational environment and practices- collaboration, reduce re-traumatization, consumer engagement, strength based services, safe environment, written policies, defined leadership.

Isobel, S., & Edwards, C. (2016, June). Using trauma informed care as a nursing model of care in an acute inpatient mental health unit: A practice development process. *International Journal of Mental Health Nursing*, 1-7.

In October 2012, an inpatient mental health unit in Sydney Australia selected the philosophy of Trauma-Informed Model of Care guide their practice—"The philosophical underpinning of the model requires all actions to be considered in awareness of these components and to be sensitive to the impact of trauma on individuals and their experiences of care." This paper describes process and effects of this implementation, through qualitative interviews with nursing staff. "The nurses were asked about changes occurring within TIC, the effects on their day-to-day work, consumers, the team and how they feel about their roles as a result" (Isobel & Edwards, 2016). The results were both good and bad. There was a consensus that the "changes needed to be slow and positively framed" (Isobel & Edwards, 2016). For example, one nurse describes the potential for losing safety, by giving more power and autonomy to consumers, when they don't really have it in reality. Another nurse states confused about what it entails/ how it will be practiced. Some nurses describe it isn't different from the philosophy they already had/ the care they were providing—more like it is just the next 'title'. Nurses faced wondering if this meant their current approach was traumatizing. Other nurses

described joy with having a guiding principle, and thought it could lead to more individualized practice. Guiding Principles of Trauma-Informed Model of Care: Safety, Empowerment, Choice, Collaboration, and Trustworthiness.

Kassam Adams, N., & Slouf, K. (2014). Nurses' Views and Current Practice of Trauma-Informed Pediatric Nursing Care. *Journal of Pediatric Nursing* , 478-484.

This study addresses this gap in the literature by examining trauma nurses' knowledge, opinions, self-rated competence, current practice, and perceived implementation barriers with regard to trauma-informed nursing care for acutely injured children. A survey of staff knowledge, practice, and attitudes with regard to trauma-informed pediatric care was undertaken as the initial step in a larger nurse-led project that explored methods for implementing screening of pediatric trauma patients and their parents by nurses in trauma centers. All nursing staff assigned to the acute care trauma unit at each site were eligible to participate and were given information sheets that described the research project and invited their participation (there were no exclusion criteria). In an IRB-approved protocol, nurses were informed that their consent to participate was implied if they chose to complete the trauma provider survey. . The survey includes 38 items in five categories, assessing: 1) knowledge about trauma-informed pediatric care (11 items); 2) opinions about trauma-informed pediatric care (6 items); 3) self-rated competence (10 items); 4) recent practice (7 items); and 5) perceived barriers to implementation of trauma informed care (4 items).
Each item for knowledge, opinions, self-rated competence, and perceived barriers is rated on a 3- or 4-point Likert-type scale with anchors appropriate for the category, e.g.,

potential barriers were rated as “not a barrier”, “somewhat of a barrier”, or “significant barrier”. In this survey of nurses working in pediatric acute care trauma units, participants were knowledgeable about many aspects of trauma-informed care. They generally held favorable opinions about integrating psychosocial considerations and awareness of potential posttraumatic stress responses into their practice. Most considered themselves moderately competent in a range of skills and practices that are elements of trauma-informed pediatric care.

Hopper, E., Bassuk, E.L., Olivet, J. (2010). Shelter from the storm: Trauma informed care in homelessness service settings. *The Open Health Services and Policy Journal, 3,* 80-100.

This article conducted a review of qualitative and quantitative studies that evaluated evidence based practice of trauma informed care in homelessness service settings. They aimed to define trauma informed care (TIC) and review programs that implement TIC. They reviewed literature from the Homelessness Resource Centre to access what best practice in TIC is considered to be. They also reviewed literature from mental health and addictions research as homelessness, addictions, and mental health can overlap. Their findings indicated that practitioners in homeless service settings feel that they need more exposure and training in TIC. They also found that TIC is no being conducted systematically in these settings, for example PTSD assessments at a addictions clinic were only being conducted for ½-⅔ of clients. An issue that emerged during research was that some clinicians fear the “Pandora’s box” effect. By addressing

trauma in settings that may not traditionally address these types of issues, they fear that they will not have the resources to properly deal with the trauma that has been brought forth. This was shown to be a concern of many organizations, leading them to be hesitant to implement system wide TIC training. They have also found that those who are accessing these programs prefer the services that approach care with a trauma informed care lens. The researchers concluded that the research on TIC is limited in homelessness service settings, but models from other areas such as mental health can be applied and be successful. They also concluded that there needs to be a standardization of TIC practice in homelessness services. They recommended utilization of a TIC framework across service settings in order to harmonize practice among institutions. In addition, there needs to be training, supervision, and support in order for TIC to be conducted successfully.

Prestidge, J. (2014). Using trauma-informed care to provide therapeutic support to homeless people with complex needs: A transatlantic search for an approach to engage the "non-engaging". *Housing, Care, and Support, 4,* 208-214.

This paper attempted to evaluate trauma informed care (TIC) practices when working with homeless populations in America. The author describes TIC practices in New York, and then discusses how it can be applied to a UK context. The writer outlines that TIC is not a type of therapy, but an approach to care in which an environment for recovery from trauma can be created. In the population being studied, many of them have complex or multi-traumas. By using a TIC approach with this population, it creates

a therapeutic relationship in which the individual will likely be able to move on to traditional therapy. Prestidge identifies four key themes of TIC:

1. Trauma awareness
2. Emphasis on safety
3. Opportunities to rebuild control
4. Strength based approach.

For TIC to be effective, there must be rigorous training of staff members, particularly those who are working on the front line. Part of this training includes letting go of the notion of 'fixing the individual' and accepting that they need to be a stable presence in the individual's life. The staff members interviewed by the writer indicated that this has changed their outlook on their work, and has increased job satisfaction. The writer's' recommendation is that any organization who is providing services to vulnerable population implement training for staff in TIC to further empower clients to take control of their care and create an environment in which recovery can take place.

Reeves, E. (2015). A synthesis of the literature on Trauma-informed care. *Issues in Mental Health Nursing, 36,* 698-709.

Reeves conducted literature review to examine what research has been done on trauma informed care. She explored research being done, how TIC is being practiced in different settings, and policies created about TIC. The synthesis includes 26 articles from midwifery, OB-GYN, prison health care, orthopedic nursing, physiotherapy, oncology, and HIV/AIDS care. Themes identified in the literature include needing to increase the occurrence of trauma screening and patient disclosure, developing

stronger therapeutic bonds with clients, minimizing distress and maximizing autonomy, enacting TIC in a variety of settings, and interdisciplinary team work using TIC. Some limitations identified are that populations were homogenous in some aspects such as they were only people who could recall their traumas, most studies were retrospective, and only one qualitative study established reliability and validity confirmation. This synthesis concluded that more research is needed on TIC. The themes identified in the synthesis can be used to develop a framework on a systemic level in order to begin enacting TIC in all service settings.