Becoming Trauma-Informed: Supporting Staff Through the Process of Change to Enhance the Care of Youth with Complex Trauma

Lauren A. Kaplan

Oregon Health & Science University School of Nursing

Becoming Trauma-Informed: Supporting Staff Through the Process of Change to Enhance the Care of Youth with Complex Trauma

Introduction

Child maltreatment generally encompasses neglect and physical, sexual, and psychological abuse to those younger than 18 years old (Centers for Disease Control & Prevention [CDC], 2018; World Health Organization [WHO], 2018). In 2016, about 676,000 children in the United States experienced abuse or neglect, of which more than 1,750 died as a result of child maltreatment (CDC, 2018). For those who survive, child maltreatment often leads to traumatic stress, which can cause disruption in brain development, impair development of nervous and immune systems, and increase risk for behavioral, physical, and mental health problems in adulthood (CDC, 2018; WHO 2018). As a result, childhood traumatic stress is associated with higher utilization of services across systems including health, mental health, child welfare, and juvenile justice systems (Briggs et al., 2013), putting increased demands on these child-serving systems, particularly in Oregon.

Problem Description

The number of child maltreatment victims in Oregon is consistently higher than the national rate. Since 2012, the child maltreatment victimization rate in Oregon has increased by 23.8% reaching 13.6 per 1,000 children compared to the national rate of 9.1 per 1,000 children (United States Department of Health & Human Services [HHS], Administration for Children and Families [ACF], Administration on Children, Youth and Families [ACYF], & Children's Bureau, 2018). Unfortunately, Oregon is failing to meet the needs of children with complex issues who are involved in multiple child-serving systems (Oregon Health Authority [OHA] & Oregon Department of Human Services [DHS], 2018). A primary recommendation to address this crisis

is for all child-serving systems to become trauma-informed (OHA & DHS, 2018). Lack of a trauma-informed approach can lead to re-traumatization and continued skill deficits in areas needed to be successful in school, work, in the community, and in interpersonal relationships. (Oregon Health Authority Addictions and Mental Health Division [OHA AMHD], 2013). Although it is well documented that trauma-informed care (TIC) can improve outcomes for child maltreatment victims, lack of knowledge about how to successfully integrate TIC into practice is a significant barrier to meeting the needs of this population.

It is estimated that only about 20-50% of changes in work process are successful (Steckler, Rawlins, Williamson, & Suchman, 2016). A lack of knowledge about how to successfully navigate work process change can impede an organization's ability to become trauma-informed, thwarting efforts to improve outcomes for children experiencing traumatic stress. Morrison Child and Family Services (MCFS) is a non-profit, community mental health organization in Oregon that serves populations at high risk for complex trauma, such as youth in residential treatment centers, in foster care, involved in the juvenile justice system, and youth experiencing poverty or homelessness (Complex Trauma Treatment Network, n.d.). In response to the need to implement trauma-informed care in child-serving systems, MCSF has started implementation of the trauma-informed intervention Attachment, Self-Regulation, and Competency (ARC). ARC is an empirically supported, evidence-based intervention that includes individual, family, and systems modalities to address complex trauma in children age zero to eighteen (OHA AMHD, 2013; NCTSN, n.d.). The consultation period from ARC trainers has concluded and given the poor rate of successful change integration in healthcare, leadership at the MCFS Beaverton clinic are seeking assistance to develop internal structures to support sustainable implementation of ARC.

Available Knowledge

Although the complexity of health care settings presents challenges to implementing evidence into practice, change can be more effective if grounded in appropriate theory (Davidoff, Dixon-Woods, Leviton, & Michie, 2015; Davis, Campbell, Hildon, Hobbs, & Michie, 2015). A change theory that can be adapted to a wide variety of settings and is based on continuous improvement can help navigate the significant gaps that exist between evidence and practice, while sustained implementation of TIC specifically requires ongoing educational support for staff. Organizational readiness for change was a common theme found in the literature on change theory. Lack of organizational readiness for change may account for up to half of unsuccessful change initiatives (Rubenstien et al., 2014). Despite inconsistent language and narrow views of readiness (Attieh et al., 2013; Rubenstien et al., 2014), similarities surfaced related to organizational dynamics, change process, innovation readiness, institutional readiness, and personal readiness (Attieh et al., 2013). The common theme of ongoing assessment at organizational and individual levels highlights the need to assess change readiness from a multilevel perspective throughout the entire change process.

Change is no longer considered time-limited, but rather thought to be a continuous process (Batras et al., 2015; Worley & Mohrman, 2014) and use of a theoretical framework is considered necessary to meet the continuous challenges of policy driven, evolving healthcare systems (Attieh, et al., 2013; Batras, Duff, & Smith, 2015; Orr & Davinport, 2015). Implementation of sustainable change requires an ability to be flexible in the pace of change, which varies across settings (Batras et al., 2015; Worley & Mohrman, 2014). Further, appropriate market and political forces, clearly defined goals, and internal change advocates are critical to successful change implementation (Batras et al., 2015). Trauma-informed care (TIC)

interventions currently have political momentum behind them driven by policy such as The Affordable Care Act and are supported by efforts of national groups such as Substance Abuse and Mental Health Services Administration and National Child Traumatic Stress Network, and by the state through the Oregon Health Authority. However, specific implementation strategies must be taken into account.

Staff support is an essential component to sustained implementation of TIC frameworks. Minimal access to trainings is a key barrier to successful ARC implementation (Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013). Psychoeducation for staff on the impacts of trauma is critical to helping staff understand the purpose of TIC and gain staff buy- in (Bryson et al., 2017). Training also provides staff with a common language that can be used to describe specific interventions and patient experiences (Bryson et al., 2017). Further, staff need continued educational support throughout the change process via activities such as recertification, ongoing training, coaching, and supervision (Bryson et al., 2017; Hodgdon et al., 2013). ARC Trainings should be both didactic and experiential with opportunities for staff to practice self-regulation (Bryson et al., 2017; Hodgdon et al., 2013). For example, clinicians can explore how to regulate their own arousal level while helping a client to process trauma. Literature also indicates an increased ability to promote a culture of safety and increased job satisfaction among providers that participate in TIC training (Damian, Gallo, Leaf, & Mendelson, 2017), which helps to sustain TIC principles in practice.

The ARC framework is designed to be flexible to adapt to numerous settings with varying resources and has improved outcomes for youth in outpatient, residential, classroom, and juvenile justice settings (NCTSN, 2012). Initial ARC implementation generally consists of an initial training and a period of consultation from ARC trainers (NCTSN, 2012). The consultation

period from ARC trainers has concluded at MFCS and further integration of ARC requires a structured implementation plan (Hodgdon et al., 2013). To ensure sustainability of ARC, a trauma team to provide leadership and focus should be established, policies and procedures should support ARC, orientation and ongoing training should be established, and there should be ongoing evaluation of ARC practice (Hodgdon et al., 2013; NCTSN, 2012). However, knowledge is lacking on how to implement these ARC specific changes. Survey of recent change theory literature (see table 1) provides rationale for a flexible theory that facilitates ongoing multilevel assessment and can guide implementation of changes specific to sustainable ARC implementation.

Table 1

Major change theories identified in the literature

Theory	Description	Benefit	Application
Organizational Readiness for Change	Readiness determined through assessment of change commitment and perceived ability to change	Contextual factors used to predict variation in uptake	Organizational
Transtheoretical Model of Change	Behavioral model; uses five stages of change; identifies decisional balance	Predicting and working with behavior change; navigating organizational change	Organizational & Individual
Lewin's Three-Step Model	Based on field theory and group dynamics	Maximizing efficiency, effectiveness, and sustainability	Organizational
Roger's Diffusion Theory	Explores communication about an innovation, how it spreads, and learning process; five stages; relies on a change advocate	Identifying barriers to change	Organizational
Organizational Learning	Establishes congruence between what is said and what is done using	Creating open and reflective learning cultures	Organizational
Theory of Organizational Culture	Change created through repeated group experiences of success	Embedding change within organizational culture	Organizational

Receptive Context for Change	Manipulation of non-static variables that influence receptiveness to change	Designing health initiatives in bureaucratic organizations	Organizational
Kotter's Eight-Step Process	Incremental transformational change	Avoiding barriers to change	Organizational

Note: Organizational Readiness for Change and Transtheoretical Model of Change information is from Rubenstein et al. (2014); Lewin's Three-Step Model, Roger's Diffusion Theory, Organizational Learning, Theory of Organizational Culture, and Receptive Contexts for Change Theory information is from Batras, Duff, and Smith (2015); Kotter's Eight-Step Process information is from Orr and Davinport (2015).

Rationale

Sustainable implementation of ARC can be achieved at MCFS Beaverton clinic through a quality improvement initiative informed by the Transtheoretical Model of Change (TMC) and focused on the development of an ARC educational support system. Leadership at the clinic are not currently using a formal change theory to guide implementation of ARC and no educational support system has been developed. TMC was the one empirically supported framework identified in the literature that can be applied at both the organizational and individual level (see table 1). Given the current healthcare environment, the multilevel application of the TMC is well suited to guide successful implementation of trauma-informed care interventions in child-serving systems, including community mental health settings. At the organizational level, TMC can help identify specific barriers and facilitators to implementing evidence-based practice, and provide direction for change implementation (Rubenstein et al., 2014). TMC also provides the flexibility of ongoing assessment which is consistent with the ongoing nature of change. At the individual

level, TMC is well suited to the situation at the MCFS Beaverton clinic as the implementation process is already underway and staff are in various stages of change.

TMC can also be used to guide the development of an educational support system informed by the literature. Staff educational support identified in the literature and not currently established at the MCFS Beaverton clinic includes initial training, ongoing training, and coaching. Development of initial and ongoing training that include didactic and experiential components can improve sustainability of ARC. TMC assessment can help identify potential change advocates who can be recruited to provide leadership and coaching that further supports staff and informs ongoing education modules based on staff identified needs.

Specific Aim

The overall aim for this project is to establish continuous educational support for staff at various entry points to enhance the sustainability of ARC, a trauma-informed practice, in a community mental health setting that serves youth experiencing complex trauma. Foundational education, ongoing education, ongoing needs assessment, coaching, and understanding of provider perceptions are goals that support this aim and are informed by the literature on change implementation in general and TIC specifically.

Methods

Context

MCFS Beaverton clinic is a non-profit, outpatient clinic that is one of nine office locations in the Portland metro area and Salem that provide comprehensive mental health and substance abuse services for youth. The clinic serves approximately 400 patients annually through the efforts of 20 employees. Patient care staff include seven Licensed Professional Counselors, four Clinical Social Workers, two Marriage and Family Therapists, one Psychiatric

Mental Health Nurse Practitioner, and one Skills Trainer. Support staff include three administrative staff, one clinical supervisor, and one clinic manager. The majority of patient care staff are new to the field and there is high turn-over among both support and patient care staff. Through informal conversations with staff and leadership, the work environment is perceived to be safe and supportive, though stressful due to the nature of the work (personal communication, April 11, 2018). Clinical staff report that leadership is highly accessible, supportive, and open to discussing new ideas (personal communication, April 11, 2018). All staff are encouraged to participate in weekly self-care activities and engage in improvement conversations during regularly scheduled weekly team meetings.

Intervention

The Model for Improvement framework was used to guide application of TMC principles to assess organizational readiness, individual readiness, as well as identify facilitators and barriers to sustainable implementation of ARC. A four-hour foundational education module was created and delivered to current staff and to new staff as part of the on-boarding process. Change advocates among staff were identified and an ARC Support Team was created to provide coaching and co-lead ongoing education modules. This author led the initial Plan, Do, Study, Act (PDSA) cycle of the quality improvement project with assistance from the clinic manager and identified change agents.

Study of the Intervention

Data was collected via an online survey that was administered before and after the foundational educational module. Links to the pre- and post- surveys were administered to all staff via work email. The survey included rating scale and open-ended question formats. The goal of tracking staff perceptions was to understand if the educational intervention had an impact

on staff movement through stages of change and what effect ARC has on clinical care. The goal for staff attendance at the foundational education module was 100%.

Measures

Outcome and process measures were collected during this initial PDSA cycle. The first outcome measure of focus was staff perceptions of knowledge of and comfort using ARC. Data was collected in Likert scale format and reported as the number and percentage of staff in each stage of change for each ARC building block. The second outcome measure of focus was staff perceptions of how using ARC impacts client interactions. A free text box was provided in the survey to gather data on the impact of ARC on client interactions and this data was categorized into themes based on similarities found in the data. The percentage of staff that participated in the initial training was the process measure used during the initial PDSA cycle.

Analysis

Information gathered at baseline and after the foundational education module was collected and stored electronically. Descriptive analysis of quantitative data was performed to summarize individual variables and find patterns. Changes were considered to be an improvement if provider perceptions reflected progression through the stages of change, indicated by frequency and percentage data. Narrative analysis was completed on qualitative data. Word repetitions were used to create a framework for identifying themes.

Ethical Considerations

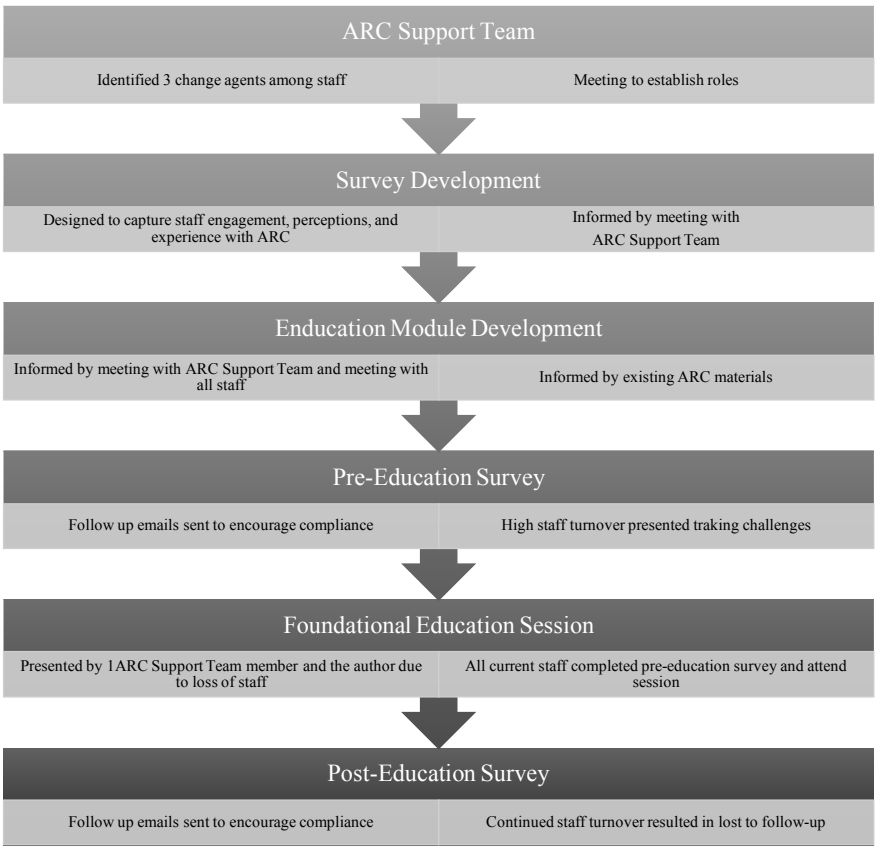
Quality improvement status was obtained via the Internal Review Board determination process. No identifying data was collected or displayed in order to maintain staff privacy. All information was stored in a secure online Box account. The foundational education module was provided at the clinic during regular business hours. No clients were scheduled for the day,

allowing all staff to participate with regular pay. There are no conflicts of interest to report. This author would like to acknowledge the cooperation and support of MCFS staff.

Results

Staffing issues resulted in some challenges. Figure 1 provides a summary of the steps taken and challenges faced during this initial PDSA cycle. Due to the loss of a significant number of staff, there were thirteen baseline survey respondents, reflecting 100% of staff at that time. Due to the loss of two ARC Support Team members this author presented the foundational education module along with the one remaining ARC Support Team member. Continued staffing issues resulted in only seven post-education survey respondents. Despite these challenges, meaningful information was obtained.

Figure 1: *Summary of first PSDA cycle*



Descriptive analysis of qualitative data revealed organizational readiness and movement through the stages of change. About 70% of staff were either in preparation, action, or maintenance stages of change at baseline, indicating the organization's overall readiness. In post-education survey data, this figure jumped to 86%, with about 43% of staff in the maintenance stage alone. Figure 2 provides the percentage of staff in each stage of change before and after the foundational educational module, clearly illustrating staff movement through the stages of change. Further, there was a global increase in staff knowledge of and comfort using ARC components (figure 3). The most improvement was found in engagement and caregiver affect management components, with the least improvement in trauma experience integration.

Figure 2: *Movement of staff through the stages of change*

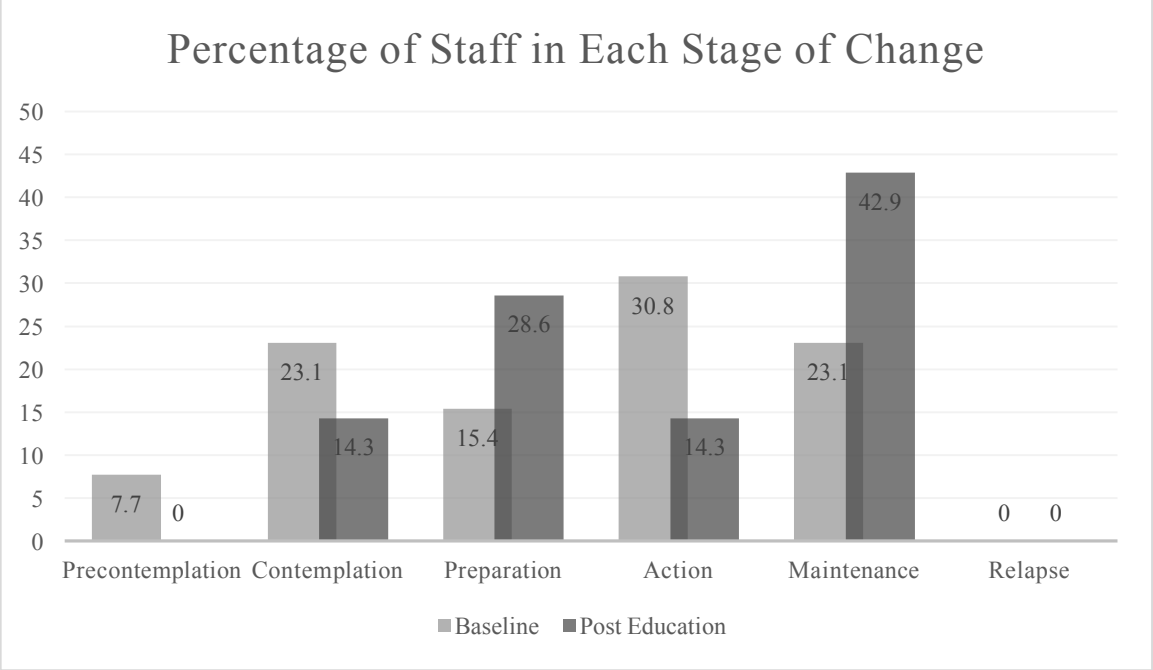
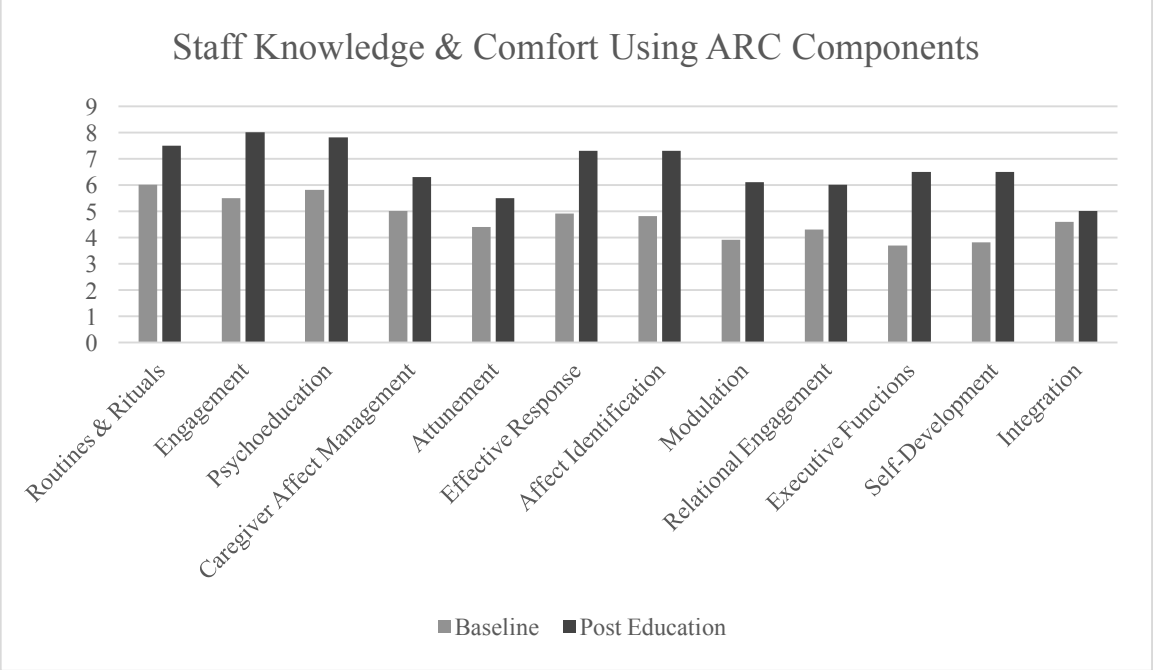
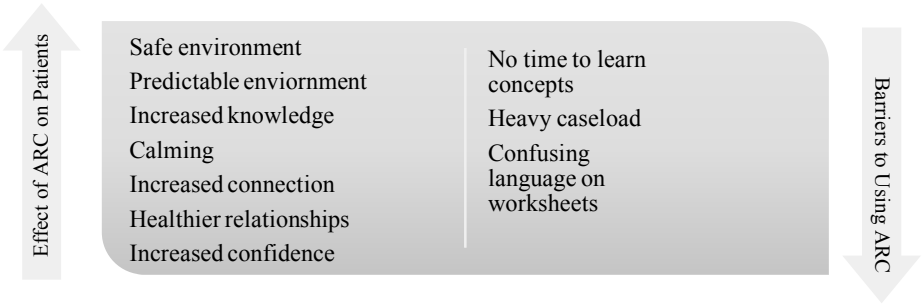


Figure 3: *Changes in staff perceptions of knowledge and comfort using ARC components*



Qualitative data analysis revealed perceived effects of ARC on patients and barriers to using ARC (figure 4). Themes related to effects on patients included safe and predictable environment, calming effect, increased knowledge, connection, and confidence, as well as healthier relationships. At baseline, several staff members were unable to articulate how ARC effected clients, which improved after the education module. Barriers included lack of time to learn concepts, heavy caseloads, and confusing language on ARC worksheets.

Figure 4: *Staff experiences using ARC*



Discussion

Summary

The foundational education module helped staff to move forward through the stages of change by increasing staff knowledge of and comfort using ARC principles. Staff also gained increased ability to identify the effects of ARC. This outcome is in line with findings from the literature and supports the project aim by providing an educational module that can be delivered as an annual review and as part of the onboarding process. Involvement of staff at each level increased buy-in and facilitated sustainability of the work beyond this authors involvement. The project also provided a framework MCFS can use to implement ongoing trainings which are vital to the success of TIC work process change.

Interpretation

Using the Model for Improvement to guide TMC principles for TIC work process change was successful in this clinic setting. Staff gained knowledge and comfort that increased the organizations ability to provide TIC. Leadership also gained knowledge of specific barriers staff face, which provides opportunities to further expand ARC fluency. This project proves to be a powerful first step toward establishing continuous educational support for staff at various entry points to enhance the sustainability of ARC. Based on the literature and outcomes of this project, it is reasonable to expect that with ongoing educational support the capacity of the organization to fully implement ARC will continue to improve. Overall, the results of this project reflect the anticipated outcomes, despite contextual challenges.

Limitations

The outcomes of this project are limited to the organization, though similar organizations may find comparable results. The small number of survey respondents make the results site specific and there may be inaccuracies in the data due the number lost to follow up. The staffing challenges that community mental health settings face will be an ongoing barrier to data accuracy in improvement work, however, this should not deter organizations from improvement work as it is vital to the success of work process change initiatives like TIC.

Conclusions

Oregon has a significantly higher rate of child maltreatment compared to the national rate, resulting in many detrimental long-term developmental outcomes. To address this crisis, Oregon Health Authority and Oregon Department of Human Services have identified TIC as a primary recommendation for child-serving systems. Successful implementation of TIC is an important work process change that can prevent re-traumatization and improve outcomes related to school, work, community involvement, and interpersonal relationships. The sustainability of this work is dependent on ongoing educational support for staff.

Next steps for this project include providing monthly education modules during regularly scheduled team meetings. Ongoing needs assessment can be obtained through the ARC Support Team by tracking how often this source is utilized and what additional staff needs are identified. Balancing measurement can be obtained via the Professional Quality of Life survey to be delivered prior to the start of monthly education modules and on a quarterly basis. This will ensure we are not losing sight of those who are caring for youth with complex trauma. After all, the key to becoming trauma-informed is supporting staff.

References

Attieh, R., Gagnon, M. P., Estabrooks, C. A., Legare, F., Ouimet, M., Roch, G., … Grimshaw, J. (2013). Organizational readiness for knowledge translation in chronic care: A review of theoretical components. *Implementation Science*, *8*(1). doi:10.1186/1748-5908-8-138

Batras, D., Duff, C., & Smith, B. J. (2014). Organizational change theory: Implications for health promotion practice. *Health Promotion International*, *31*(1), 231–241. doi:10.1093/heapro/dau098

Briggs, E. C., Fairbank, J. A., Greeson, J. K. P., Layne, C. M., Steinberg, A. M., Amaya-Jackson, L. M., . . . Pynoos, R. S. (2013). Links between child and adolescent trauma exposure and service use histories in a national clinic-referred sample. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(2), 101-109. doi: 10.1037/a0027312

Bryson, S. A., Gavin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., … Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realistic systematic review. *International Journal of Mental Health Systems*, *11*(36). doi:10.1186/s13033-017-0137-3

Centers for Disease Control and Prevention. (2018, April 5). Child Abuse Prevention. Retrieved from https://www.cdc.gov/features/healthychildren/index.html

Complex Trauma Treatment Network. (n.d.). Populations of Interest. Retrieved from https://www.cttntraumatraining.org/populations-of-interest.html

Damian, A. J., Gallo, J., Leaf, P., & Mendelson, T. (2017). Organizational and provider level factors in implementation of trauma-informed care after a city-wide training: An explanatory mixed methods assessment. *BMC Health Services Research*, *17*(1), 750–760. doi:10.1186/s12913-017-2695-0

Davidoff, F., Dixon-Wood, M., Leviton, L., & Michie, S. (2015). Demystifying theory and its use in improvement. *BMJ Quality and Safety*, *24*(3), 228–238. doi:10.1136/bmjqs-2014-003627

Davis, R., Campbell, F., Hildon, Z., Hobbs, L., & Michie, S. (2015). Theories of behavior and behavior change across the social and behavior sciences: a scoping review. *Health Psychology Review*, *9*(3), 323–344. doi:10.1080/17437199.2014.941722

Hodgdon, H. B., Kinniburgh, K., Gabowitz, D., Blaustein, M. E., & Spinazzola, J. (2013). Development and implementation of trauma-informed programming in youth residential treatment centers using the ARC framework. *Journal of Family Violence*, *28*(7), 679–692. doi:10.1007/s10896-013-9531-z

National Child Traumatic Stress Network. (2012, April). ARC Fact Sheet. Retrieved from https://www.nctsn.org/sites/default/files/interventions/arc_fact_sheet.pdf National Child Traumatic Stress Network. (n.d.). Types of traumatic stress. Retrieved from https://www.nctsn.org/what-is-child-trauma/trauma-types

Oregon Health Authority, & Oregon Department of Human Services. (2018). *Oregon's child, youth and family continuum of care: A system in crisis- proposed systemic solutions* [Draft]. Retrieved July 1, 2018 from https://www.oregon.gov/DHS/SENIORS-DISABILITIES/DD/PROVIDERS-PARTNERS/EngagementInnovation/oha-dhs-continuum-care-proposal.pdf

Oregon Health Authority Addictions and Mental Health Division. (2013). *Trauma white paper* [White paper]. Retrieved July 1, 2018 from https://www.oregon.gov/oha/HSD/AMH/Child%20MH%20System/Addressing%20the%20Effects%20of%20Trauma%20-%202013.pdf

Orr, P., & Davenport, D. (2015). Embracing change. *The Nursing Clinics of North America*, *50*(1), 1–18. doi:10.1016/j.cnur.2014.10.001

Rubenstein, L. V., Danz, M. S., Crain, A. L., Glasgow, R. E., Whitebird, R. R., & Solberg, L. I. (2014). Assessing organizational readiness for depression care quality improvement: Relative commitment and implementation capability. *Implementation Science*, *9*(1). doi:10.1186/s13012-014-0173-1

Steckler, N. A., Rawlins, D. B., Williamson, P. R., & Suchman, A. L. (2016). Preparing to lead change: An innovative curriculum integrating theory, group skills and authentic presence. *Healthcare*, *4*(4), 247–251. doi:10.1016/j.hjdsi.2015.10.005

Substance Abuse and Mental Health Services Administration. (2017, December 19). Understanding child trauma. Retrieved from https://www.samhsa.gov/child-trauma/understanding-child-trauma

United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, & Children's Bureau. (2018). *Child maltreatment 2016*. Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

White, K., Dudley-Brown, S., & Terhaar, M. (2016). *Translation of evidence into nursing and health care practice* (2nd ed.). New York, NY: Springer.

Worley, C. G., & Mohrman, S. A. (2014). Is change management obsolete? *Organizational Dynamics*, *43*(1), 214–224. doi:10.1016/j.orgdyn.2014.08.008

World Health Organization. (2018). Child Maltreatment. Retrieved from http://www.who.int/en/news-room/fact-sheets/detail/child-maltreatment