Development of a Trauma-Informed Care Resource for Emergency Nurses Caring for People with Mental Illness

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Abstract

Background: Traumatic experiences significantly affect the mental and physical health of people with mental illness (PWMI), placing a substantial burden on the healthcare system. Emergency visits for these individuals come with the potential for additional harm, including re-traumatization, which can be mitigated through the adoption of a trauma-informed care (TIC) approach. TIC practices emphasize the safety of PWMI by acknowledging the effects of trauma on health and behaviors, by avoiding re-traumatization, and by creating opportunities for empowerment. However, there is a lack of emergency-specific TIC resources and documented implementation of this approach within emergency departments. **Purpose:** To develop a TIC educational resource for emergency nurses who care for PWMI at the qathet General Hospital. **Methods:** A comprehensive literature review, an environmental scan, and consultations were utilized to inform the development of a TIC educational resource. **Results:** The literature review emphasized the effectiveness of short, interactive, in-person TIC education as beneficial in promoting the use of TIC. The environmental scan guided content and delivery decisions, while consultations identified emergency nurses' perceptions, TIC awareness, and educational needs. **Conclusion:** Two TIC resources were developed for emergency nurses who care for PWMI. The first resource takes the form of a self-learning module tailored for nurses, while the second serves as a comprehensive guide for facilitators tasked with delivering the program's content. A plan to implement the TIC resources at the qathet General Hospital will be established.

Keywords: *Trauma-informed care; People with mental illness; Emergency nursing; Training*

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Introduction

People with mental illness are increasingly accessing health care services through the emergency department, with mental health disorders being associated with frequent visits, particularly for substance use disorders (Odd ratio [OR] = 2.23, 95% CI [2.12, 2.35]) (Fleury et al., 2019). People with Mental Illness (PWMI) include individuals with a diagnosed psychiatric disorder and those who present to the emergency department for mental health reasons (Fleury et al., 2019; Hennessy et al., 2023; Vandyk et al., 2018). In British Columbia, psychiatric emergency visits constituted 1.5% of all visits in 2017-2018, with noted increases for substance use disorders from 2014-2015 (3.4 vs. 5.5 visits per 1000 population). (Lavergne et al., 2018). Emergency visits involve potential harms, such as re-traumatization, stigmatization, and coercive practices, that can affect PWMI (Hennessy et al., 2023; Vandyk et al., 2018). Environmental constraints, overcrowding, and inadequate staffing can also result in unfavorable outcomes when PWMI seek care in the emergency department (Muskett, 2014; Vandyk et al., 2018). Research has shown that most people with mental illness events have experienced traumatic experiences, which has negative impacts on their mental health, physical health, and social functioning (Adams et al., 2020; Hogg et al., 2023; López-Martinez et al., 2018; O'Hare et al., 2017). Those traumatic experiences often result in increased healthcare expenditures and service use (Davis et al., 2022; Hauw et al., 2021; Lavergne et al., 2018). If emergency nurses were able to provide safe care to PWMI using a trauma-informed care (TIC) approach, PWMI may have enhanced experiences in the emergency department.

Trauma-informed care (TIC) was developed as a new approach to mitigate the adverse effects of trauma through the provision of holistic care (Muskett, 2014). According to Wathen and Varcoe (2021), "trauma-informed care creates safety for service users by understanding the effects of trauma, and its close links to health and behavior; it is not about eliciting or treating

people's trauma" (p. 1). Moreover, it is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021). Trauma-informed care has been established and adopted in mental health and substance abuse sectors but is less prevalent in emergency departments, resulting in a deficit of skills and knowledge among emergency nurses and physicians (Brown et al., 2022; Bruce et al., 2018; Hall et al., 2016; McNamara et al., 2021; Poole et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). However, a TIC educational program has shown promising results in two large urban emergency departments in Australia (Hall et al., 2016). The authors of the study found that TIC training significantly increased emergency nurses' confidence, attitudes, and knowledge of TIC (Hall et al., 2016).

At the qathet General Hospital, a rural hospital within Vancouver Coastal Health (VCH), two PWMI per week are, on average, involuntarily admitted in the emergency department (V. Wilson, personal communication, May 22, 2023). Although emergency nurses are required to provide psychiatric care for these patients, there is currently no specialized psychiatric TIC resource or training for emergency nurses, leaving them poorly equipped to care for PWMI competently (V. Wilson, personal communication, May 21, 2023). In addition, emergency nurses face ongoing challenges in providing care for PWMI, with limited educational opportunities, time constraints, and insufficient staffing (V. Wilson, personal communication, May 21, 2023). Therefore, this practicum project aimed to develop an educational resource for emergency nurses at the qathet General Hospital to assist them in delivering trauma-informed care for PWMI.

Objectives

The overall goal of the practicum was to develop an educational resource to help emergency nurses provide trauma-informed care for People with Mental Illness (PWMI) at the qathet General Hospital.

The key practicum objectives were to:

1. Examine the prevalence, the risk factors, and the impact of traumatic events for PWMI by conducting a literature review.
2. Analyze and synthesize the current educational strategies for trauma-informed care, specifically for nurses.
3. Explore the educational needs of emergency nurses for the provision of trauma-informed care for mental health patients by consulting key stakeholders.
4. Evaluate currently available resources to assist emergency nurses in delivering trauma-informed care for mental health patients within Vancouver Coastal Health and other Canadian healthcare authorities by carrying out an environmental scan.
5. Develop an educational resource to assist emergency nurses in delivering trauma-informed care for mental health patients based on the findings from the literature review, the environmental scan, and the consultations.
6. Demonstrate advanced nursing practice competencies.

Overview of Methods

Three methods of data collection were utilized to inform the development of an educational resource about TIC for emergency nurses. First, a literature review examining the prevalence of trauma in PWMI, its impact on patients, and the contributing factors to the suboptimal care for PWMI in the emergency department was conducted. In addition, the literature review explored the effectiveness of educational interventions in improving healthcare workers' and nurses' knowledge, skills, confidence, and attitudes towards the TIC approach. Barriers and facilitators to the implementation of TIC in practice were also examined.

Second, I conducted an environmental scan to explore the available Canadian resources aimed at assisting emergency nurses in practicing a Trauma-Informed Care (TIC) approach.

Three types of resources (i.e., online programs, toolkits, and policies) were identified within Vancouver Coastal Health and other Canadian health authorities. After reviewing the resources, the collected data was analyzed and synthesized to identify the content and type of effective learning methods to be utilized for my educational resource. In addition, an informal discussion with the nurse educator allowed me to examine the TIC resources available at Vancouver Coastal Health and their limitations. The environmental scan helped me identify educational content from current TIC resources and policies that could be promptly adapted for the emergency nurses at the qathet General Hospital.

Last, through consultations, I explored emergency nurses' perceptions of caring for PWMI, their awareness of TIC, and their perceived educational needs for a TIC educational resource. I conducted nine semi-structured interviews with seven senior and junior emergency nurses, one patient care coordinator, and one nurse educator. Gaining insight into nurses' educational needs and perceived facilitators and barriers about the trauma-informed care approach enabled me to further refine the content and the educational modality of my resource about TIC to meet the needs of the local emergency department nurses.

The key findings of the literature review, the environmental scan and the consultations will be discussed in the next sections.

Summary of the Literature Review

The literature review aimed to examine the impacts of trauma on PWMI, its contributing factors, and the effectiveness of educational strategies about TIC in improving nurses' knowledge, confidence, and skills related to TIC, and attitudes towards PWMI. A literature review was conducted to summarize and synthesize relevant published studies. CINAHL and PubMed were used to search for the relevant literature published in the last eight years. The following MeSH terms and keywords were used in the search: *psychological trauma*, *attitudes of*

health care workers, *education*, *mental health*, *emergency department*, *trauma-informed care*, *trauma-informed approach*, *re-traumatization*. Quantitative, qualitative, and mixed methods studies published in English only were included in this review. Grey literature was also included using a Google Scholar search and Memorial University of Newfoundland library database. Three tools were used to critically appraise studies: 1) quantitative research studies were critically appraised using the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit for quantitative studies (PHAC, 2014), 2) the Joanna Briggs Institute (JBI) critical appraisal checklist for qualitative research (JBI, 2020), and 3) the Mixed Methods Appraisal Tool (MMAT) for mixed methods studies (Hong et al., 2018). The literature review can be found in Appendix A.

Key Findings of the Literature Review

The literature review revealed that traumatic events negatively impact PWMI' mental health, physical health, and social functioning (Adams et al., 2020; Hogg et al., 2023; López-Martinez et al., 2018; O'Hare et al., 2017). In addition, traumatic events contribute to increased healthcare expenditures and use (Davis et al., 2022; Hauw et al., 2021). Various reasons contributing to the suboptimal care of PWMI in the emergency department were examined. Nurses highlighted their lack of training and skills about the TIC approach (Stokes et al., 2017; Vicenti et al., 2017). Moreover, many emergency nurses and physicians did not feel very competent with TIC and in providing basic TIC interventions (Bruce et al., 2018). Additionally, many nurses were found to hold negative perceptions toward PWMI, thus compromising the care of PWMI in the emergency department (Hennessy et al., 2022; Isobel et al. 2021)

To address this problem, a number of educational interventions have been examined to improve nurses' knowledge, confidence, skills, and attitudes toward TIC (Berg-Poppe et al.,

2022; Carter-Snell et al., 2020; Cannon et al., 2020; Choi & Seng, 2015; Damian et al., 2019; Hall et al., 2016; Hoysted et al., 2019; Palfrey et al., 2019; Weiss et al., 2017). Although the quality of the studies was low, researchers have found that educational programs about the TIC approach could improve nurses' confidence, skills, and attitudes toward TIC (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; Choi and Seng, 2015; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017). Moreover, brief in-person TIC workshops with interactive elements (e.g., discussions, case studies) were found effective for promoting TIC adoption in a variety of settings (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; Choi and Seng, 2015; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017). However, there was mixed evidence about educational interventions strengthening HCWs' knowledge, self-efficacy and in ameliorating patient outcomes (Aremu et al., 2018; Beckett et al., 2017; Carter-Snell et al., 2020; Damian et al., 2019; Isobel & Delgado, 2018; Levine et al., 2020; McNamara et al., 2019; Weiss et al., 2017).

While the development of educational material may be evidence-based, it was essential to examine factors that can impede or assist their implementation to practice. Barriers and facilitators to the implementation of TIC in practice were in the literature review. Competing priorities, heavy workloads and limited time for education hindered its implementation to practice (Lovell et al., 2022). The reliance on standardized policies and guidelines constrained nurses' ability to provide TIC (Vicenti et al., 2022). However, nurses acknowledged that the TIC approach aligned with their professional role and their nursing duties (Isobel et al., 2021).

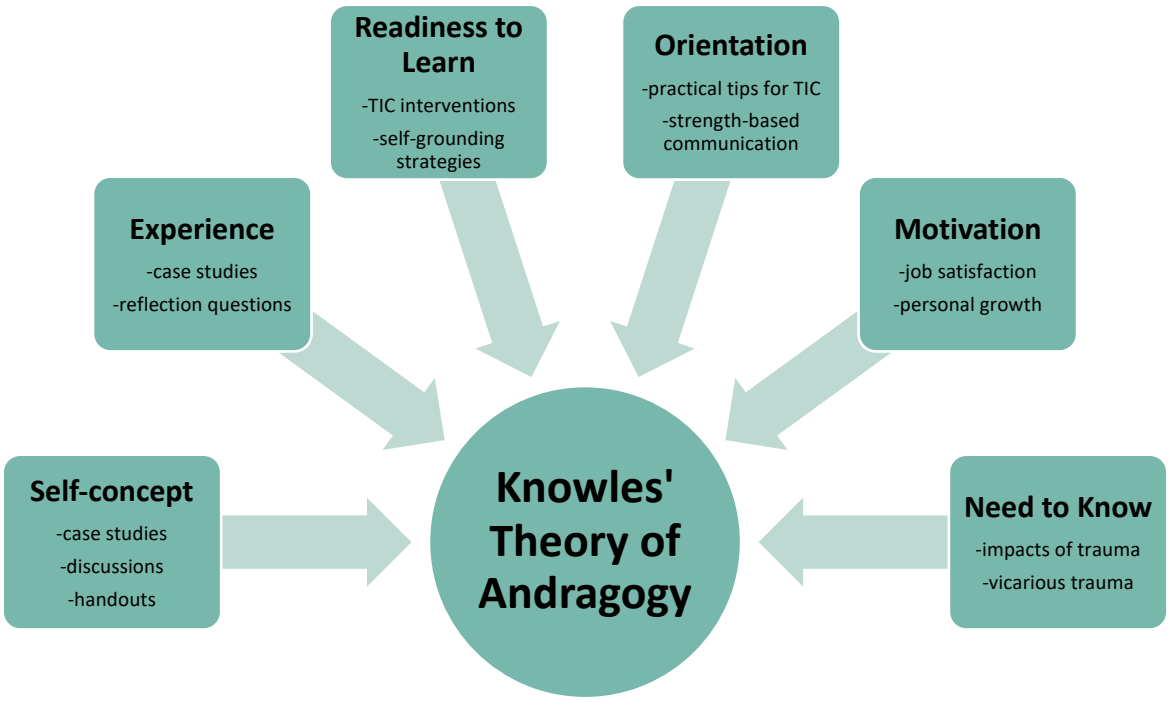
Theoretical Framework

Knowles' Theory of Andragogy

Knowles' theory of andragogy was chosen to inform the development of a TIC educational resource for emergency nurses (Chan, 2010). Andragogy is defined by six core principles (a) the learners' self-concept (b) the role of the experience (c) the readiness to learn (d) orientation to learning (e) motivation (f) the need to know (Chan, 2010). These principles will be described below and are illustrated in Figure 1.

Figure 1

Knowles' Theory of Andragogy for the TIC Resource



First, the learners' self-concept entails that adult learners are autonomous in their learning journey (Chan, 2010). By providing choices in relation to educational modalities and opportunities, adults retain their agency and interest in developing new skills (Chan, 2010). I developed an educational resource for emergency nurses that includes a variety of training modalities (e.g., case studies, discussions, self-learning modules). Second, previous experience is

a learning resource for adult learners (Chan, 2010). In such, when engaging in educational opportunities for TIC, emergency nurses can draw on their previous experiences with PWMI. Case studies or guided discussions serve a vehicle to explore and share these experiences.

Third, adult learners benefit from teachings that are relevant to their practice (Chan, 2010). As emergency nurses frequently interact and provide care to PWMI, they require knowledge and skills that they can incorporate in their daily practice. The TIC manuals include multiple examples of TIC interventions that emergency nurses can use for patients who present with psychiatric conditions. Fourth, learning offerings should be problem-centered or task-oriented (Chan, 2010). Adults prefer educational material that provides them with concrete techniques they can apply in their practice. The use of reflection questions can help emergency nurses to understand TIC principles and find ways to apply them as part of their nursing care. Fifth, adult learners are motivated in endeavors that stimulates them or when they can help others (Chan, 2010). By providing safe and competent care for PWMI, emergency nurses can improve their job satisfaction and help with their personal growth.

Finally, adult learners need to know how new knowledge is beneficial for them (Chan, 2010). Underlining the impacts of trauma on patients' and vicarious trauma may assist emergency nurses in developing an interest in TIC.

Summary of the Environmental Scan

The objective of the environmental scan was to identify the delivery methods, the types of resources currently utilized, and the content of current trauma-informed care resources within VCH and other Canadian health authorities. Specifically, my goal was to determine their usefulness and potential applicability to the local context. To assess local and provincial resources, information such as online modules for healthcare workers, guidelines for TIC, and policies for TIC were retrieved from the VCH employee portal and the LearningHub, a

healthcare training portal for HCWs in British Columbia. In addition to searching the above resources, a Google search yielded educational programs and materials (i.e., online programs, guidelines, and policies) from other Canadian healthcare authorities (e.g., Alberta Health Services). In addition, an informal discussion with the mental health nurse educator allowed me to confirm the existence of TIC resources within VCH, although none of these resources specifically addressed the needs of emergency nurses.

Key Findings of the Environmental Scan

The environmental scan provided additional insights into TIC resources that could contribute to creating an educational tool tailored for emergency nurses at qathet General Hospital. After reviewing and analyzing the retrieved resources, important topics to cover were found to be: ***1) trauma and its impacts 2) definition of TIC and its principles 3) strategies to implement TIC in practice and, 4) information on vicarious trauma and how to manage it***. The environmental scan also offered guidance for educational modalities. In addition to didactic material, recommendations from two Canadian healthcare organizations included using interactive educational methods, such as case studies and guided discussions, for emergency nurses to solidify their skills with TIC (Alberta Health Services, 2022; Registered Nurses' Association of Ontario [RNAO], 2017). The environmental scan report can be found in the Appendix B.

In sum, the environmental scan helped further refine the educational content for the TIC program, with many resources serving as a foundation for the content of the facilitators' and nurses' manuals. In the following section, I will provide an overview of the results of the consultations.

Summary of the Consultations

The consultations aimed to explore emergency nurses' perceptions of caring for PWMI, their awareness of TIC, and their learning needs for a TIC resource. Nine semi-structured interviews were conducted with seven emergency nurses, a nurse educator, and a patient care coordinator. Each interview took between 15 to 30 minutes to be completed. Emergency nurses were interviewed because they could provide unique insight regarding their role and how they contribute to the care of PWMI. Moreover, the nurse educator and the patient care coordinator further enhanced my understanding of emergency nurses' educational preferences and challenges with the implementation of the TIC approach in practice due to their expertise in offering educational opportunities for nurses.

Key Findings of the Consultations

Using Bengtsson's content analysis (2016), after analyzing the collected data, three main themes emerged: ***1) nurses' perceptions of caring for PWMI, 2) TIC in the emergency department, and 3) educational needs for emergency nurses***. When asked about their perceptions of caring for PWMI, emergency nurses highlighted the pervasive effects of the mental health stigma. Emergency nurses discussed this theme in relation to their negative attitudes towards PWMI, a reliance on standardized processes, and feeling ill-prepared and unsupported. Moreover, insufficient safety was also a recurrent theme and was further divided in three subthemes: 1) safety for all, 2) privacy, and 3) potential for vicarious trauma.

In regard to the TIC approach, the consultations provided important information about emergency nurses' perceived facilitators and barriers for the implementation of TIC within the emergency department. Despite the availability of local and provincial resources for TIC, none of the interviewees were aware of TIC resources. Moreover, although most emergency nurses had a positive attitude towards the TIC, many noted that insufficient resources, understaffing,

and a lack of time would hinder emergency nurses from practicing with a TIC approach. The educational needs of emergency nurses were also explored during the informal interviews. Emergency nurses stated they preferred in-person compressed educational sessions, supplemented with case studies and discussions, a finding reiterated by the nurse educator, with modules being seen as less engaging. In addition, the interviewees suggested the inclusion of handouts. When asked about what content should be included in a TIC resource, emergency nurses disclosed their need for an enhanced understanding of trauma, its impacts, and the principles of TIC. Communication skills, managing vicarious trauma, and debriefing were also topics seen as essential by many of the participants. A copy of the consultation report is included in the Appendix C.

In summary, the consultations with key stakeholders confirmed short in-person educational sessions with discussion and case studies as the preferred learning modality for emergency nurses. Moreover, in line with the findings from the environmental scan, the learning needs and topics were corroborated during the interviews with emergency nurses. The summary of the educational resource will be discussed below.

Summary of the Resource

Using the results of the environmental scan, the literature review, and the consultations helped inform the development of an educational resource for emergency nurses to provide trauma-informed care for mental health patients. From these findings, a TIC program, consisting of eight short sessions to educate emergency nurses on the TIC approach for PWMI, was created. Two TIC manuals were created: one intended for facilitators to assist them in delivering the resource's content, and the second manual serves as a self-learning guide for emergency room nurses who are unable to attend the sessions. These resources will be described below. A copy of both manuals can be found in Appendix D.

Part 1: Facilitators' Manual

A Trauma-informed care facilitators' manual was developed to equip facilitators with all the relevant educational material (e.g., learning objectives, handouts, reflection questions, educational material to review) necessary to conduct eight short educational sessions on trauma-informed care principles and skills. The eight short educational sessions are designed to be conducted during work hours by registered nurses with excellent interpersonal skills, leadership capabilities, and a passion for evidence-based practice and education (e.g., patient care coordinator, a charge nurse, a nurse educator, or a nurse champion). Each session, which is fifteen minutes in length, will be presented for a week following shift report (i.e., after the day and night shift report) to allow most nurses to complete the session. The target audience consists of emergency nurses responsible for the care of individuals with mental illness, requiring a group size of three to ten nurses for effective reflection and discussions. The charge nurse will determine the availability of nurses during a shift prior to engaging in the educational opportunity. For instance, sessions may need to be rescheduled if there is a high patient census or if the unit is short-staffed.

Format of the Manual

The educational material incorporates diverse learning strategies aligned with the principles of Knowles' andragogy theory, substantiated by findings from the literature review, environmental scan, and consultations (Chan, 2010).

Each session follows the same format for consistency and ease of use. The following information is provided for each session in the manual: 1) purpose of the session, 2) learning objectives for the participants, 3) a short introduction outlining general instructions for the sessions, 4) background and educational information about each topic, 5) reflection questions or

case studies to facilitate discussion, 6) key learning points, and 7) a handout for the participants. In addition, both manuals contain two evaluations surveys (i.e., pre-training survey, post-training survey) and an attendance sheet for the facilitator.

An educational resource for emergency nurses that includes a variety of training modalities (e.g., case studies, reflection questions) assists adults in developing new skills (Chan, 2010). Reflection questions also allows emergency nurses to build on their experiences with PWMI as experience is a learning resource for adult learners (Chan, 2010). In addition, as emergency nurses frequently provide care to PWMI, the inclusion of practical knowledge and skills, such as strengths-based communication, is relevant to their psychiatric nursing practice. Moreover, underlining the impacts of trauma on patients and vicarious trauma helps emergency nurses cultivate their interest in TIC.

Content of the Manual

The introductory section of the manual delineates the role and recommendations for the facilitators in order to optimize the delivery of the educational sessions. The facilitators should be well prepared prior to conduction the sessions, encourage participation in a safe learning environment, guide the sessions by connecting the learning material with participants' comments, and stimulate discussion by asking questions or redirecting comments (McFee, n.d.).

The facilitator's manual covers a range of topics derived from the four principles of TIC. Sessions should be conducted in the following order, with emergency nurses needing to attend each one of these sessions for optimal learning: 1) principles of trauma-informed care, 2) trauma, 3) vicarious trauma, 4) debriefing, 5) brief intervention, 6) strengths-based communication, 7) case study, and 8) trauma-informed care resources. These topics are further described below.

Session 1: The Four Principles of Trauma-Informed Care

In the first session, the definition of trauma-informed care and its main principles (i.e., trauma awareness, safety and trustworthiness, choice, collaboration, and connection, strengths-based approach) are explored. Examples of a TIC approach for PWMI in emergency nursing are provided (Poole et al., 2013; Wathen & Varcoe, 2021). Guided discussion is also used with reflection questions for nurses to identify additional TIC interventions for PWMI for their practice. Key learning points in this session include that TIC is a universal approach that can be easily incorporated into practice, even in the emergency department (Wathen & Varcoe, 2021).

Session 2: Trauma

The second session exemplifies the principle of trauma awareness. In this session, an overview of trauma, its impacts on well-being, and its importance in the context of emergency nursing and PWMI are presented. Questions to prompt reflection are included to identify other examples of the impacts of trauma for PWMI and how it may influence their ability to cope with their visit in the emergency department. A key learning point is that the behaviors of PWMI in the emergency department are often ways for then to cope with traumatic events (Varcoe et al., 2019).

Session 3: Vicarious Trauma

The third session highlights the principle of safety and trustworthiness. In this session, vicarious trauma is explored. Participants are invited to engage in self-care and identify grounding strategies to mitigate the effects of vicarious trauma. Due to the sensitive nature of this topics, self-reflection questions are included in a handout for participants to complete on their own time. A key learning point is that working with individuals who have a history of trauma, such as PWMI, can have an impact on emergency nurses' well-being (Poole et al., 2013). Therefore, it is important to be aware of its impact, to strive to attain balance between

professional and personal life, and to connect with supportive individuals (Center of Addictions and Mental Health, n.d.).

Session 4: Debriefing

The principle of choice, collaboration, and connection is emphasized in this session. A rationale for debriefing in the emergency department after various incidents is examined. The SENSE model of debriefing for people with mental illness in crisis is explored (Ko & Choi, 2020). Reflection questions supplement the didactic material and provide an opportunity for emergency nurses to apply the newly learned material. A key learning point is that debriefing is an opportunity for emergency nurses to openly discuss and reflect on an event, on their practice, and on their feelings in a safe environment (Arbios et al., 2022).

Session 5: Brief Intervention

The principle of choice, collaboration, and connection is highlighted in this session. An overview of the brief intervention is provided to emergency nurses. The FRAMES acronym for the brief intervention is examined with examples for PWMI in crisis in the emergency department (RNAO, 2017). A short case scenario provides an opportunity for emergency nurses to apply the newly learned material. The key message is that the brief intervention is a communication technique that can be utilized by emergency nurses to assist PWMI (RNAO, 2017).

Session 6: Strength-Based Communication

The strengths-based approach principle is illustrated in the fifth session. The principles of strength-based communication and documentation are discussed. It includes a reflection on common terms used in emergency nursing. A short case scenario provides an opportunity for emergency nurses to practice their communication and documentation skills for PWMI from a

strength-based approach. The key learning point for this session is that strength-based communication helps promote healing, increase resilience, and reduce stigma, especially for PWMI (Nathoo et al., 2018).

Session 7: Case Study

In the seventh session, emergency nurses are invited to ponder on an individual with mental illness' behavior in the emergency department based their past traumatic experiences. It is accompanied by reflection questions on TIC interventions for PWMI that can be readily incorporated to their practice. The key learning point is to reinforce that the TIC approach is compatible with the emergency nursing practice (Wathen & Varcoe, 2021).

Session 8: Trauma-Informed Care Resources

In the eighth session, the available resources for TIC and the Vancouver Coastal Health policy are examined. Reflection questions are utilized for participants to consider their role in providing care for PWMI with a TIC approach. The key message is that emergency nurses are expected to practice with a TIC approach to best support families, to improve inclusion of all individuals, and to provide a psychologically safe environment for everyone (Vancouver Coastal Health, 2020).

Part 2: Nurses' Manual

A complementary nurses' manual was developed to educate emergency nurses on the TIC approach. This learning resource includes modules with educational information on the trauma-informed care approach tailored to the emergency nurses. This manual is designed for nurses who cannot attend or complete in-person short educational sessions and for those who prefer this particular mode of learning.

The format and the content included in the facilitator's manual is mirrored in the modules

designed for emergency nurses. Therefore, in addition to using various teaching strategies, the nurses' manual similarly reflects the principles of the Knowles' theory of andragogy (Chan, 2010). Each module has the same format, which includes the following sections: 1) purpose of the session, 2) learning objectives for the participants, 3) a short introduction outlining general instructions for the modules, 4) background and educational information about each topic, 5) reflection questions, 6) key learning points, and 7) a handout for the participants.

In addition, both manuals contain two evaluations surveys (i.e., pre-training survey, post-training survey). Participants should complete the pre-training survey prior to attending the first session or finishing the first module. The post-training survey can be completed once the participants have taken part in all the eight sessions or once the modules have been done. The feedback obtained from the emergency nurses with the post-training survey, which contains summative and process evaluation questions, will be critical in providing information to further refine the educational material and optimize the methods of delivery.

Discussion of Advanced Nursing Practice (ANP) Competencies

This practicum project has allowed me to further develop advanced nursing practice competencies. The Canadian Nurses Association (CNA) (2019) outlined six competencies for ANP rooted in knowledge, research, and clinical expertise: 1) direct comprehensive care, 2) health system optimization, 3) education, 4) research utilization, 5) leadership, and 6) consultation and collaboration. Through this practicum course, I have demonstrated several advanced nursing competencies, including research utilization, education, and leadership, which are detailed below.

Research utilization

Advanced practice nurses demonstrate research competencies by summarizing and critically appraising literature to support evidence-based practice (CNA, 2019). In this practicum

project, I summarized evidence regarding educational programs for TIC by conducting a literature review and building literature summary tables to highlight the findings from selected studies. I critically appraised all studies included in the literature review using different critical appraisal tools, such as PHAC Critical Appraisal Toolkit (PHAC, 2014) for quantitative studies, the JBI critical appraisal checklist for qualitative research (JBI, 2020), and the MMAT for mixed methods studies (Hong et al., 2018). In addition, I conducted data collection through the utilization of semi-structured interviews, for which I formulated interview guide questions to guide discussions with key stakeholders. I also analyzed the data obtained through the interviews using the content analysis technique (Bengtsson, 2016). Additionally, I retrieved relevant content data from local and Canadian resources on TIC as part of an environmental scan, which was then utilized to develop the TIC educational resource.

Education

Advanced practice nurses manifest educational competencies by identifying learning needs and assisting in ameliorating nurses' knowledge and abilities (CNA, 2019). Through the consultations and the literature review, I identified educational opportunities with interactive components (e.g., guided discussions, case studies) as effective in promoting the use of TIC. This competency was also evidenced by creating tailored content for emergency nurses. I also demonstrated educational competencies throughout this practicum by developing a learning resource that can help strengthen nurses' knowledge, confidence, skills about TIC and equip them with relatable strategies that they can incorporate in their practice.

Leadership

Advanced practice nurses demonstrate leadership by facilitating change and competent nursing practice within their organization (CNA, 2019). I showed leadership competencies by

leading efforts to improve care for PWMI and advocating for the use of TIC in the emergency department to mitigate the risk of re-traumatization for PWMI.

Consultation and Collaboration

Advanced practice nurses are expected to collaborate and engage with key stakeholders to improve nursing practice (CNA, 2019). I demonstrated consultation and collaboration competencies throughout this practicum by consulting with emergency nurses, patient care coordinators, and nurse educators to identify the learning needs for the educational resource. In addition, I communicated the results of my consultations, my environmental scan, and my literature review in a practicum report. I also delivered a presentation on my educational resource during a practicum session, seeking feedback from faculty to further improve the resources I had developed. In addition, I collaborated with the nurse educator and the emergency nurses to obtain feedback while developing the learning to ensure it met the needs of the qathet General Hospital emergency nurses and was consistent the values conveyed by Vancouver Coastal Health. By collaborating with key stakeholders from the qathet General Hospital emergency department, a sound understanding of emergency nurses' perceived learning needs and the challenges they foresee in practicing with a TIC approach were underlined.

Next Steps

Moving forward, the next steps will be to approach the nursing leadership at Vancouver Coastal Health regarding the feasibility of implementing the TIC program at the qathet General Hospital. While preliminary discussions have been conducted with the critical nursing educator and the acute care manager, further approval remains necessary. A version of both manuals will be provided to the nursing leadership at the qathet General Hospital.

Once implemented, the intended evaluation for the TIC program will be multifaceted. Indicators of success to monitor the implementation of educational TIC interventions for PWMI

will be examined according to Kirkpatrick's four levels of training evaluation (Heydari et al., 2018). The first level examines the learners' evaluation of the educational session (Heydari et al., 2018). Formative assessments are tools used to verify how well learners grasp new knowledge and to identify areas for improvement (Physical and Health Education Canada, n.d.). The reflection questions and the case study will be employed as a formative evaluation, to ensure emergency nurses are progressing adequately through the educational material. The facilitator's presence will also help clarify topics, assist with enhanced comprehension, and determine whether adjustments may need to be applied to the course content. Monitoring the number of emergency nurses who attend the sessions will also be essential to examine its impact on the care of PWMI. Second, summative assessments, such as post-tests or exams, are used to verify whether the learning objectives were met at the end of a course (Physical and Health Education Canada, n.d.). The post-training survey will serve as a summative assessment, offering an opportunity to evaluate participants' ability to apply their newly acquired knowledge concerning Trauma-Informed Care (TIC). I will utilize Kirkpatrick's third level of training evaluation to assess the extent to which emergency nurses accurately employ their new skills (Heydari et al., 2018). For instance, chart reviews could be conducted to determine emergency nurses in their interactions with PWMI employ strengths-based documentation. The final level, or Kirkpatrick's fourth level of training evaluation, focuses on outcomes measures (Heydari et al., 2018). After all the eight sessions have been presented, the proportion of PWMI necessitating restraints or the use of the seclusion room could be assessed at a monthly interval. Based on the evaluation findings, the TIC program may need to be revised to better educate emergency nurses and improve the outcomes for PWMI.

Conclusion

The main goal of this practicum project was to develop an educational resource for emergency nurses at the qathet General Hospital to assist them in delivering trauma-informed care for PWMI. The literature review demonstrated the value of educational opportunities for TIC due to the significant burden traumatic events have on the lives of PWMI. The environmental scan guided the educational content for the TIC resource. Through the consultations, the learning modalities and preferred topics for the TIC program was further refined. Based on the findings from the literature review, the environmental scan, and the consultations, I feel confident that I created a TIC educational resource specific to the emergency nurses at the qathet General Hospital to assist them in delivering TIC for PWMI. In doing so, I have successfully demonstrated APN competencies. Looking ahead, I am enthusiastic about implementing this TIC educational resource to improve the care delivered by emergency nurses for individuals with mental illness at qathet General Hospital. A TIC resource has the potential not only to enhance the well-being and quality of care for PWMI, but also the safety of PWMI and emergency nurses.

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Appendix A: Literature Review

Development of a Resource about Trauma-Informed Care for Emergency Nurses: A Literature Review

People with mental illness (PWMI) are disproportionally affected by traumatic experiences (Adams et al., 2020; Watson, 2019). According to the Center for Addictions and Mental Health (n.d.), "trauma is the lasting emotional response that often results from living through a distressing event". Exposure to trauma in PWMI is a health issue, as it worsens their mental and physical well-being and can lead to substance abuse (Adams et al., 2020; O'Hare et al., 2017; Watson, 2019). Emergency nurses can mitigate the pervasive impacts of trauma on PWMI through the provision of holistic care. However, standard care practices in the emergency department, such as the use of restraints or seclusion, and stigma from healthcare providers often contribute to a disempowering, traumatizing, and unsafe care experience for PWMI (Muskett, 2014). Moreover, many emergency nurses have negative attitudes or stigmatizing behaviors towards patients requiring psychiatric care (Hennessy et al., 2023; Vandyk et al., 2018; Vincenti et al., 2022). Effective treatment of PWMI can further be compromised by nurses' lack of skills, knowledge and awareness related to safe and competent nursing care (Isobel et al., 2021; Stokes et al., 2017; Vincenti et al., 2022).

Educational initiatives to minimize stigma and to improve skills and knowledge of nurses about holistic care have been implemented the field of mental health and substance abuse (Muskett, 2014). For instance, the trauma-informed care (TIC) framework has emerged as a new approach to mitigate the adverse effects of trauma through the provision of holistic care (Muskett, 2014). According to Bruce et al. (2018), trauma-informed care approaches "endeavor to do no harm, that is, reducing potentially traumatic aspects of treatment and the delivery of care to avoid retraumatizing patients" (p. 132). It often includes a collaborative approach with

patients, the avoidance of coercive measures, providing compassionate care, or creating a safe environment (Bruce et al., 2018).

However, the implementation of holistic care interventions for nurses in the emergency settings has been deficient (Hall et al., 2016). Moreover, little is known about the effectiveness of educational interventions to inform nurses' care of PWMI in the emergency department (Hall et al., 2016). For emergency nurses to be able to practice within a TIC framework, appropriate educational initiatives exploring the impacts of trauma, TIC principles and how to incorporate TIC into practice need to be provided. Furthermore, emergency nurses require the opportunity to apply this newly gained knowledge to gain confidence in their ability to care for PWMI who are visiting the emergency department.

Education has been described as a way to familiarize and strengthen nurses' knowledge, attitudes and skills related to TIC (Cannon et al., 2020; Choi & Seng, 2015; Hall et al., 2016; Hoysted et al., 2019; Palfrey et al., 2019). Findings from multiple studies suggest that education can improve nurses' comfort, confidence, skills and attitudes toward PWMI, but there is conflicting evidence for nurses' knowledge with TIC in caring for PWMI (Aremu et al., 2018; Beckett et al., 2017; Cannon et al., 2020; Carter-Snell et al., 2020; Choi & Seng, 2015; Damian et al., 2019; Hall et al., 2016; Isobel & Delgado, 2018; Niimura et al., 2019; Palfrey et al., 2019; Weiss et al., 2017).

The purpose of this literature review is to help develop a TIC resource for emergency nurses who are caring for people with mental illness.

Methods of the Literature Review

A literature review was conducted to summarize and synthesize relevant published studies. CINAHL and PubMed were used to search for the relevant literature published in the last

eight years. The following MeSH terms and keywords were used in the search: *psychological trauma*, *attitudes of health care workers*, *education*, *mental health*, *emergency department*, *trauma-informed care*, *trauma-informed approach*, *re-traumatization*. Quantitative, qualitative, and mixed methods studies published in English only were included in this review. Grey literature was also included using a Google scholar search and Memorial University of Newfoundland library database.

The quantitative research studies were critically appraised using the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (PHAC, 2014). The qualitative research studies were critically appraised using the Joanna Briggs Institute (JBI) critical appraisal checklist for qualitative research (JBI, 2020). The mixed methods studies were critically appraised using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). Literature summary tables and critical appraisal of studies are included for ease of comprehension (see Appendix A).

Literature Review

In this section, I will discuss the definition of trauma and trauma-informed care, the prevalence of trauma in PWMI, its impact on patients, and the contributing factors to the suboptimal care for PWMI in the emergency department.

Definition of Trauma and Traumatic Experiences

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), "individual trauma results from an event, series of events, or set of circumstances that are 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). For example, it includes childhood

traumas, sexual abuse, physical abuse, or intimate partner violence. Furthermore, according to the SAMHSA's National Registry of Evidenced-based Programs and Practices (2016), "trauma refers to an experience or event; nevertheless, people use the term interchangeably to refer to either a traumatic experience or event, the resulting injury or stress, or the longer-term impacts and consequences" (p.1). Therefore, in this literature review, trauma, traumatic experiences, and traumatic events will be used interchangeably.

Definition of Trauma-informed Care

Trauma-informed care is a flexible framework that aims to mitigate the adverse effects of emotional and psychological trauma on all individuals within a system of care (Muskett, 2014). According to Substance Abuse and Mental Health Services Administration (SAMHSA) (2014), a TIC approach acknowledges that most individuals who access healthcare services have experienced trauma. Therefore, TIC providers use a holistic and patient-centered approach to recognize the potential impacts of previous trauma on one's well-being, to meet their needs, and to prevent further exacerbation of traumatic symptoms using policies and practices (SAMHSA, 2014). The six key principles are: (1) safety, (2) trustworthiness & transparency, (3) peer support, (4) collaboration & mutuality, (5) empowerment & choice, and (6) cultural, historical & gender issues (SAMHSA, 2014). Finally, a TIC approach encompasses the recognition that service providers may be affected by traumatic experiences as well, including those taking place during service delivery (SAMHSA, 2014).

Prevalence of Traumatic Experiences in PWMI

The issue of traumatic experiences has been found to be prevalent around the world. In a high-quality cross-sectional study, Kessler et al. (2017) found that 70.4% of individuals from 24 countries reported lifetime exposure to one or more traumatic experiences, with an average of 3.2

traumas per capita. Moreover, Kessler et al. (2017) estimated that the risk of the post-traumatic stress disorder (PTSD) risk after trauma exposure was 4.0% overall, with a higher risk with being raped (19.0%), and for intimate partner violence (11.7%). The burden of PSTD was also noted to be 77.7 person-years/100 respondents (Kessler et al., 2017). The prevalence of PTSD among PWMI is considerably higher. For instance, in a medium-quality cross-sectional study, Adams et al. (2020) screened 223 American clients from a community mental health clinic, using the PTSD Checklist-Civilian version, and found that 27.0% of PWMI met criteria for PTSD, 51.1% disclosed having experienced severe trauma, and 84.4% reported childhood adversities. In Canada, data for trauma-related illness is limited. However, according to Statistics Canada (2022), 64 % of Canadians disclosed having experiences a traumatic event, with 8% suffering from PTSD.

Those who experience traumatic experiences are more likely to visit the emergency department. Mental illness disorders are associated with frequent emergency department visits, especially for substance use disorders (Odd ratio [OR] = 2.23, 95%CI [2.12, 2.35]) and schizophrenia (OR = 2.20, 95%CI [2.09, 2.33]) (Fleury et al., 2019). In British Columbia, emergency visits for mental health and substance use disorders represented 1.5% of all visits in 2017-2018, with marked increases for substance use disorders and anxiety from 2014-2015 (3.4 vs. 5.5 visits per 1000 population; 2.6 vs. 3.4 visits per 1000 population) (Lavergne et al., 2022). At the qathet General Hospital, a rural hospital within Vancouver Coastal Health (VCH), PWMI frequently visit the emergency department for mental health reasons. For example, every week, there are two patients that are involuntarily admitted to the hospital and receive care from emergency nurses (V. Wilson, personal communication, May 22, 2023). Exposure to a traumatic experience can have negative impacts on patients and healthcare system.

Impacts of Trauma on PWMI

In this section, I will discuss the impacts of trauma on patients' mental health, physical health, social functioning, risky behaviors, and on healthcare costs. While the impacts of trauma exposure are well documented for the general population, few studies have described the consequences of traumatic experiences for PWMI due to the complex interplay of trauma, PTSD, and severe mental illness (Grubaugh et al., 2011).

Mental and Physical Health

A number of studies indicate that traumatic events can be distressing for patients and contribute to poor mental and physical health. In a high-quality meta-analysis of 14 reviews, Hogg et al. (2023) found that there is an association between experiencing traumatic events and mental health disorders. For instance, Hogg et al. (2023) found any type of abuse were significantly associated with mental health disorders (OR = 2.92; 95% CI [2.60, 3.28], $p < 0.001$), especially for physical abuse (OR = 2.36, 95% CI [2.13, 2.62], $p < 0.001$) and emotional abuse (OR = 2.92, 95% CI [2.26, 3.77], $p < 0.001$). For PWMI, Adams et al. (2020) found PTSD was significantly associated with bipolar disorder (OR = 3.28; 95% CI [1.05, 10.24], $p < 0.01$) and other psychiatric disorders (OR = 4.86, 95% CI [1.10, 21.50], $p < 0.01$). In their high-quality systematic review of 11 international studies, López-Martinez et al. (2018) found that five studies reported that interpersonal trauma victims had significant statistically increased risk of having somatic symptoms or unexplained physical symptoms. Moreover, patients who had traumatic experiences reported lower level of perceived health, with trauma being negatively associated with perceived health (adult sexual abuse: $r = -0.16$, $p < .05$; adult physical abuse: $r = -0.23$, $p < .05$) (López-Martinez et al., 2018). Traumatic events can also contribute to risky behaviors and difficulties with social functioning.

Social Functioning and Risky Behaviors

Traumatic exposure is associated with poor social functioning and risky behaviors. According to Bosc (2000), "social functioning defines an individual's interactions with their environment and the ability to fulfill their role within such environments as work, social activities, and relationships with partners and family" (p. 63). In a previously described study, Adams et al. (2020) examined the social effects of traumatic exposure for PWMI. Adams et al. (2020) found that PWMI with probable PTSD were significantly more at risk for victimization (OR = 4.08, 95% CI [1.45, 11.48], $p < 0.01$) and for having stressful interpersonal relationships (OR = 3.30, 95% CI [1.36, 8.00], $p < 0.01$).

Similarly, in their medium-quality cross-sectional study, O'Hare et al. (2017) examined the effects of trauma on risky behaviors for PWMI (e.g., sharing needles, having unprotected sex). In PWMI, PTSD symptoms were positively correlated with risky behaviors ($r = 0.19$, $p < 0.01$), impaired social functioning ($r = 0.23$, $p < 0.01$), and substance abuse ($r = 0.23$, $p < 0.01$) (O'Hare et al., 2018). Physical abuse was also associated with risky behaviors ($r = 0.28$, $p < 0.01$) and impaired social functioning ($r = 0.33$, $p < 0.01$) (O'Hare et al., 2017). In O'Hare et al. (2018)'s study, the study's participants were predominantly of Caucasian, African American and Hispanic ethnicity, which may not be representative of Canadian settings (O'Hare et al., 2017). Exposure to traumatic events can also result in increased healthcare costs.

Healthcare Costs and Service Use

The evidence suggests that a history of trauma is associated with increased healthcare service use and high healthcare expenditure. In a medium-quality study, Davis et al. (2022) estimated healthcare costs in 2018 for Americans with PTSD. Davis et al. (2022) found the estimated yearly healthcare expenditures for civilians who had PTSD to be 9,457$. The yearly

costs associated with unemployment, productivity loss at work, and premature mortality were estimated to be 10,174$ (Davis et al., 2022).

In a high-quality cross-sectional study, Hauw et al. (2021) assessed healthcare utilization and mental health disorders for 22,138 French participants who completed a survey. Individuals exposed to sexual or nonsexual intimate violence in the past year were significantly more likely to require psychotherapy (OR = 2.18, 95%CI [1.36, 3.50]; OR = 1.59, 95%CI [1.06, 2.38], $p < 0.05$). Moreover, a lifetime exposure to sexual violence was associated with an increased risk of seeing health care providers (OR = 1.38, 95%CI [1.05, 1.81], $p < 0.05$) or mental health specialists (OR = 1.94, 95%CI [1.51, 2.44], $p< 0.05$). Hauw et al. (2021) reported that hypnotics and antidepressants use were associated with lifetime exposure to sexual violence (OR = 1.69, 95%CI [1.14, 2.50]; OR = 1.56, 95%CI [1.11, 2.20], $p < 0.05$). As the study by Hauw et al. (2021) took place in France, cultural or geopolitical factors could limit the applicability of the findings to the Canadian context.

In summary, traumatic events have negative impacts on mental health, physical health, and social functioning for PWMI (Adams et al., 2020; Hogg et al., 2023; López-Martinez et al., 2018; O'Hare et al., 2017). In addition, trauma can lead to increased healthcare expenditures and use (Davis et al., 2022; Hauw et al., 2021). Strategies enhancing the care of PWMI are needed for emergency nurses. Several nursing factors may also play a role in the negative healthcare experiences for PWMI and will be explored in the next section.

Contributing Factors to Suboptimal Care for PWMI

A number of factors such as inadequate nurses' skills about TIC, lack of nurses' knowledge about TIC, and negative nurses' perceptions toward PWMI, can contribute to the suboptimal care for PWMI in the emergency department (Hennessy et al., 2023; Isobel et al.,

2021; Stokes et al., 2017; Vandyk et al., 2018; Vincenti et al., 2022). In addition to the above factors, environmental factors (e.g., unit layout) or personal factors (e.g., gender, experience) have been identified but are beyond the scope of this literature review (Vincenti et al., 2022).

Nurses Inadequate Skills and Lack of Knowledge of TIC

Vincenti et al. (2022) conducted a mixed method study to explore the inadequate skills of HCWs in providing TIC for PWMI. Vincenti et al. (2022) surveyed 136 Malta mental health nurses and found that many nurses were unaware of TIC and how traumatic experiences can affect PWMI. Stokes et al. (2017), in their qualitative descriptive study, conducted seven semi-structured interviews with mental health nurses to examine their knowledge of TIC and their experience in caring for PWMI. In the study by Stokes et al. (2017), nurses highlighted that they lack skills and training about the TIC and, they were not very familiar with TIC for PWMI (Stokes et al., 2017). Isobel et al. (2021) indicated that PWMI often found staff were not fully prepared in identifying or addressing traumatic experiences, with care being centered on their medical needs. However, no Canadian or North American study exploring emergency nurses' perceptions of their knowledge about TIC was found, thus limiting the generalization of these findings. This lack of knowledge about TIC can negatively affect nurses' attitudes toward the PWMI.

Negative Attitudes toward PWMI

Nurses' negative perceptions of PWMI may also contribute to improper nursing care. In a previously described study, Vincenti et al. (2022) noted that hospital nurses did not associate traumatic experiences with challenging behaviors in PWMI. Hennessy et al. (2023), in their meta-synthesis of 14 qualitative studies, explored PWMI' experiences with re-traumatization in healthcare. Patients identified nurses' negative attitudes, lack of interest in patients, and the use

of threats as contributing factors for their problematic behaviors (Hennessy et al., 2023). Moreover, the absence of empathy and honest communication elicited emotions of distrust and helplessness, and precipitated flashbacks of traumatic experiences (Hennessy et al., 2023). These findings were echoed in a Canadian qualitative study by Vandyk et al. (2018), which found that PWMI who frequently visited the emergency department often felt ostracized, disrespected by nurses, which in turn instilled feelings of frustrations and contributed to negative interactions with HCWs (Vandyk et al., 2018). Similarly, in their qualitative study, Stokes et al. (2017) noted the use of labels for PWMI based on their diagnosis or traumatic experiences further compromised their care by perpetuating a deficit-based approach in care. The evidence seems to support that nurses' negative attitudes toward PWMI can precipitate feelings and memories previously associated with trauma. However, in the study by Stokes et al. (2017), only seven nurses were interviewed, limiting the potential to obtain data saturation. Moreover, no quantitative study examining emergency nurses' attitudes towards PWMI was located.

Nurses' Perceived Competence and Attitudes Towards TIC

Bruce et al. (2018) conducted a cross-sectional study to explore attitudes, knowledge, perceived competence, and practice of TIC among emergency nurses and physicians (n = 147). Bruce et al. (2018) found that many nurses and physicians did not feel very competent with TIC. For instance, only 16.3% of emergency nurses and physicians felt very competent in understanding how traumatic responses may occur in patients (Bruce et al., 2018). Moreover, only 25.9% of emergency providers disclosed feeling competent in providing basic TIC interventions (Bruce et al., 2018). Few emergency providers (30.6%) strongly agreed with the fact that they should regularly assess for symptoms of traumatic stress (Bruce et al., 2018).

Furthermore, Bruce et al. (2018) noted that only 21.8% of emergency HCWs strongly agreed with the fact that medical care should be provided in a way to make it less stressful for patient. Only 19.7% of emergency nurses and physicians disclosed that they believed providers could teach patient s how to cope with trauma (Bruce et al., 2018). These statements indicate that emergency HCWs may not hold favorable opinions of TIC. However, as no other study exploring emergency nurses' perceived competence and attitudes toward TIC was located, no firm conclusion can be drawn.

In summary, many nurses hold negative perceptions toward PWMI and lack knowledge and skills for TIC, thus compromising the care of PWMI in the emergency department (Bruce et al., 2018; Hennessy et al., 2023; Isobel et al. 2021; Stokes et al., 2017; Vincenti et al., 2022). Emergency nurses need additional knowledge and skills related to TIC to inform their care of TIC for PWMI. To address this problem, strategies for nurses, such as educational interventions, are needed to improve their practice of TIC and improve the care of PWMI. Their effectiveness will be discussed in the next section.

Interventions to Improve Nursing Care for PWMI

In the next section, I will discuss interventions to improve nursing care for PWMI. In addition to providing about their critical appraisal, information about studies' interventions and results will be presented.

Overview of the Studies

There was a total of 15 studies that examined the impact of educational interventions on HCWs' knowledge, skills, attitudes, and competence related to TIC. Out of these 15 studies, seven studies employed quantitative research methods, with one being a randomized controlled trial (RCT) (Hoysted et al., 2019), and six being uncontrolled before and after studies (UCBA) (Berg-Poppe et al., 2022; Choi & Seng, 2015; McNamara et al., 2019; Niimura et al., 2019;

Palfrey et al., 2019; Weiss et al., 2017). Additionally, five studies were of mixed methods design (Cannon et al., 2020; Carter-Snell et al., 2020; Damian et al., 2019; Hall et al., 2016; Isobel & Delgado, 2018). One study employed a qualitative study design for data collection (Levine et al., 2020) and two studies pertained to quality improvement initiatives (Aremu et al., 2018; Beckett et al., 2017). Participants in the studies were recruited from a range of healthcare professions (e.g., social workers, registered nurses, doulas, physicians, psychologists, occupational therapists) from a variety of settings (e.g., psychiatric units, emergency department, perinatal unit).

The majority of the quantitative studies included were deemed to be of low quality and weak design, as they utilized a UCBA study design. These studies were included due to the lack of available literature (PHAC, 2017). Only the pilot randomized controlled trial by Hoysted et al. (2019) had a strong study design. The mixed-methods two quality improvement initiatives by Aremu et al. (2018) and Beckett et al. (2017) were included and were not critically appraised as they classified as case studies (PHAC, 2014). Using the MMAT, the quality of the mixed methods studies was found to be low to medium quality (Hong et al., 2018). Finally, the qualitative study by Levine et al. (2020) was deemed to have high trustworthiness (JBI, 2017). The educational programs will be examined by outcomes in the section below.

Educational Program to Improve Nurses' Knowledge About TIC

A number of educational interventions have been conducted to improve nurses' knowledge about TIC (Berg-Poppe et al., 2022; Carter-Snell et al., 2020; Cannon et al., 2020; Choi & Seng, 2015; Damian et al., 2019; Hall et al., 2016; Hoysted et al., 2019; Palfrey et al., 2019; Weiss et al., 2017).

Only one RCT examined the effectiveness of a TIC online training program for HCWs. Hoysted et al. (2019) found that HCWs (n = 39) in the intervention group (IG), who benefitted from a 15-minute online module, had a statistically significant improvement in their knowledge after the education compared to the 32 other emergency nurses and physicians in the control group (CG) who did not receive any training (One week: Contrast value knowledge score IG vs. CG = 1.7, $p < 0.001$). The authors of the study found that the results were sustained in the one-month follow-up (One month: Contrast value knowledge score IG vs. CG = 2.2, $p < 0.001$) (Hoysted et al., 2019).

Several studies identified short in-person educational sessions, ranging from one to four hours, as a way to increase the HCWs' knowledge for TIC. Didactic material was provided on TIC through lectures or slideshows and was accompanied by case studies, group discussions, panel discussions in several studies (Berg-Poppe et al., 2021, Cannon et al., 2020; Carter-Snell et al., 2020; Choi & Seng, 2015; Weiss et al., 2017). Berg-Poppe et al. (2022) found that pediatric HCWs (n = 13) reported having a better understanding of the foundational knowledge of TIC after participating in a short in-person educational session (Mean: pre vs. post = 2.46 vs. 3.42, $p < 0.01$). Cannon et al. (2020) similarly noted that nursing students who attended the TIC training reported a significant improvement in their knowledge of TIC (Mean difference: pre vs. post = 1.171, $p < 0.001$; Mean: pre vs. post = 12.8 vs. 13.5, $p < 0.001$). In the study by Choi and Seng (2015), the results from the pre-training (Mean = 12.8) and post-training questionnaire (Mean = 13.5) indicate that the short in-person course on TIC resulted in an improvement in perinatal HCWs' knowledge TIC ($p < 0.001$). These findings were echoed in the study by Weiss et al (2017), where HCWs were found to have increased understanding of TIC and the impacts of

trauma after the training (Mean: pre vs. post = 2.6 vs. 3.9, $p < 0.001$; Mean: pre vs. post = 3.3 vs. 4.2, $p < 0.001$).

In their UCBA, Carter-Snell et al. (2020) found that service providers who benefitted from the training sessions saw an improvement in their overall knowledge, although not statistically significant (Mean: pre vs. post = 2.92 vs. 3.57, $p > 0.05$). However, the study by Carter-Snell et al. (2020) also included emergency services providers (i.e., paramedics, police officers).

Educational Programs to Improve Nurses' Skills About TIC

Two studies looked at the effect of education on HCWs' skills in providing TIC (Cannon et al., 2020; Choi & Seng, 2015). Both studies included pre-training materials in the form of pre-readings and preparatory online modules and utilized the same valid and reliable questionnaire (Cannon et al., 2020; Choi & Seng, 2015). Cannon et al. (2020) found that undergraduate and graduate nursing students who attended the TIC lecture reported strengthened TIC skills (Mean difference: = 0.716, $p < 0.001$). Choi and Seng (2015) also noted that perinatal HCWs who attended the educational session about TIC had a statistically significant improvement in their skills with TIC (Mean: pre vs. post = 12.0 vs. 13.1, $p < 0.001$).

Educational Programs to Improve Nurses' Confidence with TIC

Hall et al. (2016) and Palfrey et al. (2019) explored HCWs' confidence in caring with a TIC approach. In the study by Hall et al. (2016), emergency registered nurses (n = 34) who attended a one-day educational session had statistically significant improvement in their confidence with TIC (Mean: pre vs. post = 3.2 vs. 3.9, $p < 0.001$). Palfrey et al. (2019), in their UCBA, explored the efficacy of a one-day workshop on TIC for 113 mental health professionals (e.g., registered nurses, social workers, occupational therapist). The results from the pre-training

(Mean = 5.02) and post-training questionnaire (Mean = 7.14) indicate that the one-day workshop on TIC resulted in an improvement in their confidence with applying TIC in practice, $t = -12.21$, $p < 0.001$ (Palfrey et al., 2019). There also was a significant increase in mental health professionals' confidence in responding to disclosure of trauma post-training (Mean = 7.26) compared to pre-training (Mean = 5.38), $t = -9.18$, $p < 0.001$ (Palfrey et al., 2019).

Educational Programs to Improve Nurses' Comfort, Attitudes, and Self-efficacy with TIC

A number of educational interventions have been conducted to improve nurses' comfort, attitudes, and self-efficacy with TIC (Aremu et al., 2018; Cannon et al., 2020; Carter-Snell et al., 2020; Choi & Seng, 2015; Damian et al., 2019; Hall et al., 2016; Niimura et al., 2019; Weiss et al., 2017). Carter-Snell et al. (2020) and McNamara et al. (2019) noted that HCWs enrolled in the short TIC course showed a significant improvement in their confidence with TIC (Mean: pre vs. post = 3.28 vs. 3.57, $p < 0.01$). McNamara et al. (2019) also found that HCWs' comfort levels with TIC improved by 21% ($p < 0.001$).

In terms of attitudes, Cannon et al. (2020), Choi and Seng (2015), Damian et al. (2019), and Hall et al. (2016) found thar service providers, nursing students, emergency nurses and HCWs who benefitted from TIC training experienced a positive change in attitudes toward TIC (Mean difference: pre vs. post = 0.161, $p < 0.001$; Mean: pre vs. post = 18.9 vs. 19.4, $p = 0.020$; Mean: pre vs. post = 3.5 vs. 4.0, $p = 0.023$; Mean difference: pre vs. post = 1.60, $p < 0.001$). Similarly, Niimura et al. (2019) noted a significant improvement in attitudes in mental health professionals immediately after training (Mean difference: 0.4, $p < 0.05$) and three-month post training (Mean difference: 0.3, $p < 0.05$). However, as the study by Niimura et al. (2019) took place in Japan, cultural or geopolitical factors could limit the applicability of the findings to the Canadian context. Aremu et al. (2018), in their quality improvement initiative, did not observe a

significant change in HCWs' attitudes toward violent behaviors after the first training (Mean: pre vs. post = 66.5 vs. 69.8, $p = 0.244$), while the second training session resulted in a significant change in their Management of Aggression and Violence Scale scores (Mean: pre vs. post = 70.2 vs. 69.2, $p = 0.010$). However, participants in the study by Aremu et al. (2018) benefitted from a series of TIC workshops, in contrast to the other studies.

The impact of educational programs on self-efficacy was examined in two studies (Damian et al., 2019; Weiss et al., 2017). In the study by Weiss et al. (2017), HCWs reported having an improved ability to provide TIC with a short in-person educational session (Mean: pre vs. post = 2.5 vs. 3.7, $p < 0.001$). However, there was no significant difference noted for service providers perceived capacity to provide TIC after attending a one-day training (Mean difference: pre vs. post = 2.74, $p > 0.05$) (Damian et al., 2019).

Educational Programs to Improve Other Outcomes in Relation to TIC

In addition, to the above-discussed outcomes, a number of studies have been conducted to examine the impact different interventions on different outcomes (Aremu et al., 2018; Beckett et al., 2017; Carter-Snell et al., 2020; Isobel & Delgado, 2018; Levine et al., 2020; McNamara et al., 2019). In their qualitative study, Levine et al. (2020) highlighted the organizational impacts of the one-day trauma- and violence-informed care (TVIC) training. The implementation of TVIC education resulted in changes in clinical spaces and policies to enhance patient safety, in increased use non-pharmacological approaches such as mindfulness and group therapy (Levine et al., 2020). Levine et al. (2020)'s participants disclosed in their interviews that the educational sessions with interdisciplinary discussions helped increase their knowledge of TVIC.

For referrals, Carter-Snell et al. (2020) noted increased referrals to counselling after the education (Mean: pre vs. post = 2.58 vs. 3.0, $p < 0.05$) and McNamara et al. (2019) found that

pediatric physicians were more likely to initiate referrals to the violence intervention program after attending the 90-minute TIC workshop (OR = 1.89, $p < 0.001$).

In the mixed methods study by Isobel and Delgado (2018), 93% of mental health nurses reported having confidence in promoting emotional safety for their patients after the TIC education. However, the educational intervention offered by Isobel and Delgado (2018) was the only one to include communication exercises and role play as learning modalities.

In a quality improvement initiative, Beckett et al. (2017) provided a series of in-person TIC workshops. Their quality improvement initiative also included several organizational interventions (e.g., interdisciplinary meetings, protocols and guidelines review) aside from the TIC training (Beckett et al., 2017). Following the implementation of the workshops and organizational interventions, nursing staff reported feeling more confident and motivated in engaging with patient exhibiting signs of emotional distress (Beckett et al., 2017). Beckett et al. (2018) also noted a reduction in calls to security for assistance and a reduction of 80% of seclusion use. The TIC initiative also resulted in new protocols with lower sedation doses for frail, elderly, or neuroleptic naïve patients. Patient safety was also enhanced with the use of strength-based language, a private area for female patients when restrained, and an increased availability of therapeutic activities (Beckett et al., 2018). In contrast, in the study by Aremu et al. (2018), the evidence was inconclusive for the use of pro re nata intramuscular medication, with increase rates after the first training (11.9/week vs. 12.1/week) and the second training (3.2/week vs. 5.4/week). However, lower use of pro re nata intramuscular medications was noted overall (11.9 vs. 5.4). In terms of patient experience and staff engagement, Aremu et al. (2018) did not find any significant difference after the two training sessions (Mean: pre vs. post = 32.4 vs. 33.9, $p = 0.087$; Mean: pre vs. post = 31.6 vs. 32.6, $p = 0.323$).

There is mixed evidence regarding educational interventions strengthening HCWs' knowledge and self-efficacy. Confidence, skills, and attitudes in providing TIC may be improved by educational sessions. In addition, no conclusion can be drawn for the sustainability of the learning experience as data for outcomes was only collected immediately post-training in most studies. Furthermore, two quality improvement initiative reported inconclusive evidence in ameliorating patient outcomes with TIC.

In summary, to examine the effectiveness of TIC educational interventions for HCWs, multiple quantitative studies of weak study design and one study of strong design were selected for evidence. In addition, one qualitative study of high trustworthiness, six mixed methods studies of low to medium quality, and two quality improvement studies were included. Most studies provided direct evidence of improved attitudes, skills, and confidence in providing care with a TIC approach with the provision of educational sessions. However, there was mixed evidence regarding improving HCWs' knowledge and self-efficacy. Based on Table 4 of the PHAC Critical Appraisal Toolkit (2014), the evidence for implementing educational interventions for TIC should be rated as weak CI. Many studies failed to use statistical regression measures to account for confounding factors, did not have a control group, and had limited recruitment measures. TIC educational interventions could be implemented to improve nurses' abilities to provide TIC and re-evaluated as new research becomes available.

While the development of clinical guidelines and educational material may be evidence-based, it is essential to examine factors that can impede or assist their implementation to practice. Barriers and facilitators to the implementation of TIC in practice will be examined in the next part of this paper.

Barriers and Facilitators to the Implementation of TIC in Practice

Harrison and Graham (2021) noted that the adoption of new clinical guidelines required a close examination of barriers and facilitators for a successful implementation. Moreover, knowledge translation strategies should be compatible and applicable within the local setting. Therefore, it is important to assess potential barriers to promote local uptake and support evidence-based practice (Harrison & Graham, 2021).

Several studies identified barriers and facilitators for the implementation of TIC in health settings (Isobel et al., 2021; Lovell et al., 2022; Stokes et al. 2017; Vincenti et al., 2022). HCWs emphasized the need for peer support and debriefing to solidify their skills and to mitigate the effects of trauma disclosures (Lovell et al., 2022). Moreover, HCWs reported their ongoing learning was enhanced with interdisciplinary discussions (Lovell et al., 2022). However, competing priorities, heavy workloads and limited time for education hindered its implementation to practice (Lovell et al., 2022). Although chemical and physical restraints were used as a last resort, safety concerns sometimes forced nurses to use them to provide care or meet their daily duties (Isobel et al., 2021; Lovell et al., 2022). Similarly, Vincenti et al. (2022) noted that the reliance on policies and guidelines constrained nurses' ability to provide TIC. Participants identified the need for flexible policies for enhanced patient safety, with the importance of establishing a collaborative relationship (Isobel et al., 2021). Moreover, while nurses recognized work-related and environmental constraints, they noted that TIC fact aligns with their professional role (Isobel et al., 2021).

Consequently, it will be important to provide adequate support to emergency nurses and opportunities to debrief with the implementation of TIC education. In addition, in the rural context, where resources are limited, the use of nurse champions may facilitate the implementation of TIC. Nurse champions act as mentors and persuasive leaders when

implementing projects (Harrison & Graham, 2021). The conceptual framework for the development of the educational resource for emergency nurses will be discussed in the following section.

Conceptual Framework

As the educational resources is aimed toward emergency registered nurses with various work experiences, Knowles' theory of andragogy is well-suited for this practicum project to inform the development of a TIC educational resource for emergency nurses. Andragogy is defined by six core principles (a) the learners' self-concept (b) the role of the experience (c) the readiness to learn (d) orientation to learning (e) motivation (f) the need to know (Chan, 2010). These principles will be described below.

First, the learners' self-concept entails that adult learners are autonomous in their learning journey (Chan, 2010). By providing choices in relation to educational modalities and opportunities, adults will retain their agency and interest in developing new skills (Chan, 2010). I will develop an educational resource for emergency nurses that includes a variety of training modalities (e.g., case studies, discussions). Second, previous experience is a learning resource for adult learners (Chan, 2010). When engaging in educational opportunities for TIC, emergency nurses will be able to draw on their previous experiences with PWMI. Case studies or guided discussions will serve as a vehicle to explore and share these experiences. Third, adult learners benefit from teachings that are relevant to their practice (Chan, 2010). As emergency nurses frequently interact and provide care to PWMI, they require knowledge and skills that they can incorporate in their daily practice. TIC training will include practical tips that emergency nurses can use for patients who present with psychiatric conditions. Fourth, learning offerings should be problem-centered or task-oriented (Chan, 2010). Adults prefer educational material that provides

them with concrete techniques they can apply in their practice. The use of guided discussions will help emergency nurses to understand TIC principles and find ways to apply them as part of their nursing care. Fifth, adult learners are more likely to respond to internal motivators as opposed to external motivators (Chan, 2010). Adults are motivated in endeavors that improve their self-esteem, that stimulates them, or when they can help others (Chan, 2010). By providing safe and competent care for PWMI, emergency nurses can improve their job satisfaction, their personal growth, and their self-esteem. Finally, adult learners need to know how new knowledge is beneficial for them (Chan, 2010). Underlining the impacts of trauma on patients' and vicarious trauma may assist emergency nurses in developing an interest in TIC.

Implications for Practice

Emergency nurses are in a privileged position to engage with PWMI with a TIC approach. A TIC approach is compatible with the patient-centered care philosophy conveyed by VCH (VCH, 2020). However, despite adhering to these principles, there is currently no additional training for the provision of trauma-informed care for PWMI at the qathet General Hospital (personal communication, V. Wilson, May 22, 2023). Educational opportunities for TIC have the potential to allow emergency nurses to gain skills and confidence with TIC (Cannon et al., 2020; Choi & Seng, 2015; Hall et al., 2016; Palfrey et al., 2019). Moreover, it brings awareness to resources for TIC and enables nurses to understand the physical and mental impact of trauma for PWMI (Palfrey et al., 2019). While one-day educational sessions, multicomponent strategies, and online education may strengthen nurses' skills with TIC and ameliorate their attitudes, implementing these strategies would most likely require additional funding and resources (e.g., travel reimbursement for a skilled facilitator, educational leave for in-person attendance). Thus, it is unlikely to be utilized in my setting, as nurses are often unable to attend

day-long in-person training, due to conflicting schedules and staffing issues. Consultations with stakeholders will be key to gain a greater understanding of their educational methods.

However, shorter educational sessions that include guided discussion, case studies and interactive components could promote the use of TIC in a small rural emergency setting and were described as satisfactory by HCWs (Cannon et al., 2020; Weiss et al., 2017). Topics covered should include the impacts of trauma, TIC principles, and how to implement TIC into practice (Berg-Poppe et al., 2022; Cannon et al., 2020; Choi & Seng, 2015; Damian et al., 2019; Hall et al., 2016; Hoysted et al., 2019; Levine et al., 2020; Palfrey et al., 2019; Weiss et al., 2017). Additionally, information on how to mitigate the impacts of vicarious trauma and self-care should be addressed (Levine et al., 2020; Niimura et al., 2019).

Conclusion

Routine healthcare practices within the emergency department may exacerbate the effects of past trauma for PWMI (Muskett, 2014; Vandyk et al., 2018). Exposure to traumatic events or re-traumatization can result in poor mental and physical health, in poor social functioning, and increased healthcare costs for PWMI (Adams et al., 2020; Davis et al., 2022; Hauw et al., 2021; Hogg et al., 2023; López-Martinez et al., 2018; O'Hare et al., 2017). By using a TIC approach, nurses can mitigate these impacts and provide a safe environment for PWMI (Muskett, 2014). Therefore, it is important to provide emergency nurses with educational opportunities to strengthen their knowledge and abilities of the TIC approach.

In this literature review, the effectiveness of multiple educational and training interventions about TIC, including one-day workshops and short in-person educational sessions, was examined. Research studies have found that day-long and short duration training can ameliorate nurses' confidence, skills, and attitudes toward TIC, but there is inconclusive

evidence in regard to their knowledge (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; Choi and Seng, 2015; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017). However, educational opportunities with interactive components (e.g., guided discussions, case studies) have shown effectiveness in increasing awareness and promoting the use of TIC in a variety of settings (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; Choi and Seng, 2015; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017). While every encounter with PWMI may differ, a TIC educational resource can provide a basis for nurses to better understand TIC and be equipped with relatable strategies that they can incorporate in their setting.

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Appendix A

Key Question:

Can educational interventions improve emergency nurses' knowledge, skills, and attitudes about the trauma-informed care for mental health patients?

Legend: CI: confidence interval**; CG:** control group; **ED:** emergency department; **HCWs:** health care workers; **IG:** intervention group; **IM:** intra-muscular; **MH:** mental health; **OTs:** occupational therapists; **PRN:** as needed; **PTs:** physiotherapists; **PTSD:** post-traumatic stress disorder; **RCT:** randomized controlled trial; **RNs:** registered nurses; **SAMHSA:** Substance Abuse and Mental Health Services Administration; **SD:** standard deviation; **SWs:** social workers; **TE:** traumatic experiences; **TIC:** trauma-informed care; **TIVC:** trauma and violence-informed care; **UCBA:** uncontrolled before-after; **USA:** United States of America

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

Hoysted et al. (2019)
 	
Design:
RCT (pilot)
 	
Purpose:
To investigate the effectiveness of an online TIC program for workshop for emergency nurses and physicians
 	
ONLINE EDUCATION
	Country/setting: Australia and New Zealand
	
	Sample: 71 ED nurses and physicians
	IG: n = 39
	CG: n = 32 (did not receive training)
	
	Intervention: A 15-minute online module on TIC
	
	Main outcomes measured at baseline, one week after, and one month after the training:
	• Demographic data
	• Psychosocial care survey to measure knowledge of pediatric PTSD
	  • r = .75
	• Acceptability of the training
	
	Statistical analysis using ANOVA
		Knowledge of PTSD:
		• One week follow-up:
		Contrast value knowledge score (SE)
		  • IG vs. CG = 1.7 (0.4)
		  • F= 19.75, p < 0.001
		• One month follow-up:
		Contrast value knowledge score (SE)
		  • IG vs. CG = 2.2 (0.3)
		  • F= 41.66, p < 0.001
		
		Acceptability of the training:
		• 74.2% indicated training beneficial in their role in the ED
		• 80% reported training had met their needs
			Strength of Design:
			High
			
			Quality:
			Medium
			
			Comments:
			• Multisite study with multiple recruitment measures
			• Participants mainly females; may not be representative of all HCWs in the ED
			• While acceptable, the education may have benefitted from an interactive component
			
			Support for project:
			The researchers demonstrate how a brief online TIC training significantly increases ED nurses' and physicians' knowledge of PTSD.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

Choi & Seng (2015)
 	
Design:
UCBA
 	
Purpose:
Assess the effectiveness of TIC education for perinatal health care providers
 	
SHORT DURATION EDUCATION
	Country/setting: United States
	
	Sample: 53 HCWs (SW, RNs, doulas)
	
	Intervention: A 2.5h in-person course, including pre-readings, a TED talk, an overview of TIC, and a case study
	
	Main outcomes measured at baseline, and immediately post-training with questionnaires:
	• Demographic data
	• Knowledge of TIC
	• Attitudes towards TIC
	• Skills with TIC
	  • Cronbach's alpha range [0.78,0.85]
	
	No regression statistical methods used.
	
	Secondary outcomes measured by one open-ended question: participants' perceptions on instructional methods, content and additional learning needs
		Knowledge of TIC: Mean (SD)
		• Pre vs. post: 12.8 (1.2) vs. 13.5 (1.4)
		  • $t = 3.65$, $p < 0.001$
		
		Skills with TIC: Mean (SD)
		• Pre vs. post: 12.0 (1.7) vs. 13.1 (1.5)
		  • $t = 4.76$, $p < 0.001$
		
		Attitudes towards TIC: Mean (SD)
		• Pre vs. post: 18.9 (1.6) vs. 19.4 (1.2)
		  • $t = 2.50$, $p = 0.020$
		
		Learning content and needs
		• Relevance of training: ways to respond to clients with trauma, applicable to their practice should be offered to the community
		• Additional learning needs: cultural variations, more discussions, additional examples of language to use
		• Depth of training: in-depth training based on professional scope
			Strength of Design:
			Weak
			
			Quality:
			Medium
			
			Comments:
			• Possibility of social desirability bias
			• Convenience sample
			• No demographic data collected; may be unbale to generalize findings
			• No control group
			
			Support for project:
			The researchers demonstrate how TIC training significantly increases ED nurses' confidence, knowledge of TIC and their attitudes towards TIC. The authors also identified HCWs' learning needs and their satisfaction with the training.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Berg-Poppe et al. (2022) Design: UCBA Purpose: Assess the effectiveness of TIC education for pediatric service providers ***SHORT DURATION EDUCATION***	**Country/setting:** United States **Sample:** 13 pediatric HCWs (OTs, PTs, nurses) **Intervention:** A half-day training session, including pre-training online modules, with case studies, and guided discussions Main outcomes measured at baseline and immediately post-training with Likert scale questionnaires: • Demographic data • Affective Commitment to TIC • Beliefs about trauma • Foundational knowledge • TIC self-efficacy No regression statistical methods used.	**Affective commitment to TIC: Mean (SD)** • Pre vs. post: 5.60 (0.51) vs. 5.85 (0.34) • $p > 0.05$ **Beliefs about trauma: Mean (SD)** • Pre vs. post: 4.47 (0.41) vs. 4.96 (0.41) • $p < 0.01$ **Foundational knowledge: Mean (SD)** • Pre vs. post: 2.46 (0.64) vs. 3.42 (0.38) • $p < 0.01$ **TIC self-efficacy: Mean (SD)** • Pre vs. post: 4.37 (0.82) vs. 4.82 (0.57) • $p < 0.05$	**Strength of Design**: Weak **Quality**: Low **Comments:** • Poor control of confounders • No control group • No use of regression statistical methods • Participants were selected based on availability • Some participants had prior experience with TIC **Support for project:** The authors showed TIC training significantly improved participants' knowledge of TIC and the effect of trauma and their self-efficacy with TIC.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

McNamara et al. (2019)
 	
Design:
UCBA
 	
Purpose:
Determine the effectiveness of TIC workshop for emergency HCWs
 	
SHORT DURATION EDUCATION
	Country/setting:
	Two large urban pediatric ED, USA
	
	Sample: 318 ED HCWs (e.g., RNs, physicians, students)
	
	Intervention: A 90-minute workshop on TIC with case studies and a panel discussion with patients/families
	
	Main outcomes measured pre-training, post-training and 3-month post-training (T3):
	• Demographic data
	• Referrals to the violence intervention program (VIP)
	• 5-item questionnaire for TIC
	  • Cronbach's alpha .93
	  • To measure staff's comfort with TIC
	
	No regression statistical methods used.
		Comfort levels with TIC: Mean (95% CI)
		Nurses
		• Pre vs. post:
		26.6 [22.8, 30.4] vs. 36.9 [32.8, 40.9]
		Physicians
		• Pre vs. post:
		25.3 [23.8, 26.8] vs. 35.8 [34.3, 37.4]
		For all participants
		• Pre vs. post:
		Comfort levels increase by 21%, $p < 0.001$
		
		Referrals to VIP by physicians:
		• Pre vs. T3: identified 7.3% of all referred patients vs. 47.3%
		  • OR = 1.89, $p < 0.001$
			Strength of Design:
			Weak
			
			Quality:
			Low
			
			Comments:
			• Poor control of confounders with no demographic data collected other than profession
			• Self-selection bias possible
			• Missing data for 77 participants
			
			Support for project:
			The authors found that all professions benefitted from increased comfort levels with TIC after the workshops and patient outcomes were improved by the timely identification of patients who needed VIP.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Niimura et al. (2019) Design: UCBA Purpose: Explore the efficacy of a TIC training program on health care workers attitudes towards TIC ***SHORT DURATION EDUCATION***	**Country/setting:** Tokyo, Japan **Sample:** 65 mental health professionals (e.g., RNs, LPNs, OTs, SW) from 29 psychiatric hospitals for training • 56 MHPs from 25 hospitals completed the follow-up survey **Intervention:** A 3.5 hour lecture on TIC with an hour group discussion Main outcomes measured pre-training, post-training and 3-month post-training: • Demographic data • Attitudes Related Trauma-Informed Case scale 35 (ARTIC-35) Secondary outcomes measured: clinical practice after the training and barriers for TIC No regression statistical methods used.	**ARTIC-35 score: Mean (SD)** • Pre vs. post: 5.1 (0.5) vs. 5.5 (0.5) • Pre vs. post: Mean difference (95% CI): 0.4 [0.3, 0.5] • $p < .05$ • Pre vs. 3-month post: Mean difference (95% CI): 0.3 [0.2, 0.4] • $p < .05$ **Clinical practice of TIC:** • 37% assessing patients; behavior based on TIC • 19% modifying communication based on TIC • 19% managing patients' problematic behaviors without coercive practices **Barriers for TIC:** • 50% have limited skills and/or experience with TIC • 44% experience difficulties in sharing information regarding TIC with colleagues • 25% report TIC is a time-consuming process to correct negative patient behaviors • 19% reporting time constraints, staffing shortages, or lack of staff support system for TIC	**Strength of Design**: Weak **Quality**: Low **Comments:** • No randomization or presence of CG • Multisite study with multiple recruitment measures • No use of regression statistics • Poor control of confounders • High attrition rate **Support for project:** The researchers demonstrate how TIC training significantly increases MHPs' attitudes towards TIC. The authors also described how TIC was integrated in the participants' clinical practice and their perceived barriers for TIC.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Palfrey et al. (2019) Design: UCBA Purpose: Explore the efficacy of a TIC training program on health care workers attitudes towards TIC ***ONE DAY EDUCATION***	**Country/setting**: Australia **Sample:** 113 mental health professionals (e.g., RNs, psychologists, OTs, SWs) providing mental health services tom youth in the Australian Capital Region **Intervention:** A one-day workshop on TIC with group case studies Main outcomes measured pre-training and post-training: • Demographic data • A 5-item Likert Scale questionnaire for confidence, attitudes and awareness of TIC • A 6-item questionnaire on barriers to working with clients affected by trauma Secondary outcomes measured by open-ended questions: training needs, application to practice, uptake in practice No regression statistical methods used.	**Confidence with TIC in practice: Mean (SD)** • Pre vs. post: 5.02 (1.85) vs. 7.14 (1.4) • t = -12.21, p < .001 **Confidence of TIC and responding to disclosure of trauma: Mean (SD)** • Pre vs. post: 5.38 (1.96) vs. 7.26 (1.53) • t = -9.94, p < .001 **Knowledge with TIC: Mean (SD)** • Pre vs. post: 4.90 (1.76) vs. 6.58 (1.51) • t = -9.18, p < .001 **Awareness of TIC and resources: Mean (SD)** • Pre vs. post: 4.67 (2.02) vs. 6.49 (1.75) • t = -8.04, p < .001 **Barriers** **"I don't feel like I have enough experience"** • Pre vs. post: 54.7% vs. 45.3% • p = .007 **"I'm not equipped to deal with trauma and adversity"** • Pre vs. post: 27.4% vs. 9.5% • p = .042 **Focus groups** • 58% to add questions about trauma in assessment • 20% to work on therapeutic alliance	**Strength of Design**: Weak **Quality**: Low **Comments:** • No randomization or presence of CG • No use of regression statistics • Poor control of confounders • Variety of professionals • Could have use validated questionnaires **Support for project:** The authors showed how TIC workshops significantly increased MHPs' knowledge and confidence with TIC. The authors also described how TIC was integrated in the participants' clinical practice with concrete examples.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

Weiss et al. (2017)
 	
Design:
UBCA
 	
Purpose:
Explore the implementation of TIC approach, including an educational session, into a health care network
 	
SHORT DURATION EDUCATION
	Country/setting:
	United States
	
	Sample: 294 allied healthcare professionals (e.g., RNs, physicians SW)
	
	Intervention: A 1-hour didactic session on TIC with group discussions led by an expert on trauma and a co-lead from their specific department
	
	Main outcomes measured pre-training and post-training
	• Demographic data
	• The Satisfaction Questionnaire
	  • To evaluate satisfaction with instructional methods and content
	• Trauma-Informed Medical Care Questionnaire (TIMCQ)
	  • Cronbach's alpha range [0.71, 0.98]
	
	Secondary outcomes measured by one open-ended question: participants' perceptions on how TIC impacts their practice
	
	No regression statistical methods used.
		Understand TIC: Mean
		• Pre vs. post: 2.6 vs. 3.9
		  • $t = 22.5$, $p < .001$
		  • Cohen's d = 1.42
		Understand the impact of trauma: Mean
		• Pre vs. post: 3.3 vs. 4.2
		  • $t = 5.8$, $p < .001$
		  • Cohen's d = 0.47
		Ability to provide TIC: Mean
		• Pre vs. post: 2.5 vs. 3.7
		  • $t = 21.0$, $p < .001$
		  • Cohen's d = 1.17
		Understand staff can have past TE: Mean
		• Pre vs. post: 3.8 vs. 4.3
		  • $t = 10.5$, $p < .001$
		  • Cohen's d = 0.58
		
		The Satisfaction Questionnaire:
		• 90% agreed they developed new knowledge
		• 87% agreed the teaching method was suitable
		
		Perceptions of TIC
		• Increased awareness of TE
		• Shifting perceptions by humanizing and being more sensitive to patients and families
		• Considering the bigger picture for care
		• Providing holistic and individualized care
			Strength of Design:
			Weak
			
			Quality:
			Low
			
			Comments:
			• No randomization or presence of CG
			• No use of regression statistics and poor control of confounders
			• No in-depth content analysis
			
			Support for project:
			The authors found that most HCWs were satisfied with the training. In addition, HCWs' knowledge, skills and perceived ability to provide TIC significantly increased as a result of the sessions.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Levine et al. (2020) Design: Qualitative Interpretive Descriptive Study Purpose: Explore HCWs' perceptions of the impacts of trauma and violence informed care education ***ONE DAY EDUCATION***	**Country/setting:** Canada, in two diverse primary care health clinics **Sample:** N=14 HCWs (e.g., nursing, pharmacy, medicine, counseling) **Intervention:** A one-day training, including didactic training, and an interdisciplinary guided discussion Data collection: • Face-to-face semi structured interviews • Recorded and transcribed verbatim • Use of memos Data coded and analyzed by the three authors.	**Shifts in knowledge, awareness, and confidence** • Educational sessions helped increase their knowledge, awareness, and confidence with TVIC • Some were disappointed there was no toolkit or specifics for care **Impacts on organizations** • Changes in clinical spaces and policies to avoid patient feeling unwelcomed and unsafe safety • Increased use of physiotherapy, group counseling and mindfulness **Dilemmas in practice** • Need to address health inequities • Dilemma between acute needs and structural violence **Factors influencing TVIC training** • Positive reactions if similar to own values • Local data helps identify priorities for organizational change • Interprofessional discussions more impactful than didactic material, although there are some power differentials • Policies, heavy workloads, lack of time and funds are barriers to TVIC	**Trustworthiness: High** **Comments:** • Thick description • Inter-coder checks • Verbatim transcription • Background and ideology of authors provided **Support for project:** The authors found that nurses reacted positively to educational materials about TIC, although would have liked to have a toolkit for TIC. Peer feedback and discussions assisted them in finding ways to incorporate TIC into nursing care.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Damian et al. (2019) Design: Mixed methods (UCBA with interviews) Purpose: Evaluate the effectiveness of an interdisciplinary TIC education ***ONE DAY EDUCATION***	**Country/setting:** Baltimore, USA **Sample:** 90 service providers (social services, health and education, and other government agencies) **Intervention:** A one-day training, didactic training based on the SAMHSA guidelines for TIC Main outcomes measured at baseline and immediately post-training with Likert scale questionnaires: • Demographic data • Trauma-informed knowledge, attitudes, beliefs of providers scale Multiple linear regression used. Qualitative Data collection: • 16 semi-structured interviews, with social services and law enforcement due to their differing perspectives • Recorded and transcribed verbatim • Approximately 45 minutes Data coded and analyzed by two authors using a constant comparative method	**Knowledge of TIC: Mean difference (SD)** • Pre vs. post: 3.19 (6.68) • $p < 0.001$ **Attitudes with TIC: Mean difference (SD)** • Pre vs. post: 1.60 (5.67) • $p < 0.001$ **Beliefs in capacity to provide TIC: Mean difference (SD)** • Pre vs. post: 2.74 (25.25) • $p > 0.05$ **Strengths** • Valuable framework for understanding: SAMHSA as well-defined framework • Useful lessons from other participants: helpful to listen to different perspectives **Strengths** • Support from management: need for resources and support, buy-in from leaders • Real-life applicability: broad training, hard to integrate in daily practice •	**Quality**: Medium **Comments:** • Possibility of social desirability bias • Multisite study with multiple recruitment measures • No control group • Adequate interpretation of divergences between qualitative and quantitative data **Support for project:** The researchers demonstrated how TIC training significantly increases service providers' knowledge of TIC and their attitudes towards TIC. The authors also identified limitations to TIC, such as lack of support from management and the need for tailored educational materials.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Hall et al. (2016) Design: Mixed methods (UCBA with focus groups) Purpose: Determine the effectiveness of TIC education for ED nurses ***ONE DAY EDUCATION***	**Country/setting:** 2 ED in Australian, including a rural and an urban ED **Sample:** 34 ED nurses **Intervention:** A one-day training, including 8 modules, with slide show presentation, videos, group discussions and games Main outcomes measured at baseline and immediately post-training with Likert scale questionnaires: • Demographic data • Confidence with TIC • Knowledge of TIC • Attitudes No regression statistical methods used. Qualitative Data collection: • Two semi structured focus groups • Recorded and transcribed verbatim • Field notes taken • 14 ED nurses participated, seven from each ED Data coded and analyzed by two authors using a general inductive approach	**Confidence with TIC: Mean** • Pre vs. post: 3.2 vs. 3.9 • $p < .001$ **Knowledge of TIC: Mean** • Pre vs. post: 2.7 vs. 4.2 • $p < .001$ **Attitudes with TIC: Mean** • Pre vs. post: 3.5 vs 4.0 • $p = 0.023$ **Focus groups** • Effectiveness of TIC education: use of restraints can be re-traumatizing, impact of trauma of neurobiology • Changes in nursing practice: better attitude, annoying behaviors may be caused by trauma • Person-centered care: opportunity for improved therapeutic communication, use of least restraints and holistic approach • Limitations of TIC: competing demands, heavy workload, limited time, risk of safety for staff	**Quality**: Medium **Comments:** • No randomization or presence of CG • Multisite study with multiple recruitment measures • No use of regression statistics • Poor control of confounders • No use of journaling and self-reflection • Adequate interpretation of divergences between qualitative and quantitative data **Support for project:** The researchers demonstrate how TIC training significantly increases ED nurses' confidence, knowledge of TIC and their attitudes towards TIC. The authors also identified limitations to TIC.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Cannon et al. (2020) Design: Mixed methods (UCBA with focus groups) Purpose: Assess the effectiveness of TIC education for undergraduate and graduate nursing students ***SHORT DURATION EDUCATION***	**Country/setting:** United States **Sample:** 128 undergraduate and graduate nursing students **Intervention:** A 2.5h in-person course, including pre-readings, a TED talk, an overview of TIC, and a case study Main outcomes measured at baseline, and immediately post-training with questionnaires: • Demographic data • Knowledge of TIC • Attitudes towards TIC • Skills with TIC Qualitative Data collection: • Open-ended question in surveys about how they would apply TIC and the acceptability of the training Data coded and analyzed by two authors using an inductive approach	**Knowledge with TIC: Mean difference (SD)** • 1.171 (0.625), p < .001 **Attitudes of TIC: Mean difference (SD)** • 0.161 (0.405), p < .001 **Skills with TIC: Mean difference (SD)** • 0.784 (0.716), p < .001 **Confidence to provide TIC: Mean difference (SD)** • 1.279 (1.054), p < .001 **Focus groups** • How to apply TIC: as standard precaution, universal screening, build rapport, reframe non-compliance based on traumatic experiences, more prepared to recognize signs of trauma in patients, be cognizant of own practices, give choices when possible • Improvements for training: more videos or opportunities for discussion, increased time for debriefing, include additional examples of TIC in practice	**Quality**: Low **Comments:** • Sufficient power • Poor control of confounders • Findings may not be generalizable due to different geopolitical context • Adequate interpretation of divergences between qualitative and quantitative data **Support for project:** The researchers found that the students showed significant improvement in their knowledge, attitudes, skills and comfort with TIC after the educational session. However, the students would have preferred more interactive materials and concrete examples of TIC into practice.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Carter-Snell et al. (2020) Design: Mixed methods (UCBA with focus groups) Purpose: Determine the effectiveness of TIC based sexual assault service ***SHORT DURATION EDUCATION***	**Country/setting**: 5 rural and remote communities in Western Canada **Sample**: 290 services providers (e.g., nurses, physicians, police) **Intervention:** A 4h in-person training, including 8 modules that could be accessed online for refreshers or if unable to attend; 2 modules addressed TIC and the psychological consequences of trauma Main outcomes measured at baseline, and immediately post-training, and 6-month post-training with questionnaires: • Demographic data • Knowledge and comfort with TIC • Quality of services No regression statistical methods used. Qualitative Data collection: • Six semi structured focus groups • Recorded and transcribed verbatim • Field notes taken • 15 participants Data coded and analyzed by two authors using an inductive approach	**Knowledge and comfort:** • *Knowledge overall*: Pre vs. post: 2.92 (1.07) vs. 3.57 (0.85), $p > 0.05$ • *Comfort providing client services*: Pre vs. post: 3.28 (1.26) vs. 3.57 (1.22), $p < 0.01$ • *Emotional support*: Pre vs. post: 3.19 (1.16) vs. 3.71 (0.99), $p < 0.01$ • *Comfort measures to provide*: Pre vs. post: 2.72 (1.05) vs. 3.93 (1.21), $p < 0.01$ **Quality of services:** • *Police responses to disclosure*: Pre vs. post: 3.41 (1.13) vs. 4.00 (0.67), $p < 0.05$ • *Referrals to counselling*: Pre vs. post: 2.58 (1.31) vs. 3.00 (1.41), $p < 0.05$ **Focus groups** • Enhanced collaborative services • Improved teamwork, collaboration and clear communication • Increased attention to privacy concerns and ED structure • Ongoing gaps • Lack of personnel, limited familiarity	**Quality**: Low **Comments:** • Low response to questionnaires • High attrition rate • No use of regression statistics • Adequate interpretation of divergences between qualitative and quantitative data **Support for project:** The authors found that service providers showed significant improvement in their knowledge of comfort measures and emotional support. The availability of online modules was seen as a way to mitigate the impact of high staff turnover.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments
Isobel & Delgado (2018) Design: Mixed methods Purpose: Determine the effectiveness of TIC communication workshop for MH nurses ***ONE DAY EDUCATION***	**Country/setting:** Australia **Sample:** 73 MH RNs working in acute inpatient mental heath **Intervention:** A 8h-day training, including 5 modules, short communications exercises and two role play scenarios Main outcomes measured post-training with Likert scale questionnaires: • Demographic data • Confidence with TIC • Knowledge of TIC • Experience with TIC No regression statistical methods used. Qualitative Data collection: • Observational field notes during the workshops Data analyzed by the facilitators using a basic content analysis	**Previous Knowledge of TIC:** • Some: 50%; Not much 12%; None 6% **Usefulness of Training on Knowledge of:** • Impacts of trauma: 51% A lot, 33% A little • Practicing TIC: 53% A lot, 36% A little • Promoting emotional safety: 52% A lot, 41% A little • Managing own emotions: 38% A lot, 46% A little • Use of role play: 75% A lot, 10% A little *Scale: A lot, a little, sort of, not much, not at all **Field notes** • Limited exposure to TIC prior to education • Education as first opportunity to illuminate how TIC can be incorporated into routine • Nurses often restrained by policies, communication issues and hierarchy Peer feedback and debriefing useful for finding ways to integrate TIC into care	**Quality**: Low **Comments:** • No randomization or presence of CG • No baseline data gathered • No use of regression statistics • Poor control of confounders • No recording of participants comments or in-depth content analysis • Educational materials and questionnaires developed by clinical nurse consultants, nurse manager, educator, peer working and RNs **Support for project:** Although no conclusions can be regarding increased knowledge on TIC as no baseline data was gathered, the authors found that nurses reacted positively to educational materials about TIC and role play. Peer feedback and discussions assisted them in finding ways to incorporate TIC into nursing care.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

Aremu et al. (2018)
 	
Design:
Case study (Quality Improvement Initiative)
 	
Purpose:
Improve the quality of care provided to mental health patients by strengthening TIC practice
 	
MULTI-COMPONENT INITIATIVE
	Country/setting:
	25-bed inpatient mental health unit in Illinois, USA
	Sample: Registered Nurses and Behavioral Health Technicians
	
	Intervention: A 2-hour in person TIC training for all staff in two waves
	Included Brief solution-focused therapy, and proper documentation
	
	Data collection at baseline and one-month after training:
	• Chart reviews
	• Management of Aggression and Violence Scale (MAVAS)
	• Combined Assessment of Psychiatric Environments (CAPE)
	  • Cronbach's alpha .91
	  • To measure staff engagement and patient experience
	
	Main outcomes measured at 1-month after training and every three months after:
	• Staff engagement and patient experience
	• Confidence with TIC
	• Use of PRN IM medication
	
	No regression statistical methods used.
	Basic content analysis.
		CAPE
		***First training*: Mean (SD)**
		• Pre vs. post: 32.4 (5.3) vs. 33.9 (5.9)
		• p = 0.087
		***Second training*: Mean (SD)**
		• Pre vs. post: 31.6 (3.2) vs. 32.6 (4.9)
		• p = 0.323
		
		MAVAS
		***First training*: Mean (SD)**
		• Pre vs. post: 66.5 (6.6) vs. 69.8 (5.6)
		• p = 0.244
		***Second training*: Mean (SD)**
		• Pre vs. post: 70.2 (11.9) vs. 69.2 (10.1)
		• p = 0.010
		
		Use of Brief Solution-Focused Therapy:
		• 76% of notes indicative of BSFT
		
		Use of PRN IM medication:
		First training (January 2017)
		• Baseline (2015): 11.9 injections/week
		• March 2017: 12.1 injections/week
		Second training (March 2017)
		• April 2017: 3.2 injections/week
		• May 2017: 5.4 injections/week
			Comments:
			• No control group
			• No use of regression statistical methods
			• Poor attendance for the first training sessions and increased acuity of patients on unit during the initiative
			• Lack of power for statistical significance
			
			Support for project:
			The authors showed that quality improvement initiative had mixed success. Patient care was improved by reducing the use of PRN medication and improved communication with patients. However, there was no significant change in staff knowledge and confidence with TIC.

Study/Design/ Purpose	Sample and Methods	Key Results	Comments

Beckett et al. (2017)
 	
Design:
Case study (Quality Improvement Initiative)
 	
Purpose:
Improve the quality of care provided to mental health patients
 	
MULTI-COMPONENT INITIATIVE
	Country/setting:
	27-bed inpatient mental health ward in Sydney, Australia
	
	Sample: Key stakeholders included nurses, nurse consultants, physicians, and pharmacists
	
	Interventions:
	• Chart audits
	• Series of workshop sessions aimed at
	  • Reducing seclusion and restraints
	  • Improving staff skills in de-escalation and physical safety
	  • Ensuring best practice for pharmacological interventions
	  • Introducing a strength-based philosophy
	  • Providing sexual safety training
	  • Improving access to therapeutic activities
	
	Main outcomes measured during the three-year implementation:
	• Seclusion rates
	• Confidence with TIC
	• Use of sedation
	
	No regression statistical methods used. Basic content analysis.
		Seclusion rates:
		• Reduction by 80%
		• Most incidents lasting under 60 minutes
		• Use of the seclusion suite as a voluntary des-escalation area
		Calls to security:
		• Decreased
		Confidence with TIC:
		• Nursing staff reporting feeling more confident and motivated to engage with patients exhibiting signs of emotional distress
		Sedating medications:
		• Revision of the rapid sedation protocol
		• Lower sedation doses
		• Specific medication for frail, elderly, or neuroleptic naïve patients
		Safety:
		• Strength-based language, compassion, and respect
		• Reduced use of clinical jargon
		• All staff attended sexual safety training module
		• Private area for female, avoidance of male staff restraining female patients
		Therapeutic activities:
		• Availability of relaxation, self-care, art yoga and mediation activities
			Comments:
			• No randomization
			• No control group
			• No use of regression statistical methods
			• Participants were selected based on availability although representative of population
			
			Support for project:
			The authors showed that quality improvement initiative was well received by staff and improved their practice. Patient care was improved by reducing the use of seclusion, improving access to therapeutic activities, and by nursing staff using strength-based language.

Legend: CI: *confidence interval****; CG:*** *control group;* ***ED:*** *emergency department;* ***HCWs:*** *health care workers;* ***IG:*** *intervention group;* ***IM:*** *intra-muscular;* ***MH:*** *mental health;* ***OTs:*** *occupational therapists;* ***PRN:*** *as needed;* ***PTs:*** *physiotherapists;* ***PTSD:*** *post-traumatic stress disorder;* ***RCT:*** *randomized controlled trial;* ***RNs:*** *registered nurses;* ***SAMHSA:*** *Substance Abuse and Mental Health Services Administration;* ***SD:*** *standard deviation;* ***SWs:*** *social workers;* ***TE:*** *traumatic experiences;* ***TIC:*** *trauma-informed care;* ***TIVC:*** *trauma and violence-informed care;* ***UCBA:*** *uncontrolled before-after;* ***USA:*** *United States of America*

Appendix B: Environmental Scan Report

Exposure to trauma, such as abuse, neglect, or violence, can contribute to poor psychological health and substance abuse (Watson., 2019). Unfortunately, people with mental illness (PWMI) are disproportionally affected by traumatic experiences (Hogg et al., 2023; Lavergne et al., 2018). When PWMI seek care in the emergency department, standard care practices, such as the use of restraints or seclusion, and stigma from healthcare providers are sources of re-traumatization (Muskett, 2014; Vandyk et al., 2018). Moreover, the presence of environmental constraints, inadequate staffing, and limited resources can also contribute to negative healthcare experiences for PWMI (Vandyk et al., 2018). These negative experiences could be prevented if emergency nurses are able to provide safe care to PWMI using a trauma-informed care (TIC) approach.

TIC is defined as an approach that can be used to "realize the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients, and respond by fully integrating knowledge about trauma into policies, procedures, and practices, and seek to actively resist re-traumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p.9)." The TIC approach has been developed by organizations in Canada and in the United States (Poole et al., 2013; SAMHSA, 2014). Despite its early adoption in mental health and substance abuse settings, few studies have documented the introduction of TIC practices in the emergency department (Hall et al., 2016; Hoysted et al., 2019; McNamara et al., 2021). This lack of documented exploration may have contributed to emergency nurses' lack of skills, knowledge, and attitudes related to TIC (Brown et al., 2022). For instance, only 16.3% of emergency nurses and physicians felt very competent in understanding how traumatic responses may occur in patients in a large tertiary American emergency department (Bruce et al., 2018). Moreover, only 25.9% of emergency providers disclosed feeling competent in providing basic TIC interventions

(Bruce et al., 2018). Furthermore, only 30.6% of emergency providers strongly agreed that they should regularly assess for traumatic stress symptoms in patients (Bruce et al., 2018).

To help emergency nurses improve their knowledge and practice of TIC, Hall et al. (2016) evaluated the effectiveness of TIC education for emergency nurses. The authors of this study found that a one-day training on TIC significantly improved emergency nurses' knowledge, attitudes, and confidence in applying the TIC principles in their practice ($p < 0.001$) (Hall et al., 2016).

In 2022, there were more than 210 PWMI were involuntarily admitted to the qathet General Hospital (V. Wilson, personal communication, May 21, 2023). Although there are many PWMI admitted to the emergency department, there is currently no specialized psychiatric emergency care for PWMI (V. Wilson, personal communication, May 21, 2023). In addition, emergency nurses face ongoing challenges in providing care for PWMI, with limited educational opportunities, time constraints, and insufficient staffing (V. Wilson, personal communication, May 21, 2023). As there is currently no additional training or practice guidelines for emergency nurses about TIC as an approach to care for PWMI at the qathet General Hospital, emergency nurses are poorly equipped to care for PWMI competently. Thus, through this practicum project, I aim to develop an educational trauma-informed care resource for emergency nurses to strengthen their knowledge and skills with TIC.

According to Graham et al. (2008), an environmental scan is "a tool to systematize knowledge that can guide health organizations and projects" (p. 1023). To develop this TIC educational resource, I conducted an environmental scan to determine if there were any existing educational resources related to TIC for emergency nurses and to explore the types of TIC resources currently utilized by Vancouver Coastal Health (VCH) and other Canadian health

authorities. Specifically, my goal was to explore the educational content and the modes of education delivery of these resources in order to determine their usefulness and potential applicability to the local context.

In the following sections, I describe the process used for this environmental scan, including data collection and analysis, and present the findings and subsequent implications for the development of a TIC resource for emergency nurses at the qathet General Hospital.

Specific Objectives for the Environmental Scan

The objectives of the environmental scan were to:

1. Identify if there are any educational resources about trauma-informed care for healthcare workers (HCWs) at VCH and in other Canadian health authorities.
2. Review trauma-informed care policies and guidelines in effect provincially and nationally in healthcare settings through an online search.
3. Consult with individuals with experience in promoting a TIC approach in acute care settings (if any) and the nurse educator to discuss additional educational resources, policies, and guidelines for TIC.
4. Analyze and summarize the data collected to inform the development of a TIC educational resource.

Methods

For an enhanced depth, I utilized three methods to conduct this environmental scan: a local intranet search, an internet search for resources available in Canadian healthcare authorities, as well as a consultation with mental health educator at the qathet General Hospital. The purpose and the methods used are provided in detail within this report.

Data Collection

Data was collected by viewing online resources, by reviewing the index of online programs, and by asking information to the mental nurse educator. Each resource' educational materials (i.e., online programs, guidelines, and policies) were reviewed multiple times to identify educational content and modes of education delivery.

Local Intranet Search

To assess local and provincial resources, information such as online modules for healthcare workers, guidelines for TIC, and policies for TIC were retrieved from the VCH employee portal and the LearningHub. The *LearningHub* is the primary healthcare training portal for HCWs in British Columbia. It contains training resources for many healthcare authorities (i.e., VCH, Fraser Health, Interior Health, Northern Health, Providence Health Care) (Provincial Health Services Authority, n.d). The following key terms were utilized: "*trauma-informed care*," "*training*," "*resources*," "*clinical guidelines*," "*policies*. " These sources were selected because these health authorities provide healthcare in urban and rural areas of British Columbia and have the potential to be adapted to the qathet General Hospital.

Internet Search

In addition to searching the above resources, educational materials (i.e., online programs, guidelines, and policies) from other Canadian healthcare authorities (e.g., Alberta Health Services [AHS]) were also identified using a Google search using the following key terms: "*trauma-informed care*," "*training*," "*resources*," "*clinical guidelines*," "*policies*," "*healthcare workers*," "*Canada*." The search was limited to reputable Canadian sources, as the care provision in different countries may differ due to legislative and sociopolitical factors. The search was limited to resources that address TIC in the healthcare context, ideally targeted at healthcare workers. Resources aimed at families and other disciplines, such as law enforcement or social

work, were excluded because their scope of practice, professional obligations, and education differ from those of HCWs. Additional resources (e.g., guidelines, toolkits) provided on the websites through references or supplementary material were also reviewed. The results of this scan are summarized in Appendix C of this paper.

Consultations with the Mental Health Nurse Educator and Team Lead

To strengthen the search for resources, I informally consulted with the mental health nurse educator to assess whether they knew of TIC resources within our healthcare authority, VCH, or other healthcare authorities in May 2023. I also asked the nurse educator about the perceived strengths and barriers of the identified VCH resources.

Through my local intranet search, I also identified a Knowledge Translation Challenge recipient, whose project focused on developing a training program for TIC in the ICU. I emailed team lead for this project to obtain additional information and to enquire about the possibility of conducting an interview. The email used for this purpose and an interview guide is included for ease of comprehension (see Appendix A and B). Unfortunately, no response was obtained from the team lead. Therefore, I have been unable to consult with this individual or access TIC educational material from this initiative.

Ethical Considerations

The Health and Research Ethics Board approval screening tool was used to determine ethical considerations for this project (see Appendix D). This practicum project was deemed a quality improvement project, so it was exempt from ethical clearance. No additional clearance or permission was necessary to conduct informal interviews or to access publicly available resources. However, ethical considerations were included in all communications with contacts. In addition to introducing myself and describing the purpose of the project, I explained how the

data was kept confidential (i.e., password-protected file), only shared with my supervisor, and destroyed once the project was completed. Moreover, a reminder was included for their voluntary participation and their ability to withdraw their consent for participation at any time.

Data Management and Analysis

The identified resources were analyzed, compared, and summarized using basic content analysis (Bengtsson, 2016). The collected data from resources were compiled in several Word summary tables that included a brief description of the resources, the focus of the resources, their strengths and weaknesses, and their applicability to my local setting (see Appendix C). The summary tables were divided by type of resources. For instance, summary tables for the online programs (see Table 1), for the guidelines (see Table 2), and for the policies (see Table 3) can be found in Appendix C. Finally, two summary tables outlining the educational content (see Table 4) and the educational strategies of TIC online programs and guidelines (see Table 5) were created for ease of comprehension.

Results

Overview of the Resources

Various provincial and national resources for TIC were identified through the environmental scan. Seven guidelines were identified in a Google search of publicly available TIC resources. Three TIC guides were developed in British Columbia: 1) Trauma-Informed Practice Guide by the British Columbia Provincial Mental Health and Substance Use Planning Council (BCPMHSUPC) (Poole et al., 2013), 2) Trauma-Informed Practice and the Opioid Crisis by the Centre of Excellence for Women's Health (Nathoo et al., 2018), and 3) New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy by the Center of Excellence for Women's Health (Schmidt et al., 2018).

Three other guidelines were provided by Canadian organizations from Manitoba (i.e., Klinic Community Health Centre), Nova Scotia (i.e., IWK, Nova Scotia Health & Government of Nova Scotia), and Ontario (i.e., Jean Tweed Centre). Finally, the Registered Nurses Association of Ontario (RNAO) (2017) created evidence-based practice guidelines for crisis intervention for adults using a trauma-informed approach.

Additionally, two online programs for TIC were found in this environmental scan: the Trauma and Violence Informed Care Foundations (TVICF) by University of British Columbia (UBC) (2017), and the Trauma Training Initiative for Healthcare Professionals (TTIHP) by AHS (2022). Moreover, two provincial policies were located (Fraser Health, 2017; VCH, 2020). The consultation with the nurse educator did not yield any additional resource.

The resources will be discussed below to determine which ones could be utilized to develop an educational tool for the local setting. While online modules and guidelines include informal recommendations for TIC, policies outline the standards HCWs should comply with when providing care (Fraser Health, 2017; VCH, 2020). Therefore, policies will be discussed separately. All resources will be examined in relation to their content, educational strategies, strengths, and limitations.

Online Programs and Guidelines

Educational Content

Most of the guidelines and online programs were developed for HCWs and services providers working in the field of substance abuse and mental health. As such, the educational content for TIC was similar in many of these resources. First, many guidelines and online programs emphasized the need for service providers to understand what constitutes trauma, its impacts, and its connection to substance abuse and mental health disorders (AHS, 2022; Bolton

et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). In addition, the signs and symptoms of trauma were detailed to increase awareness from service providers (AHS, 2022; Bolton et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). Second, a thorough description of TIC principles and practices was integrated into the guidelines (AHS, 2022; Bolton et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). Third, guidelines on how to implement TIC into practice were provided to assist HCWs in caring for people who have experienced trauma (AHS, 2022; Bolton et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). For example, communication techniques, strength-based language, and strategies to support collaboration were covered in the BCPMHSUPC guide (Poole et al., 2013). The RNAO (2017) further supported the use enhanced communication skills by nurses with PWMI through the brief intervention approach, as it has been shown to improve outcomes for PWMI. The FRAMES acronym summarizing the BI approach is included as a support resource in the RNAO guidelines (RNAO, 2017).

In addition, three guidelines and one online program added content about TIC from an organizational perspective (Bolton et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). The impacts of traumatic responses on service providers (i.e., vicarious trauma) were also discussed in relation to its signs, its protective and risk factors, and in finding ways to alleviate its effects on HCWs in four guides and one online program (AHS, 2020; Bolton et al., 2013; Jean

Tweed Centre, 2013; Nathoo et al., 2018; RNAO, 2017). For example, the TTIHP covered self-care strategies for HCWs (AHS, 2020). Only the toolkit by the BCPMHSUPC (2013) included an assessment tool for service providers. For instance, the Co-Occurring Joint Action Council (COJAC) screening tool is a 9-item questionnaire that assists providers in evaluating patients' substance use, mental health, and traumatic experiences (Poole et al., 2013).

Educational Strategies

Regarding educational strategies, didactic material about TIC was included in all guidelines and online programs (AHS, 2022; Bolton et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). In most cases, practice examples of TIC were covered through the use of case studies, questions to discuss, or self-reflection questions. A summary table for educational strategies can be found in Table 5 (see Appendix C). The TVICF was the only resource to involve active participation from learners with the use of quizzes and videos (UBC, 2017). In addition, the inclusion of a notebook allowed participants to record their reflections as they progressed through the course (UBC, 2017).

The RNAO guidelines provided recommendations for TIC education for nurses (RNAO, 2017). The RNAO (2017) reiterated the importance of giving nurses educational opportunities regarding TIC approaches. For nurses to integrate knowledge and skills about TIC, the RNAO (2017) suggested that interactive educational methods, such as discussions or simulation, were more effective than traditional methods. Moreover, continuing education was seen as an essential component of the integration of TIC into practice for HCWs (RNAO, 2017).

Strengths and Limitations

Both online trainings and guidelines presented advantages in terms of availability and

autonomous learning (AHS, 2022; Bolton et al., 2013; IWK, Nova Scotia Health & Government of Nova Scotia, 2015; Jean Tweed Centre, 2013; Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017; Schmidt et al., 2018; UBC, 2017). As these resources were offered online, HCWs could engage in continuous education when they have time and are motivated to learn. Learners could also proceed through the modules or chapters at their own pace. Guidelines may be a starting point to support HCWs in gaining confidence, skills, and abilities with TIC. HCWs can use the guidelines as needed and find pertinent information based on their interest. Most of the guidelines also included suggestions for practice that HCWs can adopt if they are suited to their setting.

Some limitations concerning the use of these guidelines and online programs should also be noted. First, practices and tools included in the guidelines may not be up to date, as some of the material was developed in 2013. Additionally, the Jean Tweed Centre toolkit specifically targeted women with substance use disorders, rendering its application to PWMI within an emergency setting complicated as it may be context dependent (Jean Tweed Centre, 2013). Moreover, for HCWs to integrate TIC into practice, non-traditional educational strategies (e.g., case studies, discussions, simulation) should be utilized to supplement didactic material (AHS, 2022; RNAO, 2017). While online learning may be a suitable tool in several settings, the lack of time for education and its lengthy duration might preclude emergency nurses in rural settings from engaging in these educational opportunities (V. Wilson, personal communication, May 21, 2023).

Policies

Two policies regarding TIC from health authorities in British Columbia were located during the environmental scan: the Trauma-Informed Practice (TIP) policy from VCH (2020)

and the Respecting Diversity in Daily Interactions policy from Fraser Health (2017). The VCH TIP policy was the only resource known by the mental health nurse educator (V. Wilson, personal communication, May 21, 2023).

Content and Strategies

Both policies apply to all employees within the healthcare organizations. The TIP policy from VCH (2020) outlined that all care providers will use a TIC approach to care for patients and families. The VCH policy was designed based on the BCPMHSUPC guide (Poole et al., 2013). Four main TIC principles were defined with practice examples: 1) trauma awareness, 2) safety and trustworthiness, 3) choice, collaboration, and connection, and 4) strength-based and skill-building. In addition, the TIP policy described patient and family education, documentation strategies, and self-assessment tools.

In contrast, while the Respecting Diversity in Daily Interactions policy from Fraser Health (2017) included TIC as one of its components, the policy was focused on pluralism, patient-centered care, and health equity. The commitment to patient-centered care implicated providing patients with emotional and physical safety and minimizes the risk of re-traumatization (Fraser Health, 2017). Moreover, choice and collaboration with patients and families were cornerstones of this approach, with HCWs being responsible for providing care that aligns with these values and encouraging patients and families to be partners in their healthcare journey (Fraser Health, 2017). The policy outlined several diversity competency standards for HCWs (Fraser Health, 2017). For instance, HCWs must be proficient in communication skills, self-reflection, and self-awareness to respect diversity (Fraser Health, 2017).

Strengths and Limitations

While both policies contained additional resources for TIC, neither policy addressed

HCWs' role and the organizational role in terms of educational commitment for TIC (Fraser Health, 2017; VCH, 2020). It is unknown if HCWs are expected to engage in continuous education or participate in mandatory training for TIC (Fraser Health, 2017; VCH, 2020). Additionally, the policies were broad enough to be applicable in diverse care areas but did not include examples or standards specifically for emergency nurses (Fraser Health, 2017; VCH, 2020). The lack of emergency-specific educational material for TIC was reiterated by the mental health nurse educator during an informal conversation. The mental health nurse educator expressed concerns with this gap, as educational material should be well suited to the setting in which they apply and re-emphasized the need to develop specific TIC resources for emergency nurses (V. Wilson, personal communication, May 21, 2023). Moreover, the mental health nurse educator mentioned that few nurses appeared to be aware of this policy (V. Wilson, personal communication, May 21, 2023). She added that the mental health and substance use lead team from VCH developed the resource, which could explain why acute care services staff are unaware of this resource (V. Wilson, personal communication, May 21, 2023).

However, the inclusion of competency standards and practice examples from both policies could be easily adapted for the emergency nursing practice (Fraser Health, 2017; VCH, 2020). The TIP policy also outlined patient and family education and documentation strategies, which represent tangible areas of improvement for emergency nurses for their TIC approach (VCH, 2020).

Implications for the Development of an Educational Resource

Although a variety of resources currently support a TIC practice, none specifically addressed content for emergency department nurses caring for PWMI. However, some of the resources were broad and included relevant or insightful content specifically for the development

of a TIC resource to help emergency nurses at the qathet General Hospital care for PWMI. For instance, the inclusion of communication skills, strengths-based language, and self-assessment tools provided opportunities to incorporate TIC easily and concretely in practice (Nathoo et al., 2018; Poole et al., 2013; RNAO, 2017). In addition, the presence of a TIC policy at VCH highlighted the importance for HCWs to learn about the TIC approach and infuse their practice with its principles (VCH, 2020). However, limited awareness of this policy might preclude HCWs from seeking educational opportunities for TIC or ensuring they incorporate a TIC approach with patients and families. Therefore, increased awareness of TIC policy and the development of specific TIC educational opportunities is needed to enhance the nursing practice of TIC for PWMI within the emergency department.

According to the RNAO (2017), online training, guides, and toolkits can potentially improve HCWs' knowledge of TIC. To enhance skills, HCWs need to solidify their understanding of the principles of TIC (RNAO, 2017). However, in its best practice guidelines, the RNAO (2017) supported interactive continuing education such as case studies and discussion to ensure HCWs are proficient with TIC practice. For the educational TIC resource for PWMI to meet the needs of emergency nurses at the qathet General Hospital, further information about educational content and strategies will be explored during the consultations with key stakeholders. A decision regarding the method of delivery for the TIC educational resource for emergency nurses will be made based on the information from this environmental scan, the literature review and recommendations from the emergency nurses at the qathet General Hospital during the consultations. Therefore, topics such as the principles of the TIC approach and the impacts of trauma, will be the focus of the educational resource developed for this project.

Conclusion

The environmental scan helped me identify current TIC resources, strategies, and existing policies that could be promptly adapted to the qathet General Hospital. Additionally, the environmental scan helped inform my decisions about the content and mode of delivery of the TIC educational resources. After reviewing and analyzing the retrieved resources, important topics to cover were found to be: definitions of trauma and TIC, rationale for using TIC, strategies to implement TIC in practice, information on vicarious trauma, and interventions to prevent and manage vicarious trauma. In addition, the RNAO's resource offered guidance for preferred educational strategies (RNAO, 2017). For emergency nurses to integrate knowledge and skills about TIC, the RNAO (2017) encouraged using interactive educational methods, such as discussions or simulation. Using the results of the environmental scan, the literature review, and the consultations will help the development of an educational resource for emergency nurses to provide trauma-informed care for mental health patients.

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Appendix A: Email Inquiry

Hello, my name is Maude Bellemare. I am a student in the Master of Science in Nursing program at Memorial University. I am currently working on my practicum project. As part of this project, I am hoping to develop an educational resource for emergency nurses for the provision of trauma-informed care for mental health patients. The goal of this project is to strengthen emergency nurses' knowledge and skills by providing them with education about trauma-informed care.

I would like to ask for your assistance in the creation on of the educational resource. First, I would like to know if you have or are in the process of developing trauma-informed care educational resources. If so, I would like to know if you would be able to provide me with a copy of the training material. Second, I would like to know if you are interested in taking part in an interview to help me develop this tool. I would be interested in learning about your experience in implementing the resource within your setting or, in the case that you do not have such resources, about your experience with educational tools and effective learning strategies. The interview will be informal. I will conduct the interview by phone, or online via Google Meet. The interview should take between 15 and 30 minutes to be completed. The information collected from this interview will help me to develop my TIC project for the emergency nurses.

Your participation is voluntary. The information you will only be shared with my supervisor. My notes will be kept in a password-protected file on my computer and deleted once I finish my practicum project.

I look forward to hearing from you.

Do not hesitate to contact me if you have any questions.

Kind regards,
Maude Bellemare, BScN, RN
MScN student, MUN Faculty of Nursing, St. John's, NL
403-307-2673

Appendix B: Interview Guide for the Consultations

Thank you for taking the time to meet with me. As you know, I hope to create an educational resource for providing trauma-informed care for mental health patients in the emergency department. Before we begin, I want to inform you that your participation is voluntary. You may answer the questions to the best of your ability. I will be taking notes during this interview. These notes will be transcribed in a Word document and stored on a password-protected computer. Access to these notes will be limited to my supervisor Dr. Abubaker Hamed and myself. Once my practicum project is completed, the collected notes will be deleted.

The questions we cover may generate emotional responses as it pertains to traumatic experiences. You may stop the interview at any time for any reason. You can also choose not to answer questions that make you uncomfortable. If you need additional support after this interview, please get in touch with the Employee and Family Assistance Program by calling 1-833-533-1577.

Do you have any questions or comments for me before we begin?

1. Are you aware of any nursing guidelines or policies for TIC for patients in the emergency department or in other healthcare settings?
2. Are you aware of any trauma-informed care educational resources for mental health patients or other types of patients?
3. How do you feel about TIC practice within the emergency department? Do you see any challenges or barriers to implementing trauma-informed care?
4. Do you feel like an educational resource for trauma-informed care for mental health

patients would be beneficial? If so, which format do participants usually prefer? (e.g., case studies, toolkit, discussion, lecture)

5. What content would be the most beneficial in your opinion? (e.g., communication techniques, debriefing, self-care, des-escalation techniques)
6. Do you have any other comments about trauma-informed care, educational opportunities, or the care of mental health patients in general?
7. What teaching methods have you employed with success for nurses?
8. Do you think developing a resource for trauma-informed care for mental health patients in the emergency department will be well received by nurses? How so?
9. Do you have any suggestions for developing my educational resource for trauma-informed care?
10. Would you like to be contacted to provide feedback on the trauma-informed resource I plan to develop?

Thank you for your time!

Appendix C: Summary Tables for the Sources of Information

Table 1

Summary Table for the Online Programs

Source of Information	Strategies/Focus of Resource	Strengths	Barriers	Applicability to local setting
Trauma Training Initiative for Healthcare Professionals *Alberta*	7 E-learning modules (30 minutes per module) Including TIC, trauma and emotion, the implementation of TIC, and self-care for exposure to trauma	• Autonomous learning, self-directed • Pre- and post-questionnaire to assess learning • Available at all times	• Should be supplemented with in-person workshop to consolidate learning • May be time-consuming to complete • No debriefing included • No interactive component	Limited, due to lack of time for education
Trauma and Violence Informed Care Foundations Equip Healthcare *British Columbia*	7 online modules for a total of five to seven hours of training Definition of TIVC TIVC in individual practice, work, and organizations	• Self-directed learning • Includes case studies and videos • Interactive quizzes	• No debriefing included • For those who have online access	Limited, due to lack of time for education

Table 2

Summary Table for the Guidelines

Source of Information	Strategies/Focus of Resource	Strengths	Barriers	Applicability to local setting
Trauma-Informed Practice Guide *British Columbia*	Rationale for TIC Principles of TIC At practice level: trauma awareness, destigmatizing language Various examples of statements and case studies Communication strategies with examples Cojac tool for assessment	• Autonomous learning, self-directed • Pre- and post-questionnaire to assess learning • Available at all times	• Should be supplemented with in-person workshop to consolidate learning • May be time-consuming to complete • No debriefing included • No interactive component	Yes, if specific content is applied to ED nursing (e.g., communication strategies, trauma signs and symptoms)
Trauma-Informed Practice and the Opioid Crisis *British Columbia*	Rationale for TIC Principles of TIC Numerous practice examples Discussion questions Skills and strategies for service providers Box breathing for vicarious trauma	• Self-directed learning • Includes numerous examples and case studies to present to employees	• No interactive component to the session • No assessment tools	Yes, if specific content is applied to ED nursing (e.g., case studies, vicarious trauma exercises)
New Terrain Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy *British Columbia*	Definition of TIC and the benefit of integrating TIC into care Examples of service programs that integrate TIC	• Includes gender and sex informed practices • Information for organizations • Principles of TIC • Worksheets for analysis	• No case studies or integrative components	Limited due to the lack of TIC in practice examples

Source of Information	Focus of Resource	Strengths	Barriers	Applicability to local setting
The Trauma-Informed Toolkit *Manitoba*	Definition of trauma, impacts of trauma and neurobiology Historical trauma Guidelines for working with people affected by trauma Vicarious trauma and its effects	• Includes resources for training and additional information • Scenarios with appropriate and inappropriate responses • ABC model for vicarious trauma	• No interactive component • Few exercises or examples to enhance understanding	Yes, if specific content is applied to ED nursing (e.g., ABC model, scenarios)
Trauma matters: Guidelines for Trauma-Informed Practices in Women's Substance Use Services *Ontario*	Definition of trauma and TIC Impacts of trauma Principles of TIC TIC practices Supporting staff Trauma-specific services System-level and organizational TIC practices	• Includes goals for each section • Practice considerations and examples of do's and don'ts • Self-reflection questions • Indicators for organizational objectives	• Focus on women • Few scenarios aimed for HCWs or applicable in health care settings	Limited due its focus on women and substance use
Crisis intervention for adults using a trauma-informed approach: Initial four weeks of management *Ontario*	Evidence-based Practice, policy and education recommendations for TIC Brief overview of TIC Recommendations for TIC strategies, education, policies, and organizations	• Level of evidence is included for each recommendation • FRAMES framework for TIC interactions • Outlines educational preferences for HCWs • Debriefing framework	• Could benefit from examples to assist with practice	Yes, if specific content is applied to ED nursing (e.g., FRAMES framework, debriefing framework)
Trauma Informed Approaches: an introduction guide and discussion guide for health and service providers *Nova Scotia*	Importance for TIC Basics of TIC Examples of TIC in practice Discussion questions	• Self-directed learning • Includes numerous examples and case studies to present to employees	• No interactive component to the session • No assessment tools	Yes, if specific content is applied to ED nursing (e.g., case studies and scenarios)

Table 3

Summary Table for Policies

Source of Information	Strategies/Focus of Resource	Strengths	Barriers	Applicability to local setting
Trauma Informed Practice Vancouver Coastal Health *British Columbia*	Policy for all the organization Includes information from Trauma-Informed Practice Guide (2013) Emphasis on 4 TIC principles with examples: 1) trauma awareness 2) safety and trustworthiness 3) choice, collaboration, and connection 4) strength based and skill building	• For all employees • Includes patient and family education, documentation strategies • Self-assessment tool for self-care and grounding strategies	• May be too broad to be applied to the ED • Needs to be supplemented with exercises to solidify learning	Yes However, it would benefit from specific examples related to emergency nursing
Respecting Diversity in Daily Interactions Fraser Health *British Columbia*	Policy based on the principles of pluralism, patient-centered care, and health equity Responsibilities for the organization, teams, and individuals	• For care providers and leadership Includes diversity competency standards for communication skills, self-reflection, diversity competent traits, and patient-centered care	• Broad • No examples or resources to support practice	Limited due its focus on diversity and pluralism

Table 4

Summary Table for the Educational Content

	Educational Content					
Source of information	Trauma and its effects	Definition of TIC and main principles	TIC for individuals	TIC for leadership	Vicarious trauma for workers	Assessment tools
Trauma Training Initiative (AB)	√	√	√	**X**	√	**X**
TVIC Foundations (BC)	√	√	√	√	**X**	**X**
TIP Guide (BC)	√	√	√	**X**	**X**	√
TIP and the Opioid Crisis (BC)	√	√	√	**X**	√	**X**
New Terrain: Tools for TIC (BC)	√	√	√	√	**X**	**X**
Trauma Informed Toolkit (MB)	√	√	√	**X**	√	**X**
Trauma Matters (ON)	√	√	√	√	√	**X**
Crisis intervention using TIC (ON)	√	√	√	√	√	**X**
Trauma Informed Approach (NS)	√	√	√	**X**	**X**	**X**

Legend: **AB:** Alberta; **BC**: British Columbia; **ON:** Ontario; **TIC:** Trauma-Informed Care; **TIP:** Trauma Informed Practice; **X:** Not included; **√:** Included

Table 5

Summary Table for the Educational Strategies

	Educational Content					
Source of information	Case Studies/ Scenarios to discuss	Quizzes	Examples of TIC in practice	Self-reflection questions	Videos	Didactic Material
Trauma Training Initiative (AB)	**X**	**X**	**X**	**X**	**X**	√
TVIC Foundations (BC)	√	√	√	√	√	√
TIP Guide (BC)	√	**X**	√	**X**	**X**	√
TIP and the Opioid Crisis (BC)	√	**X**	√	**X**	**X**	√
New Terrain: Tools for TIC (BC)	**X**	**X**	**X**	**X**	**X**	√
Trauma Informed Toolkit (MB)	√	**X**	√	**X**	**X**	√
Trauma Matters (ON)	√	**X**	**X**	√	**X**	√
Crisis intervention using TIC (ON)	**X**	**X**	√	**X**	**X**	√
Trauma Informed Approach (NS)	√	**X**	√	**X**	**X**	√

Legend: **AB:** Alberta; **BC**: British Columbia; **ON:** Ontario; **TIC:** Trauma-Informed Care; **TIP:** Trauma Informed Practice; **X:** Not included; **√:** Included

Appendix D: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Maude Bellemare

Title of Practicum Project: Development of an educational resource for emergency nurses for the provision of trauma-informed care for mental health patients

Date Checklist Completed: June 21, 2023

This project is exempt from Health Research Ethics Board approval because it matches item number 3 from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix C: Consultation Report

Safe and competent care for people with mental illness (PWMI) is an essential component of the emergency nursing practice. To provide compassionate and client-centered care for PWMI, nurses must understand emergency visits involve potential harms, such as re-traumatization, stigmatization, and coercive practices, and that exposure to trauma is highly prevalent in PWMI (Hennessy et al., 2023; Vandyk et al., 2018). Traumatic experiences contribute to poor mental and physical health outcomes for PWMI, significantly burdening the healthcare system (Adams et al., 2020; Davis et al., 2022; Hauw et al., 2021). There is growing literature regarding the use of trauma-informed care to address the pervasive effects of trauma and promote the health of PWMI (Brown et al., 2022; Muskett, 2014). In a systematic review, Brown et al. (2022) noted TIC contributed to a reported increased quality of care for patients, with prompter outpatient follow-up and a reduced use of restraints. Additionally, healthcare workers reported greater comfort and knowledge in providing care for people with a history of trauma (Brown et al, 2022). However, despite TIC being effectively incorporated into mental health settings, there is a lack of specific guidance for emergency nurses (Brown et al., 2022; Muskett, 2014).

Emergency departments represent a point of access for healthcare services for PWMI across Canada (Fleury et al., 2019). Although the qathet General Hospital provides healthcare for PWMI, there is no TIC educational resources available for emergency nurses to help them deal with this important population (personal communication, V. Wilson, May 22, 2023). Therefore, this practicum project aims to develop an educational resource for emergency nurses to help them provide better nursing care for PWMI. A literature review and an environmental scan were previously conducted and highlighted effective learning modalities and content for TIC training.

However, consultations were necessary to understand the specific educational needs of qathet emergency nurses and their perceptions of caring for PWMI.

Specific Objective(s) for the Consultations

The objectives of the consultations were to:

1. Identify qathet emergency nurses' knowledge of trauma-informed care policies, guidelines, and resources for PWMI.
2. Explore emergency nurses' learning needs and preferred educational modalities for TIC.
3. Determine nurses' perceptions of current nursing care of PWMI and their practice of TIC.
4. Examine potential barriers and facilitators for the implementation of TIC.
5. Identify the preferred mode of delivery of the TIC educational resource with stakeholders and emergency nurses.

Methods

In this report, I will discuss the setting and sample, data collection, data management and analysis, and results of my consultation with emergency nurses and stakeholders.

Setting and Sample

The consultations were conducted at the qathet General Hospital, which is a part of Vancouver Coastal Health. The qathet General Hospital is a rural hospital located in Powell River, British Columbia, and mental health patients must be admitted to 11-bed emergency department for medical clearance before their transfer to the psychiatry unit. Six senior emergency nurses, one new graduate nurse, a nurse educator, and a patient care coordinator were included for these consultations. These individuals were selected because they could provide unique insight regarding their role and how they contribute to the care of PWMI. In addition, the nurse educator and the patient care coordinator have expertise in implementing educational

opportunities for nurses. To ensure privacy and confidentiality, senior emergency nurses and new graduates will be referred to as emergency nurses, and the nurse educator and patient care coordinator will be referred to as key stakeholders in this text.

To recruit the participants, I sent an email to the manager of acute care services at the qathet General Hospital (see Appendix A) to obtain permission to conduct interviews with emergency nurses. I also enquired with the manager about the possibility for these interviews to take place at the workplace if desired by participants. For recruitment, as I am an employed as an emergency nurse at the qathet General Hospital, I used my work email to send a brief description of the project to the emergency nurses, the nurse educator, and the patient care coordinator (see Appendix B and C). Once nurses agreed to participate, an interview was arranged based on their availability. Moreover, some participants showed interest in being interviewed while I was present on-site to conduct consultations. After providing an overview of the practicum project, I scheduled same-day interviews with two participants and followed up by phone with two other participants for their interviews.

Ethical Considerations

Ethical considerations were included in all communications with contacts. Permission to conduct the interviews was obtained from the manager of the acute care services. Once participants agreed to be interviewed, the interviews were arranged in a private space whenever possible to ensure confidentiality. Participation was voluntary and the participants were able to withdraw their consent for participation at any time during the interview. Data was kept confidential and stored on a password-protected computer and file, and only shared with my supervisor. In addition, participants were made aware that the collected data would be destroyed once the project is completed. The participants were given a phone number for the Employee and

Family Assistance Program (EFAP), as the discussions regarding trauma-informed care could potentially elicit memories of traumatic events.

The Health and Research Ethics Board approval screening tool was also used to determine ethical considerations for this project (see Appendix F). As it was deemed a quality improvement project, it was exempt from ethical clearance.

Data Collection

Nine semi-structured interviews were conducted with six senior nurses, a new graduate nurse, a nurse educator, and a patient care coordinator. Each interview took between 15 to 30 minutes to complete. Five interviews were carried out face-to-face, three by phone, and one via Google Meet. Attempts were made to conduct the interviews in a quiet and private space to minimize distractions and interruptions. I used separate interview guides for emergency nurses, the patient care coordinator, and the nurse educator (see Appendix D). These interview guides were developed based on the findings from the literature reviews and the environmental scan. The aims of these interviews were to collect some information about nurses' awareness of TIC, their experiences in caring for PWMI, their educational preferences, and perceived challenges with the implementation of TIC in practice. I asked questions in an open-ended manner and invited the emergency nurses and key stakeholders to share their thoughts. Moreover, I sought clarifications from the participants to further enhance my understating of their answers. As the unit is relatively small, I believe conducting nine interviews was appropriate based on limited time. To ensure the quality of the data, I wrote field notes about my impressions and my thoughts after each interview. I ensured no personal data was collected and avoided using identifiers.

Data Management and Analysis

During the interviews, I took handwritten notes. I transcribed the notes in a Word

document, by taking attention to remove identifiers. I reviewed the notes and read them thoroughly multiple times to familiarize myself with the collected data. Using Bengtsson's content analysis (2016), I tried to identify patterns after gaining a deeper understanding of the comments generated in the interviews. I organized and clustered the collected data into themes into a Word document. Moreover, for the themes "*TIC in practice in the emergency department*" and "*educational needs of emergency nurses*", I supplemented the content analysis with the use of descriptive statistics to quantify the data. According to Vaismoradi et al. (2013), content analysis allows researchers to analyze data qualitatively and quantitatively.

Results

A total of nine interviews were carried out with key stakeholders and emergency nurses between July 10th and July 13th, 2023. After data analysis, three main themes emerged: 1) nurses' perceptions of caring for PWMI, 2) TIC in the emergency department, and 3) educational needs for emergency nurses.

The first main theme, *nurses' perceptions of caring for PWMI,* was further subdivided in two subthemes: *negative attitudes towards PWMI* and *insufficient safety*. Appendix E illustrates an example of analysis for the theme "nurses' negative attitudes toward PWMI". Of the first subtheme (*negative attitudes towards PWMI*), three additional subthemes emerged: *negative attitudes towards PWMI*, *reliance on standardized processes and practices*, and *feeling ill-prepared and unsupported*. Of the second subtheme (*insufficient safety*) three additional subthemes emerged: *safety for all*, *privacy*, and *potential for vicarious trauma*.

The second main theme, *TIC in the emergency department*, was further subdivided in two subthemes, which are: *lack of awareness of TIC resources and educational opportunities* and *facilitators and barriers for the implementation of TIC*. Of the second subtheme (*facilitators and*

barriers for the implementation of TIC), two additional subthemes emerged, which are *attitudes toward TIC* and *insufficient resources, understaffing and lack of time*.

The third main theme identified was *the educational needs of emergency nurses*. Of this theme, two additional subthemes emerged, namely *educational modalities* and *educational content*. These findings will be discussed in this section.

Theme 1: Nurses' Perceptions of Caring for PWMI

When asked about their experiences and perceptions about caring for PWMI, emergency nurses highlighted the pervasive effects of the mental health stigma. Moreover, insufficient safety was also a theme identified from the consultations with emergency nurses and will be explored in the following section.

Subtheme 1.1: The Stigma of Mental Health

Emergency nurses described the pervasive effects of stigma for PWMI and how it tainted their care in the emergency department. For instance, one emergency nurse noted once PWMI entered the department, a label of "*mental health*" contributed to negative experiences, with nurses often forgetting that "*people have all walk of life, and we need to see beyond their diagnosis*". Three subthemes emerged from the above theme, which are ***negative attitudes towards PWMI, reliance on standardized processes and practices, and feeling ill-prepared and unsupported***.

Subtheme 1.1.1: Negative Attitudes towards PWMI. The negative attitudes emergency nurses hold toward PWMI are one of the contributing factors for the suboptimal care of PWMI. Several participants noted that most of the emergency nurses disliked dealing with mental health patients, with many noting that mental health nursing practice is time-consuming. In addition, one participant noted that most emergency nurses "*did not excel in mental health*" because they

preferred the "*adrenaline*" medical emergencies provide. Mental health nursing was described as "*scary*" and "*as a frustrating thing to dive into*".

Emergency nurses also recognized the fact that they make assumptions about PWMI' past medical history. For example, one emergency nurse described having biases toward PWMI and often basing their care on collateral information, especially for those who also have a diagnosis of substance abuse. This often resulted in feelings that PWMI who come intoxicated to the emergency department are seen as "*less worthy of care*" as opposed to other patients.

Subtheme 1.1.2: Reliance on Standardized Processes and Practices. Many participants acknowledged a reliance on standardized processes for PWMI. For instance, once PWMI came through the emergency department with a mental health complaint, a series of steps ensued to provide emergency psychiatric treatment or to facilitate their transition to the psychiatric department. For this reason, according to one nurse, PWMI often are relocated to the seclusion room and changed into hospital pajamas. Nurses voiced that PWMI' concerns are often "*pushed to the side*" because the sole focus is for them to get medical clearance for the psychiatric department. One participant explained that this process leads to substandard care where PWMI' individual needs are not addressed. Moreover, by PWMI being often immediately put in the seclusion room, nurses acknowledged the possibility for poor experiences and an increased risk of traumatization.

Subtheme 1.1.3: Feeling ill-prepared and unsupported. Emergency nurses commented on their perceived lack of training and skills for caring for PWMI. One emergency nurse commented "*ED nurses are not trained to get to the root of the problem, to talk to them, to help them*." The majority of emergency nurses characterized their care as suboptimal due to a lack of skills in mental health nursing. Some participants voiced they felt ill-prepared to address the

complex needs of mental health patients. One nurse stated that "*my experience with PWMI comes from my personal experience with my family*".

Emergency nurses also overwhelmingly acknowledged a lack to resources and time for PWMI. Many disclosed that they were not supported by the leadership team or by the psychiatry department, with the services of a specialized mental health emergency nurses only being available on some weekdays. All the emergency nurses interviewed further discussed their lack of awareness of mental health policies within Vancouver Coastal Health. Many also noted they were unaware of mental health resources to aid their care of PWMI, leaving them inadequately prepared for caring for this population. For instance, a nurse said, "*I am not aware of any TIC resources for mental health patients or other types of patients*".

Subtheme 1.2: Insufficient Safety

Insufficient safety was a recurrent theme in the interviews. This theme was further divided in three subthemes: 1) safety for all 2) privacy, and 3) potential for vicarious trauma. The subthemes will be discussed below.

Subtheme 1.2.1: Safety for all. Emergency nurses emphasized the concept of safety within the department guided all actions and practices. For instance, despite having a desire to practice holistic nursing, participants spoke about the necessity to protect all patients, staff, and families. Safety often guided the care and the practices utilized for PWMI. For instance, if the patient was deemed a danger to themselves or other, they would be relocated in the seclusion room, where nurses could closely monitor the patient by camera. However, other rooms in the emergency department presented multiple challenges in terms of safety for PWMI. Nurses spoke about the presence of cords, medical equipment, sharps containers and a lack of visibility as concerns for patient safety.

The use of restraints was also discussed by nurses. Many nurses felt there was an overreliance on chemical restraints and physical restraints as opposed to de-escalation techniques and collaboration with PWMI. According to many participants, the choice to use restraints was often taken due to a lack of staff, time, and limited resources. Medicating patients for their safety was also seen as a way to control the unpredictability of volatile patients and enhance the safety of patients, families and HCWs within the emergency department. One participant stated that the least restraints approach was sometimes more harmful for emergency nurses, due to the heightened risk of being assaulted. Moreover, nurses felt using chemical restraints resulted in poor nursing practices as mental health patients were not benefitting from actual psychiatric care.

Subtheme 1.2.2: Privacy. The concept of safety was also explored from a privacy standpoint. Nurses commented on the physical environment of the emergency department, contributing to a lack of privacy. Emergency nurses explained that the overcrowding in the department resulted in limitations to provide safe and private rooms for PWMI. Moreover, due to their obligations of closely monitoring psychiatric patients, practices limiting patients' autonomy and privacy, such as the removal of personal belongings and the use of the seclusion room, were often utilized. Nurses felt like they had to always see mental health patients to fulfill their safety obligations.

The lack of private spaces also meant that emergency nurses had to conduct psychiatric assessments in a noisy environment, where other patients could often hear what was being said. This was compounded with the fact that many patients are well-known either by nurses or families, as the hospital is located in a rural area. This further contributed to the negative experiences of PWMI in the emergency department, as it can be harder to maintain their privacy in this environment.

Subtheme 1.2.3: Potential for Vicarious Trauma. Two nurses described the negative impacts of working with PWMI, who are trauma-prone, on their own health. Participants expressed that challenging and violent behaviors from PWMI often contributed to a lessened desire to care for these patients. Nurses thought that the provision of mental health care was often emotionally draining and was triggering for some nurses. Participants discussed they had to "*carry these micro-traumas or aggressions*" throughout their day and felt it impacted the care of other patients. A few emergency nurses expressed they suffered from compassion fatigue that was mostly caused by PWMI. The challenging behaviors of PWMI had reach far beyond their interactions with emergency nurses in this sense.

In addition to the nurses' perceptions of caring for PWMI, the consultations underlined nurses' practice of TIC in the emergency department and their perceived facilitators and challenges about its implementation within their setting. These findings will be examined in the next section.

Theme 2: TIC in the Emergency Department

Emergency nurses also discussed their perceived facilitators and barriers for the implementation of TIC within the emergency department. When asked about their experience and attitudes toward TIC, emergency nurses highlighted ***their lack of awareness of TIC resources*** and ***educational opportunities about TIC***.

Subtheme 2.1: Lack of Awareness of TIC Resources and Educational Opportunities

Although many nurses were able to guess the definition of TIC, 85.7% of emergency nurses were not aware of the concept of TIC. For instance, 71.4% of emergency nurses asked for a definition of TIC during the interview, as they were unsure of what a TIC approach entailed. In addition, it was also unclear for emergency nurses whether TIC was addressed for patients or for

HCWs. However, when asked about their definition of TIC, many highlighted their awareness of some of the core concepts of TIC. For instance, many emergency nurses alluded to the principles of trust, collaboration, and safety. For example, one participant defined TIC as an "*understanding that people have different experiences that largely explain how they perceive the environment; we need to make them feel safe and build a rapport by being patient and listening to their concerns".*

Only 14.2% of emergency nurses stated that they had received TIC education. All of the other emergency nurses stated that they had never received any training in regard to TIC. Moreover, despite the availability of local and provincial resources for TIC, none of the participants were aware of TIC resources they could utilize in their practice. One key informant, however, was aware of some TIC resources through social media, but none within the organization. When participants were informed VCH had a policy about TIC, this came as a surprise to all participants.

Subtheme 2.2: Facilitators and Barriers for the Implementation of TIC

Two subthemes emerged from the above theme, which are 1) attitudes toward TIC and 2) insufficient resources, understaffing and lack of time.

Subtheme 2.2.1: Attitudes toward TIC. Positive attitudes were noted regarding TIC. After receiving a brief definition of TIC during the interview, 71.4 % of emergency nurses stated they believed it should be implemented TIC with all patients. One nurse explained that, while TIC might be a time-consuming approach, "*it can have big repercussions if not addressed*". This participant further explained that, if PWMI are ignored or if their feelings are not acknowledged, they often escalate behaviors. Therefore, PWMI necessitate additional monitoring and medical interventions to counteract their challenging behaviors.

As above-discussed, participants touched upon many of the core principles of TIC when explaining their care for PWMI. It was imperative for many of them to facilitate a trauma-free experience by being flexible, by trying to avoid the seclusion room, or by allowing PWMI to stay in their own clothes. Most believed that building a therapeutic relationship and rapport with mental health patients was an inherent part of their nursing practice. In addition, one nurse even described the urgency of incorporating the TIC practice in the emergency department as a "*CTAS 2*", implying that it needs rapid attention and implementation.

Subtheme 2.2.2: Insufficient Resources, Understaffing and Lack of Time. When asked about the perceived barriers to the implementation of TIC in practice within the emergency department, recurrent themes, such as lack of time, lack of resources, and understaffing, were identified. Nurses often felt overwhelmed with the emergency department overcrowding. Due to the constant influx of patients and tasks to perform, nurses perceived that the implementation of TIC could be difficult to achieve amid all their other responsibilities. The lack of resources and safe spaces was also seen as a barrier to minimize re-traumatization in PWMI. Understaffing also largely contributed to the perception that it would be difficult to practice TIC in the emergency department. Understaffing often resulted in missed educational opportunities for staff, as they could not be excused from their normal shifts to engage in additional training.

However, one nurse noted that many patients and emergency nurses alike did not know how and where to access resources, especially for mental health services, implying that there should be additional support from management and the psychiatric department to provide optimal care for mental health patients.

In addition to the practice of TIC within the emergency department, the consultations highlighted nurses' educational needs for a TIC resource. These findings will be discussed in the next section.

Theme 3: Educational Needs of Emergency Nurses

Two subthemes emerged from the above theme, which are ***educational modalities*** and ***educational content***.

Subtheme 3.1: Educational Modalities

There was an overwhelming interest in the provision of TIC education by emergency nurses. All nurses deemed this initiative necessary. In terms of educational strategies, 71.4% of nurses spoke about case studies, guided discussions, and toolkits. Participants noted they were more interested in learning with clear and concrete examples that they can use in their practice. Most nurses preferred short informal sessions, such as huddles and quick simulation sessions, conducted at the beginning of the shift, at the end of the shift, or throughout the workday. A few participants suggested these short sessions could also be used after work incidents or when experiencing challenges with patients to reflect on the care that was provided. Only one participant voiced their preference for online education. In this regard, many participants noted that they were already overwhelmed with the number of mandatory online courses they had to complete.

These findings were reiterated by key stakeholders. Key stakeholders found that emergency nurses responded well to in-person compressed educational sessions and story-based education. Key stakeholders viewed online modules as less engaging. Moreover, the suggestion of adding a physical component, such as a handout, was made for ease of comprehension by key stakeholders. The inclusion of additional references, QR codes, and posters, were also seen as

effective educational tools. Key stakeholders also discussed the need to frame the educational resource for emergency nurse "*from place of curiosity, with no prescriptive actions*".

Subtheme 3.2: Educational Content

When asked about what content should be included in a TIC resource, emergency nurses felt they needed information about trauma and its impacts the principles of TIC, documentation, and communication skills with PWMI, de-escalation techniques, and the importance of debriefing. For instance, one nurse stated, "*I would like to know more about how to implement TIC, de-escalation techniques and debriefing*". Many nurses shared that they would benefit from strengthening their communication skills with PWMI. Some nurses were unsure of how to engage with PWMI, with one nurse disclosing that "*we are always afraid of saying the wrong thing*". The topic of documentation was also explored by one nurse, who stated they would be interested in learning how to include TIC principles into written documentation. Moreover, one participant expressed the desire to know more about de-escalation techniques, as PWMI often are in crisis when they come to the emergency department.

The importance of debriefing sessions was another educational topic seen as essential by emergency nurses. All emergency nurses and key stakeholders requested the inclusion of this subject, as it often get overlooked in educational sessions. Of debriefing, one nurse said, "*debriefing should always be a priority and we never make time for it*". This finding also underlined the importance of discussing how caring for PWMI may have impacts on emergency nurses' well-being. As previously noted, potential for vicarious trauma was a recurrent theme in these consultations and should be included in the educational resource. One of the key stakeholders also suggested talking about "*frequent flyers*". According to Joy et al. (2016), frequent flyers are individuals that "*make repeated and frequent visits to emergency departments*

and psychiatric crisis centers" (p. 1539). As many emergency nurses disclosed feeling frustrated with this subgroup of PWMI, one key stakeholder recommended bringing attention to this population to assist emergency nurses in being more compassionate with them.

Implications for the Development of an Educational Resource

The interviews with participants who provide direct care to PWMI have provided invaluable information that will help guide the development of TIC educational resource for emergency nurses. Based on these findings, it is evident that there is value in developing an educational resource for TIC for PWMI for emergency nurses. Emergency nurses' awareness of the TIC approach and TIC-related resources needs to be strengthened. Fortunately, emergency nurses hold positive attitudes towards TIC, which could facilitate its implementation in the department. For emergency nurses to appreciate the importance of taking a TIC approach, they need to understand its value. Therefore, baseline information about trauma and its effect on physical and psychological health of PWMI must be approached. Based on participants' responses, the inclusion of a definition of the TIC approach, its core components, and practice examples should be incorporated. Emergency nurses also would benefit from education on communication skills. Debriefing and vicarious trauma were also recognized as essential educational topics to cover.

As emergency nurses operate in a fast-paced environment with limited resources, using in short in-person educational sessions that include case studies and discussions has the potential to meet the needs of the emergency nurses. In addition, to maximize its efficacy, the inclusion of handouts with additional references was suggested.

Conclusion

The results of the consultations helped me identify emergency nurses' perceptions of the nursing care provided to mental health patients in the emergency department, their awareness of TIC, and their perceived educational needs for a TIC educational resource. The consultations highlighted an evidence-practice gap that justifies the creation of an educational resource to support nurses in their care of mentally ill patients in the emergency department. Moreover, gaining insight into nurses' educational needs and perceived facilitators and barriers about trauma-informed care enabled me to further refine the content and the educational modality of my resource about TIC to meet the needs of the local emergency department nurses. The identified learning needs for the emergency nurses about the TIC will include educational material about the TIC approach and its principles, examples of TIC into emergency nursing practice, communication skills, debriefing and vicarious trauma. The chosen method of delivery for the resource will be in short in-person sessions that can be carried out at the beginning of the shift, during the shift, or at the end of the shift. The TIC resource will also include interactive case studies and discussions to ensure emergency nurses have an enriching educational experience.

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Appendix A: Inquiry Email for the Acute Care Manager

Dear: Acute Care Manager
Date: July 1, 2023
Title: Development of a trauma informed care resource for emergency nurses who care for people with mental illness

Hello, my name is Maude Bellemare. I am a student in the Master of Science in Nursing program at Memorial University. I am currently working on my practicum project. As part of this project, I am developing an educational resource for emergency nurses to provide trauma-informed care for mental health patients. This project aims to improve mental health patients' health outcomes and support nurses in delivering safe and competent care for mental health patients in the emergency department by using TIC approach.

I would like to ask for your assistance in creating the educational resource. I would require your permission to interview nurses from our department. The interviews will be informal and conducted in-person, by phone, or online. The interviews should take between 15 and 30 minutes to be completed. I would also ask for your permission to do the interviews at work if it was requested by the nurses. If the interviews were requested to be conducted at work, I would do the interviews during meal breaks to minimize work disruption. The information collected from this interview will help me to develop my TIC project for emergency nurses.

Nurses' participation will be voluntary. Notes taken during the interviews will only be shared with my supervisor. In addition, the collected notes will be kept in a password-protected file on my computer and deleted once I finish my practicum project.

I look forward to hearing from you.

Do not hesitate to contact me if you have any questions.

Kind regards,
Maude Bellemare, RN
MScN student, MUN Faculty of Nursing, St. John’s, NL
403-307-2673
mbellemare@mun.ca

Appendix B: Recruitment Email for Emergency Nurses

Dear: Emergency nurse
Date: July 1, 2023
Title: Development of a trauma informed care resource for emergency nurses who care for people with mental illness

Hello, my name is Maude Bellemare. I am a student in the Master of Science in Nursing program at Memorial University. I am currently working on my practicum project. As part of this project, I am developing an educational resource for emergency nurses to provide trauma-informed care for mental health patients. This project aims to improve mental health patients' health outcomes and support nurses in delivering safe and competent care for mental health patients in the emergency department by using TIC approach.

I would like to ask for your assistance in creating the educational resource. I would like to know if you are interested in participating in an informal interview to help develop this educational resource. The interviews will be informal and conducted in-person, by phone, or online. The interviews should take between 15 and 30 minutes to be completed. I would like to learn about your perceptions of trauma-informed care for mental health patients. I would also like to know more about your preferred educational methods and the challenges you experience with TIC within our setting.

Your participation is voluntary. The notes collected during the interview will only be shared between my supervisor Dr. Abubaker Ahmed and myself with your permission. The collected information will be kept in a password-protected file on my computer and deleted once I finish my practicum project.

I look forward to hearing from you.

Do not hesitate to contact me if you have any questions.

Kind regards,
Maude Bellemare, RN
MScN student, MUN Faculty of Nursing, St. John’s, NL
403-307-2673
mbellemare@mun.ca

Appendix C: Recruitment Email for the Nurse Educator and the Patient Care Coordinator

Dear: Nurse Educator and the Patient Care Coordinator
Date: July 1, 2023
Title of project: Development of a trauma informed care resource for emergency nurses who care for people with mental illness

Hello, my name is Maude Bellemare. I am a student in the Master of Science in Nursing program at Memorial University. I am currently working on my practicum project. As part of this project, I am developing an educational resource for emergency nurses to provide trauma-informed care for mental health patients. This project aims to improve mental health patients' health outcomes and support nurses in delivering safe and competent care for mental health patients in the emergency department by using TIC approach.

I would like to ask for your assistance in creating the educational resource. I would like to know if you are interested in participating in an informal interview to help develop this educational resource. The interviews will be informal and conducted in-person, by phone, or online. The interviews should take between 15 and 30 minutes to be completed. I would like to learn about your perceptions of trauma-informed care for mental health patients. I would also like to know more about your preferred educational methods and the challenges you experience with TIC within our setting. I would also be interested in learning about your experience in implementing educational resources and effective learning strategies.

Your participation is voluntary. The notes collected during the interview will only be shared between my supervisor Dr. Abubaker Ahmed and myself with your permission. The collected information will be kept in a password-protected file on my computer and deleted once I finish my practicum project.

I look forward to hearing from you.

Do not hesitate to contact me if you have any questions.

Kind regards,
Maude Bellemare, RN
MScN student, MUN Faculty of Nursing, St. John’s, NL
403-307-2673
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Appendix D: Interview Guide for the Consultations

For all nurses

Thank you for taking the time to meet with me. As you know, I hope to create an educational resource for providing trauma-informed care for mental health patients in the emergency department. Before we begin, I want to inform you that your participation is voluntary. You may answer the questions to the best of your ability. I will be taking notes during this interview. These notes will be transcribed in a Word document and stored on a password-protected computer. Access to these notes will be limited to my supervisor Dr. Abubaker Hamed and myself. Once my practicum project is completed, the collected notes will be deleted.

The questions we cover may generate emotional responses as it pertains to traumatic experiences. You may stop the interview at any time for any reason. You can also choose not to answer questions that make you uncomfortable. If you need additional support after this interview, please get in touch with the Employee and Family Assistance Program by calling 1-833-533-1577.

Do you have any questions or comments for me before we begin?

11. How do you feel about the care that is currently provided to mental health patients in the emergency department?
12. Do you feel nurses face challenges in providing care to mental health patients in the emergency department?
13. Are there any nursing practices or policies that you feel may contribute positively or negatively to patients' experiences in the emergency department?

14. What does trauma-informed care mean to you?
15. Have you ever received education about trauma-informed care?
16. Are you aware of any trauma-informed care resources for mental health patients or other types of patients?
17. How do you feel about practicing trauma-informed care within the emergency department? Do you see any challenges or barriers to implementing trauma-informed care?
18. Do you feel like an educational resource for trauma-informed care for mental health patients would be beneficial? If so, which format would you prefer? (e.g., case studies, toolkit, discussion, lecture)
19. What content would be the most beneficial in your opinion? (e.g., communication techniques, debriefing, self-care, des-escalation techniques)
20. Do you have any other comments about trauma-informed care, educational opportunities, or the care of mental health patients in general?
21. Would you like to be contacted to provide feedback on the trauma-informed resource I plan to develop?

Thank you for your time!

Additional questions for the nurse educator and the patient care coordinator

1. What teaching methods have you employed with success for nurses?
2. Do you think developing a resource for trauma-informed care for mental health patients in the emergency department will be well received by nurses? How so?
3. Do you have any suggestions for developing my educational resource for trauma-informed care?

4. Would you like to be contacted to provide feedback on the trauma-informed resource I plan to develop?

Appendix E: Example of Content Analysis

Theme	Datum Supporting the Theme	Researcher's Interpretive Summary
Nurses' negative attitudes towards people with mental illness (PWMI)	*"Most of the ED nurses hate dealing with them (PWMI), they have no interest in mental health"* *"PWMI are put in a spot to keep them safe, "naughty spot" until they go to psych"* *"They are unpredictable"* *"There is severe stigma for mental health issues"* *"We make assumptions or basing everything on the collateral information; bias is so high with these patients* *"Mental health patients are seen as less worthy than medical patients"* *"Patient are worked up, even though you are being straight with them, they always get more agitated"*	Can be linked to the stigma of mental health based on the "labels" they apply to people with mental illness The negative attitudes interrelate with a perceived feeling of being ill-prepared in dealing with PWMI

Appendix F: Health Research Ethics Authority (HREA) Screening Tool

Student Name: Maude Bellemare

Title of Practicum Project: Development of a trauma informed care resource for emergency nurses who care for people with mental illness

Date Checklist Completed: July 1, 2023

This project is exempt from Health Research Ethics Board approval because it matches item number 3 from the list below.

1. Research that relies exclusively on publicly available information when the information is legally accessible to the public and appropriately protected by law; or the information is publicly accessible and there is no reasonable expectation of privacy.
2. Research involving naturalistic observation in public places (where it does not involve any intervention staged by the researcher, or direct interaction with the individual or groups; individuals or groups targeted for observation have no reasonable expectation of privacy; and any dissemination of research results does not allow identification of specific individuals).
3. Quality assurance and quality improvement studies, program evaluation activities, performance reviews, and testing within normal educational requirements if there is no research question involved (used exclusively for assessment, management or improvement purposes).
4. Research based on review of published/publicly reported literature.
5. Research exclusively involving secondary use of anonymous information or anonymous human biological materials, so long as the process of data linkage or recording or dissemination of results does not generate identifiable information.
6. Research based solely on the researcher's personal reflections and self-observation (e.g. auto-ethnography).
7. Case reports.
8. Creative practice activities (where an artist makes or interprets a work or works of art).

For more information please visit the Health Research Ethics Authority (HREA) at https://rpresources.mun.ca/triage/is-your-project-exempt-from-review/

Appendix D: Resource

TRAUMA-INFORMED CARE FOR EMERGENCY NURSES WHO CARE FOR PEOPLE WITH MENTAL ILLNESS

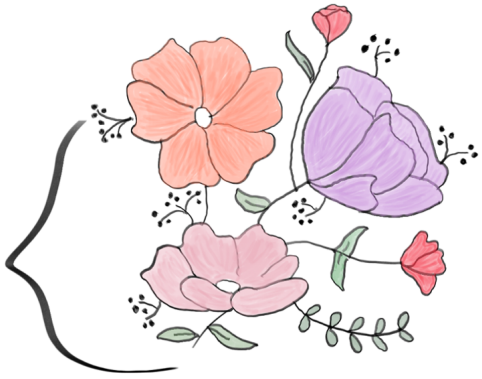

FIGURE 1. HEALING FROM TRAUMA. OWN ARTWORK.

FACILITATORS' MANUAL

DEVELOPED BY MAUDE BELLEMARE, RN

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HOW TO USE THIS MANUAL

INTRODUCTION TO THE MANUAL

The *Trauma-informed care* facilitators' manual has been developed to educate emergency nurses on the trauma-informed care approach. This manual is designed to equip facilitators with all the relevant educational material necessary to conduct short educational sessions on trauma-informed care principles and skills.

WHY WAS THIS MANUAL DEVELOPED?

- Exposure to trauma, especially among individuals with mental illness, can lead to poor psychological health, substance abuse, and re-traumatization when seeking care in emergency departments, highlighting the need for trauma-informed care by emergency nurses (Hogg et al., 2023; Lavergne et al., 2018; Muskett, 2014; Vandyk et al., 2018; Watson, 2019)
- Trauma-informed care, which integrates trauma awareness into policies and practices to prevent re-traumatization, has been established and adopted in mental health and substance abuse sectors but is less prevalent in emergency departments, resulting in a deficit of skills and knowledge among emergency nurses and physicians (Brown et al., 2022; Bruce et al., 2018; Hall et al., 2016; McNamara et al., 2021; Poole et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).
- Researchers have found that training about trauma-informed care could improve nurses' confidence, skills, and attitudes toward trauma-informed care (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017).
- Therefore, it is important to provide emergency nurses with educational opportunities to strengthen their knowledge and abilities about the use of trauma-informed care approach to care for people with mental illness.

THEORETICAL UNDERPINNINGS

Knowles' theory of andragogy was chosen to guide the creation of this trauma-informed care manual (Chan, 2010). The six principles of Knowles' theory of andragogy and their relevance for this manual are outlined below (Chan, 2010).

Self-concept	Adult learners are autonomous in their learning journey and benefit from a variety of learning modalities. This manual includes self-reflection questions, discussion opportunities, case studies and handouts.
Role of the experience	Previous experience is a learning resource for adult learners. The case studies and the reflection questions will allow emergency nurses to draw from their experience of working with people with mental illness.
Readiness to learn	Adult learners benefit from teachings that are relevant to their practice. Emergency nurses frequently interact and provide care to PWMI, so they require knowledge and skills to incorporate in their daily practice.
Orientation to learning	Learning offerings should be problem-centered. The use of guided discussions will help emergency nurses to find ways to apply trauma-informed care interventions as part of their nursing care.
Motivation	Adults are motivated in learning endeavors that stimulates them, or when they can help others. Emergency nurses can improve their job satisfaction by providing safe and competent care for PWMI.
Need to know	Adult learners need to know how new knowledge is beneficial for them. Underlining the impacts of trauma on patients' and vicarious trauma will assist emergency nurses in developing an interest in the trauma-informed care approach.

(Chan, 2010)

PURPOSE OF THE SESSIONS

These sessions are an opportunity for staff to:

- Reflect on their care
- Learn about trauma-informed care
- Practice their skills
- Discuss together in a safe learning environment.

By building on their own caring experiences and by finding ways to incorporate the trauma-informed care approach into their practice, nurses can enhance the well-being of mental health patients in the emergency department (Poole et al., 2013; Wathen & Varcoe, 2021).

FORMAT OF THE SESSIONS

When should these sessions be conducted?

These informal educational sessions should be conducted **following shift report**. Each session should be presented for a week after the day and the night shift report to allow most nurses to complete the session.

How many nurses should attend the sessions?

- Between three and ten.

The availability of nurses during a shift should be determined with the charge nurse prior to engaging in the educational opportunity. For instance, sessions may need to be rescheduled if there is a high patient census or if the unit is short-staffed.

In what order should the sessions be conducted?

Sessions should be conducted in the following order:

1. Principles of trauma-informed care
2. Trauma
3. Vicarious trauma
4. Debriefing
5. Brief intervention
6. Strength-based communication
7. Case study
8. Trauma-informed care resources

However, nurses can benefit from all sessions as a standalone educational opportunity. The facilitator can also choose to use a specific topic if it is deemed relevant. For example, a facilitator may decide to use the "debrief" topic after a work incident, such as a code white.

Nurses only need to attend each session once. Nurses' attendance can be monitored using the attendance sheet (See Appendix A). Incentives, such as gift cards for coffee, may be offered for nurses who complete all sessions to increase participation.

If nurses are unable to attend a session, a complementary nurses' manual that includes learning modules will be available to them if they want to complete the educational material. Two copies will be at their disposition: one at the nursing station in the emergency department and one in the nurse educator's office.

How long should the sessions last?

- Between 10 and 15 minutes.

Who should attend the sessions?

While the educational material is designed for emergency registered nurses, anyone who provides direct patient care (e.g., licensed practical nurses, health care aides, porters) can be included in these educational sessions.

ROLE OF THE FACILITATOR

The facilitator is responsible for presenting the educational material, guiding the discussions, and answering questions from attendees. The facilitator should be a registered nurse with excellent interpersonal skills, leadership capabilities, and a passion for evidence-based practice and education. For instance, the facilitator could be a patient care coordinator, a charge nurse, a nurse educator, or a nurse champion.

A good facilitator should:

- Encourage participation from each participant in a safe learning environment
- Guide the sessions by connecting the learning material with participants' comments and summarizing the discussions
- Help participants attain learning objectives by providing positive feedback
- Stimulate discussion by asking questions or redirecting comments (McFee, n.d.)

HOW TO USE THE EDUCATIONAL MATERIAL

This manual is divided in four sections based on the principles of trauma-informed care (i.e, **trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strengths-based approach**) and their pertaining sessions.

The following information is provided for each session in this manual:

- Purpose of the session
- Learning objectives for the participants
- A short introduction outlining general instructions for the sessions
- Background and educational information about each topic
- Guiding questions or case studies to facilitate discussion
- Key learning points
- Handouts for the participants, which can also be posted on the education board

In addition, this manual contains evaluations surveys (i.e., pre-training survey, post-training survey) (see Appendix B). Participants should complete the pre-training survey before attending the first session. The post-training survey can be completed once all the sessions have been presented. Two survey versions (i.e., short, and long versions) are included. Facilitators may choose the version that better suits their audience and their setting.

TIPS FOR CONDUCTING THE SESSIONS

- Review the educational material before conducting the sessions to ensure you understand the topic well. Have the handouts ready for the participants.
- At the beginning of the session, review the learning objectives with the participants. Emphasize with them that this is a learning opportunity. Therefore, it is a safe space for them to ask questions.
- Allow time for participants to answer questions or share their experiences.
- Keep the session short, between 10 to 15 minutes. You may need to redirect the discussions to ensure the learning objectives are covered.
- Finish the session by summarizing the key points. Ask participants if they have any questions or comments about the session (Safecare BC, 2019).

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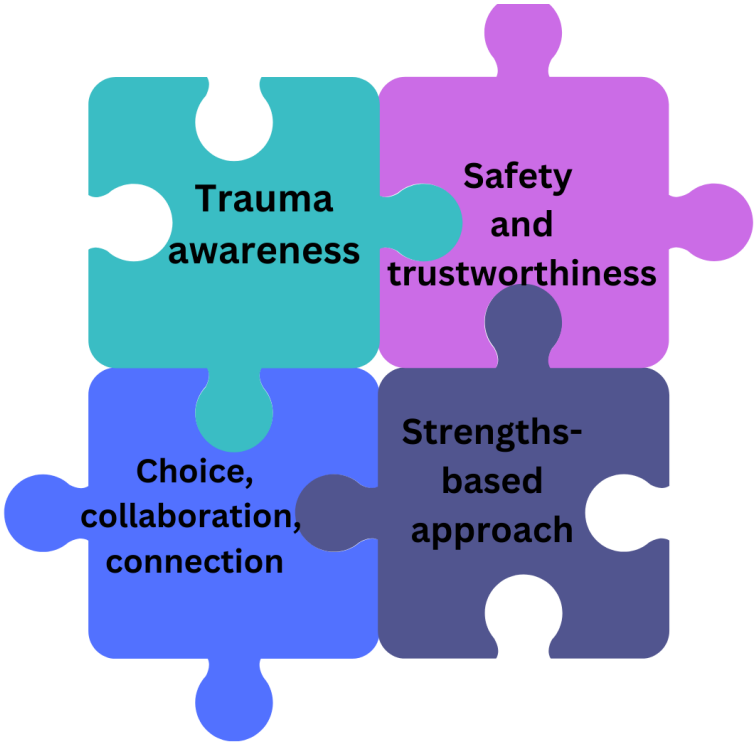

BELLEMARE, M. (2023). TRAUMA-INFORMED CARE [IMAGE]. CANVA.

EDUCATIONAL SESSIONS

SESSION 1:
THE FOUR PRINCIPLES OF TRAUMA-INFORMED CARE

PURPOSE OF THE SESSION

This session aims to discuss the principles of trauma-informed care and see how they can be applied in the emergency department.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Define trauma-informed care
- Describe the main principles of trauma-informed care
- Give examples of the trauma-informed care approach in the emergency department for people with mental illness

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will discuss the principles of trauma-informed care and see how they apply to the emergency department. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.

- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.
- Do you have any questions before we begin?

BACKGROUND

Review the background facts about the development of the trauma-informed care approach with the participants. If time is limited, you can choose to only discuss one of these statements.

- In 2005, the National Center of Trauma-Informed Care was created by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States (Center for Mental Health Services, 2012). In 2014, SAMHSA has launched a guide for the implementation of trauma-informed care for organizations (SAMHSA, 2014).
- In Canada, in 2013, the BC Centre of Excellence for Women's Health (BCCEWH) created the Trauma-informed practice guide for care providers who deliver mental health and substance use services (Poole et al., 2013).

PRINCIPLES OF TRAUMA-INFORMED CARE

Read the definition of trauma-informed care. Then, ask participants to discuss the barriers to a safe environment in the emergency department and to find ways to alleviate them.

What is trauma-informed care?

According to Wathen and Varcoe (2021), "trauma-informed care creates safety for service users by understanding the effects of trauma, and its close links to health and behavior; it is not about eliciting or treating people's trauma" (p. 1). Moreover, it is a **universal approach** that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).

REFLECTION QUESTION: What are some barriers to a safe environment in your department for people with mental illness? What are some ways to address them?

Ideas to explore with participants:
- Lack of privacy, use of "labels", standardized protocols for all patients
- Being creative and flexible, using private rooms for assessments, may choose to delay assessment to engage with patients with mental illness

Review the main principles of trauma-informed care and examples of each principle. Discuss the reflection question with the participants.

What are its main principles?

1. **Trauma awareness**: Healthcare providers need to understand how people with mental illness cope with trauma and be aware of the impact of trauma on individuals' physical and mental health (Wathen & Varcoe, 2021).
2. **Safety and trustworthiness**: Healthcare providers must strive to create a safe environment physically and emotionally for people with mental illness by providing as much control as possible for patients (Poole et al., 2013).
3. **Choice, collaboration, and connection**: Healthcare providers need to collaborate with people with mental illness to offer care options. Communication between care providers and people with mental illness should be clear and judgment-free (Nathoo et al., 2018).
4. **Strength-based approach**: People with mental illness' strengths need to be celebrated and used as a building step for enhanced skills (Poole et al., 2013).

Examples of a trauma-informed care approach in emergency nursing

- Bring the patient in a private room to do their mental health assessment
- Tell the patient they can choose not to answer some questions, or they can let you know if they want to take a break
- Ask about the patients' strengths (e.g., goals, coping skills, community connections)
- Ask patients about their pronouns

REFLECTION QUESTION: Can you recall a time when you encouraged choice and collaboration with people with mental illness? If not, how can you encourage collaboration with them in your department?

Ideas to explore with participants:

- Ask them if they would like to have family or friends present during their emergency visit if possible
- Ask where they would prefer their intramuscular injection
- Communicate openly with people with mental illness, allowing them to express their preferences
- Follow your client's lead. You will work together better by being flexible and creative when conducting your assessment and asking questions about their well-being

CONCLUSION

Conclude the session by presenting key points.

In summary:

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).
- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).
- A trauma-informed care approach can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

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THE FOUR PRINCIPLES OF TRAUMA-INFORMED CARE HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Define trauma-informed care
- Describe the main principles of trauma-informed care
- Give examples of the trauma-informed care approach in the emergency department for people with mental illness

What is trauma-informed care?

According to Wathen and Varcoe (2021), "trauma-informed care creates safety for service users by understanding the effects of trauma, and its close links to health and behavior; it is not about eliciting or treating people's trauma" (p. 1). Moreover, it is a **universal approach** that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).

Principles of trauma-informed care

Trauma awareness

It is important to understand how trauma affects individuals with mental illness and how it can shape their interactions with us

In practice:

- Consider the impact of trauma on patients' behaviors (e.g., substance use, hostility)

Safety and trustworthiness

Creating a safe and welcoming environment for all our patients is crucial.

In practice:

- Provide a private space
- Ask patients about their pronouns
- Be transparent with patients

Choice, collaboration, and connection

Creating a sense of efficacy in people with mental illness must be achieved to respect their dignity and enhance their control.

In practice:

- Allow patients to express their preferences for treatment options
- Be non-judgmental

Strengths-based approach

By focusing on their strengths, you can help people with mental illness develop a sense of agency and self-efficacy.

In practice:

- Identify patients' strengths
- Validate their feelings
- Celebrate patients' successes

(Nathoo et al., 2018; Poole et al., 2013; Wathen & Varcoe, 2021)

Pause and reflect

Can you recall a time when you encouraged choice and collaboration with people with mental illness? If not, how can you encourage collaboration with these patients in your department?

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PRINCIPLE 1: TRAUMA AWARENESS

DEFINITION

According to Nathoo et al. (2018), "being trauma aware means understanding that trauma is common, and every individual who accesses health care and social services may have an unknown trauma history" (p. 12). By using a trauma-informed care approach for all patients, including those with mental illness, nursing care can be provided in a way that minimizes re-traumatization.

PRINCIPLE 1: TRAUMA AWARENESS
SESSION 2: TRAUMA

PURPOSE OF THE SESSION

The purpose of this session is to present an overview of trauma, its impacts, and its relevance for people with mental illness in the emergency department.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Define trauma
- Provide examples of the impacts of trauma on an individual's well-being
- Explain why trauma can affect the behaviors of people with mental illness in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will discuss trauma, its impacts, and its relevance for people with mental illness in the emergency department. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin?

BACKGROUND

Have the participants review the background facts about trauma provided on their handout.

- According to Statistics Canada (2022), 64 % of Canadians disclosed having experienced a traumatic event, with 8% suffering from post-traumatic stress disorder (PTSD).
- The prevalence of PTSD among people with mental illness is considerably higher. For instance, Adams et al. (2020) found that 27.0% of PWMI met the criteria for PTSD, 51.1% disclosed having experienced severe trauma, and 84.4% reported childhood adversities.
- Mental illness disorders are associated with frequent emergency department visits, especially for substance use disorders (Odd ratio [OR] = 2.23, 95%CI [2.12, 2.35]) and schizophrenia (OR = 2.20, 95%CI [2.09, 2.33]) (Fleury et al., 2019).
- At the qathet General Hospital, people with mental illness frequently visit the emergency department for mental health reasons. For example, every week, two patients are involuntarily admitted to the hospital and receive care from emergency nurses (V. Wilson, personal communication, May 22, 2023).

TRAUMA

Read the definition of trauma and review the impacts of trauma with the participants. Then, ask participants to provide examples of traumatic experiences. Participants can also write additional examples of trauma impacts on their handout.

What is trauma?

According to the Center of Addictions and Mental Health (n.d.), "trauma is an experience that overwhelms an individual's emotional and psychological ability to cope and can result in lasting mental and physical effects." (p.1)

For example, it can be caused by bullying, physical abuse, emotional abuse, intimate partner violence, or by injuries (Center of Addictions and Mental Health, n.d.)

REFLECTION QUESTION: Can you think of examples of trauma for people with mental illness who seek care in the emergency department?

Ideas to explore with participants:
- The use of restraints and seclusion
- Experiences of discrimination or stigma
- Homelessness
- Injuries

What are the impacts of trauma?

The impacts differ for every individual and can include physical, behavioral, or psychological repercussions (Center of Addictions and Mental Health, n.d.). Below are some examples of the impacts of trauma.

Psychological	Physical	Behavioral
Depression Anxiety Guilt, shame Mistrust	Insomnia Fatigue Chronic Pain Gastrointestinal problems	Self-harming behaviors Substance use Sexualized behavior Delinquency

(Center of Addictions and Mental Health, n.d.)

REFLECTION QUESTION: What are some other examples of the impacts of trauma?

Ideas to explore with participants:
- Denial, learning difficulties, isolation
- Do you think trauma can have a long-term impact on people with mental illness?

Why is it important to consider trauma for people with mental illness in the context of the emergency department?

- People with mental illness often have suffered multiple forms of trauma (Hennessy et al., 2023).
- People with mental illness may behave with aggressivity or hostility towards healthcare staff. Moreover, in order to cope with trauma, they often resort to substance use (Hogg et al., 2023; Varcoe et al., 2019; Watson, 2019)
- They are often reluctant to access healthcare services because of the stigma they experience, not only in the society, but also in healthcare settings (Hennessy et al., 2023; Vandyk et al., 2018).

- By understanding their undesirable behaviors are often the consequences of trauma, we can help them engage in their own health and offer safe and competent health care (Wathen & Varcoe, 2021).

REFLECTION QUESTION: When people with mental illness seek help in the emergency department, do you think their past trauma influences their ability to cope with their visit? Or influences their behaviors during their visit?

Ideas to explore with the participants:
- What if they were in the seclusion room during their last visit?
- Do you think their substance use sometimes influences our nursing care? If yes, can we change that?

CONCLUSION

Conclude the session by presenting key points.

In summary:

- Most people presenting to the emergency department have a history of trauma, especially those with mental illness (Adams et al., 2020; Fleury et al., 2019).
- Traumatic events negatively impact their mental health, physical health, and social functioning, often resulting in undesirable behaviors or hostility towards healthcare staff (Adams et al., 2020; Center of Addictions and Mental Health, n.d.).
- It is important to understand that the undesirable behaviors of people with mental illness are often their way of coping with their traumatic experiences (Varcoe et al., 2019).

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PRINCIPLE 1: TRAUMA AWARENESS

TRAUMA HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Define trauma
- Provide examples of the impacts of trauma on people with mental illness' well-being
- Explain why trauma can affect the behaviors of people with mental illness in the emergency department

Did you know?

64 % of Canadians have experienced trauma, with 8% suffering from post-traumatic stress disorder (PTSD).. (Statistics Canada, 2022)	People with mental illness have an increased risk of experiencing trauma, with 51.1% having experienced severe trauma, and 27% meeting criteria for PTSD. (Adams et al., 2020)	Those who experience traumatic experiences are more likely to visit the emergency department, especially for substance use disorders and mental health reasons. (Fleury et al., 2019)	At the qathet General Hospital, PWMI frequently visit the emergency department for mental health reasons, with an average of two involuntarily psychiatric admissions per week. (V. Wilson, personal communication, May 22, 2023)

What is trauma?

According to the Center of Addictions and Mental Health (n.d.), "trauma is an experience that overwhelms an individual's emotional and psychological ability to cope and can result in lasting mental and physical effects." (p.1)

Impacts of trauma

Psychological	Physical	Behavioral
• Depression	• Insomnia	• Self-harming behaviors
• Anxiety	• Fatigue	• Substance use
• Guilt, shame	• Chronic Pain	• Sexualized behavior
• Mistrust	• Gastrointestinal problems	• Delinquency
• _____	• _____	• _____
• _____	• _____	• _____

Pause and reflect

When people with mental illness seek help in the emergency department, do you think their past trauma influences their ability to cope with their visit? Or influences their behaviors during their visit?

References

- Adams, R. E., Bonfine, N., & Ritter, C. (2020). Childhood adversity, proximal stressors and PTSD among people with severe mental illness: An exploratory study. *Community Mental Health Journal, 56*(8), 1557–1565. https://doi.org/10.1007/s10597-020-00607-6
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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

DEFINITION

Physical, emotional, and cultural safety for patients with mental illness is one of the cornerstones of the trauma-informed approach (Poole et al., 2013). As patients with mental illness often feel unsafe in the emergency department, creating a safe and welcoming environment is important (Poole et al., 2013). Moreover, the safety of emergency nurses needs to be acknowledged since secondary traumatic stress can lead to burnout and vicarious trauma (Xie et al., 2021).

PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

SESSION 3: VICARIOUS TRAUMA

PURPOSE OF THE SESSION

This session aims to review information about vicarious trauma for emergency nurses and strategies to mitigate it.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Define vicarious trauma and its signs
- Describe the ABC model of self-care
- Provide examples of grounding strategies

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSIONS

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will review information about vicarious trauma and strategies to mitigate it. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin?

BACKGROUND

If time allows, review the background facts about vicarious trauma with the participants.

- Nurses working with mental health patients are especially at risk of exhibiting vicarious trauma symptoms, with a high risk of compassion fatigue that affects between 28.57 and 44.8% of them (Xie et al., 2020).
- In Canada, 70% of healthcare workers reported worsened perceived mental health in 2019 during the COVID pandemic (Statistics Canada, 2021). More than 57% of British Columbia nurses reported high levels of burnout, with more than 80% reporting exposure to emotional abuse at work. Moreover, 50% of surveyed British Columbia nurses met the criteria for post-traumatic stress disorder (Havaei et al., 2020)
- Vicarious trauma can have adverse effects on nurses' physical health and mental health, with an increased risk for burnout (Berger et al., 2015). Furthermore, patient care can be compromised as vicarious trauma can lead to medical errors and low patient satisfaction (Berger et al., 2015).

VICARIOUS TRAUMA

Review the material regarding vicarious trauma, the ABC model of self-care and grounding strategies. Ask participants to provide additional examples of grounding strategies.

What is vicarious trauma?

According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients who have experienced or been affected by trauma." (p. 2).

Signs of vicarious trauma include:

- Discouraged to work with clients
- Being emotionally numbed
- Avoidance of clients
- Lack of empathy
- Chronic exhaustion

- Guilt

What is the ABC model of self-care?

Awareness: Healthcare workers should know their limits, resources, emotions, needs. They should connect with themselves to readily identify signs of stress. (Center of Addictions and Mental Health, n.d.)

Examples:

- Engage in self-reflection
- Write a journal
- Listen to your inner thoughts
- Set limits with your patients or co-workers
- Sometimes say no to additional responsibilities or tasks if you are overwhelmed (Vancouver Coastal Health, 2018)

Balance: Healthcare workers should strive to attain balance between their personal and professional activities. They should replenish their energy by planning self-care activities like exercise, practicing hobbies, meditating, or journaling. (Center of Addictions and Mental Health, n.d.)

Examples:

- Take a break during your shift
- Go on a vacation
- Take time off when you are ill or feeling unwell
- Spend time with children and friends
- Exercise
- Meditate (Vancouver Coastal Health, 2018)

Connection: Healthcare workers should value and build relationships with family, friends, and co-workers. It allows them to avoid isolation and ask for help when needed. (Center of Addictions and Mental Health, n.d.)

Examples:

- Connect with supportive co-workers
- See a counsellor for your mental health
- Spend time with loved ones (Vancouver Coastal Health, 2018)

Grounding strategies

These are self-care strategies that help healthcare workers focus on the present and take in what is happening in the moment (Poole et al., 2013). Grounding strategies assist healthcare workers mitigate the emotional impact of working with individuals who have a history of trauma (Poole et al., 2013). Moreover, grounding skills can be taught to patients who are experiencing flashbacks of traumatic events or distress (Poole et al., 2013).

Examples of self-grounding strategies:

- Sing or hum a favorite song
- Think about favorite memories with friends or family
- Picture oneself in a calm place
- Go for a short walk

REFLECTION QUESTION: What are some other examples of grounding strategies?

Ideas to explore with participants:

- Do math exercises in your head
- Repeat a soothing mantra
- Name ten items in a category (e.g., fruits, green objects)
- Make a doodle
- Tell yourself one of your favorite jokes

SELF-REFLECTION QUESTIONS

- What are some signs that work is starting to have a negative effect on me?
- What grounding strategies can I incorporate in my daily life?
- Who can support me when I am going through a difficult time at work?

CONCLUSION

Conclude the session by presenting key points.

In summary:

- According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients

who have experienced or been affected by trauma" such as people with mental illness (p. 2).

- The main principles of the ABC self-care model are: (1) awareness, (2) balance, and (3) connection (Center of Addictions and Mental Health, n.d.).
- Grounding strategies are a helpful way for healthcare workers to mitigate the emotional impact of working with individuals who have a history of trauma (Poole et al., 2013).

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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS
VICARIOUS TRAUMA HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Define vicarious trauma
- Describe the ABC model of self-care
- Give examples of self-care strategies you can use

What is vicarious trauma?

According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients who have experienced or been affected by trauma." (p. 2). Signs of vicarious trauma include being exhausted, having lacking empathy, or being emotionally numb (Center of Addictions and Mental Health, n.d.)

The ABC model of self-care

Awareness

Be aware your limits, resources, emotions, needs

Balance	Connection
Find balance between your personal and professional activities	Connect with yourself and others

(Center of Addictions and Mental Health, n.d.)

Some grounding strategies for distressing feelings and thoughts

- Sing or hum your favorite song
- Think about one of your favorite memories with friends or family
- Take a few slow breaths
- Picture yourself in a calm place
- Go for a short walk

(Center of Addictions and Mental Health, n.d.; Poole et al., 2013)

Pause and reflect

- What are some signs that work is starting to have a negative effect on me?

_____

- What grounding strategies can I incorporate in my daily life?

_____

- Who can support me when I am going through a difficult time at work?

_____

(Poole et al., 2013)

References

- Center of Addictions and Mental Health. (n.d.). Trauma-informed practice. https://iecho.unm.edu/sites/camh/download.hns?i=1643
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). Trauma-informed practice guide. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

SESSION 4: DEBRIEFING

PURPOSE OF THE SESSION

The purpose of this session is to discuss the importance of debriefing for emergency nurses and learn a simple framework for debriefing at work.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Explain the importance of debriefing
- Describe the SENSE model of debriefing
- Reflect on when debriefing could be done in their setting

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will discuss the importance of debriefing in the emergency department and learn about the SENSE model of debriefing. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin?

BACKGROUND

Review the background facts about debriefing with the participants.

- Emergency nurses are at an increased risk of experiencing symptoms of vicarious trauma, such as loss of motivation, helplessness, and presenteeism (Berger et al., 2015; Maddigan et al., 2023). Furthermore, the impacts of this secondary trauma can lead to decreased job satisfaction, burnout, and higher job turnover (Arbios et al., 2022).
- While debriefing for healthcare workers who attended a traumatic event is recommended after the incident in the emergency department, it is not always conducted due to competing priorities or lack of time (Gilmartin et al., 2020).
- However, in an American study, 76.2% of emergency healthcare workers expressed their desire to debrief and discuss workplace incidents with their team (Cantu & Thomas, 2020).

DEBRIEFING

Cover the material regarding debriefing. Then, ask participants to reflect on what events or situations should be debriefed.

What is debriefing?

One of the ways to alleviate stress and offer emotional support to healthcare workers is through debriefing. According to Arbios et al. (2022), debriefings "provide an opportunity to openly discuss and normalize personal thoughts and feelings with others in a safe and supportive environment" (p. 117). By allowing healthcare workers to make relevant observations and reflections on their practice, debriefings can increase job satisfaction and reduce vicarious trauma (Arbios et al., 2022).

Moreover, debriefing assists healthcare workers and healthcare teams note the strengths and weaknesses of their interventions, helping them make improvements in their care (Gilmartin et al., 2020).

REFLECTION QUESTION: What events or incidents do you think should be debriefed?

Ideas to explore with participants:

- Code white
- Unexpected death of a patient
- Resuscitation
- Any event that affected you and that you would like to discuss with your coworkers

Review the SENSE model of debriefing and its application.

What is the SENSE model of debriefing?

The Share-Explore-Notice-Support-Extend model of debriefing is designed to improve coping with stress and provide emotional support (Ko & Choi, 2020). Here is a breakdown of each of its components.

- **S**hare: Share what happened, and the emotions generated by an event (Ko & Choi, 2020)
- **E**xplore: Explore what caused the emotional response (Ko & Choi, 2020)
- **N**otice: Notice and identify alternative interventions to address the emotional response (Ko & Choi, 2020)
- **S**upport: Acknowledge the feelings and offer guidance through the identification of strength-based strategies (e.g., exercise, self-journaling, breathing exercises) (Ko & Choi, 2020)
- **E**xtend: Learn from this event and find ways to improve practice (Ko & Choi, 2020).

How can I apply the SENSE model of debriefing?

Here are some examples of sentences you can use to debrief using the SENSE model (Ko & Choi, 2020).

- **S**hare: What happened? How did we feel when it happened?
- **E**xplore: What went well? What did not go so well?
- **N**otice: How well did we achieve what we intended to? How might other team members view our intervention?
- **S**upport: Who else can support us? How can we build upon what we did?
- **E**xtend: What is important to remember for the next time? What did we learn? What will we do differently next time?

Present the section on the resources for debriefing in their setting. Have the participants reflect with the "pause and think" questions.

Who can you initiate debriefings at work?

The facilitators for debriefings could be a patient care coordinator, a charge nurse, a nurse educator, or a health care provider with specific training or knowledge. Ask your nursing leadership if you have any questions about debriefings.

At Vancouver Coastal Health, there are also additional resources for debriefings.

- Critical Incident Stress Management (CISM): Offers 24/7 confidential critical incident individual or team debriefing. Can be arranged by contacting them at 604-872-4929
- Ethics services: Provides confidential consultations to address ethical dilemmas. Can be arranged by contacting them at ethics@vch.ca
- Employee and Family Assistance Program (EFAP): Offers a 24/7 crisis line for Vancouver Coastal Health employees, as well as counselling services. Can be arranged by contacting them at 604-872-4929

REFLECTION QUESTION: Do you think some ethical dilemmas nurses face in their practice should be debriefed?

Ideas to explore with participants:
- Confidentiality (e.g., parents are requesting information about a mature minor who has consented to receive medical care)
- Patient autonomy vs. beneficence (e.g., suicidal patient refusing treatment and requesting to die)

REFLECTION QUESTION: Do you think people with mental illness would similarly benefit from debriefing?

Ideas to explore with participants:
- How they feel about the use of restraints
- How they feel about their experience in the emergency department (e.g., protocols, taking their belongings away, seclusion room)

CONCLUSION

Conclude the session by presenting key points.

In summary:

- Debriefings are an opportunity for emergency nurses to openly discuss and reflect on an event, their practice, and their feelings in a safe environment (Arbios et al., 2022).
- The main principles of the SENSE model of debriefing are: (1) share, (2) explore, (3) notice, (4) support, and (5) extend (Ko & Choi, 2020).
- Additional resources are available at Vancouver Coastal Health for debriefings. Please ask your nursing leadership if you have any questions.

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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS
DEBRIEFING HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Explain the importance of debriefing
- Describe the SENSE model of debriefing
- Reflect on when debriefing could be done in their setting

Did you know?		
Emergency nurses often witness traumatic events, which increases their risk of experiencing symptoms of vicarious trauma (Cantu & Thomas, 2020).	In an American study, 76.2% of emergency healthcare workers expressed their desire to debrief and discuss workplace incidents with their team (Cantu & Thomas, 2020).	While debriefing is recommended after a traumatic incident, it is not always conducted due to competing priorities or lack of time (Gilmartin et al., 2020).

The SENSE model of debriefing	
Share	What happened? How did we feel when it happened?
Explore	What went well? What did not go so well?
Notice	How well did we achieve what we intended to? How might other team members view our intervention?
Support	Who else can support us? How can we build upon what we did?
Extend	What is important to remember for the next time? What did we learn? What will we do differently next time?

(Ko & Choi, 2020)

At Vancouver Coastal Health, there are also additional resources for debriefings.

- **Critical Incident Stress Management (CISM):** Offers 24/7 confidential critical incident individual or team debriefing. Can be arranged by contacting them at 604-872-4929
- **Ethics services:** Offers confidential consultations to address ethical dilemmas. Can be arranged by contacting them at ethics@vch.ca
- **Employee and Family Assistance Program (EFAP):** Offers a 24/7 crisis line for Vancouver Coastal Health employees, as well as counselling services. Can be arranged by contacting them at 604-872-4929

Pause and reflect

- Do you think some ethical dilemmas nurses face in their practice should be debriefed?
- Do you think people with mental illness would similarly benefit from debriefing?

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BELLEMARE, M. (2023). TRAUMA-INFORMED CARE [IMAGE]. CANVA.

PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION

DEFINITION

A trauma-informed care approach fosters a sense of self-efficacy, control, and dignity for people with mental illness by offering them treatment options and collaborating with them during their emergency visit (Poole et al., 2013).

PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION

SESSION 5: BRIEF INTERVENTION

PURPOSE OF THE SESSION

The purpose of this session is to review the brief intervention approach for people with mental illness in crisis.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Define the brief intervention approach
- Describe the FRAMES acronym
- Illustrate each component of the FRAMES acronym in a case study

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will discuss the brief intervention approach. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin*?*

BACKGROUND

Review the background facts about the brief intervention with the participants.

- The Registered Nurses' Association of Ontario (RNAO) supports the use of the brief intervention strategy for people in crisis or with mental health issues (RNAO, 2017). The brief intervention approach has been shown to decrease symptoms of PTSD and crisis for patients in the emergency department (Des Groseilliers et al., 2013; RNAO, 2017). The brief intervention also assists individuals as it increases their self-efficacy and motivation for change (Des Groseilliers et al., 2013; RNAO, 2017).

BRIEF INTERVENTION

Review the material concerning the brief intervention and its principles. Provide an example using the FRAMES framework for an individual with alcohol use disorder.

What is the brief intervention approach?

The brief intervention is a communication technique utilized between patients and healthcare providers to assist with coping (Mattoo et al., 2018; RNAO, 2017). The brief intervention allows patients to identify problems and engages them in finding ways to address them (Mattoo et al., 2018; RNAO, 2017)

The brief intervention approach echoes the main principles of the trauma-informed care approach, as it focuses on patient safety, trustworthiness, choice, and collaboration (RNAO, 2017).

Health care workers engaging in the brief intervention should be empathetic, respectful, calm, engaged, and have good listening skills (RNAO, 2017).

What are the principles of the brief intervention?

Healthcare providers can use the FRAMES acronym to remember each of the components of the brief intervention. The principles are described below.

- **F**eedback: Allows the individual to receive information about the risks they encounter.
- **R**esponsibility: Enables the individual to make their own decisions and take accountability for them.

- **A**dvise: Recommendations and guidance are provided by the healthcare providers.
- **M**enu for change: Individuals' strengths and coping skills are highlighted by healthcare providers.
- **E**mpathy: Genuine and compassionate communication style is utilized by healthcare providers.
- **S**elf-efficacy: Healthcare providers can empower individuals and motivate them in their recovery journey (RNAO, 2017).

How can I apply the principles of the brief intervention using the FRAMES acronym?

Here are some examples of sentences you can use with people with mental illness when you assess them for their alcohol use.

- **F**eedback: "Your CAGE score is 4, which puts you at high risk for harm from substance use."
- **R**esponsibility: "How concerned are you with your CAGE score and your current drinking pattern?"
- **A**dvise: "To avoid harmful effects of alcohol use, the best way is to reduce your drinking, or consider alternatives to drinking alcohol"
- **M**enu for change: "In what situations do you feel like you need to drink? Do you have any peers that could help you reduce your use of alcohol?"
- **E**mpathy: "Let's see if we can find a way together to reduce your use"
- **S**elf-efficacy: "I'm confident that you can reduce your use" (Sarkar et al., 2020)

CASE STUDY

Have the participants read the case study. Ask participants to illustrate each component of the FRAMES acronym for this specific case study.

Mrs. S. is a 35-year-old woman who presents to the emergency department for mental health concerns. She discloses that she took multiple medications because she wanted "to end things". After triaging her, you conduct a secondary assessment including a suicide risk assessment, which is positive. Mrs. S. discloses she has other previous attempts, despite having support from many friends, taking her daily antidepressants, and being closely followed by her psychiatrist. She tells you that she has been feeling down lately and has resorted to binging alcohol. She feels that an admission to the psychiatry department would benefit her and is asking for assistance.

REFLECTION QUESTION: What principles of the brief intervention could you use with Mrs. S.? Do you have any examples?

Ideas to explore with participants:

- **F**eedback: "You screened positive for your suicide assessment, which puts you at high risk for self-harm."
- **R**esponsibility: "How concerned are you with your suicide risk and your current self-harming thoughts?"
- **A**dvise: "To avoid a suicidal crisis, the best way is to recognize your triggers and situations that may exacerbate thoughts about suicide or self-harm"
- **M**enu for change: "In what situations do you feel like you need to harm yourself? Do you have any peers that could help you take your mind away from self-harming thoughts?"
- **E**mpathy: "Our priority is to keep you safe. Let's work together to create a safety plan when you have thoughts of hurting yourself."
- **S**elf-efficacy: "I'm confident that you can find ways to address these feelings and reach out to support people when needed to keep yourself safe."

CONCLUSION

Conclude the session by presenting key points.

In summary:

- The brief intervention is a communication technique utilized by emergency nurses to assist people with mental illness in crisis (Mattoo et al., 2018; RNAO, 2017).
- The main principles of the brief intervention are: (1) feedback, (2) responsibility, (3) advise, (4) menu for change, (5) empathy, and (6) self-efficacy (RNAO, 2017).

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PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION
BRIEF INTERVENTION HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Define the brief intervention approach
- Describe the FRAMES acronym
- Illustrate each component of the FRAMES acronym in a case study

CASE STUDY

Mrs. S. is a 35-year-old woman who presents to the emergency department for mental health concerns. She discloses that she took multiple medications because she wanted "to end things". After triaging her, you conduct a secondary assessment including a suicide risk assessment, which is positive. Mrs. S. discloses she has other previous attempts, despite having support from many friends, taking her medications, and being closely followed by her psychiatrist. She tells you that she has been feeling down lately and has resorted to binging alcohol. She feels that an admission to the psychiatry department would benefit her and is asking for assistance.

What principles of the brief intervention could you use with Mrs. S.? Do you have any examples?

Feedback	"You screened positive for your suicide assessment, which puts you at high risk for self-harm."
Responsibility	"How concerned are you with your suicide risk and your current self-harming thoughts?"
Advise	"To avoid a suicidal crisis, the best way is to recognize your triggers and situations that may exacerbate thoughts about suicide or self-harm"
Menu for change	"In what situations do you feel like you need to harm yourself? Do you have any peers that could help you take your mind away from self-harming thoughts?"
Empathy	"Our priority is to keep you safe. Let's work together to create a safety plan when you have thoughts of hurting yourself."
Self-efficacy	"I'm confident that you can find ways to address these feelings and reach out to support people when needed to keep yourself safe."

Remember	Do not be afraid to say the "wrong thing". If you validate the individuals' feelings, that you are empathetic, and non-judgmental, you will be able to effectively connect with patients (Bolton et al., 2013).

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PRINCIPLE 4: STRENGTHS-BASED APPROACH

DEFINITION

A trauma-informed care approach aims to develop skills and build resiliency in people with mental illness (Poole et al., 2013). A strengths-based approach promotes healing and growth in people with mental illness who have had traumatic experiences (Nathoo et al., 2018).

PRINCIPLE 4: STRENGTHS-BASED APPROACH

SESSION 6: STRENGTH-BASED COMMUNICATION

PURPOSE OF THE SESSION

The purpose of this session is to learn about strength-based documentation about people with mental illness and how to incorporate its principles in practice.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Describe the principles of strength-based communication
- Give examples of strength-based communication and documentation in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will discuss to discuss strength-based communication. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin?

BACKGROUND

Review one of the background facts about the stigmatization of people with mental illness with the participants. These facts are also included in their handout.

- Stigma disproportionately affects people with mental illness, including those with substance use disorders (Mental Health Commission of Canada, n.d.; Pescosolido et al., 2010). For instance, while 20% of Canadians experience mental health issues in any given year, 60% are reluctant to seek help by fear of being stigmatized (Mental Health Commission of Canada, n.d.).
- Stigma refers to negative perceptions held toward a group or individual " (Couto e Cruz et al., 2019). It may lead to discrimination, which is defined as "actions from a person or group that aims to harm another" (Couto e Cruz et al., 2019). People with mental health illness' reluctance to access health care services due to the stigmatization they face is a health issue, as it worsens their mental and physical well-being (Ahern et al., 2007; Chang et al., 2017; Clement et al., 2015).
- Unfortunately, nurses' negative attitudes also contribute to the stigmatization of people with mental illness. For instance, the beliefs about people with mental health issues held by the caregivers in the Netherlands were the following: a tendency to maintain distance from people with mental illness (mean = 3.72, SD = 0.53, $p < .01$), people with mental illness engage in aggressive behavior (mean = 3.86, SD = 0.62, $p < .01$), and people with mental illness tend to cause disturbances (mean = 3.41, SD = 0.66, $p < .01$) (van Boekel et al., 2015).

STRENGTHS-BASED COMMUNICATION

Review the material regarding strength-based communication and its principles.

Why should healthcare providers use strengths-based communication?

Language can reflect an organization's values and mission. It can influence the engagement of individuals within their care and have a positive impact on their well-being (Nathoo et al., 2018). Therefore, the language used by healthcare providers should be strength-based and trauma-informed (Nathoo et al., 2018).

Strength-based communication aims to promote healing, increase resilience, and reduce stigma, especially for people with mental illness or substance use disorders (Nathoo et al., 2018). Strength-based language "respects an individual's autonomy and reflects collaboration between patients/clients and service providers "(Nathoo et al., 2018, p.39).

Using strength-based communication can also help healthcare providers better understand an individuals' condition as it allows them to focus on "what has happened to this person?" as opposed to "what is wrong with this person?" (Poole et al., 2013).

What are the principles of strengths-based communication?

Here are some principles of strengths-based communication.

1. Avoid using medical conditions to describe patients. "Labelling" clients can be detrimental to their well-being, as it may further stigmatize them. For example, instead of using "addicted baby", you can use "neonate experiencing withdrawal" (Nathoo et al., 2018).
2. Use person-centered language to reinforce the fact that the individual is not defined by a medical diagnosis or by their behaviors (Nathoo et al., 2018). For example, you may utilize "person who uses opioids" instead of the word "addict".
3. Your language should also be empathetic, non-judgmental, welcoming, and respectful (Varcoe et al., 2019).
4. Use patient quotes and objectively describe their behaviors.

REFLECTION QUESTION: What difference does it make to welcome individuals with mental illness with "nice to see you again" as opposed to "you are back again"?

Ideas to explore with participants:

- Acknowledging the individual and their concerns
- Foster connection and trust
- Support a welcoming and safe environment

What are some examples of strengths-based communication and documentation?

Here are some examples of deficit-based expressions we often use in the emergency department. You can find their strength-based alternative in the table on your handout.

Deficits-based language	Strength-based language
Attention-seeking	Seeking assistance
Drug addict	Person who uses opioids, who has substance use issues
Frequent flyer	Frequently uses healthcare services
Manipulative	Trying to seek help, resourceful
Non-compliant	Preferred not to, choosing not to
Refused	Declined
Resistant to care	Prefers other options or options that are not available; current services do not meet patient' s needs

(Nathoo et al., 2018, Varcoe et al., 2019)

REFLECTION QUESTION: What is your perspective on the term "frequent flyer"?

Ideas to explore with participants:

- Do we have preconceived thoughts about these patients? (e.g., drug-seeking, fibromyalgia, poor pain tolerance)
- Do you think other factors might contribute to them accessing care through the emergency department? (e.g., intimate partner violence, housing instability, lack of education)

CASE STUDY

Have the participants read the case study. Ask participants to rewrite the documentation note from a strength-based perspective.

Drug-seeking patient presents to the emergency department with complaint of 10/10 back pain. This is the patient's second emergency visit today. In the last visit, the patient, who is an intravenous drug user, refused to take the ibuprofen offered by the nurse. The patient started acting out with the staff, screaming "this won't do anything to take my pain away". The patient has also been non-compliant with his suboxone treatment in the past week.

REFLECTION QUESTION: How would you write this documentation note using strength-based communication?

Ideas to explore with participants:

- Use "person seeking pain relief" instead of "drug seeking"
- Replace "drug user" by "person with substance use issues"
- Use "declined" or "opted not to" instead of "refused"
- Write "patient is upset" as opposed to "acting out"
- Replace "non-compliant" by "prefers not to"

CONCLUSION

Conclude the session by presenting key points.

In summary:

- Words matter. Strength-based communication helps promote healing, increase resilience, and reduce stigma, especially for people with mental illness (Nathoo et al., 2018).
- The main principles of strength-based communication are: (1) avoid the use of labels, (2) use person-centered language, (3) utilize empathetic and respectful language, and (4) objectively describe patients' behaviors (Nathoo et al., 2018).

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PRINCIPLE 4: STRENGTHS-BASED APPROACH
STRENGTH-BASED COMMUNICATION HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Recognize the importance of strength-based communication
- Define the principles of strength-based communication
- Provide examples of strength-based communication and documentation

Did you know?

Stigma disproportionately affects people with mental illness, including those with substance use disorders. (Mental Health Commission of Canada, n.d.)	While 20% of Canadians experience mental health issues in any given year, 60% are reluctant to seek help by fear of being stigmatized. (Mental Health Commission of Canada, n.d.)	People with mental health illness' reluctance to access health care services is a health issue, as it worsens their mental and physical well-being (Chang et al., 2017).	Unfortunately, nurses' negative attitudes also contribute to the stigmatization of people with mental illness. (van Boekel et al., 2015)

Principles of strength-based communication

1. Avoid the use of labels
2. Use person-centered language
3. Utilize empathetic and respectful language
4. Describe patients' behaviors in an objective manner (Nathoo et al., 2018).

Deficits-based language	Strength-based language
Attention-seeking	Seeking assistance
Drug addict	Person who uses opioids,
Frequent flyer	Frequently uses healthcare services
Manipulative	Trying to seek help, resourceful
Non-compliant	Preferred not to, choosing not to
Refused	Declined
Resistant to care	Prefers other options

(Nathoo et al., 2018)

How would you rewrite this triage note?

Drug-seeking patient presents to the emergency department with complaint of 10/10 back pain. This is the patient's second emergency visit today. In the last visit, the patient, who is an intravenous drug user, refused to take the ibuprofen offered by the nurse. The patient started acting out with the staff, screaming "this won't do anything to take my pain away". The patient has also been non-compliant with his suboxone treatment in the past week.

References

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SESSION 7: CASE STUDY

PURPOSE OF THE SESSION

The purpose of this session is to use a case study to exemplify the principles of a trauma-informed care approach for an individual with mental illness.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Apply the principles of trauma-informed care approach in a case study situated in the emergency department
- Reflect on the barriers people with mental illness encounter in their daily lives and how it affects their behaviors in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSION

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will go through a case study to illustrate the principles of trauma-informed care for a patient with mental illness in the emergency department. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.
- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family

Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.

- Do you have any questions before we begin?

BACKGROUND

Review the background facts about the trauma-informed care approach with the participants. These facts are also included in their handout.

Here is a quick review about the trauma-informed care approach:

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).
- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).
- A trauma-informed care approach can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

CASE STUDY

Have the participants read the case study.

Mrs. T. is a 56-year-woman who frequently presents to the emergency department for mental health- or for substance use- related reasons. She currently has a safe supply of opioids and supplements with illicit substances. Her mental health issues have been exacerbated by her use of illicit substances, with several visits in the last month for increased anxiety, substance-induced psychosis, and overdoses.

As you establish rapport with Mrs. T, you learn that she grew up in an unstable household, where her mother was a victim of intimate partner violence. Mrs. T. left the family home at a young age and spent some time living in Downtown Eastside for many years. She tells you that she has had to offer "sex services" to survive and that was often physically and sexually assaulted by her clients.

Mrs T. recently relocated to her hometown. She is currently staying at the shelter as she cannot afford rent. Her only income is her "disability check", which rarely covers any food or essential items along with the purchase of illicit substances. She has been unable to keep a job due to her substance use issues.

Today, she is voluntarily coming into the emergency department. She tells you that she wants to see the emergency physician to have additional anti-anxiety medications. She informs you that she has been unable to sleep well at the shelter and that she feels lonely.

REFLECTION QUESTION: What trauma-informed care interventions could you use with Mrs. T.?

Ideas to explore with participants:

- Acknowledge Mrs. T's concerns
- Foster connection and trust by being non-judgmental and empathetic
- Support a welcoming and safe environment by inviting Mrs. T. in a private room
- Use the brief intervention approach to ask about her substance use
- Avoid using labels and refer to Mrs. T. as a woman with substance use disorder in your documentation
- Ask about Mrs. T's strengths (e.g., goals, coping skills, community connections)

REFLECTION QUESTION: What other interventions could you use to improve Mrs. T.'s access to healthcare?

Ideas to explore with participants:

- Refer Mrs. T. to the Intensive Case Management Team
- Ask Mrs. T. if you need to call a taxi or the Zunga bus to go back to the shelter.
- Check with Mrs. T. if she needs safe equipment to inject illicit substances

CONCLUSION

Conclude the session by presenting key points.

In summary:

- A trauma-informed care approach for people with mental illness can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

REFERENCES

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Wathen, C.N. & Varcoe, C. (2021). *Trauma- & violence-informed care (TVIC): A tool for health & social service organizations & providers*. https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf

CASE STUDY HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Apply the principles of the trauma-informed care approach in a case study
- Reflect on barriers people with mental illness face in healthcare

CASE STUDY

Did you know?

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).
- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).

Mrs. T. is a 56-year-woman who frequently presents to the emergency department for mental health- or for substance use- related reasons. She currently has a safe supply of opioids and supplements with illicit substances. Her mental health issues have been exacerbated by her use of illicit substances, with several visits in the last month for increased anxiety, substance-induced psychosis, and overdoses.

As you establish rapport with Mrs. T, you learn that she grew up in an unstable household, where her mother was a victim of intimate partner violence. Mrs. T. left the family home at a young age and spent some time living in Downtown Eastside for many years. She tells you that she had to offer "sex services" to survive and was often physically and sexually assaulted by her clients.

Mrs T. recently relocated to her hometown. She is currently staying at the shelter as she cannot afford rent. Her only income is her "disability check", which rarely covers any food or essential items along with the purchase of illicit substances. She has been unable to keep a job due to her substance use issues.

Today, she is voluntarily coming to the emergency department. She tells you that she wants to see the emergency physician to have additional anti-anxiety medications. She informs you that she has been unable to sleep well at the shelter and that she feels lonely.

Pause and reflect

What trauma-informed care interventions could you use with Mrs. T.?

What other interventions could you use to improve Mrs. T.'s access to healthcare?

References

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Wathen, C.N. & Varcoe, C. (2021). *Trauma- & Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations & Providers*. https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf

SESSION 8: TRAUMA-INFORMED CARE RESOURCES

PURPOSE OF THE SESSION

The purpose of this session is to review current trauma-informed care resources, including the trauma-informed care policy at Vancouver Coastal Health.

LEARNING OBJECTIVES

At the end of the session, each participant will be able to:

- Be aware of the current Vancouver Coastal Health policy for trauma-informed care
- Be able to access additional resources for trauma-informed care
- Utilize trauma-informed care resources as needed if they require additional support

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE SESSIONS

Note: *The text in italics constitutes the instructions for the session. The non-italicized text is the script for the sessions and can be read by the facilitator when conducting the session.*

Print and provide the handout for the session to all participants. Retrieve the most recent Trauma-Informed Practice policy from SHOP (http://shop.healthcarebc.ca/vch) and print a copy for the participants. To start, open the session by reviewing the purpose and the general instructions for the sessions.

Today, we will look at trauma-informed care resources, including the Vancouver Coastal Health policy. Before we begin, here are some general instructions for the session.

- These sessions are meant to be informal. Please consider this a safe learning space, where any question or comment is welcome. We are all learners, and we can benefit from everybody's perspective.
- Feel free to leave the session at any time. For example, you may need to leave to provide patient care or if the topic discussed is triggering for you. If you cannot complete the session, you may choose to attend the session again. If you are unable to do so, you can also find the educational material in the nurses' manual. Two copies will be at your disposal: one at the nursing station in the emergency department and one in the nurse educator's office.

- Please reach out to your facilitator if you are experiencing any difficulties with the sessions. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress after these sessions.
- Do you have any questions before we begin?

BACKGROUND

Review the background facts about the trauma-informed care resources with the participants.

- In 2013, the trauma-informed practice guidelines were created to assist care providers and organizations meet the need of clients with a history of trauma (Poole et al., 2013). They were designed for clients with mental health challenges and substance use disorders (Poole et al., 2013). To develop the guidelines, consultations and focus groups were conducted with care providers across all health authorities in British Columbia in 2011 (Poole et al., 2013). Moreover, consultations findings were supported by recent literature and efforts from other Canadians jurisdictions (Poole et al., 2013).
- The Vancouver Coastal Health Mental Health and Addictions leaders shortly followed with the creation of a policy surrounding the use of trauma-informed care in 2020 for all service providers, including organization leaders (Vancouver Coastal Health, 2020).

TRAUMA-INFORMED CARE RESOURCES

Read the purpose of trauma-informed care policy. Then, ask participants to discuss why they believe it is important to have a trauma-informed care policy.

What is the purpose of the trauma-informed care policy?

According to Vancouver Coastal Health (2020), all Vancouver Coastal Health "care providers will utilize a trauma-informed approach for the individuals and families they serve." (p. 1).

The purpose of the policy is:

"• To support individuals and families towards best outcomes through implementing trauma-informed practice.
• To guide care providers to implement the four principles of trauma-informed practice in supporting individuals and families.
• To reduce barriers and improve quality of services for all individuals and families, with particular attention to Indigenous Peoples, women, LGBTQI+, immigrants and refugees.

- To promote awareness around vicarious trauma and outline the importance of providing a psychologically safe workplace to support care providers to develop and maintain resilience." (Vancouver Coastal Health, 2020, p. 2)

REFLECTION QUESTION: Why is it important to have a trauma-informed care policy?

Ideas to explore with participants:
- Do you think a trauma-informed care approach contributes to creating a welcoming environment for all patients?
- Do you think a trauma-informed care approach can be a way to re-engage people with mental illness who have previously been traumatized during their stay in the emergency department?

Review the expectations for care providers in regard to trauma-informed care. Discuss with participants what they believe their role is in providing trauma-informed care to patients.

What are the expectations for care providers in regard to trauma-informed care?

- Provide care utilizing the four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach) (Vancouver Coastal Health, 2020)
- Be aware of trauma-specific services, and vicarious trauma (Vancouver Coastal Health, 2020)
- Utilized strength-based and trauma-informed care documentation (Vancouver Coastal Health, 2020)
- Provide education to patients and families about the trauma-informed care approach (Vancouver Coastal Health, 2020)

REFLECTION QUESTION: What is your role in providing trauma-informed care to individuals with mental illness and their families?

Ideas to explore with participants:
- Supporting colleagues who are experiencing vicarious trauma
- Creating safety plans for people with mental illness who are in crisis
- Reflecting on your own biases and how they can influence your practice

Review the content of the policy.

What is included in the policy?

- Information on trauma and its impact
- Description of the trauma-informed care approach
- Signs and symptoms of a trauma response
- Examples of four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach)
- Grounding strategies
- Information on vicarious trauma, along with a self-assessment tool (Vancouver Coastal Health, 2020)

Provide additional resources for trauma-informed care in British Columbia.

What are some additional trauma-informed care resources in British Columbia?

If you want to know more about trauma-informed care, there are two great additional resources.

1. Trauma-Informed Practice Guide: It includes information about trauma and its repercussions, the principles of trauma-informed care, communication strategies, and case studies. Available at https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. Trauma Informed Practice & the Opioid Crisis. It includes information about trauma and trauma-informed care. It contains numerous practice examples, discussion questions and skills for services providers for each principle of trauma informed care. Available at https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

CONCLUSION

Conclude the session by presenting key points.

In summary:

- Healthcare providers at Vancouver Coastal Health are expected to practice with a trauma-informed care approach to best support families, to improve inclusion of all individuals, and to provide a psychologically safe environment for everyone (Vancouver Coastal Health, 2020).
- Additional trauma-informed care resources are available in British Columbia: the Trauma-Informed Practice Guide and the Trauma-Informed Practice & the Opioid Crisis guide. Please ask your nurse educator if you have any questions.

REFERENCES

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health. https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Vancouver Coastal Health. (2020). *Trauma-Informed Practice*. http://shop.healthcarebc.ca/vch/VCHDSTs/BD-00-07-40107.pdf

TRAUMA-INFORMED CARE RESOURCES HANDOUT

OBJECTIVES

By the end of the session, you will be able to:

- Be aware of the current Vancouver Coastal Health policy and of your responsibilities
- Be able to access additional resources for trauma-informed care
- Utilize trauma-informed care resources as needed if you require additional support

Purpose of the policy	• "To support individuals and families towards best outcomes through implementing trauma- informed practice. • To guide care providers to implement the four principles of trauma-informed practice in supporting individuals and families. • To reduce barriers and improve quality of services for all individuals and families, with particular attention to Indigenous Peoples, women, LGBTQI+, immigrants and refugees. • To promote awareness around vicarious trauma and outline the importance of providing a psychologically safe workplace to support care providers to develop and maintain resilience." (Vancouver Coastal Health, 2020, p. 2)
The expectations for all care providers	• Provide care utilizing the four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach) • Be aware of trauma-specific services, and vicarious trauma • Utilized strength based and trauma informed care documentation • Provide education to patients and families about the trauma-informed care approach (Vancouver Coastal Health, 2020)

If you want to know more about trauma-informed care, there are two great additional resources.

1. **Trauma-Informed Practice Guide**: Includes information about trauma, trauma-informed care, communication strategies, and case studies. Available at https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. **Trauma Informed Practice & the Opioid Crisis**. Contains numerous practice examples, discussion questions and skills for services providers for trauma informed care. Available at https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

Pause and reflect	Why is it important to have a trauma-informed care policy? What is your role in providing trauma-informed care to individuals with mental illness and their families?

References

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Vancouver Coastal Health. (2020). *Trauma-Informed Practice*. http://shop.healthcarebc.ca/vch/VCHDSTs/BD-00-07-40107.pdf

APPENDICES

Appendix A

Attendance Sheet for the Facilitator

Please mark the date and initial the attendance sheet once you have completed a session. Once you have completed all the sessions, ensure to write your completion date to be entered in a gift card draw.

Name	Sessions								
	1	2	3	4	5	6	7	8	Completion date

Appendix B

Pre-Training Survey for the Modules (Long Version)

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer or write your answer on the designated lines. Please note that all surveys will remain confidential.

1. How familiar are you with the principles of trauma-informed care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

2. Can you briefly explain one principle of trauma-informed care that you are already familiar with?

3. How well do you understand the concept of trauma and its impact on individuals? (

Not well at all	Not very well	Somewhat well	Very well	Extremely well
○	○	○	○	○

4. Have you ever experienced or heard about vicarious trauma in the workplace? Please share your thoughts or experiences.

5. Are you aware of the specific challenges individuals with mental illness may face when they have a history of trauma?

Yes	No
○	○

6. If yes, can you name one challenge that individuals with mental illness who have experienced trauma might encounter?

_____

_____

_____

7. How often do you participate in debriefing sessions after challenging or traumatic incidents at work?

Never	Rarely	Occasionally	Frequently
○	○	○	○

8. What, in your opinion, is the most important outcome of a debriefing session?

_____

_____

_____

9. Are you aware of any resources available to assist you in providing trauma-informed care in your role?

Yes	No
○	○

10. Please list one resource or tool you currently use or have heard about for providing trauma-informed care.

_____

_____

_____

11. In your opinion, how do the principles of choice, collaboration, and connection align with providing trauma-informed care? Please provide an example if possible.

12. What do you believe are the key benefits of incorporating choice, collaboration, and connection in your nursing practice?

13. How familiar are you with the concept of a strengths-based approach in patient care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

14. Can you provide an example of how you might apply a strengths-based approach when caring for a patient who has experienced trauma?

Thank you for participating in this pre-training survey.

Post-Training Survey for the Modules (Long Version)

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer or write your answer on the designated lines. Please note that all surveys will remain confidential.

1. How familiar are you with the principles of trauma-informed care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

2. Can you briefly explain one principle of trauma-informed care that you are already familiar with?

3. How well do you understand the concept of trauma and its impact on individuals? (

Not well at all	Not very well	Somewhat well	Very well	Extremely well
○	○	○	○	○

4. Have you ever experienced or heard about vicarious trauma in the workplace? Please share your thoughts or experiences.

5. Are you aware of the specific challenges individuals with mental illness may face when they have a history of trauma?

Yes	No
○	○

6. If yes, can you name one challenge that individuals with mental illness who have experienced trauma might encounter?

_____

_____

_____

7. How often do you participate in debriefing sessions after challenging or traumatic incidents at work?

Never	Rarely	Occasionally	Frequently
○	○	○	○

8. What, in your opinion, is the most important outcome of a debriefing session?

_____

_____

_____

9. Are you aware of any resources available to assist you in providing trauma-informed care in your role?

Yes	No
○	○

10. Please list one resource or tool you currently use or have heard about for providing trauma-informed care.

_____

_____

_____

11. In your opinion, how do the principles of choice, collaboration, and connection align with providing trauma-informed care? Please provide an example if possible.

12. What do you believe are the key benefits of incorporating choice, collaboration, and connection in your nursing practice?

13. How familiar are you with the concept of a strengths-based approach in patient care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

14. Can you provide an example of how you might apply a strengths-based approach when caring for a patient who has experienced trauma?

What did you like about these modules?

What could be improved?

Do you have any other comments regarding the modules? Would you like to learn more about additional topics?

Thank you for all your help and for completing these sessions.

Pre-Training Survey for the Short Educational Sessions (Short Version)

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer.

Please note that all surveys will remain confidential.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
I can provide examples of the impacts of trauma on people with mental illness' well-being.	○	○	○	○	○
I understand that people with mental illness' undesirable behaviors may be rooted in previous traumatic experience.	○	○	○	○	○
I can give examples of the trauma-informed care approach in the emergency department for people with mental illness.	○	○	○	○	○
I know where to find resources to assist me provide trauma-informed care.	○	○	○	○	○
I know what signs to recognize when I feel overwhelmed at work.	○	○	○	○	○
I understand how to communicate and document using a strength-based approach.	○	○	○	○	○
I am aware of resources at work for my well-being and of who to contact for a debriefing session if needed.	○	○	○	○	○
I feel confident I can apply the trauma-informed care principles in my practice for people with mental illness.	○	○	○	○	○
I feel confident I can use grounding strategies at work.	○	○	○	○	○
I feel confident I can discuss with people with mental illness using the brief intervention for their substance use or self-harm.	○	○	○	○	○

Thank you for participating in this pre-training survey.

Post-Training Survey for the Short Educational Sessions (Short Version)

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer. If you have not attended one of the sessions regarding the statements, please fill the "not applicable" answer.

Please note that all surveys will remain confidential.

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Not applicable
I can provide examples of the impacts of trauma on people with mental illness' well-being.	○	○	○	○	○	○
I understand that people with mental illness' undesirable behaviors may be rooted in previous traumatic experience.	○	○	○	○	○	○
I can give examples of the trauma-informed care approach in the emergency department for people with mental illness.	○	○	○	○	○	○
I know where to find resources to assist me provide trauma-informed care.	○	○	○	○	○	○
I know what signs to recognize when I feel overwhelmed at work.	○	○	○	○	○	○
I understand how to communicate and document using a strength-based approach.	○	○	○	○	○	○
I am aware of resources at work for my well-being and of who to contact for a debriefing session if needed.	○	○	○	○	○	○
I feel confident I can apply the trauma-informed care principles in my practice for people with mental illness.	○	○	○	○	○	○
I feel confident I can use grounding strategies at work.	○	○	○	○	○	○
I feel confident I can discuss with people with mental illness using the brief intervention for their substance use or self-harm.	○	○	○	○	○	○

What did you like about these modules?

What could be improved?

Do you have any other comments regarding the modules? Would you like to learn more about additional topics?

Thank you for all your help and for completing these sessions.

TRAUMA-INFORMED CARE FOR EMERGENCY NURSES WHO CARE FOR PEOPLE WITH MENTAL ILLNESS

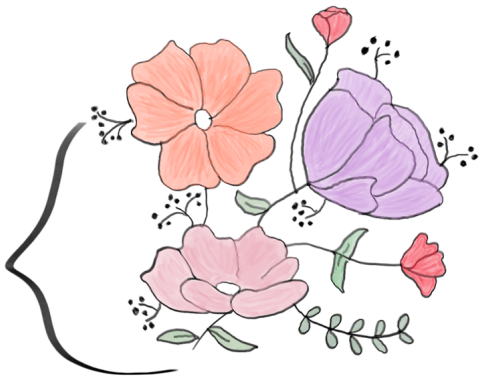

FIGURE 1. HEALING FROM TRAUMA. OWN ARTWORK.

NURSES' MANUAL

DEVELOPED BY MAUDE BELLEMARE, RN

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HOW TO USE THIS MANUAL

INTRODUCTION TO THE MANUAL

The *Trauma-informed care* manual has been developed to educate emergency nurses on the trauma-informed care approach. This manual includes modules with educational information on trauma-informed care principles and skills for emergency nurses.

WHY WAS THIS MANUAL DEVELOPED?

- Exposure to trauma, especially among individuals with mental illness, can lead to poor psychological health, substance abuse, and re-traumatization when seeking care in emergency departments, highlighting the need for trauma-informed care by emergency nurses (Hogg et al., 2023; Lavergne et al., 2018; Muskett, 2014; Vandyk et al., 2018; Watson, 2019)
- Trauma-informed care, which integrates trauma awareness into policies and practices to prevent re-traumatization, has been established and adopted in mental health and substance abuse sectors but is less prevalent in emergency departments, resulting in a deficit of skills and knowledge among emergency nurses and physicians (Brown et al., 2022; Bruce et al., 2018; Hall et al., 2016; McNamara et al., 2021; Poole et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).
- Researchers have found that training about trauma-informed care could improve nurses' confidence, skills, and attitudes toward trauma-informed care (Berg-Poppe et al., 2022; Cannon et al., 2020; Carter-Snell et al., 2020; McNamara et al., 2019; Niimura et al., 2019; Weiss et al., 2017).
- Therefore, it is important to provide emergency nurses with educational opportunities to strengthen their knowledge and abilities about the use of trauma-informed care approach to care for people with mental illness.

THEORETICAL UNDERPINNINGS

Knowles' theory of andragogy was chosen to guide the creation of this trauma-informed care manual (Chan, 2010). The six principles of Knowles' theory of andragogy and their relevance for this manual are outlined below (Chan, 2010).

Self-concept	Adult learners are autonomous in their learning journey and benefit from a variety of learning modalities. This manual includes self-reflection questions, discussion opportunities, case studies and handouts.
Role of the experience	Previous experience is a learning resource for adult learners. The case studies and the reflection questions will allow emergency nurses to draw from their experience of working with people with mental illness.
Readiness to learn	Adult learners benefit from teachings that are relevant to their practice. Emergency nurses frequently interact and provide care to PWMI, so they require knowledge and skills to incorporate in their daily practice.
Orientation to learning	Learning offerings should be problem-centered. The use of guided discussions will help emergency nurses to find ways to apply trauma-informed care interventions as part of their nursing care.
Motivation	Adults are motivated in learning endeavors that stimulates them, or when they can help others. Emergency nurses can improve their job satisfaction by providing safe and competent care for PWMI.
Need to know	Adult learners need to know how new knowledge is beneficial for them. Underlining the impacts of trauma on patients' and vicarious trauma will assist emergency nurses in developing an interest in the trauma-informed care approach.

(Chan, 2010)

PURPOSE OF THESE MODULES

These modules are an opportunity for you to:

- Reflect on your care
- Learn about trauma-informed care
- Practice your skills

By building on your own caring experiences and by finding ways to incorporate the trauma-informed care approach into your practice, you can enhance the well-being of mental health patients in the emergency department (Poole et al., 2013; Wathen & Varcoe, 2019).

FORMAT OF THE MODULES

In what order should the modules be completed?

Modules should be completed in the following order:

1. Principles of trauma-informed care
2. Trauma
3. Vicarious trauma
4. Debriefing

5. Brief intervention
6. Strength-based communication
7. Case study
8. Trauma-informed care resources

However, you can benefit from all modules as a standalone educational opportunity. You can also choose to use a specific topic if it is deemed relevant. For example, you may decide to complete the "debrief" module after a work incident, such as a code white.

You can monitor your progress through the modules by using the "Module completion tracking sheet" (See Appendix A). Incentives, such as gift cards for coffee, may be offered for nurses who complete all sessions.

How long should it take to complete a module?

It should take approximately 15 minutes to complete one module.

HOW TO USE THE EDUCATIONAL MATERIAL

This manual is divided in four sections based on the principles of trauma-informed care (i.e, **trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strengths-based approach**) and their pertaining modules.

The following information is provided for each module in this manual:

- Purpose of the module
- Learning objectives for the module
- A short introduction outlining general instructions for the modules
- Background and educational information about each topic
- Guiding questions or case studies
- Key learning points
- Handouts to use as a reference

In addition, this manual contains two evaluations surveys (i.e., pre-training survey, post-training survey) (see Appendix B). You should complete the pre-training survey prior to completing the first module. The post-training survey can be completed once you have done all the modules.

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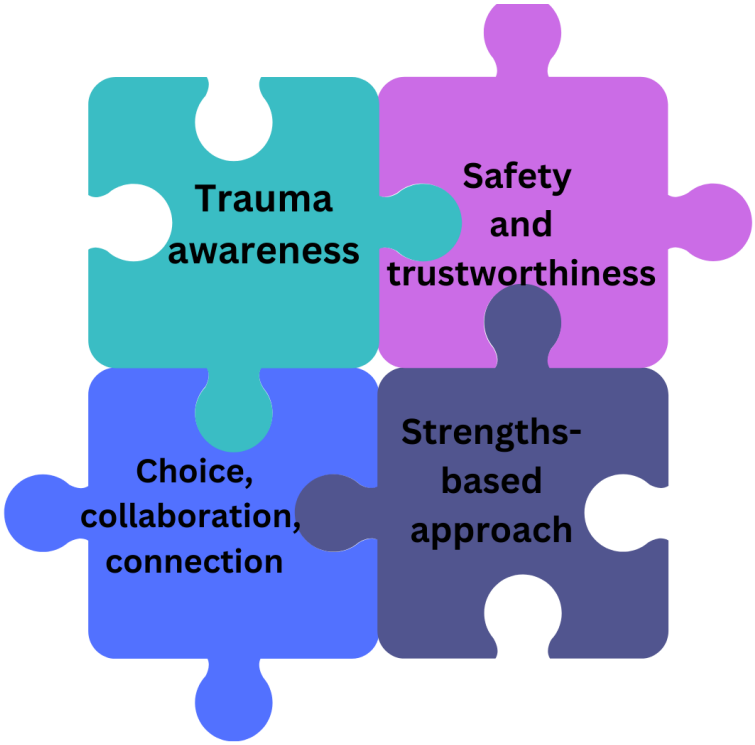

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EDUCATIONAL MODULES

MODULE 1:
THE FOUR PRINCIPLES OF TRAUMA-INFORMED CARE

PURPOSE OF THE MODULE

The purpose of this module is to discuss the principles of trauma-informed care and see how they can be applied in the emergency department.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Define trauma-informed care
- Describe the main principles of trauma-informed care
- Give examples of the trauma-informed care approach in the emergency department for people with mental illness

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, the principles of trauma-informed care will be discussed as well as how they apply to the emergency department. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- In 2005, the National Center of Trauma-Informed Care was created by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States (Center

for Mental Health Services, 2012). In 2014, SAMHSA has launched a guide for the implementation of trauma-informed care for organizations (SAMHSA, 2014).

- In Canada, in 2013, the BC Centre of Excellence for Women's Health (BCCEWH) created the Trauma-informed practice guide for care providers who deliver mental health and substance use services (Poole et al., 2013).

PRINCIPLES OF TRAUMA-INFORMED CARE

What is trauma-informed care?

According to Wathen and Varcoe (2021), "trauma-informed care creates safety for service users by understanding the effects of trauma, and its close links to health and behavior; it is not about eliciting or treating people's trauma" (p. 1). Moreover, it is a **universal approach** that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What are some barriers to a safe environment in your department for people with mental illness? What are some ways to address them?

Here are some barriers to providing safe nursing care in the emergency department:

- Lack of privacy
- Use of "labels" for people with mental illness
- Standardized protocols for all patients

Here are some ways to address these barriers:

- Follow your client's lead. You will work together better by being flexible and creative when conducting your assessment and asking questions about their well-being.
- Using private rooms for mental health assessments
- Refer to patients by their preferred pronouns or name

What are its main principles?

1. **Trauma awareness**: Healthcare providers need to understand how people with mental illness cope with trauma and be aware of the impact of trauma on individuals' physical and mental health (Wathen & Varcoe, 2021).
2. **Safety and trustworthiness**: Healthcare providers must strive to create a safe environment physically and emotionally for people with mental illness by providing as much control as possible for patients (Poole et al., 2013).
3. **Choice, collaboration, and connection**: Healthcare providers need to collaborate with people with mental illness to offer care options. Communication between care providers and people with mental illness should be clear and judgment-free (Nathoo et al., 2018).
4. **Strength-based approach**: People with mental illness' strengths need to be celebrated and used as a building step for enhanced skills (Poole et al., 2013).

Examples of a trauma-informed care approach in emergency nursing

- Bring the patient in a private room to do their mental health assessment
- Tell the patient they can choose not to answer some questions, or they can let you know if they want to take a break
- Ask about the patients' strengths (e.g., goals, coping skills, community connections)
- Ask patients about their pronouns

----------**PAUSE AND REFLECT**----------

REFLECTION QUESTION: Can you recall a time when you encouraged choice and collaboration with people with mental illness? If not, how can you encourage collaboration with them in your department?

Here are some examples on how, as an emergency nurse, you can encourage choice and collaboration:

- Ask people with mental illness if they would like to have family or friends present during their emergency visit if possible
- Ask them where they would prefer their intramuscular injection
- Communicate openly with people with mental illness, allowing them to express their preferences

CONCLUSION

In summary:

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).
- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).
- A trauma-informed care approach can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

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THE FOUR PRINCIPLES OF TRAUMA-INFORMED CARE HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Define trauma-informed care
- Describe the main principles of trauma-informed care
- Give examples of the trauma-informed care approach in the emergency department for people with mental illness

What is trauma-informed care?

According to Wathen and Varcoe (2021), "trauma-informed care creates safety for service users by understanding the effects of trauma, and its close links to health and behavior; it is not about eliciting or treating people's trauma" (p. 1). Moreover, it is a **universal approach** that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).

Principles of trauma-informed care

Trauma awareness

It is important to understand how trauma affects individuals with mental illness and how it can shape their interactions with us

In practice:

- Consider the impact of trauma on patients' behaviors (e.g., substance use, hostility)

Safety and trustworthiness

It is crucial to create a safe and welcoming environment for all our patients.

In practice:

- Provide a private space
- Ask patients about their pronouns
- Be transparent with patients

Choice, collaboration, and connection

Creating a sense of efficacy in people with mental illness must be achieved to respect their dignity and enhance their control.

In practice:

- Allow patients to express their preferences for treatment options
- Be non-judgmental

Strengths-based approach

By focusing on their strengths, you can help people with mental illness develop a sense of agency and self-efficacy.

In practice:

- Identify patients' strengths
- Validate their feelings
- Celebrate patients' successes

(Nathoo et al., 2018; Poole et al., 2013; Wathen & Varcoe, 2021)

Pause and reflect

Can you recall a time when you encouraged choice and collaboration with people with mental illness? If not, how can you encourage collaboration with these patients in your department?

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- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
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PRINCIPLE 1: TRAUMA AWARENESS

DEFINITION

According to Nathoo et al. (2018), "being trauma aware means understanding that trauma is common, and every individual who accesses health care and social services may have an unknown trauma history" (p. 12). By using a trauma-informed care approach for all patients, including those with mental illness, nursing care can be provided in a way that minimizes re-traumatization.

PRINCIPLE 1: TRAUMA AWARENESS
MODULE 2: TRAUMA

PURPOSE OF THE MODULE

The purpose of this module is to examine trauma, its impacts and its relevance for people with mental illness in the emergency department.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Define trauma
- Provide examples of the impacts of trauma on an individuals' well-being
- Explain why trauma can affect the behaviors of people with mental illness in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, trauma, its impacts and its relevance for people with mental illness in the emergency department will be examined. Before we begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- According to Statistics Canada (2022), 64 % of Canadians disclosed having experienced a traumatic event, with 8% suffering from post-traumatic stress disorder (PTSD).
- The prevalence of PTSD among people with mental illness is considerably higher. For instance, Adams et al. (2020) found that 27.0% of PWMI met the criteria for PTSD,

51.1% disclosed having experienced severe trauma, and 84.4% reported childhood adversities.

- Those who experience traumatic experiences are more likely to visit the emergency department. Mental illness disorders are associated with frequent emergency department visits, especially for substance use disorders (Odd ratio [OR] = 2.23, 95%CI [2.12, 2.35]) and schizophrenia (OR = 2.20, 95%CI [2.09, 2.33]) (Fleury et al., 2019).
- At the qathet General Hospital, people with mental illness frequently visit the emergency department for mental health reasons. For example, every week, two patients are involuntarily admitted to the hospital and receive care from emergency nurses (V. Wilson, personal communication, May 22, 2023).

TRAUMA

What is trauma?

According to the Center of Addictions and Mental Health (n.d.), "trauma is an experience that overwhelms an individual's emotional and psychological ability to cope and can result in lasting mental and physical effects." (p.1)

For example, it can be caused by bullying, physical abuse, emotional abuse, intimate partner violence, or by injuries (Center of Addictions and Mental Health, n.d.)

----------**PAUSE AND REFLECT**----------

REFLECTION QUESTION: Can you think of examples of trauma for people with mental illness who seek care in the emergency department?

Here are some examples of trauma for people with mental illness who seek care in the emergency department:

- The use of restraints and seclusion
- Experiences of discrimination or stigma
- Homelessness
- Injuries

What are the impacts of trauma?

The impacts differ for every individual and can include physical, behavioral, or psychological repercussions (Center of Addictions and Mental Health, n.d.). Below are some examples of the impacts of trauma.

Psychological	Physical	Behavioral
Depression Anxiety Guilt, shame Mistrust	Insomnia Fatigue Chronic Pain Gastrointestinal problems	Self-harming behaviors Substance use Sexualized behavior Delinquency

(Center of Addictions and Mental Health, n.d.)

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What are some other examples of the impacts of trauma?

Here are some other examples of the impacts of trauma:

- Denial
- Learning difficulties
- Isolation

Here is an additional idea that may help your reflection for the question above:

Do you think trauma can have a long-term impact on people with mental illness?

Why is it important to consider trauma for people with mental illness in the context of the emergency department?

- People with mental illness often have suffered multiple forms of trauma (Hennessy et al., 2023).

- People with mental illness may behave with aggressivity or hostility towards healthcare staff. Moreover, in order to cope with trauma, they often resort to substance use (Hogg et al., 2023; Varcoe et al., 2019; Watson, 2019)
- They are often reluctant to access healthcare services because of the stigma they experience, not only in the society, but also in healthcare settings (Hennessy et al., 2023; Vandyk et al., 2018).
- By understanding their undesirable behaviors are often the consequences of trauma, we can help them engage in their own health and offer safe and competent health care (Wathen & Varcoe, 2021).

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: When people with mental illness seek help in the emergency department, do you think their past trauma influences their ability to cope with their visit? Or influences their behaviors during their visit?

Here are some additional ideas that may help your reflection for the question above:

- What if they were in the seclusion room during their last visit?
- Do you think their substance use sometimes influences our nursing care? If yes, can we change this?

CONCLUSION

In summary:

- Most people presenting to the emergency department have a history of trauma, especially those with mental illness (Adams et al., 2020; Fleury et al., 2019).
- Traumatic events have negative impacts on mental health, physical health, and social functioning, often resulting in undesirable behaviors or hostility towards healthcare staff (Adams et al., 2020; Center of Addictions and Mental Health, n.d.).

- It is important to understand that the undesirable behaviors of people with mental illness are often their way of coping with their traumatic experiences (Varcoe et al., 2019).

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PRINCIPLE 1: TRAUMA AWARENESS

TRAUMA HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Define trauma
- Provide examples of the impacts of trauma on people with mental illness' well-being
- Explain why trauma can affect the behaviors of people with mental illness in the emergency department

Did you know?

64 % of Canadians have experienced trauma, with 8% suffering from post-traumatic stress disorder (PTSD).. (Statistics Canada, 2022)	People with mental illness have an increased risk of experiencing trauma, with 51.1% having experienced severe trauma, and 27% meeting criteria for PTSD. (Adams et al., 2020)	Those who experience traumatic experiences are more likely to visit the emergency department, especially for substance use disorders and mental health reasons. (Fleury et al., 2019)	At the qathet General Hospital, PWMI frequently visit the emergency department for mental health reasons, with an average of two involuntarily psychiatric admissions per week (V.Wilson, personal communication, May 22, 2023)

What is trauma?

According to the Center of Addictions and Mental Health (n.d.), "trauma is an experience that overwhelms an individual's emotional and psychological ability to cope and can result in lasting mental and physical effects." (p.1)

Impacts of trauma

Psychological	Physical	Behavioral
• Depression	• Insomnia	• Self-harming behaviors
• Anxiety	• Fatigue	• Substance use
• Guilt, shame	• Chronic Pain	• Sexualized behavior
• Mistrust	• Gastrointestinal problems	• Delinquency
• _____	• _____	• _____
• _____	• _____	• _____

Pause and reflect

When people with mental illness seek help in the emergency department, do you think their past trauma influences their ability to cope with their visit? Or influences their behaviors during their visit?

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- Adams, R. E., Bonfine, N., & Ritter, C. (2020). Childhood adversity, proximal stressors and PTSD among people with severe mental illness: An exploratory study. *Community Mental Health Journal, 56*(8), 1557–1565. https://doi.org/10.1007/s10597-020-00607-6
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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

DEFINITION

Physical, emotional, and cultural safety for patients with mental illness is one of the cornerstones of the trauma-informed approach (Poole et al., 2013). As patients with mental illness often feel unsafe in the emergency department, creating a safe and welcoming environment is important (Poole et al., 2013). Moreover, the safety of emergency nurses needs to be acknowledged since secondary traumatic stress can lead to burnout and vicarious trauma (Xie et al., 2021).

PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

MODULE 3: VICARIOUS TRAUMA

PURPOSE OF THE MODULE

The purpose of this module is to review information about vicarious trauma for emergency nurses and strategies to mitigate it.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Define vicarious trauma and its signs
- Describe the ABC model of self-care
- Provide examples of grounding strategies

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, you will learn about vicarious trauma and strategies to mitigate it. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- Nurses working with mental health patients are especially at risk of exhibiting vicarious trauma symptoms, with a high risk of compassion fatigue that affects between 28.57 and 44.8% of them (Xie et al., 2020).
- In Canada, 70% of healthcare workers reported worsened perceived mental health in 2019 during the COVID pandemic (Statistics Canada, 2021). More than 57% of British

Columbia nurses reported high levels of burnout, with more than 80% reporting exposure to emotional abuse at work. Moreover, 50% of surveyed British Columbia nurses met the criteria for post-traumatic stress disorder (Havaei et al., 2020)

- Vicarious trauma can have adverse effects on nurses' physical health and mental health, with an increased risk for burnout (Berger et al., 2015). Furthermore, patient care can be compromised as vicarious trauma can lead to medical errors and low patient satisfaction (Berger et al., 2015).

VICARIOUS TRAUMA

What is vicarious trauma?

According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients who have experienced or been affected by trauma." (p. 2).

Signs of vicarious trauma include:

- Discouraged to work with clients
- Being emotionally numbed
- Avoidance of clients
- Lack of empathy
- Chronic exhaustion
- Guilt

What is the ABC model of self-care?

Awareness: Healthcare workers should know their limits, resources, emotions, needs. They should connect with themselves to readily identify signs of stress. (Center of Addictions and Mental Health, n.d.)

Examples:

- Engage in self-reflection
- Write a journal
- Listen to your inner thoughts
- Set limits with your patients or co-workers
- Sometimes say no to additional responsibilities or tasks if you are overwhelmed (Vancouver Coastal Health, 2018)

Balance: Healthcare workers should strive to attain balance between their personal and professional activities. They should replenish their energy by planning self-care activities like exercise, practicing hobbies, meditating, or journaling. (Center of Addictions and Mental Health, n.d.)

Examples:

- Take a break during your shift
- Go on a vacation
- Take time off when you are ill or feeling unwell
- Spend time with children and friends
- Exercise
- Meditate (Vancouver Coastal Health, 2018)

Connection: Healthcare workers should value and build relationships with family, friends, and co-workers. It allows them to avoid isolation and ask for help when needed. (Center of Addictions and Mental Health, n.d.)

Examples:

- Connect with supportive co-workers
- See a counsellor for your mental health
- Spend time with loved ones (Vancouver Coastal Health, 2018)

Grounding strategies

These are self-care strategies that help healthcare workers focus on the present and take in what is happening in the moment (Poole et al., 2013). Grounding strategies assist healthcare workers mitigate the emotional impact of working with individuals who have a history of trauma (Poole et al., 2013). Moreover, grounding skills can be taught to patients who are experiencing flashbacks of traumatic events or distress (Poole et al., 2013).

Examples of self-grounding strategies:

- Sing or hum a favorite song
- Think about favorite memories with friends or family
- Picture oneself in a calm place
- Go for a short walk

----------**PAUSE AND REFLECT**----------

REFLECTION QUESTION: What are some other examples of grounding strategies?

Here are additional examples of grounding strategies that you can use:

- Do math exercises in your head
- Repeat a soothing mantra
- Name ten items in a category (e.g., fruits, green objects)
- Make a doodle
- Tell yourself one of your favorite jokes

SELF-REFLECTION QUESTIONS

These questions will help you identify your own signs of vicarious trauma, ways to manage them and supports that are available to you. Please take time to fill them. In doing so, you are taking steps to enhance you emotional well-being at work.

SELF-REFLECTION QUESTION: What are some signs that work is starting to have a negative effect on me?

SELF-REFLECTION QUESTION: What grounding strategies can I incorporate in my daily life?

SELF-REFLECTION QUESTION: Who can support me when I am going through a difficult time at work?

CONCLUSION

In summary:

- According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients who have experienced or been affected by trauma" such as people with mental illness (p. 2).
- The main principles of the ABC self-care model are: (1) awareness, (2) balance, and (3) connection (Center of Addictions and Mental Health, n.d.).
- Grounding strategies are a helpful way for healthcare workers to mitigate the emotional impact of working with individuals who have a history of trauma (Poole et al., 2013).

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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS
VICARIOUS TRAUMA HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Define vicarious trauma
- Describe the ABC model of self-care
- Give examples of self-care strategies you can use

What is vicarious trauma?

According to the Center of Addictions and Mental Health (n.d.), vicarious trauma, also known as compassion fatigue, "is the impact on a clinician of working directly with clients who have experienced or been affected by trauma." (p. 2). Signs of vicarious trauma include being exhausted, lacking empathy, or being emotionally numb (Center of Addictions and Mental Health, n.d.)

The ABC model of self-care

Awareness

Be aware your limits, resources, emotions, needs

Balance	Connection
Find balance between your personal and professional activities	Connect with yourself and others

(Center of Addictions and Mental Health, n.d.)

Some grounding strategies for distressing feelings and thoughts

- Sing or hum your favorite song
- Think about one of your favorite memories with friends or family
- Take a few slow breaths
- Picture yourself in a calm place
- Go for a short walk

(Center of Addictions and Mental Health, n.d.; Poole et al., 2013)

Pause and reflect

- What are some signs that work is starting to have a negative effect on me?

_____

- What grounding strategies can I incorporate in my daily life?

_____

- Who can support me when I am going through a difficult time at work?

_____

(Poole et al., 2013)

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- Center of Addictions and Mental Health. (n.d.). Trauma-informed practice. https://iecho.unm.edu/sites/camh/download.hns?i=1643
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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS

MODULE 4: DEBRIEFING

PURPOSE OF THE MODULE

The purpose of this module is to discuss the importance of debriefing for emergency nurses and learn a simple framework for debriefing at work.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Explain the importance of debriefing
- Describe the SENSE model of debriefing
- Reflect on when debriefing could be done in their setting

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, the importance of debriefing in the emergency department will be discussed. You will also learn about the SENSE model of debriefing. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- Emergency nurses often witness traumatic events due to the nature of their work. As a result, emergency nurses are at an increased risk of experiencing symptoms of vicarious trauma, such as loss of motivation, helplessness, and presenteeism (Berger et al., 2015;

Maddigan et al., 2023). Furthermore, the impacts of this secondary trauma can lead to decreased job satisfaction, burnout, and higher job turnover (Arbios et al., 2022).

- While debriefing for healthcare workers who attended a traumatic event is recommended after the incident in the emergency department, it is not always conducted due to competing priorities or lack of time (Gilmartin et al., 2020).
- However, in an American study, 76.2% of emergency healthcare workers expressed their desire to debrief and discuss workplace incidents with their team (Cantu & Thomas, 2020).

DEBRIEFING

What is debriefing?

One of the ways to alleviate stress and offer emotional support to healthcare workers is through debriefing. According to Arbios et al. (2022), debriefings "provide an opportunity to openly discuss and normalize personal thoughts and feelings with others in a safe and supportive environment" (p. 117). By allowing healthcare workers to make relevant observations and reflections on their practice, debriefings can increase job satisfaction and reduce vicarious trauma (Arbios et al., 2022).

Moreover, debriefing assists healthcare workers and healthcare teams note the strengths and weaknesses of their interventions, helping them make improvement in their care (Gilmartin et al., 2020).

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What events or incidents do you think should be debriefed?

Here are some examples of events or incidents that may need to be debriefed:

- Code white
- Unexpected death of a patient
- Resuscitation
- Any event that affected you and that you would like to discuss with your coworkers

What is the SENSE model of debriefing?

The Share-Explore-Notice-Support-Extend model of debriefing is designed to improve coping with stress and provide emotional support (Ko & Choi, 2020). Here is a breakdown of each of its components.

- **S**hare: Share what happened, and the emotions generated by an event (Ko & Choi, 2020)
- **E**xplore: Explore what caused the emotional response (Ko & Choi, 2020)
- **N**otice: Notice and identify alternative interventions to address the emotional response (Ko & Choi, 2020)
- **S**upport: Acknowledge the feelings and offer guidance through the identification of strength-based strategies (e.g., exercise, self-journaling, breathing exercises) (Ko & Choi, 2020)
- **E**xtend: Learn from this event and find ways to improve practice (Ko & Choi, 2020).

How can I apply the SENSE model of debriefing?

Here are some examples of sentences you can use to debrief using the SENSE model (Ko & Choi, 2020).

- **S**hare: What happened? How did we feel when it happened?
- **E**xplore: What went well? What did not go so well?
- **N**otice: How well did we achieve what we intended to? How might other team members view our intervention?
- **S**upport: Who else can support us? How can we build upon what we did?
- **E**xtend: What is important to remember for the next time? What did we learn? What will we do differently next time?

Who can you initiate debriefings at work?

The facilitators for debriefings could be a patient care coordinator, a charge nurse, a nurse educator, or a health care provider with specific training or knowledge. Ask your nursing leadership if you have any questions about debriefings.

At Vancouver Coastal Health, there are also additional resources for debriefings.

- **Critical Incident Stress Management (CISM):** Offers 24/7 confidential critical incident individual or team debriefing. Can be arranged by contacting them at 604-872-4929
- **Ethics services**: Provides confidential consultations to address ethical dilemmas. Can be arranged by contacting them at ethics@vch.ca

- **Employee and Family Assistance Program (EFAP):** Offers a 24/7 crisis line for Vancouver Coastal Health employees, as well as counselling services. Can be arranged by contacting them at 604-872-4929

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: Do you think some ethical dilemmas nurses face in their practice should be debriefed?

Here are some examples of ethical dilemmas that may need to be debriefed:

- Confidentiality (e.g., parents are requesting information about a mature minor who has consented to receive medical care)
- Patient autonomy vs. beneficence (e.g., suicidal patient refusing treatment and requesting to die)

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: Do you think people with mental illness would similarly benefit from debriefing?

Here are some ideas that may help your reflection for the question above:

- How do people with mental illness feel about the use of restraints?
- How do they feel about their experience in the emergency department (e.g., protocols, taking their belongings away, seclusion room)?

CONCLUSION

In summary:

- Debriefings are an opportunity for emergency nurses to openly discuss and reflect on an event, their practice, and their feelings in a safe environment (Arbios et al., 2022).
- The main principles of the SENSE model of debriefing are: (1) share, (2) explore, (3) notice, (4) support, and (5) extend (Ko & Choi, 2020).
- Additional resources are available at Vancouver Coastal Health for debriefings. Please ask your nursing leadership if you have any questions.

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PRINCIPLE 2: SAFETY AND TRUSTWORTHINESS
DEBRIEFING HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Explain the importance of debriefing
- Describe the SENSE model of debriefing
- Reflect on when debriefing could be done in their setting

Did you know?		
Emergency nurses often witness traumatic events, which increases their risk of experiencing symptoms of vicarious trauma (Cantu & Thomas, 2020).	In an American study, 76.2% of emergency healthcare workers expressed their desire to debrief and discuss workplace incidents with their team (Cantu & Thomas, 2020).	While debriefing is recommended after a traumatic incident, it is not always conducted due to competing priorities or lack of time (Gilmartin et al., 2020).

The SENSE model of debriefing	
Share	What happened? How did we feel when it happened?
Explore	What went well? What did not go so well?
Notice	How well did we achieve what we intended to? How might other team members view our intervention?
Support	Who else can support us? How can we build upon what we did?
Extend	What is important to remember for the next time? What did we learn? What will we do differently next time?

(Ko & Choi, 2020)

At Vancouver Coastal Health, there are also additional resources for debriefings.

- **Critical Incident Stress Management (CISM):** Offers 24/7 confidential critical incident individual or team debriefing. Can be arranged by contacting them at 604-872-4929
- **Ethics services:** Offers confidential consultations to address ethical dilemmas. Can be arranged by contacting them at ethics@vch.ca
- **Employee and Family Assistance Program (EFAP):** Offers a 24/7 crisis line for Vancouver Coastal Health employees, as well as counselling services. Can be arranged by contacting them at 604-872-4929

Pause and reflect

- Do you think some ethical dilemmas nurses face in their practice should be debriefed?
- Do you think people with mental illness would similarly benefit from debriefing?

References

- Cantu, L., & Thomas, L. (2020). Baseline well-being, perceptions of critical incidents, and openness to debriefing in community hospital emergency department clinical staff before COVID-19, a cross-sectional study. *BMC Emergency Medicine, 20*(1), 82–88. https://doi.org/10.1186/s12873-020-00372-5
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PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION

DEFINITION

A trauma-informed care approach fosters a sense of self-efficacy, control, and dignity for people with mental illness by offering them treatment options and collaborating with them during their emergency visit (Poole et al., 2013).

PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION

MODULE 5: BRIEF INTERVENTION

PURPOSE OF THE MODULE

The purpose of this module is to review the brief intervention approach for people with mental illness in crisis.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Define the brief intervention approach
- Describe the FRAMES acronym
- Illustrate each component of the FRAMES acronym in a case study

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, the brief intervention approach will be discussed. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- The Registered Nurses' Association of Ontario (RNAO) supports the use of the brief intervention strategy for people in crisis or with mental health issues (RNAO, 2017). The brief intervention approach has been shown to decrease symptoms of PTSD and crisis for patients in the emergency department (Des Groseilliers et al., 2013; RNAO, 2017). The

brief intervention also assists individuals as it increases their self-efficacy and motivation for change (Des Groseilliers et al., 2013; RNAO, 2017).

BRIEF INTERVENTION

What is the brief intervention approach?

The brief intervention is a communication technique utilized between patients and health care providers to assist with coping (Mattoo et al., 2018; RNAO, 2017). The brief intervention allows patients to identify problems and engages them in finding ways to address them (Mattoo et al., 2018; RNAO, 2017)

The brief intervention approach echoes the main principles of the trauma-informed care approach, as it focuses on patient safety, trustworthiness, choice, and collaboration (RNAO, 2017).

Healthcare workers engaging in the brief intervention should be empathetic, respectful, calm, engaged, and have good listening skills (RNAO, 2017).

What are the principles of the brief intervention?

Healthcare providers can use the FRAMES acronym to remember each of the components of the brief intervention. The principles are described below.

- **F**eedback: Allows the individual to receive information about the risks they encounter.
- **R**esponsibility: Enables the individual to make their own decisions and take accountability for them.
- **A**dvise: Recommendations and guidance are provided by the healthcare providers.
- **M**enu for change: Individuals' strengths and coping skills are highlighted by healthcare providers.
- **E**mpathy: Genuine and compassionate communication style is utilized by healthcare providers.
- **S**elf-efficacy: Healthcare providers can empower individuals and motivate them in their recovery journey (RNAO, 2017).

How can I apply the principles of the brief intervention using the FRAMES acronym?

Here are some examples of sentences you can use with people with mental illness when you assess them for their alcohol use.

- **F**eedback: "Your CAGE score is 4, which puts you at high risk for harm from substance use."

- **R**esponsibility: "How concerned are you with your CAGE score and your current drinking pattern?"
- **A**dvise: "To avoid harmful effects of alcohol use, the best way is to reduce your drinking, or consider alternatives to drinking alcohol"
- **M**enu for change: "In what situations do you feel like you need to drink? Do you have any peers that could help you reduce your use of alcohol?"
- **E**mpathy: "Let's see if we can find a way together to reduce your use"
- **S**elf-efficacy: "I'm confident that you can reduce your use" (Sarkar et al., 2020).

CASE STUDY

Mrs. S. is a 35-year-old woman who presents to the emergency department for mental health concerns. She discloses that she took multiple medications because she wanted "to end things". After triaging her, you conduct a secondary assessment including a suicide risk assessment, which is positive. Mrs. S. discloses she has other previous attempts, despite having support from many friends, taking her daily antidepressants, and being closely followed by her psychiatrist. She tells you that she has been feeling down lately and has resorted to binging alcohol. She feels that an admission to the psychiatry department would benefit her and is asking for assistance.

----------**PAUSE AND REFLECT**----------
REFLECTION QUESTION: What principles of the brief intervention could you use with Mrs. S.? Do you have any examples? **F**eedback:
Responsibility:
Advise:
Menu for change:
Empathy:
Self-efficacy:

Here are some examples of the brief intervention approach that you could use with Mrs. S.:

- **F**eedback: "You screened positive for your suicide assessment, which puts you at high risk for self-harm."
- **R**esponsibility: "How concerned are you with your suicide risk and your current self-harming thoughts?"
- **A**dvise: "To avoid a suicidal crisis, the best way is to recognize your triggers and situations that may exacerbate thoughts about suicide or self-harm"
- **M**enu for change: "In what situations do you feel like you need to harm yourself? Do you have any peers that could help you take your mind away from self-harming thoughts?"
- **E**mpathy: "Our priority is to keep you safe. Let's work together to create a safety plan when you have thoughts of hurting yourself."
- **S**elf-efficacy: "I'm confident that you can find ways to address these feelings and reach out to support people when needed to keep yourself safe."

CONCLUSION

In summary:

- The brief intervention is a communication technique utilized by emergency nurses to assist people with mental illness in crisis (Mattoo et al., 2018; RNAO, 2017).
- The main principles of the brief intervention are: (1) feedback, (2) responsibility, (3) advise, (4) menu for change, (5) empathy, and (6) self-efficacy (RNAO, 2017).

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PRINCIPLE 3: CHOICE, COLLABORATION AND CONNECTION
BRIEF INTERVENTION HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Define the brief intervention approach
- Describe the FRAMES acronym
- Illustrate each component of the FRAMES acronym in a case study

CASE STUDY

Mrs. S. is a 35-year-old woman who presents to the emergency department for mental health concerns. She discloses that she took multiple medications because she wanted "to end things". After triaging her, you conduct a secondary assessment including a suicide risk assessment, which is positive. Mrs. S. discloses she has other previous attempts, despite having support from many friends, taking her medications, and being closely followed by her psychiatrist. She tells you that she has been feeling down lately and has resorted to binging alcohol. She feels that an admission to the psychiatry department would benefit her and is asking for assistance.

What principles of the brief intervention could you use with Mrs. S.? Do you have any examples?

Feedback	"You screened positive for your suicide assessment, which puts you at high risk for self-harm."
Responsibility	"How concerned are you with your suicide risk and your current self-harming thoughts?"
Advise	"To avoid a suicidal crisis, the best way is to recognize your triggers and situations that may exacerbate thoughts about suicide or self-harm"
Menu for change	"In what situations do you feel like you need to harm yourself? Do you have any peers that could help you take your mind away from self-harming thoughts?"
Empathy	"Our priority is to keep you safe. Let's work together to create a safety plan when you have thoughts of hurting yourself."
Self-efficacy	"I'm confident that you can find ways to address these feelings and reach out to support people when needed to keep yourself safe."

Remember	Do not be afraid to say the "wrong thing". If you validate the individuals' feelings, that you are empathetic, and non-judgmental, you will be able to effectively connect with patients (Bolton et al.,2013).

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PRINCIPLE 4: STRENGTHS-BASED APPROACH

DEFINITION

A trauma-informed care approach aims to develop skills and build resiliency in people with mental illness (Poole et al., 2013). A strengths-based approach promotes healing and growth in people with mental illness who have had traumatic experiences (Nathoo et al., 2018).

PRINCIPLE 4: STRENGTHS-BASED APPROACH

MODULE 6: STRENGTH-BASED COMMUNICATION

PURPOSE OF THE MODULE

The purpose of this module is to learn about strength-based documentation about people with mental illness and how to incorporate its principles in practice.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Describe the principles of strength-based communication
- Give examples of strength-based communication and documentation in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, strength-based communication will be examined. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- Stigma disproportionately affects people with mental illness, including those with substance use disorders (Mental Health Commission of Canada, n.d.; Pescosolido et al., 2010). For instance, while 20% of Canadians experience mental health issues in any given

year, 60% are reluctant to seek help by fear of being stigmatized (Mental Health Commission of Canada, n.d.).

- Stigma refers to negative perceptions held toward a group or individual " (Couto e Cruz et al., 2019). It may lead to discrimination, which is defined as "actions from a person or group that aims to harm another" (Couto e Cruz et al., 2019). People with mental health illness' reluctance to access health care services due to the stigmatization they face is a health issue, as it worsens their mental and physical well-being (Ahern et al., 2007; Chang et al., 2017; Clement et al., 2015).
- Unfortunately, nurses' negative attitudes also contribute to the stigmatization of people with mental illness. For instance, the beliefs about people with mental health issues held by the caregivers in the Netherlands were the following: a tendency to maintain distance from people with mental illness (mean = 3.72, SD = 0.53, $p < .01$), people with mental illness engage in aggressive behavior (mean = 3.86, SD = 0.62, $p < .01$), and people with mental illness tend to cause disturbances (mean = 3.41, SD = 0.66, $p < .01$) (van Boekel et al., 2015).

STRENGTHS-BASED COMMUNICATION

Why should healthcare providers use strengths-based communication?

Language can reflect an organization's values and mission. It can influence the engagement of individuals within their care and have a positive impact on their well-being (Nathoo et al., 2018). Therefore, the language used by health care providers should be strength-based and trauma-informed (Nathoo et al., 2018).

Strength-based communication aims to promote healing, increase resilience, and reduce stigma, especially for people with mental illness or substance use disorders (Nathoo et al., 2018). Strength-based language "respects an individual's autonomy and reflects collaboration between patients/clients and service providers "(Nathoo et al., 2018, p.39).

Using strength-based communication can also help healthcare providers better understand an individuals' condition as it allows them to focus on "what has happened to this person?" as opposed to "what is wrong with this person?" (Poole et al., 2013).

What are the principles of strengths-based communication?

Here are some of the principles of strengths-based communication.

1. Avoid using medical conditions to describe patients. "Labelling" clients can be detrimental to their well-being, as it may further stigmatize them. For example, instead of using "addicted baby", you can use "neonate experiencing withdrawal" (Nathoo et al., 2018).

2. Use person-centered language to reinforce that fact that the individual is not defined by a medical diagnosis or by their behaviors (Nathoo et al., 2018). For example, you may utilize "person who uses opioids" instead of the word "addict".
3. The language you use should also be empathetic, non-judgmental, welcoming and respectful (Varcoe et al., 2019).
4. Use patient quotes and describe their behaviors in an objective manner.

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What difference does it make to welcome individuals with mental illness with "nice to see you again" as opposed to "you are back again"?

Here are some ideas that may help your reflection for the question above:

- Acknowledging the individual with mental illness and their concerns
- Foster connection and trust
- Support a welcoming and safe environment

What are some examples of strengths-based communication and documentation?

Here are some examples of deficit-based expressions we often use in the emergency department. You can find their strength-based alternative in the table on your handout.

Deficits-based language	Strength-based language
Attention-seeking	Seeking assistance
Drug addict	Person who uses opioids, who has substance use issues
Frequent flyer	Frequently uses healthcare services
Manipulative	Trying to seek help, resourceful
Non-compliant	Preferred not to, choosing not to
Refused	Declined

Resistant to care	Prefers other options or options that are not available; current services do not meet patient' s needs

(Nathoo et al., 2018, Varcoe et al., 2019)

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What is your perspective on the term "frequent flyer"?

Here are some ideas that may help your reflection for the question above:

- Do we have preconceived thoughts about these patients? (e.g., drug-seeking, fibromyalgia, poor pain tolerance)
- Do you think other factors might contribute to them accessing care through the emergency department? (e.g., intimate partner violence, housing instability, lack of education)

CASE STUDY

Read the following triage note.

Drug-seeking patient presents to the emergency department with complaint of 10/10 back pain. This is the patient's second emergency visit today. In the last visit, the patient, who is an intravenous drug user, refused to take the ibuprofen offered by the nurse. The patient started acting out with the staff, screaming "this won't do anything to take my pain away". The patient has also been non-compliant with his suboxone treatment in the past week.

----------**PAUSE AND REFLECT**----------

REFLECTION QUESTION: How would you write this documentation note using strength-based communication?

Here are some ideas that may help your reflection for the question above:

- Use "person seeking pain relief" instead of "drug seeking"
- Replace "drug user" by "person with substance use issues"
- Use "declined" or "opted not to" instead of "refused"
- Write "patient is upset" as opposed to "acting out"
- Replace "non-compliant" by "prefers not to"

CONCLUSION

In summary:

- Words matter. Strength-based communication helps promote healing, increase resilience, and reduce stigma, especially for people with mental illness (Nathoo et al., 2018).
- The main principles of strength-based communication are: (1) avoid the use of labels, (2) use person-centered language, (3) utilize empathetic and respectful language, and (4) describe patients' behaviors in an objective manner (Nathoo et al., 2018).

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- Mental Health Commission of Canada. (n.d.). *Anti-stigma*. https://mentalhealthcommission.ca/what-we-do/anti-stigma/
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- Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *The American Journal of Psychiatry, 167*(11), 1321–1330. https://doi.org/10.1176/appi.ajp.2010.09121743
- van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2015). Comparing stigmatising [sic] attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists and clients. *The International Journal of Social Psychiatry, 61*(6), 539–549. https://doi.org/10.1177/0020764014562051
- Varcoe, C., van Roode, T., & Wilson Strosher, H. *Trauma- and Violence- Informed Care: An Orientation Tool for Service Providers in the Homelessness Sector*. Public Health Agency of Canada. 2019, Ottawa, ON. Retrieved from www.equiphealthcare.ca.

PRINCIPLE 4: STRENGTHS-BASED APPROACH
STRENGTH-BASED COMMUNICATION HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Recognize the importance of strength-based communication
- Define the principles of strength-based communication
- Provide examples of strength-based communication and documentation

Did you know?

Stigma disproportionately affects people with mental illness, including those with substance use disorders. (Mental Health Commission of Canada, n.d.)	While 20% of Canadians experience mental health issues in any given year, 60% are reluctant to seek help by fear of being stigmatized. (Mental Health Commission of Canada, n.d.)	People with mental health illness' reluctance to access health care services is a health issue, as it worsens their mental and physical well-being (Chang et al., 2017).	Unfortunately, nurses' negative attitudes also contribute to the stigmatization of people with mental illness. (van Boekel et al., 2015)

Principles of strength-based communication

1. Avoid the use of labels
2. Use person-centered language
3. Utilize empathetic and respectful language
4. Describe patients' behaviors in an objective manner (Nathoo et al., 2018).

Deficits-based language	Strength-based language
Attention-seeking	Seeking assistance
Drug addict	Person who uses opioids,
Frequent flyer	Frequently uses healthcare services
Manipulative	Trying to seek help, resourceful
Non-compliant	Preferred not to, choosing not to
Refused	Declined
Resistant to care	Prefers other options

(Nathoo et al., 2018)

How would you rewrite this triage note?

Drug-seeking patient presents to the emergency department with complaint of 10/10 back pain. This is the patient's second emergency visit today. In the last visit, the patient, who is an intravenous drug user, refused to take the ibuprofen offered by the nurse. The patient started acting out with the staff, screaming "this won't do anything to take my pain away". The patient has also been non-compliant with his suboxone treatment in the past week.

References

- Chang, K.-C., Lin, C.-Y., Chang, C.-C., Ting, S.-Y., Cheng, C.-M., & Wang, J.-D. (2019). Psychological distress mediated the effects of self-stigma on quality of life in opioid-dependent individuals: A cross-sectional study. *PLoS ONE, 14*(2), 1–15. https://doi.org/10.1371/journal.pone.0211033
- Mental Health Commission of Canada. (n.d.). *Anti-stigma.* https://mentalhealthcommission.ca/what-we-do/anti-stigma/
- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.
- van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2015). Comparing stigmatising [sic] attitudes towards people with substance use disorders between the general public, GPs, mental health and addiction specialists and clients. *The International Journal of Social Psychiatry, 61*(6), 539–549. https://doi.org/10.1177/0020764014562051

MODULE 7:
CASE STUDY

PURPOSE OF THE MODULE

The purpose of this module is to use a case study to exemplify the principles of a trauma-informed care approach for an individual with mental illness.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Apply the principles of trauma-informed care approach in a case study situated in the emergency department
- Reflect on the barriers people with mental illness encounter in their daily lives and how it affects their behaviors in the emergency department

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, a case study will be used to illustrate the principles of trauma-informed care for a patient with mental illness in the emergency department. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

Here is a quick review about the trauma-informed care approach:

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).

- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).
- A trauma-informed care approach can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

CASE STUDY

Read the following case study.

Mrs. T. is a 56-year-woman who frequently presents to the emergency department for mental health- or for substance use- related reasons. She currently has a safe supply of opioids and supplements with illicit substances. Her mental health issues have been exacerbated by her use of illicit substances, with several visits in the last month for increased anxiety, substance-induced psychosis, and overdoses.

As you establish rapport with Mrs. T, you learn that she grew up in an unstable household, where her mother was a victim of intimate partner violence. Mrs. T. left the family home at a young age and spent some time living in Downtown Eastside for many years. She tells you that she has had to offer "sex services" to survive and that was often physically and sexually assaulted by her clients.

Mrs T. recently relocated to her hometown. She is currently staying at the shelter as she cannot afford rent. Her only income is her "disability check", which rarely covers any food or essential items along with the purchase of illicit substances. She has been unable to keep a job due to her substance use issues.

Today, she is voluntarily coming into the emergency department. She tells you that she wants to see the emergency physician to have additional anti-anxiety medications. She informs you that she has been unable to sleep well at the shelter and that she feels lonely.

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: What trauma-informed care interventions could you use with Mrs. T.?

Here are some examples of trauma-informed care interventions you could use with Mrs. T.:

- Acknowledge Mrs. T's concerns
- Foster connection and trust by being non-judgmental and empathetic
- Support a welcoming and safe environment by inviting Mrs. T. in a private room
- Use the brief intervention approach to ask about her substance use
- Avoid using labels and refer to Mrs. T. as a woman with substance use disorder in your documentation
- Ask about Mrs. T's strengths (e.g., goals, coping skills, community connections)

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: *What other interventions could you use to improve Mrs. T.'s access to healthcare?*

Here are some examples of interventions you could use to improve Mrs. T.'s access to healthcare:

- Refer Mrs. T. to the Intensive Case Management Team
- Ask Mrs. T. if you need to call a taxi or the Zunga bus to go back to the shelter.
- Check with Mrs. T. if she needs safe equipment to inject illicit substances

CONCLUSION

In summary:

- A trauma-informed care approach for people with mental illness can be easily incorporated into practice, even in the emergency department (e.g., being non-judgmental, allowing patients to choose their treatment options) (Wathen & Varcoe, 2021).

REFERENCES

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Wathen, C.N. & Varcoe, C. (2021). *Trauma- & violence-informed care (TVIC): A tool for health & social service organizations & providers*. https://equiphealthcare.ca/files/2021/05/GTV-EQUIP-Tool-TVIC-Spring2021.pdf

CASE STUDY HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Apply the principles of trauma-informed care approach in a case study
- Reflect on barriers people with mental illness face in healthcare

CASE STUDY

Did you know?

- Trauma-informed care is a universal approach that aims to minimize harm and requires safe and respectful care for all individuals (Wathen & Varcoe, 2021).
- The main principles of trauma-informed care are: (1) trauma awareness, (2) safety and trustworthiness, (3) choice, collaboration, and connection and, (4) strength-based approach (Nathoo et al. 2018; Poole et al., 2013; Wathen & Varcoe, 2021).

Mrs. T. is a 56-year-woman who frequently presents to the emergency department for mental health- or for substance use- related reasons. She currently has a safe supply of opioids and supplements with illicit substances. Her mental health issues have been exacerbated by her use of illicit substances, with several visits in the last month for increased anxiety, substance-induced psychosis, and overdoses.

As you establish rapport with Mrs. T, you learn that she grew up in an unstable household, where her mother was a victim of intimate partner violence. Mrs. T. left the family home at a young age and spent some time living in Downtown Eastside for many years. She tells you that she has had to offer "sex services" to survive and was often physically and sexually assaulted by her clients.

Mrs T. recently relocated to her hometown. She is currently staying at the shelter as she cannot afford rent. Her only income is her "disability check", which rarely covers any food or essential items along with the purchase of illicit substances. She has been unable to keep a job due to her substance use issues.

Today, she is voluntarily coming to the emergency department. She tells you that she wants to see the emergency physician to have additional anti-anxiety medications. She informs you that she has been unable to sleep well at the shelter and that she feels lonely.

Pause and reflect

What trauma-informed care interventions could you use with Mrs. T.?

What other interventions could you use to improve Mrs. T.'s access to healthcare?

References

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
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SESSION 8: TRAUMA-INFORMED CARE RESOURCES

PURPOSE OF THE MODULE

The purpose of this module is to review current trauma-informed care resources, including the trauma-informed care policy at Vancouver Coastal Health.

LEARNING OBJECTIVES

At the end of the module, you will be able to:

- Be aware of the current Vancouver Coastal Health policy for trauma-informed care
- Be able to access additional resources for trauma-informed care
- Utilize trauma-informed care resources as needed if they require additional support

INTRODUCTION AND GENERAL INSTRUCTIONS FOR THE MODULE

In this module, trauma-informed care resources will be examined, including the Vancouver Coastal Health policy. Before you begin, here are some general instructions for the module.

- Review the background information and the educational material.
- Take time to do the reflection questions included in the "Pause and reflect" box. Answer to the best of your ability. You will find examples of answers below the reflection questions.
- You can use the handout as a reference while you complete the module or for future use.
- Please reach out to Maude Bellemare (maude.bellemare@vch.ca) if you are experiencing any difficulties with the modules. Please also be aware that you can always contact the Employee Family Assistance Program at 1-833-533-1577 if you are experiencing distress while completing these modules.

BACKGROUND

- In 2013, the trauma-informed practice guidelines were created to assist care providers and organizations meet the need of clients with a history of trauma (Poole et al., 2013). They were designed for clients with mental health challenges and substance use disorders (Poole et al., 2013). To develop the guidelines, consultations and focus groups were

conducted with care providers across all health authorities in British Columbia in 2011 (Poole et al., 2013). Moreover, consultation findings were supported by recent literature and efforts from other Canadians jurisdictions (Poole et al., 2013).

- The Vancouver Coastal Health Mental Health and Addictions leaders shortly followed with the creation of a policy surrounding the use of trauma-informed care in 2020 for all service providers, including organization leaders (Vancouver Coastal Health, 2020).

TRAUMA-INFORMED CARE RESOURCES

Retrieve and review the most recent Trauma-Informed Practice policy from SHOP (http://shop.healthcarebc.ca/vch).

What is the purpose of the trauma-informed care policy?

According to Vancouver Coastal Health (2020), all Vancouver Coastal Health "care providers will utilize a trauma-informed approach for the individuals and families they serve." (p. 1).

The purpose of the policy is:

"• To support individuals and families towards best outcomes through implementing trauma-informed practice.
• To guide care providers to implement the four principles of trauma-informed practice in supporting individuals and families.
• To reduce barriers and improve quality of services for all individuals and families, with particular attention to Indigenous Peoples, women, LGBTQI+, immigrants and refugees.
• To promote awareness around vicarious trauma and outline the importance of providing a psychologically safe workplace to support care providers to develop and maintain resilience." (Vancouver Coastal Health, 2020, p. 2)

----------PAUSE AND REFLECT----------

REFLECTION QUESTION: Why is it important to have a trauma-informed care policy?

Here are some ideas that may help your reflection for the question above:

- Do you think a trauma-informed care approach contributes to creating a welcoming environment for all patients?
- Do you think a trauma-informed care approach can be a way to re-engage people with mental illness who have previously been traumatized during their stay in the emergency department?

What are the expectations for care providers in regard to trauma-informed care?

- Provide care utilizing the four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach) (Vancouver Coastal Health, 2020)
- Be aware of trauma-specific services, and vicarious trauma (Vancouver Coastal Health, 2020)
- Utilized strength-based and trauma-informed care documentation (Vancouver Coastal Health, 2020)
- Provide education to patients and families about the trauma-informed care approach (Vancouver Coastal Health, 2020)

----------**PAUSE AND REFLECT**----------

REFLECTION QUESTION: What is your role in providing trauma-informed care to individuals with mental illness and their families?

Here are some ideas that may help your reflection for the question above:

- Supporting colleagues who are experiencing vicarious trauma
- Creating safety plans for people with mental illness who are in crisis
- Reflecting on your own biases and how they can influence your practice

What is included in the policy?

- Information on trauma and its impact
- Description of the trauma-informed care approach
- Signs and symptoms of a trauma response
- Examples of four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach)
- Grounding strategies
- Information on vicarious trauma, along with a self-assessment tool (Vancouver Coastal Health, 2020)

What are some additional trauma-informed care resources in British Columbia?

If you want to know more about trauma-informed care, there are two great additional resources.

1. **Trauma-Informed Practice Guide**: It includes information about trauma and its repercussions, the principles of trauma-informed care, communication strategies, and case studies. Available at https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. **Trauma Informed Practice & the Opioid Crisis**. It includes information about trauma and trauma-informed care. It contains numerous practice examples, discussion questions and skills for services providers for each principle of trauma informed care. Available at https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

CONCLUSION

In summary:

- Healthcare providers at Vancouver Coastal Health are expected to practice with a trauma-informed care approach to best support families, to improve inclusion of all individuals, and to provide a psychologically safe environment for everyone (Vancouver Coastal Health, 2020).
- Additional trauma-informed care resources are available in British Columbia: the Trauma-Informed Practice Guide and the Trauma Informed Practice & the Opioid Crisis guide. Please ask your nursing leadership if you have any questions.

REFERENCES

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers*. Vancouver, BC: Centre of Excellence for Women's Health. https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide*. BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Vancouver Coastal Health. (2020). *Trauma-Informed Practice*. http://shop.healthcarebc.ca/vch/VCHDSTs/BD-00-07-40107.pdf

TRAUMA-INFORMED CARE RESOURCES HANDOUT

OBJECTIVES

By the end of the module, you will be able to:

- Be aware of the current Vancouver Coastal Health policy and of your responsibilities
- Be able to access additional resources for trauma-informed care
- Utilize trauma-informed care resources as needed if you require additional support

Purpose of the policy	• "To support individuals and families towards best outcomes through implementing trauma- informed practice. • To guide care providers to implement the four principles of trauma-informed practice in supporting individuals and families. • To reduce barriers and improve quality of services for all individuals and families, with particular attention to Indigenous Peoples, women, LGBTQI+, immigrants and refugees. • To promote awareness around vicarious trauma and outline the importance of providing a psychologically safe workplace to support care providers to develop and maintain resilience." (Vancouver Coastal Health, 2020, p. 2)
The expectations for all care providers	Provide care utilizing the four main principles of trauma-informed care (i.e., trauma awareness, safety and trustworthiness, choice, collaboration and connection, and strength-based approach) Be aware of trauma-specific services, and vicarious trauma Utilized strength based and trauma informed care documentation Provide education to patients and families about the trauma-informed care approach (Vancouver Coastal Health, 2020)

If you want to know more about trauma-informed care, there are two great additional resources.

1. **Trauma-Informed Practice Guide**: Includes information about trauma, trauma-informed care, communication strategies, and case studies. Available at https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
2. **Trauma Informed Practice & the Opioid Crisis**. Contains numerous practice examples, discussion questions and skills for services providers for trauma informed care. Available at https://cewh.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf

Pause and reflect	Why is it important to have a trauma-informed care policy? What is your role in providing trauma-informed care to individuals with mental illness and their families?

References

- Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma- informed practice and the opioid crisis: A discussion guide for health care and social service providers.* Vancouver, BC: Centre of Excellence for Women's Health.
- Poole, N., Urquhart, C., Jasiura, F., Smylie, D., & Schmidt, R. (2013). *Trauma-informed practice guide.* BC Centre of Excellence for Women's Health and Ministry of Health. https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- Vancouver Coastal Health. (2020). *Trauma-Informed Practice.* http://shop.healthcarebc.ca/vch/VCHDSTs/BD-00-07-40107.pdf

APPENDICES

Appendix A

Module Completion Tracking Sheet

Please mark the date and initial the tracking sheet once you have completed a module. Once you have completed all the modules, you will entered in a gift card draw.

Name: Role:	Completion date
Module 1	
Module 2	
Module 3	
Module 4	
Module 5	
Module 6	
Module 7	
Module 8	

Appendix B

Pre-Training Survey for the Modules

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer or write your answer on the designated lines. Please note that all surveys will remain confidential.

1. How familiar are you with the principles of trauma-informed care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

2. Can you briefly explain one principle of trauma-informed care that you are already familiar with?

3. How well do you understand the concept of trauma and its impact on individuals? (

Not well at all	Not very well	Somewhat well	Very well	Extremely well
○	○	○	○	○

4. Have you ever experienced or heard about vicarious trauma in the workplace? Please share your thoughts or experiences.

5. Are you aware of the specific challenges individuals with mental illness may face when they have a history of trauma?

Yes	No
○	○

6. If yes, can you name one challenge that individuals with mental illness who have experienced trauma might encounter?

_____

_____

_____

7. How often do you participate in debriefing sessions after challenging or traumatic incidents at work?

Never	Rarely	Occasionally	Frequently
○	○	○	○

8. What, in your opinion, is the most important outcome of a debriefing session?

_____

_____

_____

9. Are you aware of any resources available to assist you in providing trauma-informed care in your role?

Yes	No
○	○

10. Please list one resource or tool you currently use or have heard about for providing trauma-informed care.

_____

_____

_____

11. In your opinion, how do the principles of choice, collaboration, and connection align with providing trauma-informed care? Please provide an example if possible.

12. What do you believe are the key benefits of incorporating choice, collaboration, and connection in your nursing practice?

13. How familiar are you with the concept of a strengths-based approach in patient care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

14. Can you provide an example of how you might apply a strengths-based approach when caring for a patient who has experienced trauma?

Thank you for participating in this pre-training survey.

Post-Training Survey for the Modules

Please answer this survey to the best of your ability. Fill the circle that corresponds to your answer or write your answer on the designated lines. Please note that all surveys will remain confidential.

1. How familiar are you with the principles of trauma-informed care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

2. Can you briefly explain one principle of trauma-informed care that you are already familiar with?

3. How well do you understand the concept of trauma and its impact on individuals? (

Not well at all	Not very well	Somewhat well	Very well	Extremely well
○	○	○	○	○

4. Have you ever experienced or heard about vicarious trauma in the workplace? Please share your thoughts or experiences.

5. Are you aware of the specific challenges individuals with mental illness may face when they have a history of trauma?

Yes	No
○	○

6. If yes, can you name one challenge that individuals with mental illness who have experienced trauma might encounter?

_____

_____

_____

7. How often do you participate in debriefing sessions after challenging or traumatic incidents at work?

Never	Rarely	Occasionally	Frequently
○	○	○	○

8. What, in your opinion, is the most important outcome of a debriefing session?

_____

_____

_____

9. Are you aware of any resources available to assist you in providing trauma-informed care in your role?

Yes	No
○	○

10. Please list one resource or tool you currently use or have heard about for providing trauma-informed care.

_____

_____

_____

11. In your opinion, how do the principles of choice, collaboration, and connection align with providing trauma-informed care? Please provide an example if possible.

12. What do you believe are the key benefits of incorporating choice, collaboration, and connection in your nursing practice?

13. How familiar are you with the concept of a strengths-based approach in patient care?

Not at all familiar	Not very familiar	Somewhat familiar	Very familiar	Extremely familiar
○	○	○	○	○

14. Can you provide an example of how you might apply a strengths-based approach when caring for a patient who has experienced trauma?

What did you like about these modules?

What could be improved?

Do you have any other comments regarding the modules? Would you like to learn more about additional topics?

Thank you for all your help and for completing these modules!