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An Investigation into Trauma-Informed Care within Mental Health Inpatient Settings

Section A: A Systematic Review of the impact and effectiveness of Trauma Informed Care training for mental health inpatient staff.
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Section B: An investigation into the culture of mental health inpatient wards and the introduction of Trauma-Informed Care through workshops.
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Context Statement

In March 2020 England entered a national lockdown aimed to control infection rates of COVID-19 (Institute for Government, 2021). This negatively impacted many individuals and placed enormous strain on NHS services (Huang & Ougrin, 2021, Liberati et al., 2021), specifically individuals using and working in NHS mental health inpatient settings (Liberati et al., 2021). As this research project focuses on NHS mental health inpatient staff, it is important to keep in mind the context within which these staff members were working, and how this may have affected their capacity to engage in research and integrate changes into their clinical work.

Portfolio Summary

Section A is a systematic review of the effectiveness and impact of Trauma Informed Care (TIC) training for mental health inpatient staff. Seventeen papers identified various training designs, content, timings, facilitators, staff included, and outcome measures. TIC training had positive impacts on staff and clients in the short, medium, and long-term. Barriers and facilitators to impactful training included documentation of TIC changes, support of staff, and leadership support. Training heterogeneity, unvalidated outcome measures, and varied methodologies, impeded on conclusive strength. Future research could use high quality longitudinal designs, control groups, multi-sites, validated measures, and mixed methods.

Section B presents a mixed-methods investigation into the current culture of mental health inpatient wards and the potential role of Trauma-Informed Care, introduced through staff workshops. Various professionals (n = 31) completed quantitative measures assessing TIC awareness, attitudes, and restrictive practice. Participants were invited to a TIC-workshop, followed by a semi-structured interview reviewing the feasibility and impact of the workshop, analysed using Reflexive Thematic Analysis (RTA). 39% of staff were involved in restrictive practice, these were severe and detrimental to staff and clients. Above average TIC attitudes and climate were found, however systemic challenges were indicated. RTA highlighted positive workshop impacts, however conceptual and practical barriers, such as lack of leadership support, were also identified.

Table of Contents

List of Tables

Section A: Literature Review

Section B: Empirical Study

List of Figures

Section A: Literature Review

Section B: Empirical Study

List of Appendices

Section A: Literature Review

Section B: Empirical Study

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Section A: Critical Review

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Abstract

Background and Objectives

Inpatient settings care for individuals with severe mental health challenges who have experienced trauma. Despite attempts to provide quality care, the nature of inpatient settings can re-traumatise and exacerbate challenges. This review investigated the effectiveness and impact of Trauma Informed Care training (TIC) for mental health inpatient staff.

Methodology

The literature was systematically reviewed to identify relevant empirical research into the effectiveness and impact of mental health inpatient staff training on TIC and its integration within their work.

Results

Sixteen papers identified varied training designs, content, timings, facilitators, staff included, and outcome measures. Results indicate TIC training had positive impacts on inpatient staff and clients, maintained in the short, medium, and long-term. Barriers and facilitators to impactful training were identified, including documentation of TIC changes, support of staff, and leadership TIC commitments.

Considerations and Conclusions

TIC training heterogeneity, unvalidated outcome measures, and methodological variability,

impeded the strength of conclusions that can be drawn from findings. Nonetheless, findings suggest moderate support for inpatient staff TIC training and provide an insight into systemic transitions towards trauma-informed practice. Future research could develop our understanding using high-quality longitudinal designs that use a control group, multi-sites, validated measures, and mixed methods.

Keywords: Inpatient, Inpatient Staff, Trauma Informed Care, Training

Introduction

Inpatient Settings

Mental health (MH) inpatient settings support individuals experiencing severe MH challenges by providing a safe space and intensive medical and psychological treatment (Janner et al., 2012). Most inpatient services are managed by local NHS Trusts, with some provided by private organisations, this review will focus on the former. Severe MH challenges are often associated with violence and self-harm (Gebeyehu et al., 2021). Measures to manage these often include physical restraint (Lee et al., 2003), which can risk client safety (Thibaut et al., 2019). Moreover, the fast-paced nature of inpatient environments often results in difficulty accessing supervision (Cleary et al., 2010), leading to reduced client discussions, and reduced provision of support for clients' psychosocial needs (Donaghay-Spire et al., 2016).

MH wards primarily care for individuals experiencing psychotic disorders (Feifel, 2000), personality disorders (Zimmerman et al., 2008), and other complex presentations (Berry et al., 2013). These conditions are most associated with early life trauma (MacIntosh et al., 2015), long-term adversity such as poverty (Lepiece et al., 2015), and unemployment (Van Rihn et al., 2016). Research shows a significant portion of MH inpatient clients with psychotic symptoms have experienced childhood abuse (Read & Argyle, 1999; Read et al., 2004). A review by Read (1997) on reports of childhood abuse by female psychiatric inpatients found this to be as high as 64%.

MH conditions associated with inpatient settings are also more highly associated with Black and Minority Ethnic Communities (Majors et al., 2020), who are most at risk of racial discrimination (Berger & Sarnyai, 2015). Indeed, these settings house a disproportionately

large number of Black and Minority Ethnic individuals, many of whom have been detained against their will (Williams & Etkins, 2021).

Many clients report inpatient settings to be emotionally harmful due to fear of violence, witnessing of violence, punitive enforcement of rules, and depersonalisation (Robins et al., 2005). These practices, alongside seclusion (Elsom et al., 2007), forced medication, and involuntary detention, can traumatise (Bateman et al., 2013), or re-traumatise vulnerable individuals (Ashmore et al., 2015). Recent concern around the detrimental effects of restrictive practices (McKeown et al., 2017), has led to international policy shifts (McKenna, 2016). Within the UK this has resulted in guidance by the Department of Health (2014) and NICE (2015) on the management of violence and aggression.

Despite policy changes, restraint resulting in death has risen within the UK (Duxbury, 2015; Soininen et al., 2016), with many believing they would not be taken seriously if they reported excessive force (Cusack et al., 2016). This has led to serious concerns being raised (Care Quality Commission [CQC] 2017). However, continuous admissions, behaviours that challenge, and understaffing, often result in staff believing restrictive practice is inevitable (Cusack et al., 2018).

Inpatient Staff and Culture

MH wards employ a variety of professionals, including MH Nurses, Psychiatrists, Occupational Therapists, Support Workers, and Psychologists. Despite popularisation of the biopsychosocial model (Engel, 1981), many wards employ a medicalised model, focusing on biological treatments (Waldemar et al., 2018), prioritising risk management (Walton, 2000), with lesser value given to psychological therapies (Raphael et al., 2021). Inpatient staff often report challenges incorporating psychosocial thinking into their formulations (Mullen, 2009),

including the role of trauma (Butler et al., 2011), with studies showing staff rarely ask about trauma and therefore do not identify its presence or offer appropriate psychosocial interventions (Read et al., 2005, 2018).

Inpatient staff report high rates of burn-out (Potter, 1969), compassion fatigue (Jacobowitz et al., 2015), and sickness (Santana et al., 2020). This results in high staff turn-over (Scanlan & Still, 2019), and bank staff overuse (Baker et al., 2019), both associated with violence (Martin & Daffern, 2006), physical restraints (Bonner et al., 2002), staff distress (Jacobowitz et al., 2015), job dissatisfaction (Aiken et al., 2002), and reduced quality of care (Kanai-Pak et al., 2008). Following these challenges, and involvement in traumatic experiences (Kelly et al., 2016), staff report feeling overworked (Jenkins & Elliott, 2004), and unable to undertake additional work or reflect on their (or their client's) psychological needs (Mullen, 2009). This results in task-oriented approaches (McAllister & Moyle, 2008), such as restrictive practice, which may re-traumatise clients (Rippon et al., 2018).

Trauma

Early descriptions of trauma date back to the American Civil War with 'Soldier's Heart' (Ben-Extra, 2004), describing soldiers increased propensity for physical illness and mental distress. As trauma conceptualisations have developed, descriptions now include psychological distress (Strauss, Lang, Schnurr., 2011), fear or helplessness (Jeter & Brannon, 2014), through witnessing, or learning of events (Jordan, 2010).

Increasingly, conceptualisations now include multiple incidents, known as complex trauma (Kliethermes et al., 2014). Complex or single traumas have been seen to impact individuals' behaviours and MH (Stinson et al., 2016). The Diagnostic and Statistical Manual (DSM-V)

and the International Classification of Diseases (ICD-11) propose diagnostic criteria for post-traumatic stress disorder (PTSD; Table 1). Traumatic events often involve a sense of helplessness, pain, confusion (Carlson & Dalenberg, 2000) and changes to views of the world Substance Abuse and Mental Health Administration (SAMHSA, 2014a). Risk factors for PTSD include trauma severity, life stress, psychological processing (Breslau et al., 1995), as well as childhood abuse, MH problems, and low socio-economic status (Wade et al., 2013).

Table 1. *DSM-V and PTSD-11 Diagnostic criteria for PTSD.*

PTSD (DSM-V, 2013)	PTSD (ICD-11, 2018)
A. Exposure to actual or threatened death, serious injury, or sexual violence	• Exposure to an extremely threatening or horrific event or series of events
B. Intrusions C. Avoidance D. Changes in cognitions and mood E. Arousal and reactivity	• Re-experiencing • Avoidance • Persistent perceptions of heightened current threat
F. Duration of more than 1 month G. Clinically significant distress or impairment of function H. Due to event, not due to physiological effects of a substance or medical condition	• Must last for at least several weeks • Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning

Several core theories of trauma have recently developed, including Sweeney et al.'s (2018) 'Three E's', which proposes that trauma involves an event, experience, and effect. This understanding emphasises the importance of individual experience on its effect. Research highlighting the disparity between individuals in the development of PTSD suggests neurobiological structures may play a moderating role (Olff et al., 2019).

Alternative research has reviewed the role discrete life events and cumulative life stress may

have on the development of trauma symptoms (Holmes and Rahe, 1967). Of most prominence is the Adverse Childhood Experience (ACE) scale (Felitti et al., 1998), which showed a relationship between childhood abuse and household dysfunction on adult physical well-being (Bellis et al., 2019) MH (Merrick et al., 2017), incarceration (Messina & Grella., 2006), homelessness (Kim et al., 2010), and academic challenges (Stein et al., 2003). Socio-ecological models have proposed there are even wider levels of influence on the development of PTSD, such as social, community, organisational, and historical factors (Kilanowski et al., 2017).

Trauma Informed Care

Following the identification that trauma is a pervasive and complex experience, which can have detrimental impacts on well-being, the concept of trauma-informed care (TIC) developed as a way of acknowledging these experiences and reducing their impact (Becker-Blease, 2017). There is currently no globally accepted definition of TIC (Marsac et al., 2016), however SAMHSA (2014a) compiled four core principles, known as the four "R's" (Table 2).

Table 2. *The Four R's (SAMHSA., 2014)*

Core Principle	What this involves
1. Realizes	Realizes the widespread impact of trauma
2. Recognizes	Recognises the signs and symptoms of trauma among clients and staff
3. Responds	Responds by integrating knowledge about trauma into practice and policy
4. Resists	Proactively resists retraumatization

Frameworks for implementing TIC have developed, including Sweeney et al.'s (2018) recovery environments, and Bloom's (2013) Sanctuary Model. However, Harris and Fallot's (2001; Fallot & Harris, 2008) five-dimensional model is most prominent, proposing everyone has experienced trauma and organisations should acknowledge trauma in their policies. Harris and Fallot (2001) recommend organisations should design environments following five key principles: safety, trustworthiness, choice, collaboration, and empowerment. These reflect the opposite conditions experienced during trauma and are intended to reduce the impact of trauma and chance of retraumatisation (Harris and Fallot, 2001).

Support for TIC has grown (Becker-Blease, 2017) in MH, child protection, and substance abuse services, and recently gained traction in diverse fields, including learning disabilities (Keesler, 2014), social policy (Bowen & Murshid, 2016), dentistry (Raja et al., 2015), policing (Brodie et al., 2022), prisons (Vaswani & Paul, 2019), local government (Kagi & Regala, 2012), and politics (Purtle & Lewis, 2017). Trauma-informed principles have also been embraced in national policy across Norway, Sweden, and Scotland (Johnson, 2017; NHS Education for Scotland, 2017b).

Trauma Informed Care in Inpatient Settings

Despite potential benefits of TIC, many organisations, especially MH inpatient services, are overpowered by environmental issues (Hales et al., 2017), such as the management of risky behaviours, which leads to reactive responses, fixation on rules, and coercive practices (Bloom & Farragher, 2011). Keesler et al (2017) has proposed that re-traumatisation happens within systems (through policies and procedures) and relationships (through power, control, and subversiveness), both present in inpatient settings. These practices have the potential to be the original trauma, as well as development of further MH challenges, physical injury, and

even death (Sturmey et al., 2015).

Movement away from these practices is compounded by vicarious trauma many inpatient staff develop through involvement and witnessing of coercive practices (Pearlman & Saakvitne, 1995), as trauma can induce powerlessness (Patterson et al., 2019) and reduce critical or long-term thinking (Foa & Rauch, 2004). Many have proposed that health care organisations, are themselves traumatised systems, which leads to reduced staffing levels, institutional discrimination, and high use of bank staff (McElvaney & Tatlow-Golden, 2016).

Organisations which have implemented TIC have shown benefits are not experienced evenly across staff and clients (Kusmaul et al., 2015). Research into its implementation has highlighted the importance of staff education (Van Dam et al., 2008), continued organisational support, routine training and supervision, funding, and sufficient staffing levels (Conners-Burrow et al., 2013); resources which inpatient services struggle to secure (Bannister, 2021). Some propose the most important aspect is routinely, respectfully, and neutrally asking clients about trauma (Sweeney et al., 2018), which requires changes to policies and cultures. These resources can be hard to come by for government services, who are facing funding cuts and/or funding not in-keeping with inflation (Cummins, 2018, Macintyre et al., 2018, McDaid & Knapp, 2010).

Despite challenges in implementing TIC, inpatient settings support vulnerable individuals with complex needs (Berry et al., 2013), many of whom have experienced trauma (Buswell et al., 2021). Indeed, research has shown a significant correlation between PTSD and psychosis requiring hospitalisation (Bentall, 2003; Berry et al., 2013; Panayi et al., 2022). Inpatient settings therefore support individuals who could benefit the most from TIC and trauma-

focused interventions (Chadwick & Billings, 2022). Several positive outcomes for clients have been associated with TIC, such as decreases in challenging behaviour (Keesler & Isham, 2017) and forced medications (Keesler & Isham, 2017).

TIC implementation may also help staff, as its implementation can reduce use of physical restraints (Azeem et al., 2011), staff burnout (Handran, 2015) and compassion fatigue (Keesler, 2020), and increase staff retention (Hales et al., 2019). Trauma-informed services also reduce costly and lengthy inpatient stays, and improve the quality of care provided (Brophy, 2016). Although the benefits of TIC in inpatient settings are often reported, the research into TIC implementation is underdeveloped, with a lack of sufficient empirical evidence (Valenkamp et al., 2014). The evidence available identifies several barriers to delivery of trauma-focused interventions and TIC cultural changes (Chadwick & Billings, 2022).

Trauma Informed Care Training for Inpatient Staff

Despite growing support for TIC, there are still questions around how to successfully create trauma-informed organisations (Hanson & Lang, 2016). Many have proposed the first step is the provision of comprehensive training for staff (Bryson et al., 2017). Generally, staff training provides an overview of the effects and prevalence of trauma, as well as the principles of TIC, with the aim of improving awareness and changing staff behaviour towards clients and each other (Bryson et al., 2017). SAMHSA (2014a) propose training is essential and its provision has become a principal recommendation in the agenda for addressing adverse childhood experiences (Bethell et al., 2017) and trauma-informed paediatric health care (Marsac et al., 2016). Trauma-informed training for staff is also the only consistent recommendation for trauma-informed justice systems (Branson et al., 2017).

Summary of Rationale for Review

Considering the evidence supporting the role trauma has on well-being, it is understandable that research into TIC and reducing re-traumatisation is growing. Despite this, there is currently no systematic review which examines the impact or effectiveness of training in adult inpatient settings. An investigation into this would add to our understanding of the possible benefits of this training and aspects which improve or reduce its effectiveness. Findings may have important implications for the well-being of MH inpatient staff and clients.

Aims and Scope of the Current Review

This systematic review aims to examine the effectiveness and impact of TIC training for MH inpatient staff. While there are previous reviews, such as that by Purtle (2020) or Muskett (2014), these have focused on evaluating TIC organisational interventions, some of which include staff training, but do not focus on it. Other reviews focus on staff training within specialist inpatient services, such as youth services (Bryson et al., 2017), or within specific geographical locations or time frames (Muskett, 2014). No research has assessed long-term effects, and few have assessed effects on clients. Moreover, evidence supporting TIC organisational interventions is limited by single-group studies, pre-post-test designs with short follow-up time frames, inconsistent use of outcome measures, and primitive analysis methods (Purtle, 2020).

Therefore, the current review will add original material to this field by analysing up-to-date research on the impact of TIC training on inpatient staff and clients, in the short and long-

term, using a variety of study designs and analytical methods. This review will also focus on mechanisms through which changes occurs. The specific questions to be answered in this review are:

1. What impact does MH inpatient staff TIC training have on staff awareness, attitudes, and clinical practice?
2. What are staff perceptions of the impact of staff TIC training on MH inpatient clients?
3. How effective is MH inpatient staff TIC training in the short, medium, and long-term?
4. What are the mechanisms which make MH inpatient staff TIC training impactful and effective?

Methodology

Protocol

A systematic search was completed in May 2022 using the following electronic databases: Applied Social Sciences Index and Abstracts (ASSIA), Web of Science, Medline, and PsychInfo. Databases were selected as their literature base covers Health and Medicine, and Psychology and Social Sciences, fields relevant to the reviews topic. Reference lists and citations of included texts were also scanned for additional relevant literature. Further literature was identified through a Google Scholar search. No time-period filters were used.

Search Terms

Prior to conducting the systematic search a scoping of the literature helped to identify and inform the search terms. The following search terms were used: ti("trauma informed care") OR ti("trauma informed") AND ti(inpatient OR ward) AND ti(staff OR nurse* OR therapist* OR psychologist* OR clinician* OR doctor* OR consultant*) AND ti(training OR workshop) AND ti(effective* OR evaluat*) AND ti("mental health") AND ti(psych*). Selected search terms were purposefully broad to enhance sensitivity.

Eligibility Criteria

Studies were identified as eligible when they met the following criteria:

1. Published in English in a peer-reviewed journal
2. Was conducted in MH Adult Inpatient Settings
3. Working inpatient staff are included as participants

4. The methodology includes intervention of training on Trauma-Informed Care

5. The write-up includes commentary on the effectiveness or impact of the training.

6. The Full text is available to access

Exclusion Criteria

Studies were excluded if they were:

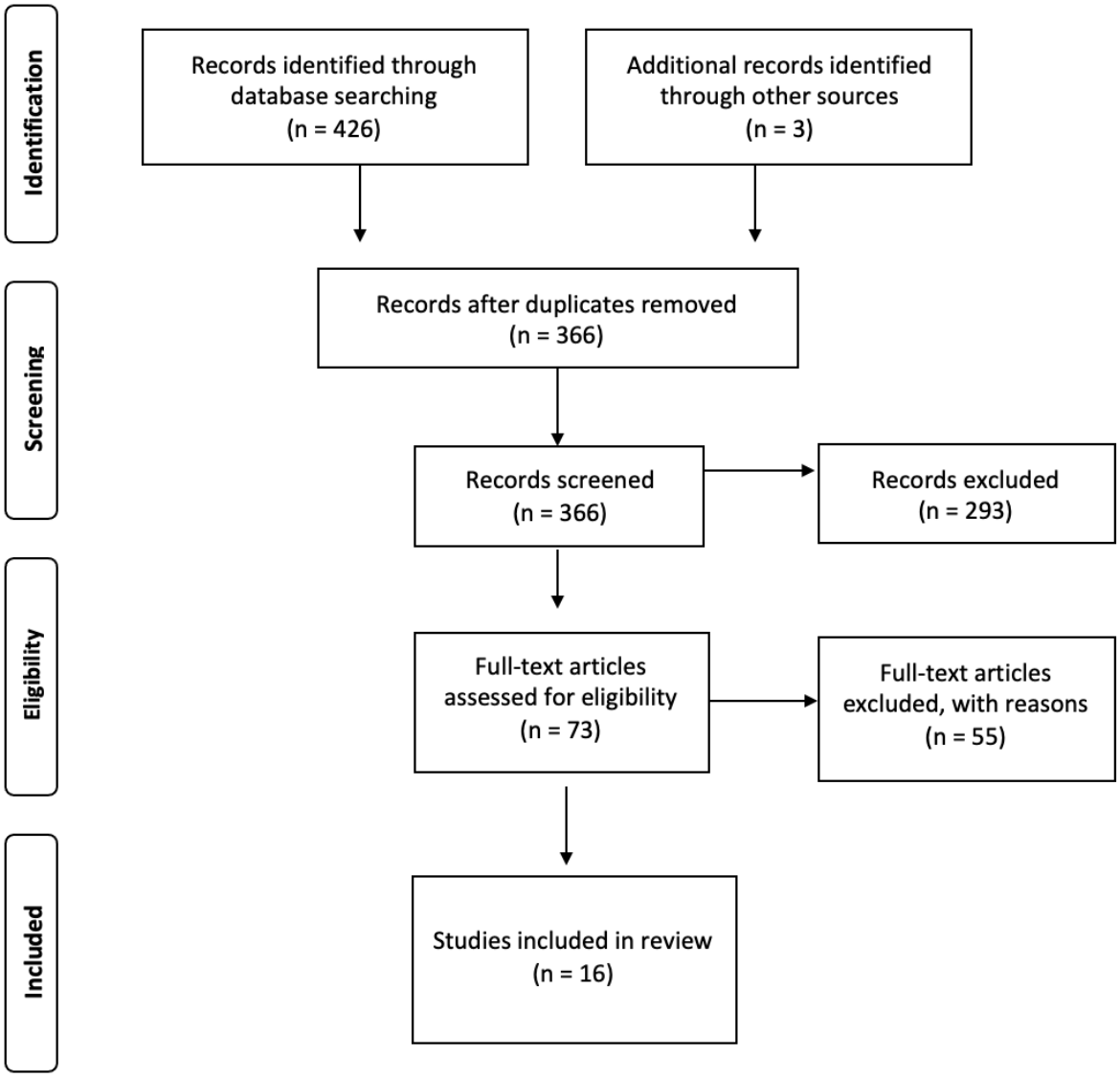
1. Not available in English

2. Only accessible at abstract level

3. Included Trauma-Informed Care training of staff not in Adult Inpatient Settings

4. Did not report original empirical data e.g., study protocol or other reviews.

Figure 1
PRISMA 2009 Flow Diagram
Flowchart of Systematic Literature Search



*Reasons for full text exclusion can be found in Appendix A.

Systematic Review

Structure of Review

This systematic review followed Khan et al's (2003) five-step guidance. This included framing review questions, identifying relevant work, assessing the quality of studies, summarizing the evidence, and interpreting the findings.

A summary of each included article is presented in Table 3. The 16 studies are described collectively, concentrating on key elements relating to design and analysis, country of origin, training provided, measurement tools, and outcomes. Due to the heterogeneity of provided training, settings, and populations (Popay et al., 2006), statistical synthesis of findings through meta-analysis did not seem feasible or appropriate. To tell a trustworthy story of the data and their relationship to the research questions, findings have been synthesised narratively (Campbell et al.,2018; Popay et al., 2006).

Drawing on guidance from Popay et al., (2006) and Rodgers et al., (2009), a textual approach was taken to 'tell the story' of included studies. This process began by producing textual descriptions of included studies and organising these in tabular form (Tables 3, 5 and 6). The research questions were then used to summarise themes and key learning across the studies. Relevant methodological challenges and the robustness of the synthesis were then reflected on. The findings are discussed and interpreted in the context of current research. Implications for future research and clinical practice are also reviewed.

Quality Appraisal Tools

The Critical Appraisal Skills Programme (CASP, 2018) checklist was drawn on to assess the quality of each article and ascertain whether it should be included in the review. The checklist is a widely used and accepted quality analysis tool for qualitative research. Quality is assessed in distinct areas, such as methodology, design, and analysis, with yes or no answers as to whether the article meets the quality standard. Each article was assessed using the checklist, independently by both the author and their Trainee Clinical Psychologist colleague. Upon completion of the checklist for all articles both compared their findings, with only one disparity which was resolved following a brief discussion.

The final checklist overview for each article (Table 4) was then discussed with an academic supervisor. The CASP checklist highlighted most of the research was of high quality standard. Two studies were deemed of lower quality but as this field of research is in its infancy and they were deemed to be valuable, it was agreed they would be included but that conclusions drawn from these studies would be tentative.

Overview of Studies

Of the 16 studies included, seven were conducted in the United States (Aremu, 2018; Chandler, 2008; Gathings, 2020; Hales et al., 2019; Iyengar, 2018; Medlin et al., 2017; Thompson, 2020), eight in Australia (Cations et al., 2021; Isobel & Delgado, 2018; Isobel & Edwards, 2017; McEvedy et al., 2017; Nation et al., 2022; Palfrey et al., 2018; Walsh & Benjamin, 2020; Williams & Smith., 2017), and one in Japan (Nimura et al., 2019).
Four of the studies described a qualitative design involving post-training interviews

(Chandler, 2008; Isobel & Edwards, 2017; McEvedy et al., 2017; Walsh & Benjamin, 2020). 12 of the studies used a single-group pre-test post-test design (Aremu, 2018; Cations, 2021; Gathings, 2020; Hales, 2019; Isobel & Delgado, 2018; Iyengar, 2018; Medlin et al., 2017; Nation et al., 2022; Nimura et al., 2019; Palfrey et al., 2018; Thompson, 2020; Williams & Smith). Of these 12 studies, six were purely quantitative in their design; (Gathings, 2020; Isobel & Delgado, 2018; Iyengar, 2018; Nimura et al., 2019; Palfrey et al., 2018; Thompson, 2020), and two were mixed with a small qualitative component (Hales et al., 2019; Nation et al., 2022). Four of these 12 studies also included an organisational change component (Aremu, 2018; Cations et al., 2021; Medlin et al., 2017; and Williams & Smith, 2017).

The quality appraisal tool revealed a moderate-high level of quality across studies. Some studies were identified to have limitations, such as poor recruitment rates (Hales et al., 2019; Isobel & Edwards, 2017; Palfrey et al., 2018; and Thompson, 2020) and a lack of rigorous analysis (Cations, 2021; Isobel & Delgado, 2018; and Isobel & Edwards, 2017; Walsh & Benjamin, 2020; Williams & Smith, 2017) creating some doubt about the validity, and therefore generalisability, of their findings. For some studies it was hard to identify clear methods due to multi-faceted organisational change projects (Aremu, 2018; Cations et al., 2021; Medlin et al., 2017; and Williams & Smith, 2017). However, only two studies did not adequately meet criteria for high quality in most areas (Isobel & Edwards, 2017; Walsh & Benjamin, 2020).

Table 3. *Included Studies*

Trauma-Informed Care Training									
	Study	Country	Design	Measure(s)	Participants	Training Setting	Training Information	Impact/Outcome	Factors Influencing Effectiveness
1	Walsh & Benjamin (2020)	Australia	A practice change project using TIC compatible methods to support staff to identify current Trauma-informed practices and issues further shifting towards this. This involved semi-structured group interviews and a world café to generate solutions to implementing TIC on the wards.	1. BEET - to produce an engagement statement. 2. CCI - to identify claims, concerns, and issues. 3. SCARF – a Heuristic engagement framework. 4. Staff voted for favourable solutions to implement.	15 members of the multidisciplinary team including psychiatrists, nurses, and allied health professionals.	A 10-bed public subacute mental health inpatient unit	A one-day training course in "Trauma Informed Care Principle".	-An engagement statement was created and circulated among the team. -The CCI tool helped create several claims, concerns and issues which were discussed during the world café. -No comment made on the process of implementing most voted solutions or their success.	Processes instilled a sense of safety and trustworthiness in the project as evidenced by the high level of staff engagement in all the elements of the project.
2	Lyengar (2018)	US	A pretest-posttest design evaluating staff's TIC knowledge and confidence implanting TIC principles following an educational intervention. Data were analysed using descriptive and comparative statistics.	1.The 'Knowledge of Trauma-Informed Care and Confidence in Implementation' a self-developed questionnaire based on SAMHSA (2014) guiding principles of TIC. 2. A five-point likert scale with one question about confidence implementing TIC.	20 nursing staff members of an acute care hospital, including nurses, care workers, and social service clinicians, working full and part time.	The Psychiatric Department of a 500-bed mid-Atlantic Urban hospital with an academic affiliation. The department includes two adult inpatient units and a crisis centre.	A web-based TIC educational presentation, delivered through test and video clips, estimated to take 50 minutes to complete. Participants independently accessed the educational material on a private website.	- Data analysis showed that the project intervention was effective and improved nurses' knowledge and confidence in implementing TIC principles in their work moving forward.	None Mentioned

3	Williams & Smith (2017)	Australia	A "naturalistic" study examining the long-term impact of TIC training from the perspective of clinicians and managers, on changing practice at the individual, clinician, and workplace level. TIC training was provided, and 12 months later participants completed an online survey	An online survey with items based on a five-point likert scale with the opportunity for additional comments. This survey aimed to examine 1) The impact on participants' values, attitudes, and knowledge of TIC. 2) Participants' ability to implement TIC. 3) Participants' ability to enable change in their practices. 4) Participants' support for the strategy to embed TIC into services. 5) Factors that helped or hinder implementation.	271 clinicians and managers from public mental health services.	Local publicly provided mental health inpatient services in Western Australia.	A one-day training for clinicians and a separate programme of half-day training for managers. The training, provided by the Adults Surviving Child Abuse Organisation, aimed to equip clinicians with basic knowledge and skills to apply to their roles. Manager training was aimed at supporting them to implement TIC principles within their services.	-Clinicians reported a moderate impact on their individual practice and both groups reported very limited successes in bringing about change in their workplaces. -Workforce development and organisational factors were identified by both clinicians and managers as being barriers to implementation. -One year post-training, both clinicians and managers reported that training had increased their awareness and knowledge and had a positive impact on their attitudes towards TIC.	-Only 30% of participants responded to the survey and this was not based on any objective measure of behaviour change. -This highlights the importance of contextual factors, where behaviour change is needed to effect organisational change.
4	Nation et al. (2022)	Australia	A mixed-methods approach was applied using baseline measures of staff TIC attitudes, quantitative description of TIC training, and semi-structured interviews of TIC implementation.	1.The Organisational Change Readiness Assessment (OCRA) survey. 2. Analysis of the interviews using inductive thematic approach.	123 staff members from 8 mental health rehabilitation services.	A large metropolitan public mental health inpatient service.	Introductory training explaining what trauma is and how it affects people. The course outline included an introduction, complex trauma, secondary and vicarious trauma, TIC, and TIC considerations. No time frame for this	-Interviews identified 4 broad themes of learning: 1) The need to respect the person's life journey including the risk of re-traumatisation. 2) The importance of considering the context of implementing TIC training	-Effectiveness compounded by staff fatigue due to high demands. -Training may not have met the needs of a diverse workforce. -The ability to provide specific trauma therapy was identified as a gap in care, it is

							training course was provided.	3) TIC being an essential part of mental health care. 4) Staff may also have trauma histories	necessary to have a whole service structured competency framework to address this need. -Comprehensive organisational response would also include provision for staff supervision and ongoing training.
5	Isobel & Delgado (2018)	Australia	-Evaluation of a training workshop. This was one component of a larger evaluative mixed methods study.	-A 5-point likert scale questionnaire to capture self-reported beliefs of the workshop. No pre-test measure and as the scale is self-report only, with no knowledge testing, no attempts were made to develop content or construct validity measures. Descriptive statistics were used to report the results of the questionnaire. -Clinical supervision groups were also formed post workshops.	73 registered nurses working in acute inpatient mental health units. attended 10 workshops between 2014-2016.	An acute inpatient mental health unit.	Training was designed by a nurse unit manager, 2 clinical nurse consultants, and a nurse educator with knowledge of the effects of trauma and TIC. The workshop designed as an 8-h one day skills-based programme with didactic and practical components, aimed at increase knowledge of potential impacts of trauma on clients, and translate TIC concepts into their communication approach. Including psychological safety, strengths-	-Nurses responded positively to TIC implementation. -Most of the impact of the workshop through the sustainability of altered practice was identified to be reliant upon an embedded clinical support program. This was seen through lack of use of the post workshop supervision groups.	-Many participants had limited exposure to TIC prior to workshops. -Nurses felt restrained by policies, communication issues within the team, and medical hierarchy. -Nurses reported struggling with therapeutic communication, often skipping to problem solving, practical solutions, and medication.

							focused approaches, reflection, involving exercises, practicing skills, and interactive role plays using a paid actor.		
6	Gathings (2020)	US	Pre-test and post-test survey following training in knowledge of ACEs and TIC for mental health nurses	Pre and post training surveys were completed. The pre-test survey measured ACE/TIC knowledge before training (as well as demographics), it consisted of 18 interval choice questions. The post-training survey measured effectiveness, knowledge, skill, and changes in care. The post-training survey consisted of 9 questions on an interval choice scale.	26 healthcare professionals, specifically mental health nurses and psychiatrists, psychologists, social workers, and therapists, who work in inpatient behavioural health facilities and have more than a year of mental health experience.	An inpatient behavioural health facility.	The training was online due to COVID-19 and took approximately 15 minutes to complete. The video aimed to increase their knowledge and skills to provide quality healthcare to patients with mental health illness.	-Pre training surveys showed participants felt moderately aware and confident in assessing and responding to trauma. -After training and education, the results show that clinicians s did gain knowledge, awareness, and confidence in identifying ACE's and trauma.	-Despite results showing training was effective, there was a need for additional information on TIC to be provided. -Only 11 participants completed the study.
7	Aremu (2018)	US	A quality improvement project aimed to educate staff on methods to incorporate TIC into daily practice and use brief solution-focused therapy techniques in escalating situations. -Pre and post measurement of	Process evaluations involved reviewing data collected 1 month after the initial training and every 3 months. These data included 1) The management of aggression and violence attitude scale (MAVAS), a self-reference scale of 30 items. 2) The Combined Assessment of	-Training wave 1 included 11 staff members currently working on the adult behavioural health unit. -Training wave 2 included 22 staff members from the same unit.	An inpatient Adult Psychiatric Unit with 25 beds that has served the community for more than 35 years.	-Staff received education on creating and maintaining TIC principles, building trusting relationships and creating a safe, healing environment. -Ongoing discussion of these principles with staff helped create buy-in from	-Prior to training staff were interviewed about the project. Many expressed concerns of not having time or skills, to sit and engage with clients, and concerns around safety reducing PRN. -Upon completion of the project, there was a decrease in PRN IM medications,	-Leadership were committed to implementing TIC principles and using the best evidence available to reduce the risk of traumatizing patients and keeping patients safe. Nursing leadership is critical in ensuring educational

			attitudes towards patient aggression and engagement with patients following two waves of staff education	Psychiatric Environment (CAPE)-brief version, assessing staff engagement and staff experience of care in inpatient psychiatric units. Outcome evaluation was accomplished by; 1) Assessing staff comfort of patient engagement before and after engagement training. 2) Reviewing shift documentation and nurses' notes reflecting patient engagement 3) Monitoring the amount of PRN IM medications administered.			front-line nurses. -For several months, at unit meetings staff were reminded about the project.	improvement in staff attitudes towards patient aggression, and improved sense of staff competency in handling tense situations was noted.	training needs and setting organisational culture. -A later review of clinical notes showed clear examples of patient engagement and solution-focused ideas in 76% of the 21 notes. -Attendance in the second wave improved when training was made mandatory.
8	Cations et al. (2021)	Australia	This was a Type 1 hybrid implementation-effectiveness study, using a co-design method, the principles of TIC were transformed into an implementation strategy including staff training, establishment of highly trained 'champions' on each ward,	Existing and routinely collected ward data was used i.e., incidents of responsive behaviour, perceived threat by client, and use of PRN in response to a responsive behaviour event. The incidence of each outcome per occupied bed-days per month was calculated and monitored over time. -The RE-AIM framework of	Multidisciplinary staff working in the participating inpatient units. (Number not provided).	Four inpatient psychiatric units for adults and older adults within public hospitals participated, including 79 beds.	-Staff were involved in education and organisational change. Participants received changes to care protocols because of the implementation strategy. -Staff attended meetings to gather views about how TIC could be generalised in their setting, transcripts of these meetings	-Themes from initial meeting identified 1) A sense of relevance to use of TIC. 2) Low mental health expertise. 3) Lack of knowledge. -The subsequent plan included leadership roles, education, development of materials, and quality improvement projects. -Incidents related to	-TIC has potential to improve the safety and accessibility of hospital wards for people who have survived psychologically traumatic events. -Reducing potential for re-traumatisation may reduce responsive behaviour change and improve

			screening for trauma-related needs, and amending ward policies and procedures. Primary outcomes were examined using an interrupted time-series design and are monthly incidence of responsive behaviour incidents and use of chemical restraint. The inclusion of a process evaluation allowed the identification and reporting of changes made on each ward and provide recommendations for future implementation efforts. -This study included an 18 month pre-intervention period and 36 months of routine data collection.	knowledge translation assessed the success of knowledge translation. -Field notes tracked reach, which referred to the portion of staff who complete the online training module within the intervention period, volunteer for champion roles, are screened for trauma-related needs and patients followed up according to the new protocol.			were thematically analysed and guided the implementation strategy -Staff completed an online training module outlining the principles of TIC, approaches to assessing for a trauma history, identifying signs of distress, situational awareness, de-escalation strategies, and debriefing and information sharing. -Online training was supplemented by in-service events to reinforce training messages and answer specific questions.	responsive behaviour and use of PRN chemical sedation in response to a responsive behaviour event, reduced.	quality of life for clients -TIC principles were well established. -18 month follow up may be insufficient to detect a significant effect. -Successful TIC implementation relies on a cultural change within the organisation and, like other quality improvement initiatives, can and was slowed by staff turnover, competing priorities, and other contextual factors.
9	Isobel & Edwards (2017)	Australia	-A mixed methods case study design to evaluate the overall implementation of TIC and effects on the nursing	-Semi structured in depth interviews with a small snapshot purposive convenience sample.	-5 nurses working in an acute inpatient mental health unit participated in the	An acute inpatient mental health setting.	-Education and training opportunities and multimodal communication	-No outcomes of the implementation process are identified, however nursing workforce data suggests some	-Informing people about TIC was a significant obstacle to introducing a trauma informed

			workforce of using a Practice Development Process. -An open working group was designed which people could join to learn about TIC and support its implementation. Some staff members were then interviewed about their experience.		interviews. -No number is provided for those who partook in the working group or learning opportunities.		pathways were taken.	positive effects on the experience of nurses with some concurrent pockets of continuing resistance and scepticism.	approach to care. Many complained that TIC was too simplistic or controversial, and there were misunderstandings about the intent of the approach based upon its name. -Some nurses reported feeling criticised as their current approach was being labelled as traumatising, others feared the lack of safety that could arise from changes to long standing practice.
10	McEvedy et al. (2017)	Australia	A qualitative research design was adopted to report descriptions of the effectiveness of the training intervention without being overly interpretative.	-Data collection consisted of semi-structured interviews, focus group discussions, and one paired in-depth interview.	-21 semi-structured interviews with a variety of mental health inpatient staff (nurses, OT's, and social workers). No numbers provided for focus group discussions.	-Study participants were from 19 public area mental health services in Victoria, supporting people with severe mental health requiring inpatient services.	Training included a mix of didactic and interactive activities, vignettes and video resources about TIC. Each session was delivered over two days with the focus on providing knowledge and confidence to educate their colleague and enact the TIC principles in their work.	-Participants fed back they appreciated the in-depth knowledge and theory provided. -Some participants share they continued to use materials in their work after the training sessions ended. -Some shared that inpatient service users responded well to the implementation of TIC principles following their training. -Participants fed back that they were not	-All participants described the high number of competing demands as an impediment to the use of their learning. -Few services collected substantive data to gauge the impact of TIC on reducing seclusion. -Moving forward some participants felt the need for

								well-supported to implementing their learning into their work environments. -Some services implemented sensory rooms to support clients in distress.	further training sessions, whilst others felt their training was sustainable long-term. -Some reported updating clinical governance policies, documentation, and procedures as ways of translating knowledge into practice.
11	Palfrey et al. (2018)	Australia	Mental health practitioners attended a workshop designed to introduce TIC principles and practices. Participants completed pre and post measures of confidence, awareness, and TIC attitudes.	1. A 5-item measure of self-rated confidence, awareness and attitude towards TIC developed by the team using a 10-point response scale. 2. A 6-item checklist of perceived barriers to working with clients affected by trauma, also developed by the team. Respondents selected a statement from a series of options or an open ended response. 3. Qualitative questions following the workshops relating to most important clinical aspect of workshop, intended changes to clinical	Nursing, medical, and allied health professionals. No numbers provided.	An acute mental health inpatient unit.	1. Clinicians were supported to assess their clients for trauma histories. 2. Interactive TIC training on the definition, prevalence, impact, and clinical presentation of trauma, as well as the role of attachment theory, skills for responding to trauma disclosure, evidence-based trauma therapies and resources for clients. 3. Supported to learn a TIC intervention.	The workshop was rated as highly relevant and useful to clinician's practice. Participants self-reported confidence, awareness, and attitudes towards TIC significantly increased, and perceived number of barriers to TIC working significantly decreased. Perceived barriers included: 1) Not having enough experience/skill to work with people affected by trauma. 2) Concerns around causing further distress. -Participants shared the content of training on trauma as the most important aspect of	At a 12-month follow-up, clinicians reported to routinely screen for trauma and 80% had received training in a trauma specific intervention e.g. (EMDR and TF-CBT). Researchers concluded the service was moving towards a Trauma-informed lens. Participants endorsed practical components of training (role plays, case studies and group discussions). -Post workshop 58% of clinicians

				practice, participants further training needs.				training, including the importance of screening for trauma, skills and responding to disclosure.	stated they adapted their practice by including routine questions regarding trauma history into their assessments. 80% at 12-month follow-up. -20% increased their focused on therapeutic alliance. -10% less intimidated by presentation of trauma.
12	Nimura et al. (2019)	Japan	A pre-post study, with a 3 month follow-up, on the effectiveness of a 1-day trauma-informed care training programme on attitudes in psychiatric hospitals.	1. The Attitude Related to Trauma-Informed Care Scale (ARTIC-35).	65 mental health professionals, the majority of which were women.	29 psychiatric hospitals in Tokyo.	A 1-day programme consisting of a 3.5 hour lecture and 1 hour discussion. The aim of the programme was to improve knowledge of trauma and TIC and motivate mental health professionals to embed TIC into their clinical practice. Programme content included definitions/evidence of trauma/TIC, behavioural, social, and emotional responses to trauma, re-	ARTIC scores significantly increased post-training and after 3 months, reflecting improved attitudes towards TIC.	After 3 months participants claimed to have implemented TIC practice in daily clinical settings. The most frequently reported clinical practice was 'assessing patients' behaviour based on TIC (37%). This included attempting to understand why patients exhibited problematic behaviour, considering their life histories and

							traumatisation, TIC practices.		family relationships based on TIC. The second most common practice was 'modifying communication with patients based on TIC' (19%) and managing patients' problematic behaviour without coercive practices and instead TIC favourable practices (19%). 60% reported barriers to implementing TIC practice, such as limited opportunities, skills/experience, lack of confidence, difficulty sharing TIC information with colleagues,
13	Chandler (2008)	US	A qualitative design using content analysis to provide an in-depth description of the experience of staff who had successfully transitioned from traditional care to trauma-informed	Qualitative interviews. No additional information was provided.	20 nurses and 14 mental health counsellors attended the training. Of this, 10 staff members including nurses, physicians, social workers, and mental health	A 20-bed inpatient psychiatric unit at a community hospital. This unit, which had instituted trauma-informed guidelines,	Training included education on adopting and implementing trauma-informed philosophy.	Content analysis showed patterns clustered into the following categories: 1) Changing perspectives 2) Developing collaborative relationships 3) Implementing safety measures	Staff underwent a deep cultural change that subsequently won state recognition for the reduction of seclusion and restraints. Moving from traditional care to trauma-informed will

			treatment. The secondary aim was to describe how the staff created a trauma-informed culture of safety.		counsellors were interviewed.	won state-wide recognition for decreasing patient restraints.		4) Prescribing educational resources.	involve incremental change. Leadership needs to be involved in educational initiatives and practice behaviours to establish a deep cultural change. Policies and procedures need to be reviewed through a trauma-informed lens. Cultural change takes both individual commitment and structural supports.
14	Hales et al. (2019)	US	A mixed-methods longitudinal study looking at the influence of implementing TIC on a variety of organizational, staff, and client outcomes.	1.Organizational change was monitored through the Trauma Informed Climate Scale (TICS) 2. Organisational policies, procedures and practices were assessed using Trauma informed organisational self-assessment. 3. Staff satisfaction was assessed using a 24-item instrument created internally by the non-profit organisation, based on	All permanent staff working within the agency, and clients using the facility. No numbers were provided	A residential addiction treatment agency.	The Institute on Trauma and trauma-informed care (ITTIC) training for all employees on the core tenants of TIC; Identifying, training, and coaching TIC mentors and champions; developing selected trainers to deliver the foundational TIC training to new hires; and collaborating with senior leadership on	Following TIC implementation there were positive changes in each of the five outcomes assessed. Workplace satisfaction, climate, and procedures improved by moderate to large effect sizes, while client satisfaction and the number of planned discharges improved significantly.	The greatest organisational changes occurred in supervision, support, self-care, training, conducting intake assessments, and involving former clients. Only a moderate effect size change in TI policies, procedures and practices were found. Staff satisfaction increased

				a 5-point likert-type scale. 4. Client satisfaction was assessed using a dichotomous 42-item instrument. 5. Client treatment retention was operationalised as a client-planned discharge status, either as planned or unplanned.			revising policies and procedures to ensure their alignments with a TI perspective.		following TIC implementation, specifically staff trust and confidence in each other. Client satisfaction increased with more clients giving feedback, possibly also due to an increase in client retention in treatment, with a high number of planned successful discharges.
15	Medlin et al. (2017)	US	A multidisciplinary, multimodal quality improvement program to implement TIC-related interventions in a biomedical model unit. This involved staff training, environmental changes, promotion of less-restrictive interventions, and client involvement in care.	Descriptive data were collected regarding the implementation of TIC. Patients attending psychotherapy and occupational therapy groups were tracked in a log. For high-risk patients the psychology team recorded the number of behavioural program referrals/interventions. Every week, clerical staff recorded the presence or absence of coping skills checklists in charts. Occupational Therapy recorded the number of patients contracts.	Nurses, behavioural health technicians, psychiatrists, advanced practice providers, psychologists, licensed professional counsellors, and occupational therapists, over 100 staff.	An adult inpatient psychiatry unit with 41 beds, that previously lacked a formal treatment philosophy.	Two groups were conducted per day and were run by either occupational therapy or nursing floor staff. Most of the programme was unstructured and mandatory. Training involved 1 session on verbal de-escalation and physical management of agitated patients. The curriculum trained staff on principles of TIC as well as specific unit initiatives, this involved an introduction to TIC, its benefits, role	Preliminary results indicate initial successes in helping patients better utilise coping skills, as well as in improving patient engagement in non-pharmacological interventions like group and individual therapy.	Repetition, consistency, oversight, and administration support/funding were important factors in assuring consistent and high-quality services. No long-term outcomes reported.

							play simulations, discussions on daily TIC-decision making, training on various interventions, and a presentation by a peer recovery specialist regarding his experience.		
16	Thompson (2020)	US	A single group pre-post-test design with a 1-month follow-up assessment.	Staff attitudes towards TIC were evaluated by a psychometrically validated tool (ARTIC-35). Additionally, participants were asked to share if they had incorporated TIC into their work with patients and if they experienced any barriers to implementing TIC since training. Data was collected at 3 points; one week prior to training, immediately post training, and 1 month post training.	6 female Mental Health professionals, 3 registered nurses and 3 social workers.	An acute psychiatric inpatient unit.	Training included information on the psychological and physiological effects of trauma, core concepts of TIC, strategies to avoid re-traumatisation & foster a culture of safety, best practice guidelines, strategies to recognise secondary traumatic stress, strategies to reduce the impacts of secondary traumatic stress, and strategies to promote self-care of behavioural healthcare workers.	Immediately following the training, ARTIC-35 scores increased on average by 11%, demonstrating that attitudes related to TIC improved as a result of the training. All 6 participants reported changes to their practice following training, including 1) Consideration of colleagues' trauma 2) Modifying communication with patients based on TIC, 3) Reduction in coercive practice. One month following the training, all participants maintained their score. Participants also claimed they changed their practice to incorporate TIC into their work with patients.	Barriers to implementing TIC included 1) having limited skills or experience with TIC 2) Lack of opportunities to try TIC in clinical settings.

Table 4. *Critical Appraisal Skills Programme Quality of Evidence*

Critical Skills Appraisal Section												
Author	**1 Clear Aim**	**2 Appropriate Methodology**	**3 Appropriate Design**	**4 Appropriate Sampling & Recruitment**	**5 Appropriate Data Collection**	**6 Consideration of Research/ Participant Relationship**	**7 Consideration of Ethical Issues**	**8 Rigorous Analysis**	**9 Findings Clearly Stated**	**10 Is this research valuable**	**Criteria Met**	**Include?**
Walsh & Benjamin (2020)	Y	N	N	Y	N	Y	Y	N	N	Y	5/10	Y
Lvengar (2018)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Williams & Smith (2017)	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	9/10	Y
Nation et al. (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Isobel & Delgado (2018)	Y	Y	Y	Y	N	Y	Y	N	Y	Y	8/10	Y
Gathings (2020)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Aremu (2018)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Cations et al. (2021)	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	9/10	Y
Isobel & Edwards (2017)	Y	Y	N	N	N	Y	Y	N	N	Y	5/10	Y
McEvedy et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Palfrey et al. (2018)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	8/10	Y
Nimura et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y
Chandler (2008)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10/10	Y

Hales et al. (2019)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	9/10	Y
Medlin et al. (2017)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	9/10	Y
Thompson (2020)	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	9/10	Y

Data Synthesis

Trauma Informed Care Training

General Overview

There appeared to be a lack of consistency in the content, delivery, and length of training across studies. Three studies did not publish details regarding the content or design of their training, using vague descriptions with no reference to specific information provided (Iyengar, 2018; and Isobel & Edwards, 2017; Walsh & Benjamin., 2020). Of the remaining 13 studies which provided details, three referenced the designer of the training, including The Adults Surviving Child Abuse Organisation (Williams & Smith, 2017), A nurse educator with TIC knowledge (Isobel & Delgado, 2018), and The Institute on Trauma and Trauma Informed Care (ITTIC; Hales et al., 2019).

The CASP (2018) Checklist highlighted that all studies clearly stated their aims, used appropriate methodologies, considered ethical issues and researcher-participant relationships, and produced valuable findings. Most studies used appropriate research designs, data collection, and clearly stated their findings. The checklist identified that several studies fell short with their sampling, recruitment, and analysis.

Specific Training Content

Of the 13 studies which reported the content of their training, five main subjects formed core training components (Table 5). An additional six topics (see Table 6) were covered in several

training packages.

Table 5. Primary Training Subjects

	Training Content Subjects	Studies	Number of Studies
1.	What is Trauma?	Gathings (2020), Nation et al. (2022), Nimura et al. (2019), Palfrey et al. (2018), Williams & Smith (2017)	5
2.	The Impact & Effects of Trauma (Biological, behavioural, social, and emotional)	Isobel & Delgado (2018), Nimura et al. (2019), Nation et al. (2022), Palfrey et al. (2018), Thompson (2020)	5
3.	Retraumatisation & Strategies to avoid it	Medlin et al. (2017), Nimura et al. (2019), Thompson (2020)	3
4.	TIC Principles	Aremu (2018), Chandler (2008), Hales et al. (2019), Isobel & Delgado (2018), Nation et al. (2022), Nimura et al. (2019), Williams & Smith (2017), Thompson (2020)	8
5.	How to Apply TIC Principles with Inpatient Clients (Building trusting relationships and safe environments)	Aremu (2018), Chandler (2008), Gathings (2020), Hales et al. (2019), Isobel & Delgado (2018), McEvedy et al. (2017), Medlin et al. (2017), Nation et al. (2022), Nimura et al. (2019), Williams & Smith (2017), Thompson (2020)	11

Table 6. Secondary Training Subjects

	Secondary Training Content Subjects	Studies	Number of Studies
1.	Vicarious Trauma and its Impact	Nation et al. (2022) Thompson (2020)	2
2.	Attachment Theory	Palfrey et al. (2018)	1
3.	How to Assess for Trauma/Respond to Disclosures	Cations et al. (2021) Palfrey et al. (2018)	2
4.	TIC Communication & De-escalation Skills	Cations et al. (2021) Medlin et al. (2017)	2
5.	Evidence Based Psychological Trauma Therapies	Palfrey et al. (2018)	1
6.	How to Embed TIC Principles into Policies/Procedures	Cations et al. (2021) Hales et al. (2019) Thompson (2020)	3

Of these 13 studies, four provided specific aims of the training (Gathings, 2020; Isobel & Delgado, 2018; Nimura et al., 2019; Williams & Smith, 2017). These four studies contained

two key similarities, the desire to increase clinicians' knowledge of Trauma and TIC, and the second being a desire to improve TIC-related clinical skills. One study specifically mentioned the aim of improving clinicians' communication skills (Isobel & Delgado, 2018), and one mentioned the aim to improve the quality of the healthcare provided (Gathings, 2020).

Training Length

There appeared to be inconsistency in the length of the training provided. Ten studies provided no information on training length (Aremu, 2018; Cations et al., 2021; Chandler, 2008; Hales et al., 2019; Isobel & Edwards, 2017; McEvedy et al., 2017; Medlin et al., 2017; Nation et al., 2022; Palfrey et al., 2018; Thompson, 2020). The six studies that provided details disclosed a range from 15 minutes (Gathings, 2020), 50 minutes (Iyengar, 2018), one day (Isobel & Delgado, 2018; Walsh and Benjamin, 2020; Williams & Smith, 2017; Nimura et al., 2019), to two days (McEvedy et al., 2017).

Training Delivery

Eight studies did not provide information on the mode of training delivery (Aremu, 2018; Chandler, 2008; Hales et al., 2019; Nation et al., 2022; Nimura et al., 2019; Thompson, 2020; Walsh & Benjamin, 2020; Williams & Smith, 2017). Within the eight remaining studies, there was a wide range of training delivery methods, including video clips (Iyengar, 2018), and live online presentations (Gathings, 2020). Some utilised a combination of online and face-to-face sessions (Cations et al., 2021; Isobel & Edwards, 2017). Others used one training method, namely face-to-face, but drew on a variety of teaching methods, such as didactic lecturing, practical tasks, role-plays, discussions (Isobel & Delgado, 2018; Medlin et al.,

2017), video clips, clinical vignettes (McEvedy et al., 2017), and interaction (Palfrey et al., 2018).

Included Participants

All studies provided training for staff; however, six studies did not include information on attendees' professions (Aremu, 2018; Cations et al., 2021; Hales et al., 2019; Nation et al., 2022; Nimura et al., 2019; Williams & Smith, 2017). Two studies only included nursing staff (Isobel & Delgado, 2018; Isobel & Edwards, 2017), the remaining eight included a combination of professionals (Chandler, 2008; Gathings, 2020; Iyengar, 2018; McEvedy et al., 2017; Medlin et al., 2017; Palfrey et al., 2018; Thompson, 2020; Walsh & Benjamin, 2020). One study specified participating staff members could be full or part-time employees (Iyengar, 2018), and one specified that participants needed a year of experience (Aremu, 2018). Two studies mentioned attendance was mandatory (Aremu, 2018; Medlin et al., 2017). None of the studies included MH inpatient clients as participants.

Training Overview

There appears to be minimal consistency in the TIC training provided. This can be seen through the inconsistent training designers, designs, and references to TIC models and literature. This is however understandable, considering the recent development of TIC literature (Becker-Blease, 2017), and wide variety of models and conceptualisations (Birnbaum, 2019). Although most studies shared similar aims, the content of the training varied greatly. Considering the wide variations in trainings, it is hard to make generalisations about TIC training based on these heterogenous studies. This is especially relevant as there

may be extraneous variables unaccounted for when considering the lack of detail shared by many studies about the training provided.

The Impact of TIC Training

Impact on Staff

Despite the wide variety of training provided, nearly all studies shared positive results regarding the impact training had on staff. Three studies did not report positive impacts, these included Medlin et al. (2017), McEvedy et al. (2017) who reported staff were not supported to implement their learning, and Isobel & Edwards (2017), who identified resistance and scepticism. Of the 13 studies which reported positive impacts, these can be clustered into seven primary themes: impacts on staff awareness, knowledge, confidence, attitudes towards TIC, changes to clinical practice, changes to restrictive practice, and changes to medication use.

The impact training had on TIC awareness was reported by three studies. Williams and Smith (2017) reported a moderate impact on awareness immediately following training, and significant improvements to awareness one year post-training. A similar improvement in awareness was reported by Gathings (2020) and Palfrey et al. (2018). All three studies reported that improvements in awareness were followed by other positive impacts (such as improved attitudes and confidence in TIC working), suggesting that awareness was a key factor. However, none of the studies used validated or psychometrically robust measures of awareness, reducing the reliability and generalisability of findings.

Five studies reported that TIC training had a positive impact on staff knowledge of TIC. Four studies did not report what knowledge was retained or how this was seen (Gathings, 2020; Iyengar, 2018; McEvedy et al., 2017; Williams & Smith, 2017). However, one study reported specific improvements to staff knowledge and grouped these into four themes: knowledge of the risk of retraumatisation, how to implement TIC principles, the necessity of TIC, and staff may have trauma histories. Three studies reported training had an impact on confidence in implementing TIC into clinical work (Iyengar, 2018), confidence in identifying ACE's and trauma histories (Gathings, 2020), and one did not specify (Palfrey et al., 2018). However, none of these studies used validated or psychometrically robust outcome measures, which draws the strength of these findings into question.

Six studies reported improvements in staff attitudes towards TIC. Four studies reported this generally (Nimura et al., 2019; Palfrey et al., 2018; Thompson, 2020; and Williams & Smith, 2017), and two reported specific changes, such as improved management of aggression (Aremu, 2018), and discussions around TIC issues (Walsh & Benjamin, 2020). These studies used a variety of measures, including validated psychometrics, unvalidated surveys, and semi-structured interviews. Consistent findings across these measures could suggest reliability. Two studies also reported significant reductions in seclusions and restrictive practices (Chandler, 2008; Thompson, 2020), and two reported a reduction in chemical sedation (Aremu, 2018; Cations et al., 2021). Similarly, these drew on a variety of measures, such as semi-structured interviews, validated and objective psychometric measures, ward documentation and incident reports, indicating consistency, validity, and reliability in the findings.

Six studies reported positive impacts on clinical practice. Isobel and Delgado (2018) and

Williams and Smith (2017) reported general and moderate impacts on clinical practice. Four studies shared specific changes to clinical practice, including improvements in handling tense situations (Aremu, 2018), reduced violent incidents (Cations et al., 2021), consideration of colleagues' trauma, and improved communication (Thompson, 2020). McEvedy et al. (2017) reported continued use of training materials and implementation of a sensory room. Of these studies, two used semi-structured interviews, two used validated psychometric measures, and two used a combination of validated measures and routine ward data. As a positive impact has been captured across a range of robust measures, this could suggest validity in these finding.

Impact on Inpatient Clients

It is important to note that none of the studies directly surveyed or interviewed MH inpatient clients, and so accounts of client impacts is based off staff perceptions, and therefore should be interpreted cautiously. A small group of three studies reported on the impact training had on clients from staff perspectives. McEvedy et al. (2017) reported that clients responded well to implementation of TIC principles. Hales et al. (2019) elaborated further by sharing that client satisfaction and the number of successful planned discharges improved. Medlin et al. (2017), described improved client outcomes, such as utilising coping skills, displaying less challenging behaviour, and engagement talking therapy. However, the validity of the findings might be limited by outcome measures used as these included semi-structured interviews, descriptive data, and only one validated measure.

The Long Term Impacts of TIC Training

Seven studies only reported immediate changes following training (Gathings, 2020; Isobel & Delgado, 2018; Iyengar, 2018; Medlin et al., 2017; Nation et al., 2022; Walsh and Benjamin, 2020). One study by Isobel and Edwards (2017) reported challenges to producing long-term impacts and described resistance by nursing staff who complained that TIC was simplistic and critical of their current approach. They also reported resistance stemming from fears that changes would introduce a lack of safety, due to its move away from long standing practice. The authors recommended updating clinical governance policies and formal procedures, as ways of translating TIC principles into practice. However, it is important to note Isobel and Edwards (2017) was one of the lower quality standard studies according to CASP (2018), and this finding should be considered cautiously.

Two studies mentioned medium-term impacts, one categorised medium-term as one month following training and reported that positive attitudes were maintained, and practice changes were incorporated into their work (Thompson, 2020). Nimura et al., (2019) categorised medium-term as three months post-training and reported that staff fully integrated TIC into their practice through three methods; using TIC principles to assess client's behaviour, modifying their communication, and managing patients' problematic behaviour without coercive practices.

The remaining seven studies considered the long-term impact of their training. Cations et al. (2021) reviewed their findings at 18 months but concluded there was insufficient power to detect changes, recommending other factors be considered when reflecting on long-term gains, such as reduced staff turn-over. McEvedy et al. (2017) similarly recommended further

TIC training to see sustainable long-term changes. Williams and Smith (2017) report limited success immediately following training, but one year post-training both clinicians and managers reported significant increases in awareness, knowledge, and attitudes to TIC. Similarly, Aremu (2018) reviewed clinical notes post-training and identified improved communication and use of solution-focused ideas. However, no specific long-term time frame for this follow-up was provided. The validity of Williams and Smith's (2017) and Aremu's (2018) findings are limited by their outcome measures, despite Aremu (2018) using a combination of validated measures and descriptive data, Williams and Smith (2017) used unvalidated measures and received only a 30% response rate. Moreover, attributing any long-term change to TIC training is problematic without in-depth knowledge of all other factors occurring during that period.

Palfrey et al. (2018) completed a twelve month follow-up, reporting significant long-term impacts post-training, such as 80% of staff routinely screening for trauma, a 20% increased focus on therapeutic alliances, and 10% reported feeling less intimidated by the presentation of trauma. Authors interpreted findings as indicators that training was impactful and concluded the service was moving towards being trauma-informed. However, the authors used a brief and unvalidated measure of TIC awareness and qualitative measures post-training, therefore caution is required regarding the validity of these findings.

Factors Influencing Effectiveness of Trauma Informed Care Training

Of importance to note is the variation of methods and designs across studies. Although all studies provided a form of TIC training, six studies provided this training as part of larger organisational projects. These six studies (Aremu, 2018; Cations, 2021; Isobel & Delgado,

2018; Isobel & Edwards, 2017; Medlin, 2017; Walsh & Benjamin, 2020) introduced additional changes, including TIC working groups, TIC champions, TIC policy changes, promotion of less-restrictive interventions, physical ward changes, service-user involvement groups, and training in de-escalation through solution-focused therapy techniques. These may act as confounding variables which impede our ability to understand the impact and effectiveness of the TIC training. Interpretations and conclusions should therefore be made with caution.

Fifteen studies included information on perceived barriers and facilitators affecting the effectiveness of their TIC training, with Iyengar (2018) omitting information on this. Five studies included information on specific facilitators which supported the positive outcomes of their training. Facilitators can be grouped into three main categories: change achieved through documentation, change achieved through long-term engagement and support of staff, and the quality of provided training. Three studies reflected on long-term change by updating documentation, such as clinical governance and organisational policies, through a trauma-informed lens (Chandler, 2008; McEvedy et al., 2017), as well as production of documents detailing the TIC training discussions (Walsh & Benjamin, 2020). Two studies reported on the importance of the quality of training provided, specifically the detail of TIC knowledge drawn on and materials provided (McEvedy et al., 2017; Palfrey et al., 2018). One study credited the long-term success of their training to open discussions for staff, which instilled a sense of safety and trustworthiness (Walsh & Benjamin, 2020).

Thirteen studies reflected on perceived barriers to the success of their training, these grouped into four categories: prior staff TIC knowledge and team dynamics, general workforce developments and challenges, organisational factors, and specific qualities of the training.

Limited prior knowledge on trauma, limited opportunities to implement TIC changes, lack of staff confidence, and hierarchical dynamics amongst the team, were identified as specific factors which reduce training effectiveness. However, information on barriers and facilitators were collected through small samples of qualitative interviews and anecdotal reflections from authors, making them speculative, therefore reducing the reliability and generalisability of these findings.

Five studies reported on barriers stemming from workforce challenges and developments, including staff turnover (Cations et al., 2021), inadequate staffing, high workloads, and fatigue (Nation et al., 2022), challenges providing trauma-informed supervision (Isobel & Delgado, 2018; Nation et al., 2022), and organisational factors needed to implement TIC (Williams & Smith, 2017). Isobel & Edwards (2017) reflected on wider staff culture which revealed resistance and fear of TIC following allegiance to the medical model and traditional hierarchical ways of nursing. Nation et al. (2022) additionally reflected on the lack of trauma specific therapy provided, which many felt reflected a lack of commitment to TIC from a wider service perspective.

A review of organisational factors which may impede on TIC changes revealed three themes: workload priorities, leadership commitment to TIC, and wider organisational culture. Three studies spoke of competing demands and opposing priorities, resulting in staff feeling overwhelmed and unable to consider new ways of working (Cations et al., 2021; McEvedy et al., 2017; Nimura et al., 2019). Similarly, four studies identified a lack of commitment to TIC from leadership was a deterrent to wider cultural change, through lack of support to implement TIC (Aremu, 2018; Cations et al., 2021; Chandler, 2008; McEvedy et al., 2017). These themes were recorded across various validated psychometric measures, routine

inspection of ward data, field notes, focus groups, and semi-structured interviews. The consistent identification of this theme improves the veracity and reliability of this finding.

Six studies reported the need for leaders and executives to be committed to TIC and offer structural support (Chandler, 2008; Hales et al., 2019; Isobel & Delgado, 2018; Isobel & Edwards, 2017; Medlin et al., 2017; Williams & Smith, 2017). A lack of response, funding, engagement in TIC projects, and resistance to change, were identified as key factors affecting change (Isobel & Edwards, 2017; Medlin et al., 2017; Williams & Smith, 2017). Similarly, many reported feeling restrained by non-TIC policies, which drew on the medical model (Hales et al., 2019; Isobel & Delgado, 2018).

Five studies critiqued the quality of the training provided, citing this as a barrier to long-term effectiveness of training. Two studies cited the need for training with more detailed TIC information (Gathings, 2020; McEvedy et al., 2017), while others felt training needed materials to be used in clinical working (Cations et al., 2021). Additionally, one study felt staff were more engaged when training was mandatory (Aremu, 2018), and another highlighted the need for training to be tailored to the specific needs of each diverse workforce (Nation et al., 2022).

Discussion

Overall Results

This review provides a report on staff's perceptions of the impact of MH inpatient staff TIC training on staff and clients. The secondary aim of this review was to understand the impact of training over time and learn about the barriers and facilitators to impactful and effective training. The review identified a variety of training designs, content, lengths, and methods of delivery, as well as a variety of staff participant groups. Across the training most studies reported moderate positive impacts on staff. These were seen through positive changes to staff awareness, knowledge, TIC attitudes, changes to clinical practice, and reductions in restrictive practice and medication use. A smaller portion of studies reported positive impacts of TIC training on inpatient clients. These positive impacts included increased client satisfaction, an increased use of coping skills, a reduction in challenging behaviour, and increased engagement in psychological interventions. The review also identified many studies simultaneously introduced other TIC interventions and some used unvalidated measures or qualitative interviews on small sample sizes, and so the validity of these findings has been questioned.

Of the studies which investigated the impact of their training over time, all but one reported positive medium-long term impacts. Reported long-term impacts were varied, and included positive impacts at the client, staff, and organisational levels. Examples include improvements to assessments, communication, organisational policies, service user involvement, reductions in challenging behaviour, coercive practices, and staff turnover. A smaller portion of studies also reported the introduction of screening for trauma, training in trauma-focused interventions, and trauma-informed supervision. One study reported ongoing

resistance and scepticism from staff, who felt TIC criticised their current approach.

The secondary outcome of this review, investigating mechanisms which support the impact of TIC training, identified several barriers and facilitators. Facilitators were grouped into three themes: change through documentation, long-term staff engagement and support, and training quality. Barriers to effective change were grouped into four themes, the level of pre-training TIC knowledge and team dynamics, and organisational developments and challenges. Overall, the review identified that TIC training may have positive impacts on staff and on client wellbeing, in the medium and long-term, however this is dependent on factors within the specific setting. However, determining the key training and extent of the impact is not clear due to the limited studies available and methodological challenges identified.

Moreover, six studies included larger organisational movements, and so conclusions regarding their training must be done with caution. Five of these studies reflect on the importance of support from leadership in creating an organisational culture change, which allowed the training to be drawn on in clinical practice (Aremu, 2018; cations, 2021; Isobel & Delgado, 2018; Medline, 2017; Walsh & Benjamin, 2017). From this, we could surmise that TIC training is most effective and impactful when accompanied by leadership and organisational support.

Methodological Considerations

Design

Most studies used a pre-test post-test design using quantitative measures (Aremu, 2018; Cations et al., 2021; Gathings, 2020; Hales et al., 2019; Iyengar, 2018; Medlin et al., 2017; Nimura et al., 2019; Palfrey et al., 2018; Thompson, 2020). Pre-test post-test design is a practical approach to measuring change (Dimitrov & Rumrill, 2003), especially drawing on quantitative measures which can provide accuracy and objectivity (Sjoberg & Horowitz, 2013). However, none of these studies used a control ward for comparison, and many completed post-measures immediately following training, with a limited number of studies using wider time frames (Cations et al., 2021, Palfrey et al., 2018, Williams & Smith, 2017). Changes may therefore be more indicative of possible changes and altered beliefs during training (De Los Reyes & Kazdin, 2006).

Most studies using this design also only completed one follow-up on one ward, without a comparison site, this may not be enough to identify stable change, and change that is identified may not be attributable to the intervention (Gottman & Rushe, 1993). This may in part be due to the potential presence of confounding variables, such as support from leadership, or the provision of training by staff within the teams (Isobel & Delgado, 2018; Medlin et al., 2017). The nature of pre-test measure may also alert participants to the hypothesis and result in a behaviour change (Gottman & Rushe, 1993). Moreover, only one study (Nation et al., 2022), incorporated both quantitative and qualitative components into their design. These identified weaknesses diminish the quality and generalisability of findings.

The second most prominent design was post-test only, using quantitative (Isobel & Delgado, 2018; Williams & Smith, 2017) or qualitative measures (Chandler, 2008; Isobel & Edwards, 2017; McEvedy et al., 2017). This design takes a snapshot measure following training, it is recommended for preliminary investigations (Christensen et al., 2011) and can provide insight when utilising only qualitative methods (Frey, 2018). However, this design has been critiqued due to be the absence of a comparison group (Frey, 2018), reducing the usefulness and validity of these findings.

Small sample sizes were also identified, with seven studies reporting 5-20 participants (Aremu, 2018; Chandler, 2008; Gathings, 2020; Isobel & Edwards, 2017; Iyengar, 2018; McEvedy et al., 2017; Thompson, 2020; Walsh & Benjamin, 2020). For the quantitative studies with reduced participant numbers and pre-test post-test designs (Aremu, 2018; Cations et al., 2021; Gathings, 2020; Isobel & Edwards, 2017; Iyengar, 2018; Thompson, 2020), we can surmise a lack of power to find significant differences across time. None of the reviewed studies reported on whether power calculations were made, and so the validity of their findings is compromised.

Moreover, the lack of control groups and randomisation across all included studies (identified as the research gold standard; Hariton & Locascio, 2018), can be interpreted as a design flaw. Moreover, all studies used single-site investigations, and only two included multiple inpatient wards within the same hospital setting (Cations et al., 2021; Iyengar, 2018). Generalisation of these findings are further compounded by the limited variation of countries within which the studies were conducted, Australia, USA, and Japan. As identified using the CASP tool, two studies (Isobel & Edwards, 2017; Walsh & Benjamin, 2020) did not meet high quality

standards for multiple checklist areas but were included in the review. Although inclusion of these articles has allowed for a wider scope of relevant research, it might reduce the validity of the review's findings. This was managed by reflecting on findings based solely on these studies and highlighting that these can only be made tentatively. This was noted on only one occasion, with all other findings being drawn from a mixture of studies.

Measure and reporting on the impact of TIC Training

Measures used varied in quality, with five studies using non-validated scales (Gathings, 2020; Isobel & Delgado, 2018; Iyengar, 2018; Palfrey et al., 2018; Williams & Smith, 2017). Findings based on these measures must be interpreted with caution (Boateng et al., 2018; Hammarstrom et al., 2016). Moreover, studies which drew on validated measures looked at a wide range of experiences, such as TIC attitudes (ARTIC-35; Baker et al., 2021), trauma-informed climate (TICS; Hales et al., 2019), and change readiness (OCRA; Helfrich et al., 2009). Considering the wide variety of measures and phenomenon being investigated, interpretation of these findings as one coherent unit may not be advisable. The investigation into staff perceptions of the impact of staff TIC training on MH inpatient clients did not draw on any measures, validated or otherwise, and drew only on staff reports based on their opinions. This reduces the validity and generalisability of these findings.

Implications

Clinical Implications

Given the tentative evidence and potential positive impacts TIC training can have on staff and clients in the short, medium, and long-term, it seems fair to suggest TIC training should continue to be introduced in inpatient settings, alongside robust evaluations of its impact and effectiveness. The presence of some resistance to TIC also suggests its importance in educating staff of the harms of punitive and traumatising methods. Moreover, training can be brief, flexible, and designed to meet specific team needs. This review suggests the critical component to training is the provision of the core TIC content (Table 4). The creation of a standardised training package may further support TIC education, as well as the provision of robust multi-site research to bolsters the evidence base.

Identified barriers and facilitators may also work as a guide for services looking to implement TIC. For example, training may be better embraced if TIC principles are embedded into the whole service culture, including a leadership commitment to TIC, and embedding of TIC principles into organisational policies. Leadership support should also result in staff feeling secure in embracing TIC into their clinical work. Staff wellbeing support and TIC supervision should also be provided, which could reduce rates of staff turnover and inadequate staffing which places a strain on remaining staff. Although these changes may require funding, the long-term gains of implementing TIC in inpatient care may save services significantly in the future, and can therefore be viewed as an investment into the wellbeing of inpatient staff and clients.

Research Implications

Research into inpatient staff TIC training is in its infancy, however, its early findings tentatively suggest some positive impacts and provide reason to continue exploring it. Future research should prioritise the inclusion of direct client perspectives and a control group, or if possible, a control group and randomisation. Randomisation and the use of a control arm, currently heralded as the gold standard design (Hariton & Locascio, 2018), would allow for clear comparisons and conclusions to be drawn about the impact and long-term effectiveness of TIC training. As the studies in this review do not provide this, it is not clear whether their findings are truly valid. Moreover, there is a paucity of longitudinal designs, reducing the support for long-term positive benefits of training. Future research may consider including larger follow-up time frames to expand this evidence base.

Another major consideration is the use of self-designed non-validated outcome measures, reducing the validity of findings (Garland et al., 2003). As support for TIC approaches have grown, the availability of validated measures has grown, and so future research may benefit from drawing on these. From this review, the most popular validated TIC measure was the ARTIC (ARTIC-35; Baker et al., 2021), followed closely by The Trauma-Informed Climate Scale (TICS; Hales et al., 2019), these could be utilised as primary and secondary measures for future research.

Research including control groups, significant sample sizes, as well as multi-site studies, would support the establishment of the clear benefits of TIC training, as it would allow for power for comparisons across sites (Flynn, 2009). This would also reduce the possibility of confounding variables affecting findings and therefore generalisability (Beischel et al., 2016).

Moreover, many studies only drew from one method, either quantitative or qualitative, leaving room for speculation. Future research may therefore build on this by using mixed-methods designs, creating a clearer and stronger picture (Almalki, 2016).

Limitations of the Review

The scope of this review covered several broad themes, including the specific impact of TIC training and the long-term effectiveness of these impacts. The heterogeneity of these themes, alongside the diversity of study designs, sample sizes, TIC training, and outcome measures, disrupts the ability to effectively synthesis findings and assert conclusions. Nonetheless, as this field is in its infancy, a broad approach has allowed for useful themes to emerge and identification of several future research opportunities.

This review focused on adult government provided inpatient services, which excluded several high-quality studies on private facilities and child and adolescent facilities. Several reviews were also excluded as they included a larger TIC project, which staff TIC training played a small part which was not specifically reported on. Findings from these studies may have added further insight into staff TIC training, however, it was decided that a focused and specific approach would be of a higher value.

Conclusions

This review investigated the impact of MH inpatient staff TIC training on inpatient staff and clients, in the short, medium, and long-term, and explored the mechanisms which support or impede this impact. The prominence of single-site pre-test post-test designs, small sample sizes, training heterogeneity and general methodologies, impedes on the strength with which conclusions can be drawn. However, the results indicate some preliminary evidence that training has positive impacts. For staff, TIC training appeared to improve awareness, knowledge, TIC attitudes, management of challenging behaviour, and reduced restrictive practice. For clients, training appeared to improve their satisfaction with care, use of coping skills, increased planned discharge rates, and improved engagement in talking therapies.

There was some evidence that these impacts were maintained in the short, medium, and long-term. Facilitators supporting these impacts included documentation of TIC changes, long-term engagement and support of staff, and quality of training provided. Barriers to positive impacts included organisational factors, lack of leadership commitment to TIC, team culture/dynamic challenges, staff fatigue, lack of supervision, and inadequate staffing. These findings provide some support for the provision of TIC training for inpatient staff and provide an insight into ways to make a successful cultural move towards trauma informed practice. Further research is needed to test the validity of these findings and develop our understanding further, this may best be done by using high quality longitudinal designs that use a control group, multi-sites, and mixed methods.

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Section B: Empirical Research

An investigation into the culture of mental health inpatient wards and the introduction of Trauma-Informed Care through workshops.

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Abstract

Objective

Research has identified traumatising practices, within mental health inpatient settings. As these settings care for vulnerable individuals who are likely to have experienced trauma, new ways of working have developed to reduce re-traumatisation, such as trauma-informed care (TIC). Some positive benefits for staff and clients have been found from introducing TIC, however barriers to TIC working have been identified, and the research base quality has been questioned. The aim of this study was to examine the current culture of mental health inpatient wards, and the potential role and feasibility of introducing TIC through staff workshops.

Methodology

Thirty-one mental health inpatient staff from a variety of professions participated in this mixed methods study. Participants completed quantitative measures assessing their attitude, practices, and ward climate in relation to Trauma Informed Care (TIC). Participants were then invited to attend one workshop, on the role of trauma in mental health, TIC principles, and ways to integrate TIC into clinical practice. Following the workshops, 10 semi-structured interviews were conducted with staff to understand the current ward culture, as well as the potential role of, barriers to, and perceived impact of, introducing TIC in mental health inpatient settings. Quantitative measures provided descriptive statistics and interviews were analysed using reflexive thematic analysis (RTA).

Results

Staff reported above-average positive attitudes towards TIC and an above-average TIC-climate. However, staff also reported below-average personal and systemic support to

implement TIC into practice. Staff also reported recent restrictive practices to be severe in response to perceived aggression (SOAS-R), and detrimental to staff and clients (ATTACKS). These findings suggest staff theoretically support TIC values but may not be able to incorporate them into their practice.

These findings are supported by the RTA which identified a lack of TIC knowledge and practices which contradict TIC-values. The RTA indicated several cultural and organisational barriers to implementing TIC into practice, including lack of staffing and leadership support. Staff who attended the TIC workshop reported positive impacts, such as improved TIC knowledge and reductions in restrictive practice. Many also reported a desire for further TIC training and a cultural move towards TIC.

Conclusions

Although participants identified a need for a TIC-intervention and reported positive impacts of introducing TIC through training, several identified barriers to TIC working may reduce its possible effectiveness. The support of management and leadership in the implementation of TIC working is vital in facilitating this cultural shift.

Keywords: Trauma Informed Care, Mental Health, Inpatient, Staff, Workshops

Introduction

Inpatient Settings

Despite support for psychiatric inpatient treatment (Gowers & Rowlands, 2005), their 'insane asylums' history (Symonds, 1995) and use of inhumane practices (Chatterjee, 2022; Clark, 2015), aimed to control (Scull, 1997), have been heavily critiqued. Although there is a well-documented move (Houston, 2020) towards a biopsychosocial model (Engel, 1981), inpatient settings are still dominated by the medical model of mental health (MH), i.e., the belief MH challenges derive from physical illnesses (Handerer et al., 2021). The medical model often prioritises risk management, despite movements away from stigmatising clients as 'dangerous' (Mehta et al., 2015). Prioritising risk may relate to the type of conditions inpatient settings treat (Janner et al., 2012), such as psychosis, which can be associated with unsafe behaviours (Gebeyehu et al., 2021).

Risk management often involves restrictive practices (Lee et al., 2003), such as physical restraint, seclusion, and chemical control (Bloom & Farragher, 2011). These can be traumatising for clients (Frueh et al., 2005), and staff (Bonner et al., 2002), and cause further MH difficulties, injury, and death (Sturmey et al., 2015). However, staff often believe restrictive practice is necessary for safety (Butterworth, Wood, & Rowe, 2022). Research within inpatient settings highlights medical model overreliance, possibly demonstrated by power imbalances between clients and staff, as well as within and between staff professions (Scholz & Stewart., 2021). Moreover, psychosocial factors are often overlooked (Braslow & Messac., 2018) in favour of risk management (Barnes et al., 2022).

Inpatient Staff and Culture

Most MH inpatient services in England are managed by NHS funded Trusts. Austerity and public healthcare spending cuts (Knapp, 2012; Mattheys, 2015), have shrunk services (Cummins, 2018), and salaries (Mahase, 2022). Individuals experiencing poverty or MH problems, are most negatively impacted by austerity, leading to increased need for NHS mental healthcare (Cummins, 2018). Greater need and reduced availability of support has resulted in increased pressure and workloads for MH staff (Kiely, 2021). This leads to staff burn-out (Iliffee & Manthorpe, 2019), and physical and MH challenges (Renwick et al., 2019), especially during the COVID-19 pandemic (Germaine et al., 2021).

Staff experiences are compounded by witnessing of trauma, resulting in vicarious trauma (Ham et al., 2022). Low pay, high workloads, and vicarious trauma may account for high staff turnover (Scanlan & Still, 2019), and recruitment challenges (Oates et al., 2020). Despite initiatives (Phiri et al., 2022), services report bank staff overuse (Baker et al., 2019), which correlates with violence and low staff morale (Johnson et al., 2011; Martin & Daffern, 2006).

Possibly due to medicalisation, the structure of inpatient settings has been described as hierarchical (Eaton, 2017, Weller et al., 2014), causing powerlessness for clients and staff (Stacey et al., 2016). Powerlessness correlates with poor communication (Cleary et al., 2012), low job satisfaction (Hood & Patton, 2022), punitive methods of control, and reduced psychosocial thinking (Butterworth, Wood, & Rowe, 2022). This environment may impede staff's long-term thinking (McAllister & Moyle, 2008), consideration of alternative treatments (Mullen, 2009), and ability to engage in changes or training (Raphael, 2021).

National pressures and inpatient-specific challenges create a difficult organisational culture for staff to work and thrive in. Organisational culture refers to an unconscious set of values and norms that create a shared meaning system (Burke & Litwin, 1992). Given the context of medicalisation, hierarchy, austerity, and traumatic coercive practices within UK MH inpatient settings, it is likely inpatient staff teams are systemically traumatised (Goldsmith et al., 2014). This results in a culture of distress, a lack of focus on client needs, and resistance to change (McElvaney & Tatlow-Golden, 2016). Due to this traumatised culture, staff may identify that changes could be beneficial in aligning their practices with NHS values, but feel unable to execute those changes (Lavender, 2023).

Trauma

Trauma's definition has evolved over time, with earlier definitions referring to direct experiences of life-threatening injury (Strauss, Lang, & Schnurr, 2017). More recent conceptualisations include psychological distress (Jeter & Brannon, 2014), indirect experiencing (Jordan, 2010), and multiple incidents (Kliethermes et al., 2014).

The most recent related diagnosis is Post-Traumatic Stress Disorder (PTSD; North et al., 2009). Prominent diagnostic manuals (ICD-11; WHO, 2018a; DSM-V; APA, 2013) assert criteria, outlined in Table 1, are required for a PTSD diagnosis. Research has identified PTSD risk factors, including previous trauma, previous MH problems, low socio-economic status, trauma severity, social support, life stress, and psychological processing during and after (Breslau et al., 1995; Wade et al., 2013).

Table 1. *DSM-V and ICD-11 Diagnostic Criteria for PTSD*

PTSD (DSM-V, 2013)	PTSD (ICD-11, 2018)
A. Exposure to actual or threatened death, serious injury, or sexual violence	• Exposure to an extremely threatening or horrific event or series of events
B. Intrusions C. Avoidance D. Changes in cognitions and mood E. Arousal and reactivity	• Re-experiencing • Avoidance • Persistent perceptions of heightened current threat
F. Duration of more than 1 month G. Clinically significant distress or impairment of function H. Due to event, not due to physiological effects of a substance or medical condition	• Must last for at least several weeks • Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning

The impact of cumulative life stress on trauma symptoms has been researched (Holmes & Rahe, 1967). Of most prominence is Felitti et al's (1998) Adverse Childhood Experience (ACE) scale, which highlighted a relationship between childhood abuse, long-term physical well-being (Bellis et al., 2019), MH (Merrick et al., 2017), incarceration (Messina & Grella., 2006), and homelessness (Kim et al., 2010). This research proposes a move from understanding trauma as individualistic experiences, towards cumulative wider levels of influence, such as community factors (Kilanowski et al., 2017).

Research shows associations between trauma and MH conditions that are prevalent among MH inpatients (Morris et al., 2021), including psychosis (Gibson et al., 2016). Inpatient settings therefore care for individuals who have likely experienced trauma (McFarlane et al., 2001), are at risk of further trauma (Berry et al., 2013), and place staff at risk of traumatisation through vicarious trauma (Olashore et al., 2018). Despite these findings, the

medical model, which dominates inpatient settings (Handerer et al., 2021), often downplays the role of trauma (Demke, 2022), commonly reducing trauma to a potential trigger for a biological vulnerability (Jakovljevic et al., 2012).

Trauma Informed Care

Increased awareness of trauma's effects has led to the development of approaches that acknowledge the role of trauma and aim to reduce re-traumatisation; these approaches are known as trauma-informed care (TIC) (Becker-Blease, 2017). Although there is no universally accepted TIC definition (Marsac et al., 2016), the Substance Abuse and Mental Health Administration (SAMHSA., 2014a), propose the "Four R's", found in Table 2.

Table 2. *The Four R's (SAMHSA., 2014)*

Core Principle	What this involves
1. Realizes	Realizes the widespread impact of trauma
2. Recognizes	Recognises the signs and symptoms of trauma among clients and staff
3. Responds	Responds by integrating knowledge about trauma into practice and policy
4. Resists	Proactively resists retraumatization

Various TIC frameworks have emerged, however, Harris and Fallot's (2008) Five-Dimensional model is most prominent. This model asserts everyone experiences trauma and organisations should acknowledge this by following five principles of safety, trustworthiness, choice, collaboration, and empowerment. These aim to reduce re-traumatisation and align with NHS values (Sykes & Durham, 2014).

TIC has grown in popularity (Becker-Blease, 2017) across learning disabilities (Keesler, 2014), social policy (Bowen & Murshid, 2016), forensics (Vaswani & Paul, 2019), and politics (Purtle & Lewis, 2017). Norway, Sweden, and Scotland have integrated TIC into national policy (Johnson, 2017, NHS Education for Scotland, 2017a/b). Research supports TIC in meeting trauma survivors needs and mitigating health disparities (Reeves, 2015).

Trauma Informed Care in Inpatient Settings

Inpatient clients have likely experienced trauma (Buswell et al., 2021), with Panayi et al., (2022) showing correlations between those hospitalised with psychosis and PTSD. Trauma-focused support could therefore be beneficial in inpatient settings for clients (Chadwick & Billings, 2022). Various methods of introducing TIC into MH inpatient settings have developed, offering an alternative framework for services to follow in place of the medical model and restrictive policies. These include the use of Open Dialogue (Jacobsen et al., 2018), the Power Threat Meaning Framework, psychological stabilisation, and staff TIC training (Nikopachos & Burrell, 2020; Nikopachos et al., 2023).

Positive outcomes have been identified from these methods, most notably from staff TIC training, including reductions in restrictive interventions (Azeem et al., 2011), increased staff TIC awareness and confidence (Nikopachos et al., 2023), reduced staff burnout (Handran, 2015), increased staff retention (Hales et al., 2019), and improved care quality (Brophy, 2016). Investigations into implementing TIC often recommend prioritising staff education (Van Dam et al., 2008).

The Potential Effects of TIC

Most studies report positive TIC effects through staff training. These effects include improved TIC awareness (Williams & Smith, 2017), knowledge (McEvedy et al., 2017), attitudes (Thompson, 2020), confidence (Gathings, 2020), clinical skills (Aremu, 2018), trauma communication (Walsh and Benjamin, 2020), and reduced seclusions, restrictive practices, and chemical sedation (Cations et al., 2021; Chandler, 2008). Reductions in violence (Cations et al., 2021), increases in consideration of colleagues' trauma (Thompson., 2020), and increases in Trauma-informed policies (McEvedy et al., 2017), have also been found. Staff also report improved client recovery and discharge rates (Hales et al., 2019), utilization of coping skills, decreases in challenging behaviour, and increased talking therapy engagement (Medlin et al., 2017). However, research by Isobel and Edwards (2017) reported staff were resistant to TIC working and even reported fear that TIC working was unsafe.

Furthermore, there has been criticism around the quality of the evidence base and some inconsistencies in reported conclusions. Some research has reported no impacts (Medlin et al., 2017), or lack of support to implement TIC (McEvedy et al., 2017). Research design quality has been questioned, with no trials using randomization (Hariton & Locascio, 2018), and many reporting small samples, single methodologies, and unvalidated measures, reducing their reliability and generalizability (Almalki, 2016, Garland et al., 2003). The literature therefore identifies a mixture of benefits to implementing TIC in inpatient settings, with calls for further empirical evidence (Valenkamp et al., 2014).

Trauma Informed Care Training for Staff

Attention has turned to ways to create trauma-informed organizations (Hanson & Lang, 2016), focusing on staff training (Bryson et al., 2017). Staff training has become an integral component of TIC organizational change, with SAMHSA (2014a), the Agenda for Addressing Adverse Childhood Experiences (Bethell et al., 2017), The Trauma-Informed Justice System (Branson et al., 2017), and the Trauma-Informed Pediatric Healthcare Networks (Marsac et al., 2016) declaring it essential.

Staff training aims to increase TIC-awareness and TIC-working. However, there are inconsistencies in training design, content, delivery, and length (Gathings, 2020; Nation et al., 2022; Nimura et al., 2019; Thompson, 2020). Inconsistencies and heterogeneity make it hard to generalize the effects of TIC training on individual practices as well as wider team cultures.

The Feasibility of TIC Implementation

While there are successful examples of services implementing TIC, such as Prytherch, Cooke, and Marsh's (2021) Trauma-Informed crisis house, there remain practical difficulties in introducing TIC in UK settings (Hales et al., 2017). This may be true for inpatient services where coercive practices still exist (Szasz, 1970), and are deemed necessary, so alternatives are rarely attempted (May, 2008). Coercive practices, such as forced medication and restrictive practices, are contradictory practices to TIC (Bloom & Farragher, 2011) i.e., practices which do not follow TIC principles and are known to traumatise (Sturmey et al., 2015). Additionally, as TIC lacks a coherent theoretical basis (Marsac et al., 2016) it is likely

many services default to the well-established medical model (Smith & Monteux, 2023).

Capacity for change is also impeded by staff trauma (Pearlman & Saakvitne, 1995), which can reduce critical thinking (Foa & Rauch, 2004). Some organisations which have overcome challenges and implemented TIC report uneven benefits (Kusmaul et al., 2015), required continued leadership support, staffing, and funding (Conners-Burrow et al., 2013), resources lacking within inpatient settings (Bannister, 2021). Studies have reflected on TIC implementation facilitators, including updating organisational policies through a trauma-informed lens (McEvedy et al., 2017), and staff training quality (Palfrey et al., 2018).

Potential barriers have included, limited prior trauma knowledge, high staff turnover (Cations et al., 2021), high workloads and fatigue (Nation et al., 2022), lack of trauma-informed supervision (Isobel & Delgado, 2018), lack of organisational support (Cations et al., 2021), and medical model allegiance (Isobel & Edwards, 2017). Other organisational barriers include competing prioritised demands (Nimura et al., 2019), linked to contradictory TIC policies (Isobel & Delgado, 2018). Investigations into overcoming these conceptual and practical barriers are needed.

Rationale and Aims

Considering the dominance of the medical model, pressurised, risk-focused, and traumatising restrictive practices in MH inpatient settings, investigations into ways to improve practices, increase psychosocial thinking, and reduce re-traumatisation of clients and staff, are needed. This is further emphasised by the high proportion of MH inpatient clients who have likely experienced trauma and are vulnerable to re-traumatisation. Considering the mostly positive

effects identified following the introduction of TIC, albeit from a limited research base, it is of value to investigate whether TIC values are present in UK MH inpatient setting cultures. It is also important to further our understanding of the feasibility of introducing TIC into these cultures, to learn how staff and team cultures respond, and consider the impact this may have on client care.

This investigation aimed to explore the culture of two MH inpatient wards in relation to TIC, through quantitative measures and semi-structured interviews with staff. This involved assessing staff attitudes, clinical practices (such as restrictive practice) and descriptions of the ward climate in relation to TIC. Interviews were used to investigate staff perceptions of the feasibility of introducing TIC into these settings, providing insight into potential conceptual and practical barriers present in these cultures. Conceptual barriers include implicit ideas which guide the care provided, and practical barriers include contextual challenges which prevent services from delivering TIC. This research also tentatively explores the potential individual staff and team effects that may be possible following TIC workshops. These are assessed through semi-structured interviews with staff TIC workshop attendees.

Research Questions

This research aimed to answer the following questions:

1. How do MH inpatient staff describe their current attitudes, practices (including the use of restrictive practice), and the ward climate in relation to TIC?
2. What are staff perceptions of the feasibility of introducing TIC in MH inpatient settings?
a) What conceptual barriers to TIC do staff describe?

b) What practical barriers to TIC do staff describe?

3. How do MH inpatient wards respond to TIC workshops, and how do attending staff describe the effects of TIC training on their individual practice and wider teams?

Methodology

Design and Sampling

The original study design intended to conduct a pre-post evaluation of TIC workshops on 40 employees from two MH inpatient wards. However, due to poor workshop attendance and staff attrition, this design proved infeasible. The challenges identified in this original design speak to the current culture and feasibility of introducing TIC into this setting and are further reflected on in a research diary in Appendix L.

From the data that was collected it was possible to use a new mixed methods design to address the three research questions detailed above. The new design drew on findings from interviews with ten staff members, five of whom had attended the workshop, to answer the three research questions. Findings from the quantitative measures provided insight into the wards culture and therefore support research question one. Reported below is the methodology used for the adapted study design.

31 participants completed quantitative measures before being invited to attend one three-hour TIC workshop. Measures were used to investigate various components of the ward culture, including staff TIC attitudes, practices, and ward climate. A sample of 10 participants, five of whom had attended the workshop, were then invited to attend a semi-structured interview investigating the feasibility, ward response, and potential effects of introducing TIC in inpatient settings.

Overall, a mixed methods approach was chosen (Creswell & Clark, 2011; Fetters et al., 2013) as it offered the strongest way of investigating the research questions (Almalki, 2016;

Kimmons, 2022). Purposive sampling of 10 staff members (five of whom attended the workshop) and a qualitative method was used to investigate all research questions (Rai & Thapa, 2015). Interview data from staff workshop attendees were used to answer research question three. Quantitative data was used to further explore the first research question.

Ethical Considerations

Approval was provided by Canterbury Christ Church University, Salomons Institute for Applied Psychology (Appendix A) and the NHS Health Research Authority (Appendix B) and it complied with the human research ethics code (BPS, 2021). Prior to providing consent (Appendix C), participants were informed of the research purpose, provided with an information sheet (Appendix D), and given time to ask questions. Participants were informed of their right to withdraw or have their data destroyed with no repercussions.

Participants

Participants (N = 31) were full-time permanent MH professionals working in two NHS adult acute MH inpatient wards in a large city. These wards cared for adults aged 18-65 with severe and enduring MH conditions, requiring intensive support and observation. One ward supported female clients and the other male clients. Both wards supported formal and informal clients (not detained under the Mental Health Act). These wards were located within a large MH hospital which contained other inpatient units and specialist community teams. The NHS Trust supports over one million people across four boroughs.

Due to the diverse inpatient workforce, participants from any MH profession, age, gender,

ethnicity, or employment timeframe were included. Bank staff and students were excluded due to the transient nature of these roles (Monday et al., 2020) which could increase their risk of drop-out. A break-down of participant characteristics for quantitative measures and interviews can be found in Tables 3 and 4.

Table 3. Participant Characteristics

Characteristic	**Total N (31)**
Profession	
Registered Mental Health Nurse	6
Ward Manager	2
Health Care Assistant	3
Clinical Support Worker	12
Peer Support Worker	1
Clinical Psychologist	1
Occupational Therapist	1
Ward Administrator	1
Activity Coordinator	1
Psychiatrist	1
Trainee Doctor	1
Clinical Service Lead	1
Sex	
Female	9
Male	22
Other	0
Length of Time in Current Post	
<1 Year	10
>1 Year	12
>3 Years	7
>5 Years	2
>10 Years	0
Ethnicity	
Black African	9
Black British	4
Black Caribbean	7
White Caucasian	1
White Other	4
Asian British	3
Other	3

Table 4. Semi-Structured Interview Participants Characteristics

Participant	Sex	Length of Time in Post	Ethnicity
1	Female	<1 Year	White Other
2	Male	<1 Year	Black African
3	Female	<1 Year	White Caucasian
4	Female	>1 Year	Black Caribbean
5	Female	>1 Year	Black British
6	Female	>3 Years	Asian British
7	Male	>5 Years	Black British
8	Male	<1 Year	White Other
9	Female	<1 Year	Black British
10	Female	>1 Year	White Other

Service User Involvement

Two lived experience practitioners provided guidance on research design, interview questions, and supported the first two TIC workshops, providing personal insight into their experience. Both were financially reimbursed.

Procedure

Recruitment took six months across three phases. Within phase one, which lasted two months, researchers provided staff with information sheets and consent forms (Appendices C & D), if consent was provided pre-workshop measures were completed. In phase two, researchers organised workshops which could be attended face-to-face or online (via Microsoft Teams). Workshops included an overview of the role of trauma, TIC models, and TIC adaptations to clinical practice. Workshops involved PowerPoint presentations, group discussions, and hand-out materials. A detailed account can be found in Appendix E. In phase three, 10 semi-structured interviews were conducted with five workshop attendees and five non-attendees. Eight interviews were conducted online, and two in person.

Quantitative Measures

Four quantitative measures were used to investigate staff attitudes, practices, and the ward climate in relation to TIC. Two of these measures were used to specifically explore staff's use of restrictive practice.

TIC attitudes and climate were measured by The Attitudes related to Trauma-Informed Care Scale (ARTIC; Baker et al., 2016) and The Trauma Informed Climate Scale (TICS; Hales et al., 2019) (Appendix F). The ARTIC is a self-report measures which contains seven subscales, depicted below in Table 5. The ARTIC assesses staff TIC awareness and attitudes (Champine et al, 2019). Good internal consistency, reliability, and construct validity have been illustrated by Baker et al., (2020).

Table 5. ARTIC-45 Subscale

	Subscale	Meaning
1.	Underlying Causes of Problem Behaviour & Symptoms	Emphasizes behaviour and symptoms as adaptations and malleable vs behaviour and symptoms as intentional and fixed.
2.	Responses to Problem Behaviour & Symptoms	Emphasizes relationships, flexibility, kindness, and safety as the agent of behaviour and symptoms change vs rules, consequences, and accountability as the agent of change.
3.	On-The-Job Behaviour	Endorses empathy-focused staff behaviour vs control-focused staff behaviour.
4.	Self-efficacy at Work	Endorses feeling able to meet the demands of working with a traumatised population vs feeling unable to.
5.	Reactions to the Work	Endorses appreciating the effects of secondary trauma/vicarious traumatization and coping by seeking support vs minimizing the effects of secondary trauma/vicarious traumatization and coping by ignoring or hiding the impact.
6.	Personal Support of TIC	Endorses being supportive of, and confident about, implementation of TIC vs concerns about implementing TIC.
7.	System-Wide Support of TIC	Endorses feeling system-wide support for TIC vs NOT feeling supported by colleagues, supervisors, and the administration to implement TIC.

The TICS is based on Harris and Fallot's (2001) five values (safety, trustworthiness, choice, collaboration, and empowerment) and assesses whether the climate is trauma-informed for staff and clients. Good internal consistency and validity have been illustrated by Hales et al. (2017).

The nature of restrictive practices was measured using the Staff Observation Aggression Scale- Revised (SOAS-R) (Nijman et al., 1999; Appendix G) and The Attempted and Actual Assault Scale (ATACKS; Bowers et al., 2002; Appendix H). Participants completed these if they had been involved in restrictive practice within the last two months. The SOAS-R monitors inpatient aggressive incidents and staff responses. It is quick and easy to complete. Palmstierna and Wistedt (1987) found satisfactory interobserver reliability of the scale, and Nijman et al. (1997a), and Shah et al., (1991) illustrated its reliability and validity. The ATACKS measures assaults and has been found an acceptable and valid measure of inpatient interpersonal violence (Bowers et al., 2002).

Qualitative Interviews

Ten Semi-structured interviews were conducted, five with workshop attendees and five with non-attendees. Interviews lasted 30-60 minutes and were conducted in person or online. Two interview schedules were developed, one for attendees and one for non-attendees, found in Appendices I and Appendix J. Semi-structured interviews were selected as they allowed for a consistent protocol while providing room for natural discovery (Magaldi & Berler, 2020).

Quality Assurance

The quality assurance guide from Elliot et al. (1999) was followed and a positioning statement (Appendix K) was created to consider the researcher's perspectives, potential biases, and ways to minimise their impact (Castleberry & Nolen, 2018). This statement reflected on the researcher's potential insider status, having previously worked on these wards prior to conducting the research. This statement was reflected on with a supervisor and used to discuss ways to minimise bias and influencing research outcomes. A reflective research diary was also kept by the lead researcher throughout the research process (see Appendix L).

Informal discussions around coding and theme extracts were held between the research team (Nowell et al., 2017), and participant quotes are presented in Appendix M to increase transparency and integrity (Hill et al., 2005). Situating the sample was done by describing research participants so readers can independently judge findings' generalisability (Elliot et al., 1999). Credibility checks involved analytic auditing through supervisors checking themes against raw data, and testimonial validity (Elliot et al., 1999) by checking results with a Support Worker participant.

Data Analysis

As the ARTIC is in development with no current norms, the scale's authors advise using the scales midpoint as an average to compare with participants' averages (Baker et al., 2016). Similarly, average scores across subscales were calculated from the TICS, but these were compared to averages normed from previous TICS outcomes on similar participants (Hales et

al., 2019; Kusmaul, Wilson, & Nochajski, 2015), these are described in the results and can be found in Table 9 and Appendix N. An overview of participants demographics used for norming the TICS can be found in Appendix O.

The SOAS-R used subscale scores to produce a total score which was compared to a SOAS-R 'Severity Score Range' produced by Nijman et al., 2005, found in Table 6. ATACK subscale scores were summed to produce a severity score using Bowers, Nijman, & Palmstierna, (2007) formula (Figure 1), an average across participants was then calculated and compared to Bowers, Nijman, & Palmstierna's (2007) average of 29.1. Involvement in restrictive practice percentages were created using the number of staff reporting involvement in restrictive practice and the overall number of participants. Results from descriptive statistics were used as a narrative tool.

Table 6. SOAS-R Severity Scoring Range (Nijman et al., 2005)

SOAS-R Score	Aggression Severity Range
0-7	Mild Aggression
8-15	Moderate Aggression
16-22	Severe Aggression

Figure 1. ATTACKS Severity Formula (Bowers, Nijman, & Palmstierna, 2007)

ATTACKS Severity =

((Weapon Score + Target Score) x Intensity) + (Commitment to Harm vas + Injury Potential VAS)

Interviews were analysed using Reflexive Thematic Analysis (RTA; Braun & Clarke, 2021). RTA identifies patterns of meaning across qualitative datasets, while remaining flexible and epistemologically cohesive with quantitative approaches (Braun & Clarke, 2006). This

provided insight into staff understanding and attitudes towards TIC, and perceived feasibility of introducing TIC. RTA was used inductively and deductively to allow for themes to be drawn from the data, while also drawing on potential prior coding from theoretical underpinnings, such as Fallot and Harris (2008) TIC principles. RTA stages, found in Table 7, show a flexible, fluid, and iterative process (Braun & Clarke, 2021). Interview data from the five workshop attendees were used to develop the themes supporting research question 3.

Table 7. Six Stages of Reflexive Thematic Analysis

	Phase	Description
1.	Familiarising yourself with the dataset.	Becoming familiar with the content of your dataset through immersion. Reading & re-reading your data and making brief notes on analytic ideas or insight you may have on each data item or the whole dataset
2.	Coding	Working through your dataset to identify interesting, relevant, or meaningful segments and apply analytically meaningful descriptions. In reflexive TA you code at a range of levels, from explicit (semantic) to implicit (latent), capturing your 'analytic take' on your data. Code your entire dataset systematically and when done collate your code labels and compile your relevant segments of data for each code.
3.	Generating initial themes	Identifying shared pattern meaning across the dataset by compiling clusters of codes that share a core concept and might prove meaningful in answering your research question. Theme development is an active process, constructed by the researcher. Whereas codes capture specific or meaning, themes describe broader, shared meanings. Once identified collate all coded data relevant to each candidate theme.
4.	Developing & reviewing themes	Assess the initial fit of your provisional themes to the data, and viability of your overall analysis, by going back to the full dataset. Check that themes make sense in relation to coded extracts and the full dataset. Radical revision might be needed. Candidate themes may be retained, discarded, collapsed together, or split into new themes. Each theme must have a central organising, and consideration placed on the relationship between themes, existing knowledge, practice in the field, and wider research context.
5.	Refining, defining & naming themes	Fine-tune your analysis, ensuring each theme is clearly demarcated and built around a strong core concept. Key activities include writing a brief synopsis of each theme, deciding on a concise name, and deciding to let go if your refining process indicates more development is needed.
6.	Writing up	Analytic writing starts from phase 3, with familiarisation notes and reflexive journaling, these can feed into the formal write-up. The aim is to weave together your analytic narrative and compelling data extracts to produce a coherent and persuasive story about the dataset that addresses your research question.

Epistemologically, this investigation employed a critical realist stance (Bhaskar, 2013), sitting between ‘observable’ and ‘real’ dimensions. This stance considers the social processes, such as social desirability bias, and sociocultural contexts, and assumes that interviews provide inexact accounts of ‘real’ thoughts. An additional Trainee Psychologist reviewed coded data before it was reviewed by the research team.

Results

Quantitative Measures

Thirty-one full-time, permanent staff members, working as MH professionals across two NHS adult acute MH inpatient wards, consented, and completed quantitative measures. All participants were offered attendance at one of the six workshops. Across the six workshops, 18 participants attended, resulting in a 58% attendance rate. The findings of these measures are now presented in relation to the research question they support.

Research Question 1 – How do MH inpatient staff describe their current attitudes, practices (including use of restrictive practice), and the ward climate in relation to TIC?

Current Attitudes

The ARTIC (Baker et al., 2016), which assessed staff TIC awareness and attitudes, was completed by all 31 participants, is presented in Table 8, and shows overall attitudes towards TIC (3.9/7), were slightly above the midpoint (3.5). When reviewed by sub-scale, participants scored above the midpoint for 5 subscales, and below the midpoint on Personal Support of Trauma-Informed Care and System-wide Support for Trauma-Informed Care. Results indicate staff described positive attitudes towards TIC but were not supportive of, or confident in, implementing TIC, or supported by colleagues, supervisors, or administrators to implement TIC.

Table 8. The Attitudes Related to Trauma-Informed Care Scale Mean Averages and Ranges (ARTIC; Baker et al., 2016)

	Underlying Causes of Problem Behaviour & Symptoms	**Responses to Problem Behaviour & Symptoms**	**On-The-Job Behaviour**	**Self-Efficacy at Work**	**Reactions to the Work**	**Personal Support of Trauma-Informed Care**	**System-Wide Support for Trauma-Informed Care**	**Overall Total Average**
Total Mean Average (Range)	*4.5/7 (3.14-6.00)*	*4.6/7 (2.43-6.83)*	*4.6/7 (2.43-6.43)*	*4.7/7 (2.00-6.86)*	*4.8/7 (2.71-7.00)*	*2.4/7 (2.00-7.00)*	*2.1/7 (2.50-5.80)*	*3.9/7 (3.00-6.09)*

The Ward Climate

The TICS (Hales et al., 2019), which measured how trauma-informed the climate was, was completed by all 31 participants, is scored on a Likert scale with two items per TIC value. Higher scores indicated a more trauma-informed climate (Harris & Fallot, 2001). Subscale averages were taken for comparison from Hales et al. (2019) and Kusmaul, Wilson, and Nochajski (2015), who used this scale with American MH and behavioural staff. Most of their staff participants were female and Caucasian, and a full break-down of their characteristics can be found in Appendix 0.

As seen in Table 9 and Appendix N, overall participants scored above average across all subscales, indicating an above-average trauma-informed climate. When reviewed by TIC value, participants reported safety as the highest, followed by choice, collaboration, trust, and lastly empowerment.

Table 9. Average Mean Scores and Ranges for The Trauma Informed Climate Scale (TICS; Hales et al., 2019)

TICS-10 Subscale	Hales et al., (2019)	Kusmaul, Wilson, & Nochajski (2015)	Current Study
Safety	3.60	4.05	5.6/7 (2.5-7)
Trust	3.34	3.78	4.6/7 (1.5-7)
Choice	3.23	3.75	5.5/7 (1-7)
Collaboration	3.23	3.61	4.65/7 (1-7)
Empowerment	3.35	3.88	4.56/7 (2.5-7)
Total TIC Climate	16.75	19.07	24.91/35 (13-35)

Practices (Including use of restrictive practice)

During the completion of the quantitative measure's participants were asked how often they had been involved in restrictive practice in the last 2 months. As seen in Table 10, of the 31 participants, 12 participants (39%) reported involvement in at least one incident of restrictive practice. Of these 12, six participants (19%) reported involvement in two+ incidents of restrictive practice.

Table 10. Overview of Staff Reported Involvement in Restrictive Practice in the last 2 months

Reporting	Total (n=31)	Percentage
Involved in 1 Restraint (Last 2 months)	12	39%
Involved in 2+ Restraints (Last 2 months)	6	19%

The 39% who reported restrictive practice involvement then completed the SOAS-R and the ATACKS. The 61% of participants who did not report involvement in restrictive practice were not asked to complete these measures as they had no recent incidents to describe and reflect on. The SOAS-R, which measured inpatient aggressive incidents and staff responses, found incidents were severe in aggression, and staff responses used extreme measures of restrictive practice, resulting in extreme consequences, such as fear, pain, and injury. Table 6 depicts the SOAS-R scoring range, and the results can be found in Table 11.

Table 11. The Staff Observation Aggression Scale Revised (SOAS-R; Nijman et al., 1999)

PT	Time	Provocation (0-2)	Means (0-3)	Target of Aggression (0-4)	Consequences for Victim (0-9)	Measures to stop Aggression (0-4)	Total Score (0-22)	Severity
1	30 Min	1 – Unknown, Mental Health	2 – Verbal Aggression, Objects Thrown	3 – Staff, Other patients	6 – Damage/Replaced, Others Felt Threatened	4 – Held with Force, Other Measures (tranquiliser)	15	Moderate
3	30 Min	1 – Unknown, Mental Health	2 – Verbal Aggression, Objects Thrown	1 – Objects	6 – Damage/Replaced, Others Felt Threatened	4 – Talk to Patient, Held with Force, Physical Restraints	13	Moderate
6	60 Min	2 – Staff requiring patient to take medication, leave denied	2 – Verbal Aggression, Objects Thrown	3 – Male staff members	9 – Damage/Replaced, Others Felt Threatened, Visible Injury	4 – Physical Restraint	20	Severe
13	60 Min	0 – Mental health, leave denied	2 – Kicking, Biting, Spitting	3 – Staff, Other Patients	9 – Visible Injury, Pain, Felt Threatened	4 – Talk to Patient, Held with Force, Physical Restraints	18	Severe
14	60 Min	2 – Staff requiring patient to take medication, leave denied	2 – Kicking, Biting, Spitting	3 – Staff	9 – Pain, Injury, Need for Treatment by Physician	4 – Held with Force, Physical Restraints, Seclusion	20	Severe
15	5 Min	0 – Patient denied something	2 – Punching	3 – Staff	6 – Felt Threatened	0 – None	11	Mild
21	45 Min	0 – Patient denied something	2 – Verbal Aggression, Spitting	3 – Staff, Other patients	9 – Damage/Replaced, Felt Threatened,	4 – Spoke to client, Calmly Brought Away, Held with	18	Severe

					Pain Over 10 min, Visible Injury, Need for Treatment by Physician	Force, Seclusion, Physical Restraint		
22	45 Min	1 – Unknown, Mental Health	2 – Kicking, Biting, Spitting	3 – Staff, Other patients	9 – Visible Injury, Pain, Felt Threatened	4 – Physical Restraint	19	Severe
24	60 Min	1 – Unknown, Mental Health	2 – Verbal Aggression, Hitting, Kicking	3 – Staff	9 – Pain Over 10 minutes, Felt Threatened	4 – Put in Seclusion	19	Severe
Total/ Average	37 Min	0.8	2	2.7	8	3.5	17	Severe

The ATACKS measured the nature and severity of inpatient assaults and staff responses, across 11 components using a formula found in Figure 1. Scores range from 0-60 with an average of 29.1 (Bowers, Nijman, & Palmstierna, 2007). Most respondents (67%) reported significantly above-average severity scores at 32.3. These findings, seen below in Table 12, reflect above-average severity of assaults, with high levels of injury, with all participants reporting pain, most reporting visible injury, and some requiring medical and police intervention. Moreover, 88% of staff responses involved restrictive practice such as, Intramuscular Medication (IM) and the client being held with force. 88% of incidents were also followed by Special Observation, 44% were followed by an increase in client's medication, and 33% were followed by client transfer to a more secure ward.

Table 12. The Attempted and Actual Assault Scale (ATACKS; Bowers et al., 2002)

Role	Antecedents	Primary Victim	Warning by patient	Attempted or Actual Assault	Target	Intensity (Strikes)	Commitment (To Attack)	Potential For Injury	Injury	Immediate Response	Secondary response	Attack Severity Score (0-60)
CSW	Agitated/ Disturbed, Medication	Role: Staff Age: 16-30 Sex: F	Clear Verbal Threat, Threatening Gesture	Body Weapons: Hitting **(3)** Weapons: Heavy Object Thrown **(3)**	Limbs Torso Whole Body **(7.5)**	2 or more **(2)**	70% **(7cm)**	100% **(10cm)**	Visible Injury Requiring Treatment	IM, Held with Force	Special Observation, Medication Increase	**44**
CSW	Agitated/ Disturbed, Medication	Role: Staff/ Patient Age: 16-60 Sex: All	Verbal abuse/anger Threatening Gesture	Body Weapons: Hitting **(3)** Weapons: Heavy Object Thrown **(3)**	Limbs Head **(7)**	2 or more **(2)**	100% **(10cm)**	100% **(10cm)**	Visible Injury Requiring Treatment, Police Intervention	IM, Held with Force	Special Observation, Restricted to Quiet Area	**46**
CSW	Agitated/ Disturbed, Misunderstanding, Physical Restraint	Role: Staff/ Patient Age: 16-30 Sex: M	Clear Verbal Threat (Racial Slurs)	Body Weapons: Scratching **(1)**	Limbs **(2)**	Once **(1)**	50% **(5cm)**	50% **(5cm)**	Pain less than 10 minutes	IM Talk with patient, Calmly brought away	Special Observation, Medication Increase	**13**
Ward Manager	Agitated/ Disturbed, Medication, Misunderstanding, Physical Restraint, Provocation, Self-Harm	Role: Staff Age: 31-60 Sex: M	Clear Verbal Threat, Threatening Gestures	Body Weapons: Spitting, Biting, Poking, Scratching, Kick **(7)**	Whole Body **(2.5)**	2 or more **(2)**	100% **(10cm)**	30% **(3cm)**	Pain less than 10 minutes	IM Held with Force	Special Observation, Continuous Holding, Medication Increase	**32**

CSW	Medication	Role: Staff, Age: 31-60 Sex: F	Clear Verbal Threat, Verbal Abuse/Anger	Body Weapons: Hitting **(3)**	Limbs, Head, Torso **(10)**	2 or more **(2)**	100% **(10cm)**	100% **(10cm)**	Visible Injury Requiring A&E Intervention	IM Held with Force	Transfer to more secure Ward	**46**
CSW	Agitated/ Disturbed, Misunderstanding	Role: Staff, Age: 31-60 Sex: F	None	Body Weapons: Hitting **(3)**	Limbs **(2)**	Once **(1)**	50% **(5cm)**	30% **(3cm)**	Pain less than 10 minutes	IM Held with Force	Special Observation, Medication increase	**13**
RMN	Agitated/ Disturbed, Alcohol/Drugs Medication, Physical Restraint, Restrictions	Role: Staff, Age: 31-60 Sex: M	Clear Verbal Threat, Verbal Abuse/Anger, Threatening Gestures	Body Weapons: Spitting, Kicking, Strangling **(9)**	Whole Body **(2.5)**	2 or more **(2)**	100% **(10cm)**	100% **(10cm)**	Visible injury, pain more than 10 minutes, A&E Intervention, Police Intervention	IM Held with Force	Special Observation, Transfer to Secure Ward	**43**
Clinical Service Lead	Agitated/ Disturbed, Alcohol/Drugs Medication, Physical Restraint, Restrictions	Role: Staff, Age: 31-60 Sex: M	Clear Verbal Threat, Verbal Abuse/Anger, Threatening Gestures	Body Weapons; Spitting, Kicking, Strangling **(9)**	Whole Body **(2.5)**	2 or more **(2)**	100% **(10cm)**	100% **(10cm)**	Visible injury, pain more than 10 minutes, A&E Intervention, Police Intervention	IM Held with Force	Special Observation, Transfer to Secure Ward	**43**
CSW	Other: Mental Health	Role: Staff, Age: 31-60 Sex: M	None	Body Weapons; Punching **(3)**	Limbs **(2)**	Once **(1)**	30% **(3cm)**	30% **(3cm)**	Pain more than 20 minutes	Talk with patient, calmly brought away	Special Observation, Restricted to Quiet Area, Seclusion	**11**
Average												**32.3**

From these findings we could surmise that staff described incidents to be severely aggressive, and their responses to be severe and detrimental, involving the use of restrictive practice. As restrictive practice is understood as coercive, with the potential to traumatise individuals, these staff accounts highlight use of clinical practices that contradict TIC principles and may traumatise or re-traumatise clients.

In summary, in relation to research question 1, the findings from the quantitative data illustrate staff report an above-average TIC-Climate and above average attitudes towards TIC. However, staff also report they are not supported or confident in implementing TIC into their practice. Non-TIC practices are further highlighted by staff reports of the use of restrictive practices.

Reflexive Thematic Analysis

RTA was conducted on semi-structured interviews with 10 permanent, full-time employees of various professions, across the two adult acute MH impatient wards. Five of the interviewed participants attended the workshops, and their data were used to develop the themes for research question 3 regarding responses to TIC workshops and descriptions of the effects of TIC training on their individual practices and wider teams. An overview of participant characteristics can be found in Table 4.

RTA identified eight main themes and 23 sub-themes, these are presented in Table 13, alongside example quotes and the research question they correspond with. A thematic map for this analysis is presented in Figure 2 and every theme is presented with verbatim interview quotes. Due to space constraints, interview data has been covered concisely within this report, however, all quotes are tabularly presented by theme and sub-theme in Appendix M. To maintain confidentiality, participant quotes have been presented with pseudonymised names and minor changes have been made to prevent identification.

Table 13. RTA Table of Main Themes and Sub Themes with Accompanying Quotes and Research Questions

Research Question Key:
1 – Staff current attitudes, practices, and ward climate in relation to TIC
2 – Staff perceptions of the feasibility of introducing TIC
3 – Responses to TIC and effects of TIC training on individual practice and wider teams

	Main Theme	**Sub Theme**	**Example Quote**	**Relevant Research Question**
1	Lack of TIC Awareness	Lack of TIC Knowledge	"Yes, I think the wards are trauma informed, when someone comes on the ward we minimise risk, like we take away any sharp objects, any piece of ligature equipment..." (Richard) "I don't think I have heard of it [TIC]…I have no idea… what is it again?" (Pamela)	Question 1
		Counter TIC Beliefs & Practices	"It's [restraint] a useful way to manage …restraining is like showing them, shut up, this is what's going to happen to you! Then take them to their rooms to sedate them." (Aleysha) "Sometimes restraints need to be done. Umm, they actually need to be done because maybe medication is needed, or isn't working, or maybe a patient's gone acting out of order like so you can't just allow the patient to do what they want." (Bradley)	Question 1
2	Inpatient Culture	The Medicalised Environment	"They'll [inpatient Psychiatrists] talk to you about like the biology stuff like that and why people are… you know as in how it works and the chemical imbalances and stuff like that and you know, but no I'd never thought about like upbringing and stuff people had gone through making them the way they are acting now on the ward" (Mia) "And there's a lot of hierarchy issues…like nurses, CSW, they get pushed around." (Natalia)	Question 1
		Risk Aversion	"If you have certain people on shift who kind of just have that mindset [to restrain], I think it kind of just works out like that… if one person was very hands on and they started doing it, other people are like, OK, we need to go and join in too and then they learn that you react that way too, they don't learn to diffuse things first." (Lewis)	Question 1

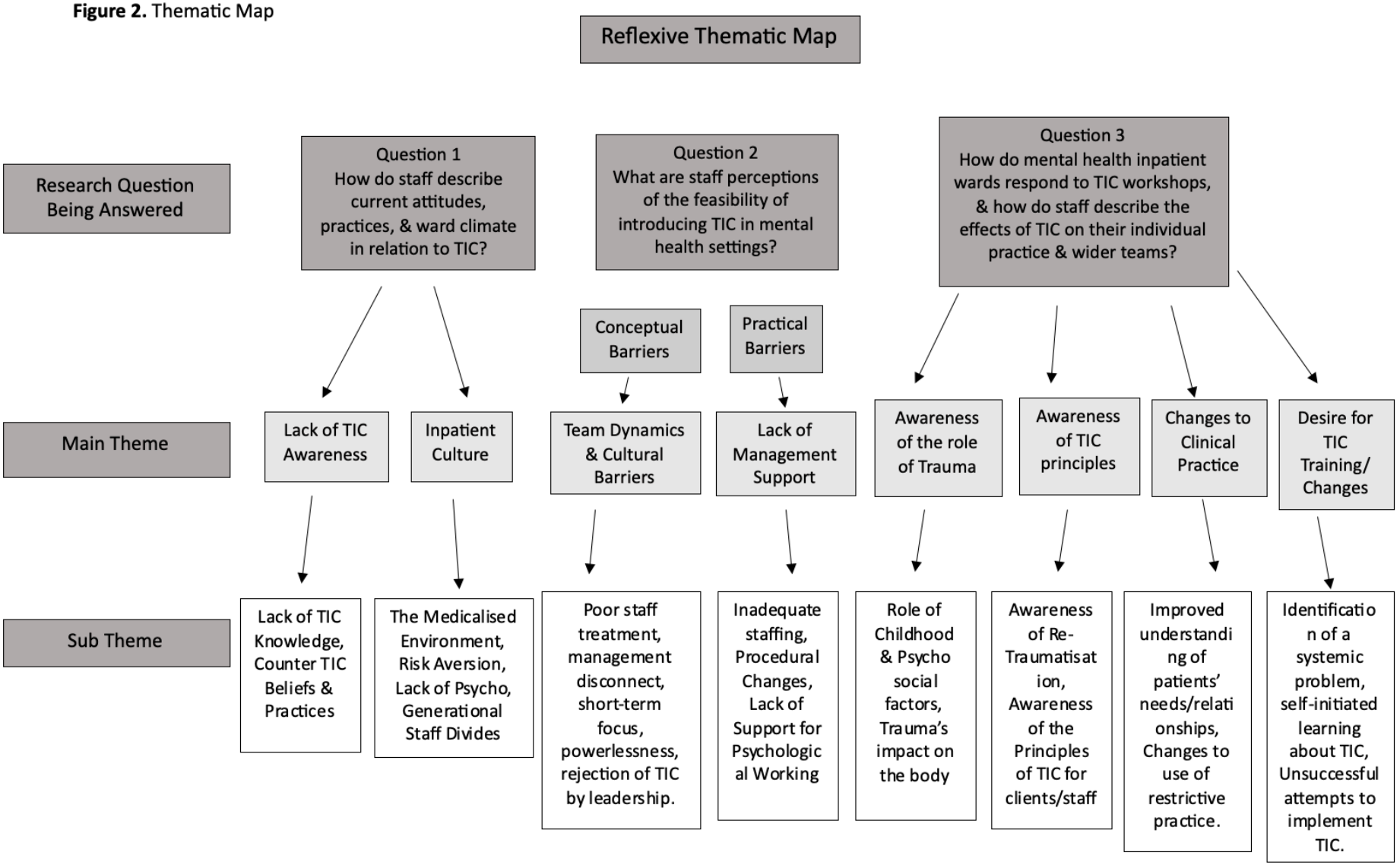
		Lack of Psychological Awareness & Skills	"We really should be talking about what the person has been through, but we're just not, we avoid it and just medicate, which is not a good thing. If I really sit back and think about it, like why this person is here [on the ward] it gives me more understanding and I could even give them better care..." (Kiara)	Question 1
		Generational Staff Divides	"People don't see training as priority unless it's mandatory, unless it's in their contract, you know...so it's a cultural thing, especially those who have been working for many years..." (Pamela)	Question 1
3	Team Dynamics & Cultural Barriers	Poor Treatment of Staff	"Especially for clinical support workers. There's one girl on [ward name] actually, she was physically abused by one of the patients and had her hair pulled and had scars and everything, you know, she was off for a few days, but she's even bank, which makes it worse because she has to work, there's nothing in place to support her, no proper appreciation. There's no structure in place where maybe someone senior can come and visit. Sit down, reassure them, or give them some sort of a nice wellbeing break…You know, you have to deal with that traumatic event by yourself" (Pamela) "In the beginning, they treated me, excuse my expression, like c**p, you know? And even [other employee name]. This is just the culture…I just thought you cannot talk to me this way…don't treat me that way because that's wrong." (Natalia)	Question 2
		Management Disconnect	"Just everything's like tick box. And as long as everyone looks great, but they [senior management] don't care about the people." (Aleysha) "I just feel like those at the top are so out of touch, they probably won't ever see or hear of the emails discussing the trauma people experience. They should personally be attending meetings with people who have been affected so they can really appreciate their experience and see what they need to change." (Pamela)	Question 2
		Short-Term Focus	"… the resistance is because they are stressed and stretched thin and overwhelmed that they don't think they can handle adding essentially like another task to their list and kind of in looking at it as a tick box, not seeing how that trauma informed care approach could lead to a lesser workload in the future. Yeah, they don't realize the trade-off." (Kelly)	Question 2
		Powerlessness	"So, I mean after [the training] I was keen to do stuff like including considerations of trauma and ACEs in like care plans and stuff like that. That's something that I feel like it's really hard	Question 2

			to change the way that's it's done already. You need someone senior to bring that and say, we're doing it differently now." (Mia)	
		Rejection of TIC by Leadership	"It comes back to higher management valuing trauma informed care and valuing well educated staff. The way they act, I don't get the sense that they do, they pretty much rejected all of my trauma informed ideas..." (Deborah)	Question 2
4	Lack of Management Support	Inadequate Staffing	"And we were significantly understaffed. We're now getting a whole team back up again. So, fingers crossed. But again, don't know how long it's gonna take, so we're relying on bank to cover, it's a mess, so we just can't prioritise training." (Aleysha)	Question 2
		Procedural Challenges	"I think it's important for everyone, for senior management, to know what it's really like working on the wards, and to ease off on the amount of paperwork expected of nursing..." (Richard)	Question 2
		Lack of Support for Psychological Working	"Uh, maybe if there was a phrase, we can add to this official guide to be like, how does everyone feel? What do we know about the patient? What about other patients that observed this? Do they have any trauma in the past? Do we have to go and speak to them? Maybe a little prompt, something like that will make it more effective. So that kind of almost like a structure in place, so people can just go and get the manual and read it out loud." (Natalia)	Question 2
5	Awareness of the role of Trauma	The Role of Childhood & Psychosocial Factors	"It just highlighted how important childhood is and how life stressors can kind of affect things and stuff like that. So it just makes you think like there's lots of things that contribute to like mental health or even just like us maybe not feeling 100%." (Kelly)	Question 3
		Trauma's Impact on the Body	"I do think it's really important to think about how past events have affected…how it's like currently affecting someone and kind of shapes their perceptions and maybe unknowingly, you know that biological response. Yeah, like it makes you more understanding of things that you see that it doesn't make sense to you because you don't react that way. But of course, you don't have the same history." (Kelly)	Question 3
6	Awareness of TIC Principles	Awareness of Re-traumatisation	"The people [clients], you know, they have to be asking for every little thing. They don't have their belongings, and then we're loudly knocking at 7:00 AM or something asking for medication and turning on their lights. You know, it's like to think if that happened to you like, I would be very irritated as well. And I might snap at people and. And with the training like I can now think that yeah, might be retraumatizing something in the past. Yeah. So that's something new that I think I gained from the training." (Lewis)	Question 3

		Awareness of Principles of TIC for Clients & Staff	"Yeah, especially with people who have EUPD I mean, I find that they get a bad rap and are kind of marginalized, what they're doing is just typical EUPD and people say it's just a cry for attention or whatever, and it's like well but we also know that a lot of people with that diagnosis also have a lot of trauma in their background so how can we give them power? How can we acknowledge that past trauma and help them maybe not fall into these same things and instead of just brushing it off as EUPD like maybe actually call it PTSD and empower them to better their lives?" (Deborah)	Question 3
7	Changes to Clinical Practices	Improved Understanding of Patients Needs	"I think before we had the session most times I will just go in and I would just treat the patients from just the way they were behaving. Most of the time they're very abusive and you can't really say what you're actually thinking. I'd get really frustrated, at times I'd go, sit down and cry, but it's actually helped, like going through everything that you talked about that has is helped me a lot. I don't just go by what they say to me, I do a bit of digging. So, when I go on the floor and hear what they're saying I don't really take it to heart like I used to. So, in that aspect It's helped me quite a bit." (Kelly)	Question 3
		Improved Relationships with Clients & Colleagues	"You can avoid that person in an hour's time, trying to throw a chair at you, you know, let's work all together, like we're here to work for their needs and put that first, it does work" (Lewis) "I think my issue has always been not giving them that time to understand them. So, this has helped me to give them that time to just sit with them somewhere for 20 minutes. for them to talk.… Yeah, it actually makes me feel as if I'm doing my job properly, that someone can actually feel comfortable coming to me, approaching me to talk about their experience and what's going on. And for them to feel that comfortable. I feel it's actually a real privilege and I really appreciate it." (Kelly)	Question 3
		Changes to use of Restraint & Restrictive Practice	"I try to keep myself neutral, you can't always help it you know, you do get irritated but I try to own up to it, you can get prideful sometimes, especially if someone's getting really agitated, but I just try to remind myself it's not personal, it's this environment, it's mental health, it's their stuff, so I can keep my cool." (Lewis)	Question 3
8	Desire for Further TIC Training/Changes	Identification of a Systemic Problem	"I think everyone's attitude and behaviour can be so much better. I don't know whether it's just the way they are or whether they are aware, but I think we can do better. And in terms of I don't know, speaking to people, interacting with them much better, we're just not there yet, and it concerns me now that I'm more aware of it." (Mia)	Question 3

			"If its unsafe we're not discharging patients, and I don't care what they [senior management] say, because there's no point in being a hospital and being caring and kind and whatever and then like at the point of discharge chucking them onto the street. No. They'll be right back here in a few days and the cycle continues". (Aleysha)	
		Self-Initiated Learning about TIC & Trauma	"After the training I actually took some time off, some annual leave, I realised I was so tired and hadn't stopped and I needed a proper break, and I went online to try and see, like, to learn more about trauma and some other stuff in patients lives. Then going back to work it kind of made me feel like a new person, like I had new energy and a different objective, which wasn't so punishing, you know?" (Deborah)	Question 3
		Unsuccessful Attempts to Implement TIC	"I did try a few times, and everyone was just like we don't understand you and you're wasting our time." (Lewis)	Question 3

Figure 2. Thematic Map



Research Question 1 – How do MH inpatient staff describe their current attitudes, practices (including use of restrictive practice), and the ward climate in relation to TIC?

Main Theme 1 -Lack of TIC Awareness

Staff reported a lack of awareness of trauma and re-traumatisation, and strong beliefs in non-TIC practices. Staff who attended the workshops reported a lack of awareness prior to the training. This main theme comprises two sub themes.

Lack of TIC Knowledge. Non-attendee interviewees shared limited knowledge of trauma and TIC.

"What is it? [TIC]… I know we did all those questionnaires about it, but urm… maybe… I'm just going to waffle now, so maybe you just tell me again." (Bradley)

Counter TIC Beliefs and Practices. Staff reported beliefs and practices which oppose TIC principles.

"I feel like a lot of the time staff, including myself sometimes, want to show whose boss, you know? So they use that as a way to restrain." (Pamela)

Main Theme 2 - Inpatient Culture

Interviewees faced challenges implementing TIC in a medicalised environment, which prioritises physical health and safety. This main theme comprises four sub themes.

The Medicalised Environment. Participants described a focus on medical treatment and a hierarchical structure.

“Yeah, I think it's [care of clients] more just getting them better with the medication, that’s really the main thing we do here. Now I do try and read the clients notes, to like try and understand why they’re behaving like that, but we’re not given enough time for it…” (Kiara)

Risk Aversion. Participants described a reactive culture whereby staff were quick to use restrictive practice and blindly follow rules to diminish potential risk.

“I see a situation escalating… It's like, come on, guys… we don’t need to immediately call the team and restrain…” (Kelly)

Lack of Psychological Awareness & Skills. Participants spoke about a lack of psychological working which acts as a barrier to asking about trauma and communicating TIC to clients and colleagues.

“If it [trauma] was talked about more then maybe we’d all feel more confident talking about it and working with it too, and then it might even push people to think that talking to people … about how they’re feeling is actually part of their role…” (Mia)

Generational Staff Divides. Participants reported reduced interest in client wellbeing and new learning from long-time staff members.

"They don't want things to change, they don't want to grow, they want to carry on doing the same thing with minimal effort and get paid." (Deborah).

Research Question 2 – What are staff perceptions of the feasibility of introducing TIC in MH inpatient settings?

A) What conceptual barriers to TIC do staff describe?

Main Theme 3- Team Dynamics and Cultural Barriers

Participants reflected on difficult team dynamics which got in the way of their ability to work and grow. This main theme comprises five sub-themes.

Poor Treatment of Staff. Staff reflected on experiences of trauma, bullying, low-pay, and uneven work distribution.

"We have some other issues, which is finances for a lot of people, and inflation and worries about salaries…and maybe a bit of burnout, you know." (Natalia)

"I filed a complaint against [staff member]. And then like nothing happened, it continued to escalate multiple times..." (Deborah)

Management Disconnect. Staff reflected on management's lack of awareness of the challenges of clinical working.

“Leadership definitely has to be invested in it [training], and I think you can tell they just aren’t. They don’t care about staff members development; they just want bodies on the floor so the ward can keep going”. (Mia)

Short-Term Focus. Interviewees reflected on the wards inability to consider long-term benefits of training and change, and instead focuses on short-term working.

“… Upper levels of management might be looking at what the trust can do to improve in 10 years, but everyone else just doesn’t have capacity for that.” (Deborah)

Powerlessness. Staff reported feelings of powerlessness and ability to make meaningful change.

“It feels like as ***** [professional role] you don't really have much power to make much change…” (Deborah)

Rejection of TIC by Leadership. Participants reported overt rejection of trauma-informed working by leaders.

“I saw my manager after…and I don't think they found it particularly something they'd be interested in, like implementing, you know...” (Mia)

Research Question 2 – What are staff perceptions of the feasibility of introducing TIC in MH inpatient settings?

B) What practical barriers to TIC do staff describe?

Main Theme 4 - Lack of Management Support

All interviewees commented on a lack of management support for trauma-informed working, which may prevent staff from attending training and embedding learning into clinical practice. This main theme comprises three sub themes.

Inadequate Staffing. Staff spoke of chronic understaffing, placing pressure to overwork, and impeding on training and supervision attendance.

"It's more management writing enough staff…because I mean I don't know that we're ever gonna fully have enough staff to patient ratio." (Kiara)

"We were significantly understaffed… so we're relying on bank to cover, it's a mess, so we just can't prioritise training." (Aleysha)

Procedural Changes. Staff commented on ways management changes that would have allowed them to attend the training.

"I guess if it's not protected in in their schedule, it's not going to happen. And maybe one of the things that ward managers can do is just give them protected time…" (Natalia)

Lack of Support for Psychological Working. Staff reflected on challenges implementing TIC considering the lack of knowledge and support for psychological working.

"They know that patients have very troubled pasts, but it's hard to ask people about that, we

don’t want to open up a can of worms we can’t deal with… it’s not what we do or prioritise.” (Richard)

Research Question 3 – How do MH inpatient wards respond to TIC workshops, and how do attending staff describe the effects of TIC training on their individual practice and wider teams?

Main Theme 5 - Awareness of the role of Trauma

Following the workshops, attendees commented on increased awareness of trauma. This main theme comprises two sub themes.

The role of Childhood and Psychosocial Factors. Participants reflected on learning the importance of childhood development and psychosocial experiences on MH.

“It just gave me a different viewpoint, you know, sometimes you won't think too much of why people are here… I’m asking these questions now and trying to figure out what happened to you for you to get to this point.” (Lewis)

Trauma’s impact on the Body. Participants commented on learning the fight or flight system and neurological changes following trauma.

“… hearing about the biological side, how it's affected like the development of these physical systems and it's like so easily triggered by different things happening around them... And I think I tried to keep that in mind now when I see patients like that, I try to be a bit more

understanding and patient." (Lewis)

Main Theme 6 - Awareness of TIC Principles

Workshop attendees shared an improved sense of awareness of what TIC is, how it is enacted, and the aim of reducing re-traumatisation. This main theme comprises two sub themes.

Awareness of Re-Traumatisation. Participants highlighted the importance of reducing re-traumatisation.

"I'm definitely talking about trauma and not wanting to like re-traumatise people a lot more now I've noticed..." (Deborah)

Awareness of the Principles of TIC for Clients and Staff. Participants reported improved TIC awareness.

"Being sectioned could be quite traumatic…Like they have to eat the ward food, and eat it when we tell them, take medication when we tell them…there is just no freedom or choice and I'm trying to consider these things." (Mia)

Main Theme 7 - Changes to Clinical Practice

Workshop attendees shared improved TIC awareness, how it is enacted in clinical working, and the aim of reducing re-traumatisation. This main theme comprises three sub themes.

Improved Understanding of Patient's Needs. Participants reported greater understanding and meeting of client needs, resulting in improved client outcomes. Staff reported reading client histories and using workshop materials, such as the Power Threat Meaning Framework.

"… I need to go and read about his risk and his history, if not then I'm not really aware of why he's behaving like that… I can see where they're coming from, why they're behaving that way. And I'm more patient with them and understanding." (Kiara)

Improved Relationships with Clients and Colleagues. Attendee participants reported more empathy and improved relationships with clients and colleagues.

"I think I'm more understanding, I give them time, I talk to them more..." (Kiara)

"I think a lot of people, they're quite irritated a lot of the time and just understanding that this is a difficult environment…They don't have power currently, and then that can sort of remind you of past experiences." (Mia)

Changes to use of Restraint & Restrictive Practice. Participants reported changed feelings towards restraint and restrictive practice.

"So, I'm not put in that position of actually physically having to touch someone that much anymore. Just because now I just feel like I prefer all the verbal de-escalation, I like it and it really does work, so restraining is literally the last resort..." (Kelly)

Main Theme 8 - Desire for further TIC Training/Changes

Workshop attendees identified a systemic lack of TIC awareness and practices and a desire for further TIC changes. Others shared independent TIC learning and reading on trauma. This main theme comprises three sub themes.

Identification of a Systemic Problem. Staff reported a lack of TIC awareness and working within the organisation.

"Something needs to change at every level for us to actually be providing quality care." (Deborah)

Self-initiated Learning about TIC and Trauma. Workshops gave some an incentive to do further research into trauma, TIC, and trauma-focused psychological support.

"I went on their website and started reading about EMDR and talking about what I've seen, and I'm thinking I might try and organise it for myself." (Kiara)

Unsuccessful Attempts to Implement TIC. Staff reported struggles to embedding learning into clinical practice and communicating TIC to their colleagues and clients.

"I did try a few times [to talk to other staff members about TIC], and everyone was just like we don't understand you and you're wasting our time." (Lewis)

Discussion

This mixed methods research investigated the current culture of two MH inpatient wards in one Trust, in relation to TIC. This research also explored the feasibility of introducing TIC into these settings, and the potential role and effects of introducing TIC through workshops. Results are presented in relation to the three research questions, existing literature, and the study's limitations.

Research Question 1 – How do MH inpatient staff describe their current attitudes, practices (including use of restrictive practice), and the ward climate in relation to TIC?

Responses to the ARTIC (Baker et al., 2016) suggested that staff had above-average attitudes towards TIC, but also found below-average personal and system-wide support for TIC. This may therefore suggest that staff theoretically support TIC but that personal and organisational barriers may prevent staff from drawing on TIC. Similarly, TICS scores (Hales et al., 2019) found an above-average Trauma-Informed climate in comparison to a similar sample of professionals in the US (Appendix O). However, subscales revealed 'Trust and Empowerment' to be the lowest scoring values, which may link with ARTIC findings suggesting a lack of organisational support for TIC. However small staff samples reduce findings generalizability, requiring further research to investigate this.

39% of staff had engaged in restrictive practice in the last 2 months, and the SOAS-R (Nijman et al., 1999) and ATACKS (Bowers et al., 2002) revealed staff restrictive practices were severe and detrimental. As restrictive practice is coercive and can be traumatising for all involved, these findings highlight staff practices do not align with TIC values. Non-TIC

practices, such as the use of violence, are common and increasing in inpatient settings (Anderson & West, 2011), differences between staff and client views on the 'problem' and appropriate response have been identified as factors contributing to the level of violence and aggression displayed by both staff and clients (Duxbury, 2002).

Quantitative findings therefore indicate positive attitudes towards TIC and an above-average TIC-Climate. However high rates of severe restrictive practice, alongside below-average reports of personal and organisational support for TIC, indicate the culture within these settings may not be trauma-informed in practice. Potential organisational resistance to TIC working, identified by the ARTIC and TICS, could highlight the need for TIC across all organisational levels.

The finding that staff may be Trauma-Informed in principle, but not in practice, appears to be supported by the findings from the RTA. The RTA identified that staff lack TIC awareness and hold beliefs and engage in practices that are contradictory to TIC values. This was highlighted by the casual way staff spoke of the need for and punitive use of restrictive practice. Interviews highlighted a culture of medicalisation and risk aversion, where long-standing staff members reject change, and the culture can be resistant to psychosocial working. These findings reflect the medical model of MH, prominent in these settings, which supports the idea that staff are treating an illness, not a person. Consequently staff-client relationships are not prioritised as a form of therapeutic intervention. It follows that these medicalised beliefs, embedded within the culture, would mean staff believe forced medication is necessary, and not something that could potentially re-traumatise clients. These findings therefore also speak to research question 2 by highlighting cultural barriers to TIC.

In summary, we could ascertain that at first glance, on a superficial level, the ward climate as reported by staff appears to be trauma-informed, but on a closer inspection staff attitudes and practices do not appear trauma-informed, and in fact could be described as non-trauma-informed. These findings are supported by research which also identifies a lack of TIC knowledge (Cations et al., 2021), counter-TIC practices (Bloom & Farragher, 2011), and a culture of resistance to psychosocial thinking within MH wards (Isobel & Edwards, 2017; McElvaney & Tatlow-Golden, 2016; McEvedy et al., 2017; Nation et al., 2022; Pearlman & Saakvitne, 1995).

Research Question 2 – What are staff perceptions of the feasibility of introducing TIC in MH inpatient settings?

a) What conceptual barriers to TIC do staff describe?

b) What practical barriers to TIC do staff describe?

Staff were readily able to identify an abundance of conceptual and practical barriers to introducing TIC, such as rejection of TIC by leadership, procedural challenges, and inadequate staffing. It appears the context of limited staffing, procedures which favour medical models of MH, and rejection of TIC by leadership, result in less client-staff interactions and less opportunities to work within TIC values, such as working collaboratively, providing choice, or empowering clients. This was further illustrated by several rich staff descriptions which emphasised that staff do not perceive their roles, or the nature of the setting, to include the provision of psychosocial care, with biological support for 'illnesses' monopolising staff time. A lack of organisational support (Cations et al., 2021; Williams & Smith, 2017), TIC-resistance (Isobel & Edwards, 2017) and non-TIC policies (Isobel & Delgado, 2018) are previously identified TIC-barriers.

These findings indicate staff perceive that it is not feasible to introduce TIC into these settings. Feasibility challenges when introducing TIC were also identified through the lead researchers experience of implementing TIC staff workshops. Due to low attendance at workshops, additional workshops were offered, but this still only achieved a 58% attendance rate. Reflections on the challenges of implementing TIC workshops are included in a research diary in appendix L. These reflections support the presence of several conceptual and practical barriers, such as a lack of leadership support, understaffing, rejection of TIC by leadership, and procedural challenges.

Cultural barriers, including a lack of support for psychological working, and the power of the dominant medical model, which focuses on short-term interventions, risk avoidance, and over-reliance on rules (Hales et al., 2017), are commonly identified barriers to TIC change (Bloom & Farragher, 2011). Other previously identified cultural barriers include limited trauma knowledge, prioritisation of competing demands (Nimura et al., 2019), and fatigue (Nation et al., 2022). Team dynamics were effected by understaffing leading to unpleasant experiences with colleagues and clients, leaving present staff overwhelmed and unable to engage in additional tasks. Understaffing (Cations et al., 2021), and discrimination, have been identified as markers of systemic trauma within healthcare organisations (McElvaney & Tatlow-Golden, 2016). As the impact of trauma can affect critical thinking (Foa & Rauch, 2004) it follows that staff within traumatised services are unable to consider new ways of working, such as TIC.

RTA findings, reinforced by descriptive findings indicate staff desire TIC-working. However, there is a lack of knowledge, skills, and agency to confidently engage in TIC-working among

staff who are constrained by conceptual and practical barriers such as non-TIC policies and a lack of leadership support. Moreover, adopting TIC principles within individual teams may not be effective in a non-trauma-informed organisation (Conners-Burrow et al., 2013). This is reflected in the many studies implementing TIC as part of wider organisational change projects (Aremu, 2018; Walsh & Benjamin, 2020). Findings may also reflect socially structured defences in response to barriers to inpatient staff's primary task i.e., caring for clients (Menzies-Lyth, 1959). Interviews highlighted staff challenges and distress in meeting clients' needs, possibly resulting in non-TIC practices, a pattern identified in other ward cultures (Blacker et al., 2017).

Despite the host of barriers to TIC-working identified, several studies have also identified facilitators to counteract barriers, such as the provision of TIC training materials (Palfrey et al., 2018), ongoing TIC discussions (Walsh & Benjamin, 2020), and TIC-updating of organisational policies (McEvedy et al., 2017). Therefore, TIC working may be feasibly introduced if paired with an organisational initiative which engages potential facilitators and addresses systemic barriers. Such initiatives might include increased staffing (Oats et al., 2020) reduced workloads (Kiely, 2021), and higher salaries (Mahase, 2022). These require leadership support, on-going training, staffing, and funding (Conners-Burrow et al., 2013), scarce inpatient resources (Bannister, 2021).

Research Question 3 – How do MH inpatient wards respond to TIC workshops, and how do attending staff describe the effects of TIC training on their individual practice and wider teams?

RTA identified four main themes highlighting mostly perceptions of positive effects of TIC including increased awareness of the role of trauma and TIC Principles. Changes to clinical practice were reported, such as changes in restrictive practice, improved understanding of client's needs, and improved relationships with clients and colleagues. Staff reported a desire for further TIC training and changes and identified a systemic issue among the non-TIC policies and practices within the organisation.

These findings correspond with other research showing increased TIC knowledge (McEvedy et al., 2017), awareness (Williams & Smith, 2017), attitudes (Thompson, 2020), confidence and skill (Aremu, 2018, Gathings, 2020), increased trauma communication (Walsh & Benjamin, 2020), satisfaction, reduced restrictive practice (Cations et al., 202; Handran, 2015), and increased consideration of trauma in colleagues' lives (Thompson, 2020) following the introduction of TIC. These findings therefore add to the literature supporting potential positive TIC effects.

Limitations

Several methodological considerations may limit the validity and generalisability of these findings. Firstly, mixed methodology can produce robust findings (Kimmons, 2022), but is complex and requires resources than may not have been available (Malina et al., 2011). The principal researcher's involvement in data collection, the TIC workshops, and analysis, may have biased identified themes (Clarke & Braun, 2013; Elliott et al., 1999) and resulted in demand characteristics and social-desirability bias (Bergen & Labonte, 2020). This may have been worsened by the principal researcher's insider status, having previously worked on these two wards prior to the research commencing. However, potential impacts may have been counteracted by quality assurance measures such as reflexive journaling and creation of a position statement, allowing the researcher to identify their perspective and develop ways to reduce its impact (Braun & Clarke, 2022b). Moreover, the researcher's insider status may have been beneficial, having already developed staff rapport, which may have resulted in more candid and meaningful responses. Researcher bias may also have been mitigated by quantitative components which can reduce researcher interpretation bias (Norris, 1997).

Although quantitative measures showed good internal consistency, reliability, and validity (Baker et al., 2020; Bowers et al., 2002; Hales et al., 2017; Nijman et al., 1997a), none provided normative data, reducing results validity (Kendall & Sheldrick, 2000). Staff retention challenges also meant pre-post comparisons from the original study design were impossible, weakening claims regarding the effects of TIC workshops. Without follow-up or long-term measurement, it is unclear whether reported effects were representative or maintainable.

Moreover, no post workshop measures were completed and not every participant reported restrictive practice and therefore completed the SOAS-R and ATACKS. This significantly limits the validity and generalisability of quantitative findings (Cohen, 2013). Similarly, only ten interviews were conducted and only five attended the workshops, reducing the potential to capture phenomena (Baker & Edwards, 2012; Galvin, 2015). This is especially true for research question three RTA themes, drawn from the interview data from only the five workshop attendees. Moreover, workshop attendees reporting less restrictive practice may not reflect overall reductions in ward restrictive practice, as these tasks may simply have been transferred to other staff. The unrepresentative spread of professions may also compromise validity and generalisability, with only one of many professions and no bank or student staff included.

Implications

Clinical Implications

Findings identified supportive attitudes towards TIC and a desire for trauma-informed working, as well as detrimental restrictive practices and several barriers to trauma-informed working. Considering the profound impact these findings may have on the well-being of staff and clients, changes are needed in some form. An in-depth understanding of the organisational contexts and support for TIC may be beneficial prior to TIC-intervention development. This scoping may identify resistance to address or identify avenues for change which can inform intervention design. Possible interventions aside from specific staff TIC training include TIC-debriefs, prioritising psychological training, allocating client history reading time, and equal distribution of workloads.

This study supports the desirability of implementing TIC and highlights how vital ongoing leadership and management support is in introducing and successfully implementing TIC in these settings. Should TIC be introduced through staff training, support from leadership and management should ensure adequate staffing to facilitate attendance and increase the likelihood of implementing learning into clinical practice. Management support may also lead to trauma informed policy changes, allowing for a TIC-culture shift. Should TIC workshops be used, they could be adapted to meet specific staff needs and be designed and delivered in collaboration with local lived experience practitioners.

Considering its potential positive impacts, TIC workshop attendance could be made compulsory for staff of all professions and seniority. Mandatory attendance may remove

choice and therefore not fit TIC values (Harris & Fallot, 2001), but may increase attendance and produce TIC-culture shifts. Leaders may benefit the most from attendance as their power to initiate organisational change may be the most important in the adoption of TIC (Lavender, 2023). Indeed, leadership and organisational support should be confirmed prior to any TIC-intervention implementation. Although some short-term gains could be seen from one TIC-workshop, they are unlikely to create organisational-wide cultural shifts. Long-term gains may be supported with follow-up workshops, ongoing Trauma-informed supervision, or regular TIC discussions led by psychosocial professionals, such as Clinical Psychologists.

Research Implications

As the evidence base identifies a mixture of TIC benefits and barriers to its implementation, further research is needed (Valenkamp et al., 2014). There is a need for more robust evidence investigating the impact of introducing TIC, using pre-post comparisons, multi-sites, and appropriately powered randomised control trials, currently heralded as the gold standard design (Hariton & Locascio, 2018). These may be difficult to establish in inpatient settings and will need organisational leadership and management support. Validated TIC-outcome measures, such as the TICS and ARTIC, could be used, which will also support the development of normative data for these measures.

Measurement of direct client outcomes, such as recovery rates, should also be included, considering promising initial findings (Hales et al., 2019; Medline et al., 2017). Research with sufficient power could review potential differences across professions, such as TIC attitudes and clinical impacts post-TIC intervention, which may have implications for TIC-

intervention or training design. Inclusion of multiple follow-ups post-training may also allow researchers to identify whether change can be sustained from one workshop.

Conclusion

This research shows tentative support for inpatient staff TIC-working, due to its potential positive impacts, lack of prior TIC understanding, and use of detrimental restrictive practice. However, lack of leadership and management support is a fundamental barrier to any TIC intervention. Future inpatient TIC-interventions should firstly address practical and conceptual barriers prior to implementation. Addressing barriers, such as understaffing, short-term, risk, and medicalised focus, and challenging team dynamics requires time and resources, but may facilitate sustainable TIC movement. Future efforts should focus on improving the evidence quality through a randomised design, as well as on tailoring TIC introductions to staff and team needs, offering TIC-discussions, and ongoing TIC-supervision.

Of paramount importance to the success and impact of TIC is the support of leadership. Without this, unsupported and poorly attended TIC training or interventions are unlikely to make meaningful long-term change. The phenomenon of 'The myth of the Hero-Innovator' highlights this challenge, identifying that one small change is unlikely to impact wider organisational change (Georgiads & Phillimore, 1975). However, Radaelli et al.'s (2014) research into hospital organisational change identified the presence of a 'Hero-innovator' within all successful cases, suggesting they are necessary but insufficient alone (Whitby, 2020). Similar challenges have led to the development of consumer-orientated systems that create systemic long-lasting organisational change (Praill & Baldwin, 1988). Future work may benefit from following these to reduce barriers and enhance facilitators of long-term change.

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Appendices – Literature Review

Appendix A – Reason for Full-Text Article Exclusion

1. Full article not available/accessible through researchers means
2. Research conducted in Child and Adolescent Mental Health Service
3. Research conducted with public health staff not currently working in inpatient settings
4. Research did not include implementing Trauma Informed Care training
5. Research included Trauma Informed Care principles with clients but not a staff intervention/training.

Appendices – Empirical Study

Appendix A – Salomons Institute for Applied Psychology Ethics Approval Letter

This has been removed from the electronic copy.

Appendix B – Health Research Authority Approval Letter

This has been removed from the electronic copy.

Appendix C – Participant Consent Form

Canterbury Christ Church University
Salomons Institute for Applied Psychology

[redacted]

Participant Consent Form

Participant ID Number:
Title of Project: Do inpatient Trauma Informed Care workshops impact on violent incidents, restrictive practice, and staff attitudes?

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐
4. I understand that the information held and maintained by SLAM NHS and Salomon's institute for applied Psychology will be stored securely within an encrypted folder. ☐
5. I agree to attend three separate 50-minute workshops about Trauma Informed Care, and understand attendance can be in person, online, or viewing or the recorded session. ☐
6. I agree to complete a set of questionnaires prior to the workshops, after the workshops, and at a 6-month follow-up from the workshops. ☐
7. I consent to my name being entered into a raffle with the possibility of winning a £30 Amazon voucher. ☐
8. I understand that I may be invited to attend a 30-45 minute interview with the researchers to share my experience of the workshops in more detail. ☐
9. I understand that I will have the opportunity to attend a debrief with the researchers following my participation. ☐
10. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

22.03.2022 Version 2 (V2)

Appendix D – Participant Information Sheet

Canterbury Christ Church University
Salomons Institute for Applied Psychology

[redacted]

Participant Information Sheet

Do inpatient Trauma Informed Care workshops impact on violent incidents, restrictive practice, and staff attitudes?

The Salomons Institute for Applied Psychology and the research team would like to invite you to participate in a research project taking place on [redacted]. You have been identified as a potential participant for this study as you are currently a permanent member of staff in either [redacted].

Your participation in this project is entirely voluntary and will not impact on your ability to work. Elements of this project, including the attendance of the three Trauma-Informed Care workshops, may be mandatory but this will be at the discretion of your ward manager. Before you decide whether to participate, we would like to explain the purpose of the research and what your participation will involve. A member of the research team will go through this information sheet with you to help you decide whether to participate, during this you will also have the opportunity to ask any questions you might have. We suggest you take 10 minutes to review this information sheet and feel free to speak to others about the study if you wish to do so. Should you have any questions about this research project please email the research team on [redacted]

Purpose

The purpose of this research is to understand whether inpatient staff training on Trauma Informed Care leads to any changes in staff attitudes, incidents of violence, and restraint and restrictive practice.

What your participation will involve

Should you decide to participate you will be invited to three Trauma Informed Care workshops. These three separate 50 minute workshops will be run in person in the ward board room. Should you be unable to attend in person, a recorded version will be made available for you to watch in your own time.

Prior to attending the workshops, you will be asked to complete five brief questionnaires. These questionnaires investigate your attitude towards Trauma Informed Care, the Trauma Informed Climate of your workplace, and your recent experience of violent incidents and restraint and restrictive practice. When you have attended all three workshops you will be asked to repeat these questionnaires. Following a 6-month period you will be asked to complete these questionnaires for a third time. Once all data has been collected you will be invited to attend an optional debrief with the researchers to share any feedback on the project. You will also be offered an option to receive a summary of the research findings by email.

A small portion of participants will also be asked to attend a 30-45 minute interview to investigate your experience of the workshops. There is no obligation to be involved in this part of the research. All participants will be entered into a riffle with the chance to win a £30 Amazon gift voucher.

All collected information will be anonymised so none of your information can be identified, they will be stored securely in encrypted, and password protected NHS files only accessible to the research team. After completion of the project the data will be provided in a password protected and encrypted file to be stored in Salomon's Institute for Applied Psychology office for 10 years and will then be destroyed.

Benefits to participation

Involvement in this research provides the opportunity to learn more about Trauma Informed Care practices and contribute towards training and development on a wider scale.

Potential participation risks

Although previous research involving these workshops and teachings have suggested they do not cause any significant harm, they workshops may at times involve discussions around trauma experienced by yourself or others, which may lead to feeling distressed. The surveys also ask about violent incidents, and therefore if you have experienced these you may feel distress in answering these questions, although they are brief and not detailed. Should this happen to you, we would ask you to let the research team know so they can support you directly or provide the contact details to the staff counselling service and other crisis numbers. You might wish to speak with your GP about what further support could be helpful, or contact NHS 111, by dialling 111 or using https://111.nhs.uk/

Confidentiality

As previously stated all collected information from the questionnaires and interviews will be anonymised in order to maintain your confidentiality. Only one member of the research team will have access to identifiable information. A write-up of the research findings will be submitted for publication. No identifiable information will be included in this either.

Should you disclose information which indicates risk of harm to yourself or others, confidentiality may be breached in order to ensure the safety of all involved. Should a confidentiality breach occur due to your disclosure you will be informed of this, unless it is deemed unsafe to do so.

If any part of the research, or your potential involvement, does not sound clear then please ask a member of the research team to clarify.

If you have read this information sheet and would like to participate then please read and sign the 'Participant Consent Form'.

Appendix E - Detailed Account of Workshops

Breakdown of Workshops

Workshop Number	Date	Number of Attendees	Format	Training Environment
Workshop 1	June 2022	4	Face-to-Face Only	Board Room
Workshop 2	June 2022	0	Face-to-Face Only	Board Room
Workshop 3	June 2022	3	Both Face-to-Face & Online	Board Room
Workshop 4	July 2022	4	Both Face-to-Face & Online	Board Room
Workshop 5	July 2022	4	Both Face-to-Face & Online	Ward Meeting Room
Workshop 6	July 2022	3	Both Face-to-Face & Online	Ward Meeting Room

Content of the Workshop

The session structure was divided into three parts, with a 10 minute comfort break between each part.

Part	Overview	Timing	Main Content	References	Activity/Discussion
Part 1	What is Trauma?	30 min	-The 3 E's -Diagnostic criteria for PTSD. -The Trauma Response -Risk factors for PTSD -History of Trauma -Physical vs Psychological Trauma -Life Stress vs Trauma -Adverse Childhood Experiences -Biological impact of Trauma -Social & Cultural Factors in Trauma	Sweeney et al., (2018) DSM V (2013) ICD-10 (2018a) Felitti et al (1998)	-What does trauma mean to you? (Discussion) -Do you recognise any trauma symptoms in clients you're working with (Discussion) -Review ACE worksheet with client in mind (Activity)
Part 2	What is Trauma Informed Care?	30 min	-Power Threat Meaning Framework -What Trauma Informed Care means	Johnstone & Boyle (2018) SAMHSA (2014a)	-Reviewed Power Threat Meaning Framework for a client (Activity) -Discuss in pairs

			-The 4 R's -Re-traumatisation -Becoming Trauma Informed -Asking about Trauma	Bloom (2013)	practices that might be retraumatising on the wards (discussion/activity)
Part 3	Trauma Informed Care in an Inpatient Setting	30 min	-The Impact of Austerity and Brexit -The role of vicarious Trauma -Traumatised Systems -Ways of self-sooth, relax and ground when distressed. -What TIC-led Inpatient systems could look like, possible steps towards this. -Outcomes associated with TIC. -Successful TIC implementation	Pearlman & Saakvitne, 1995). Menzies-Lyth (1960) Keesler & Isham., (2017) Nikopaschos et al (2020)	-Do you identify any traumatised system practices on the wards? (Discussion) -Handed out booklets on self-soothing, relaxation, and grounding techniques (Activity) -Ways to work towards a TIC ward (Discussion)

Workshop Materials

Please contact the author for a copy of the workshop presentation and training materials.

Appendix F – Trauma-Informed Climate Scale (TICS-10) (Hales et al., 2019).

This has been removed from the electronic copy.

Appendix G – The Staff Observation Aggression Scale- Revised (SOAS-R) (Nijman et al., 1999)

This has been removed from the electronic copy.

Appendix H – The Attempted and Actual Assault Scale (ATACKS) (Bowers et al., 2002)

This has been removed from the electronic copy.

Appendix I – Semi-Structured Interview Schedule for Attendees

1. How did you find the TIC workshops?
2. Were there aspects of the workshops you
   - A Enjoyed?
   - B Found useful?
   - C Found interesting?
3. Were there aspects of the workshops you…
   - A Did not enjoy?
   - B Did not find useful?
   - C Did not fine interesting/relevant?
4. What did it feel like to be in the TIC workshops?
5. Do you think the workshops have impacted the way you interact with clients?
6. Do you think the workshops could have been improved/more effective? How so?
7. What was the impact of your attendance at the workshop in the immediate term?
8. What was the impact of your attendance at the workshop in the short term (weeks after)?
9. What was the impact of your attendance at the workshop in the long term (month after)?
10. What is your attitude towards TIC now?
11. How relevant do you think trauma (and adverse childhood experiences) are in understanding the causes of human distress?
12. Do you believe trauma plays a role in how people feel long-term?
13. Having completed the workshops, do you feel different when interacting with service users?
14. If you do feel different when interacting with service users, in what way?
15. Have the principles of TIC helped you in your daily work?
16. Have the principles of TIC helped you in your daily personal life?
17. Since completing the workshops have you behaved differently at work? If so, how?
18. Do you think the workshops have impacted on you in any way? If so, how?
19. Since completing the workshops, have you experienced changes in your levels of safety?
20. Since completing the workshops, have you been involved in any incidents of violence?
21. Since completing the workshops, have you been involved in any incidents of restraint/restrictive practice?
22. Since completing the workshops, have you reflected on any experiences of trauma in your past?
23. What was it (if anything) about the training that could have led to changes? Could something else other than the training have caused these changes? If it was due to the training, then what specifically could have caused this and why?
24. What facilitated your attendance at the workshop?
25. What do you think might have got in the way of your attendance at the workshop?
26. To what extent do you feel your ward is Trauma informed?
27. Do you feel the leadership of this organisation supported you to attend this workshop?
28. Do you feel the leadership of this organisation support TIC principles and practice?

Appendix J – Semi-Structured Interview Schedule for Non-Attendees

1. What possible barriers did you face in attending the workshop?
2. What could have better facilitated your attendance?
3. What is your understanding of TIC principles and practice?
4. What do you think could reduce violence/aggression on the ward?
5. What do you think could reduce restrictive practice on the ward?
6. How do you feel about restrictive practice?
7. What do you think would support wards to better implement changes?
8. Do you think the wards are able to implement changes?
9. To what extent do you feel your ward is Trauma informed?
10. Do you feel the leadership of this organisation supported you to attend this workshop?
11. Do you feel the leadership of this organisation support TIC principles and practice?

Appendix K - Positioning Statement

In an attempt to minimise the impact of my potential biases on the research process and its findings, I am reflecting on my pre-existing beliefs and experiences. I am hoping that my transparency and awareness of these factors will reduce the likelihood of these factors negatively impacting on the research.

As a Trainee Clinical Psychologist, I am also a supporter of psychosocial formulations and interventions for mental health challenges. Although I acknowledge biological formulations and treatments can be relevant to some individual experiences, the overt medicalisation and subsequent hierarchical nature of these wards is not something I support. These beliefs are further enforced by my own experiences of family members being sectioned and treated within similar settings, and not showing improvements in their wellbeing. Moreover, at the start of my career in mental health I worked as a Clinical Support Worker in these exact inpatient wards, and so I am aware of the medicalised culture and the speed with which restrictive interventions are drawn on in these wards. My first placement as a Trainee Clinical Psychologist was also back on these wards, and so I have now seen these wards from the perspective of a Clinical Support Worker and Trainee. Having witnessed restrictive practice, and the profoundly negative impact of this on all involved, I am not an advocate of its use, and hold strong beliefs that this practice needs to be minimised to less restrictive options. These experiences may impact my mindset when entering these wards for this project. For example, uncomfortable memories may be prominent in my mind, and this may make me feel frustrated or negative towards staff, which may impact on my engagement with staff and subsequently the data I collect.

Having seen the impact of these medicalised interventions as an employee in two roles, and a family member, I am keen to reduce restrictive practices and the medicalisation of these settings. I have also seen the benefit of psychosocial interventions in these settings and how hard it is for staff to support these interventions in such medicalised cultures. This explains my interest and passion for introducing psychosocial working in these settings, but this needs to be kept in check throughout this process to prevent me from inadvertently biasing the results. This could happen through me exposing my beliefs and views towards the nature of these settings and my desire for psychosocial working during the collection of quantitative measures, the workshops, or completion of the semi-structured interviews.

To avoid this happening, I will be engaging in some grounding exercises and a reminder of my pre-existing biases prior to entering the wards. I will also be feeding back my experiences to my supervisor throughout data collection, and I will be ensuring the qualified Clinical Psychologist takes the lead during the workshops to ensure I do not bias the learning process and discussions. I will also be recording all my semi-structured interviews and sharing these with my supervisor who will be auditing them and providing me with feedback. I have also enlisted the support of a fellow Trainee Clinical Psychologist, who has never worked on inpatient wards but does have specialist Reflexive Thematic Analysis experience. This Trainee will be reviewing my interviews, codes, and theme development. I have had a reflective and in-depth discussion with this Trainee, during which I shared my beliefs and hopes for the project and asked they be mindful of this and look out for times where I may be interpreting data to match my hopes. Due to my experiences, my hope was that staff show supportive attitudes towards Trauma Informed Care, identify barriers that can be overcome to

make Trauma Informed Care implementation feasible, and report positive effects of Trauma Informed Care workshops on their individual practice and wider teams. My overall hope from these outcomes would be improvements in the care provided to the clients on these wards.

I am of the belief that Trauma Informed Care principles of Safety, Trust, Choice, Collaboration, and Empowerment, should be values present in these caring settings. I must, however, keep this belief neutral to maintain my natural curiosity when questioning staff, as overt support of Trauma Informed Care may shut their true beliefs down and push them into a defensive stance, especially if they believe Trauma Informed Care is not possible in these settings. Indeed, to accurately assess the feasibility of introducing Trauma Informed Care principles into these settings I need staff to be open and honest about the barriers they face. This may be challenging to do, as I would like to show integrity in my beliefs without them affecting the project.

Moreover, as a white, working class, cisgendered, heterosexual female, it is also likely my experiences in all facets of society will be very different to both the clients and staff working and living in these inpatient wards. It is likely I will not have faced the challenges or discrimination many individuals will have faced prior to and during their time on these wards. This will mean I may be unaware of some of the challenges present in incorporating Trauma Informed Care. This may cause friction with staff participants considering my current beliefs that Trauma Informed Care values could be of useful for both clients and staff. I must also be aware of the potential power imbalances present during data collection, workshops, and interviews. As I will be entering as a white band 6 employee, a hierarchical setting such as these inpatient wards may mean staff agree to engage in the project or agree with certain ideas when these are not their true feelings. However, as ward managers are band 7's, interactions with them may need to be mindful of respecting their power and not making them feel they are being disrespected, as this may affect the longevity of the research project and its ability to positively affect the wards and clients.

Having worked on these wards recently I also have a good working relationship with many of these staff members. This puts me in a unique position to complete this research as it means I know staff and they may feel comfortable speaking to me about sensitive topics such as trauma, client care, restrictive practice, and ward challenges. However, this may not work in my favour, and staff may feel they need to refrain from being honest to maintain our working relationship. They may also be aware of my professional role, and subsequent beliefs about mental health, and therefore not feel comfortable sharing their true beliefs (which may contradict mine). To manage this, I am going to offer staff participants the opportunity to complete their quantitative measures independently and be interviewed by another member of the research team.

Appendix L – Research Diary

Entry 1 – June 2021
My MRP proposal seems to have gone down well, only minor changes needed, and they felt reasonable. It feels like a good start, but I am anxious about ethics and data collection. I've heard a few horror stories about people's MRP and I'm hoping mine is a much more positive story. It feels like it is possible to put the work in and ensure ethics comes through, but data collection seems to have lots of extra variables that are out of my control. Another Trainee mentioned they chose a project based purely off the ease of the design, as it was all put together for them with data ready to be analysed. I felt a little panicked that I chose something I was passionate about that might be challenging, but if I'm going to do this for three years, I want it to be something I am interested in and that might make a difference.

Entry 2 – September 2021
Ethical approval has been provided! It felt almost too easy, everyone else is sharing stories of delays and issues with IRAS. I've tried to be helpful and share my knowledge/experience, but it feels like a lot of this is down to luck and specific details about your project. Salomons also provided their approval, and the trust has said it's ok to begin collecting data. I've had to attend a very frustrating 3-hour long training to learn to use the system the trust uses to log research participants. It felt particularly challenging as the system is straight forward. I'm still waiting to hear back from my external supervisor about when I can come on the ward to actually collect my data. Maybe I'll be more excited about using this system when I can begin!

Entry 3 – November 2021
I still haven't begun data collection yet. I was promised this would be the easiest part, but it's feeling impossible. My external supervisor has been off sick for months and may well be off for much longer, so I feel quite lost. I've tried calling the wards, emailing the ward managers, and even got on the train and attended the wards in person, and still couldn't speak to anyone. My next placement will be nearby so I'm hoping to use that proximity to my advantage. It feels clear to me that I am on my own in this endeavour as Salomons tell me to contact the trust and the trust tell me to contact Salomons, so no-one is actually supporting me in data collection. I'm feeling fortunate that my internal supervisor is responsive.

Entry 4 – January 2022
I now have half of my pre-workshop measures, but it has been an ordeal and so I'm not celebrating just yet. I used weekends, evenings, lunch breaks, and even took annual leave to physically be on the wards collecting these pre-workshop measures. I am fortunate to have good professional relationships with ward staff but have had to use lots of charm (and even chocolate) to get staff to complete my premeasures. Most staff appear tired and apologetic that they can't do my measures, but some staff appear irritated by my presence, even when I back off. One staff member pretended to be writing on a clip board to avoid talking to me. I noticed they weren't holding a pen and the clip board had no paper and so I (equally as irritated by this point) continued speaking to this staff member, who then physically turned their back on me to make me. I have never been treated like this in a professional setting by another professional, and couldn't understand why they didn't use their words to let me know they were unavailable? I felt so rejected and then I thought if I'm being made to feel this way, I can only imagine how the vulnerable people living on the wards must be treated and feel. This made me think about the values of Trauma Informed Care, and whether values such as choice, collaboration, or empowerment, were present in interactions between staff and

clients. This feels unlikely if they are not present between staff members.

Entry 5 – February 2022
Data collection has continued to be a nightmare, and I'm only at the beginning of this project, with workshops, post measures, and interviews still left. It feels like my project was too ambitious and I've became annoyed that this wasn't highlighted to me earlier, but maybe this is unreasonable of me. I'm almost at the minimum number of participants but I don't think I could do this again for post workshop measures, which is a problem. I've been told that lots of ward staff members have quit following some staff conflict. Everyone has been keen to share details of the conflict which has felt difficult to navigate. I feel for the wards who are now even further understaffed. I'm also concerned that this will be another spanner in the works for my project.

Entry 6 – February 2022
I had a particularly difficult interaction with a staff member yesterday which left me feeling upset. I approached the ward manager to discuss which staff members met my research inclusion criteria and he took me to a support worker and told her she could leave her task and instead fill in my measures. When I sat down with her, she appeared irritated and said "I shouldn't be doing this with my time, this isn't right" I asked her what she meant and she said "I was doing something, you can't just do this". I felt so uncomfortable, especially as she was so nice in front of the manager. I told her she didn't have to do the measures (after all this is trauma-informed right?), but they'd only take 10 minutes, she stood up and walked out without saying anything else. I was upset and wanted to share this with the ward manager but didn't know how helpful this would be, so I left. I'm feeling quite desperate and fear I'm putting too much pressure on people to participate but don't know what else to do as managers are telling me to carry on. I am trying to not take this personally but do feel like I might be doing something wrong.

Entry 7 – March 2022
I contacted my internal supervisor in a panic to communicate my concerns, and he's been responsive and supportive. I met with him and told him that my external supervisor has not been present and involved, and that workshops and post-workshop measures feel impossible. As I have all my pre-measures and they've taken me 30+ hours to collect we want to make use of them. I also feel like I am on to something very interesting with these measures and general project. We've agreed that it is not possible for me to spend more time on post-workshop measures (alongside placement, other academic reports, and living a normal life). We've come up with a modified research question which feels like a good fit, but they depend on my external supervisor responding to me and supporting the workshops. I've amended my proposal and have tried to contact the Salomons staff member, but he has not been responsive, and so I've escalated this to senior members of staff.

Entry 8 – April 2022
I've had my amended proposal approved and my external supervisor has contacted me and told me they can still help with workshops; it feels like things are taking a turn for the better. I told her of my challenges, but she is optimistic that we can make these workshops happen. It feels naïve to believe her without question, having had so many challenges already. We booked in a date and time for our first workshop, and I've emailed ward managers and senior staff. As these dates and times were based off their feedback, I'm hoping we will get lots of staff in attendance.

Entry 9 – May 2022
The workshops have felt like a real mixed bag. Our very first one had only a few people in attendance. We were promised 10 people, so this was disappointing. However, the conversations felt powerful, especially the ones involving the lived experience practitioners. It felt like some of the staff members really valued the session and internalised a lot of the TIC models and ideas. However, a part of me thinks these staff members may already have held TIC values and so I wonder how helpful the workshops are for these people. With other staff members it has felt like TIC is a different language. Introducing the idea of not re-traumatising clients through restraint was met with scoffs and confusion. I am also disappointed at the low turnout. We were promised every staff member would attend at least one workshop and they haven't, despite us offering more and more workshops (and so many nice snacks). It feels like they are unable to consider sending staff to the workshops as they are only focused on having bodies on the ward floor to manage "risk".

There have been more challenging interactions with staff during these workshops. Several staff members have "joined" online but switched their cameras and microphones off. This has made discussions hard and so at points we have asked them questions to get them involved. This has not gone well and on one occasion a staff member unmuted to say "we're listening, just carry on!". I wonder if they were listening, because they didn't answer the question and were quite rude about it. I am struggling to stay compassionate and empathetic to their challenges and have experienced a lot of thoughts about their professionalism and capabilities. Once again, I'm thinking about their treatment of me and how they might treat vulnerable clients on the ward.

Entry 10 – July 2022
We decided to stop offering more workshops and accepted the number of people who attended as a win. I am feeling grateful for my external supervisor's support in running these workshops, but still feel frustrated at how poor the attendance has been and how hard it has been overall. It feels like we both underestimated how hard this would be. I've begun my interviews and they are proving challenging but at least this is the final hurdle. Some workshop attendees have reported their affinity to TIC and newfound interest in psychological models, but these interesting findings have been overshadowed by many reporting their inability to incorporate TIC into their work. One staff member even reported that their manager was anti-TIC and had laughed at the idea of incorporating TIC into their procedures. As this manager had joined a workshop (online with their camera and microphone off) this filled me with lots of frustration, as I don't think they participated or learnt what TIC really was. Alternatively, maybe they did pay attention but just don't agree with TIC, which makes me even more concerned.

Entry 11 – September 2022
I've finished collecting my interviews and feel extremely relieved. People have been incredibly candid with me and shared their thoughts on lots of personal experiences and opinions. I feel incredibly privileged to have heard these stories, but also feel devastated to hear the extent of people's challenges working on the wards. It feels like people enter the wards with high hopes of helping but soon realise that this is not possible. It feels like these wards are not places of care and I've felt hopeless thinking of how this can be fixed. It feels clear these workshops on TIC are not enough and I'm feeling disheartened. It feels like something drastic is needed, like starting all NHS inpatient services afresh in new buildings, with new policies and procedures, possibly even with new staff in management. I think a few staff members could benefit from knowing there is support available if they would like to talk

more about what they have seen and how it's affected them. I've had to really reign myself in as I don't want to overstep my boundaries with staff or bias my findings by becoming over involved with staff members.

Entry 12 – October 2022
I started my reflexive thematic analysis and decided to invest in the newest book to make sure I'm doing it properly; I'm giving it all a lot of consideration as I want to do my findings justice. I am eternally grateful for MS Teams auto-transcribe which has saved me hours. My Trainee friend came round to help with coding and was horrified to find I was doing it on paper across my floor! I've downloaded Nvivo and must admit she was right, it's much easier and better for the environment! We've had some debate around a few themes as some barriers and facilitators appear to be the same thing but in reverse. I discussed this with my internal supervisor who also looked at my interviews and transcripts. We feel like we've got some great findings and I hope I can do them justice with my write-up. I did the raffle for the participant voucher and found out the winner no longer works for the trust. I did the raffle again and found out the new winner also doesn't work for the trust; it seems there has been another mass exodus of staff. Sadly, no-one knew how to contact them or where they'd gone, it was like they had never been there.

Entry 13 – December 2022
It's Christmas but I'm spending a lot of time finalising my themes. I'm resenting the fact that I'm not taking a proper break while others appear to be unwinding. I'm hoping the work I'm putting in will be worth it and I'll be able to produce a good quality piece of work.

Entry 14 – February 2023
I've shown my internal supervisor my finalised thematic map and they are happy with it, which is great as I'm happy with it too! I'm getting into my write-up and have a draft of most of my sections except my conclusions and implications. I have received a lot of feedback on my initial draft sections which was a bit disappointing, but I've tried my best to take them on board as I want this to be a good piece of work. My 30th birthday is roughly the same time as the deadline so I've decided to be 29 for another year and celebrate my 30th next year so I can focus on my write-up.

Appendix M – Quotes Supporting Themes and Sub-themes.

Theme	Sub-Theme	Quote
Lack of TIC Awareness	Lack of TIC Knowledge	"Yes, I think the wards are trauma informed, when someone comes on the ward we minimise risk, like we take away any sharp objects, any piece of ligature equipment, anything that might harm and traumatise them, the team definitely speak about like how to prevent damage to the person and like others too." (Richard) "I don't think I have heard of it [TIC]… No worry I have no idea, my mind is so blank right now, what is it again?" (Pamela) "It's that (Lack of understanding) and also a combination of staff anxiety, as soon as they see certain behaviours it's like oh ok, yeah, you can't be managed here back to PICU! There's none of the de-escalation, or even thinking about why the presentation has changed, what can we do to try and avoid them to go back to PICU." (Aleysha) "What is it? [TIC] That's a good question, I know we did all those questionnaires about it, but urm… maybe… I'm just going to waffle now, so maybe you just tell me again." (Bradley)
	Counter TIC Beliefs & Practices	"Sometimes restraints need to be done. Umm, they actually need to be done because maybe medication is needed, or isn't working, or maybe a patient's gone acting out of order like so you can't just allow the patient to do what they want." (Bradley) "But then if the manager is not there, a lot of the staff want to resort to restraint, it's just quicker and easier." (Natalia) "No-one likes it [restraint]. It's a necessary evil. Some clients are dangerous and the safety of myself and staff comes first. Also, the other patients on the ward, we need to protect them and sometimes that means using restriction, like seclusion or medication. Sometimes a client might have it coming if they've been acting up all day." (Richard)

		"It's [restraint] a useful way to manage, instead of constantly being like, no, don't do this, we said we'll do that, you know, but restraining is like showing them, shut up, this is what's going to happen to you! Then take them to their rooms to sedate them." (Aleysha) "I feel like a lot of the time staff, including myself sometimes, wants to show who's boss, you know? So they use that as a way to restrain." (Pamela) "I think they are [staff aware of TIC], they know that patients have very troubled pasts, but it's hard to ask people about that, we don't want to open up a can of worms we can't deal with…Yeah no time to delve into this, it's not what we do or prioritise." (Richard)
Inpatient Culture	The Medicalised Environment	"They'll [inpatient Psychiatrists] talk to you about like the biology stuff like that and why people are… you know as in how it works and the chemical imbalances and stuff like that and you know, but no I'd never thought about like upbringing and stuff people had gone through making them the way they are acting now on the ward" (Mia) "Uh, it's the consultant on the wards that needs to be more psychologically savvy and promote it [TIC] or it's never going to happen. And maybe the medics and nurses to let psychology take the lead a little bit more than they're allowing… medication has its place, but it's not the be all and end all, it's not enough there." (Natalia) "You know, psychology is just a conduit and not an important part of the healing process. We need to work shoulder to shoulder together, psychiatry has its place, but we certainly have our place as well, you know, and maybe it is holding on to their profession. But I also think it's more than that. It's just them dismissing us. Thinking well, yes, psychology is there and it's important, but they don't give it the real credence that they need to, you know. Urm and perhaps it's the trust as well. You know, this is this is a trust that is very medicalized, and we have to accept that." (Natalie) "And there's a lot of hierarchy issues…like nurses, CSW, they get pushed around." (Natalia) "Yeah, I think it's [care of clients] more just getting them better with the medication, that's really the main thing we do here. Now I do try and read the clients notes, to like try and understand why they're

		behaving like that, but we're not given enough time for it, we just do what we're told and focus on obs and getting medication out [observations]" (Kiara)
	Risk Aversion	"If you have certain people on shift who kind of just have that mindset [to restrain], I think it kind of just works out like that… if one person was very hands on and they started doing it, other people are like, OK, we need to go and join in too and then they learn that you react that way too, they don't learn to diffuse things first." (Lewis) "How I hear them speak or I see a situation escalating… It's like, come on, guys, you know, let that person be and express themselves, they're not ok, that's why they're here, we don't need to immediately call the team and restrain, it isn't necessary, the risk isn't even there but you're making it" (Kelly)
	Lack of Psychological Awareness & Skills	"We really should be talking about what the person has been through, but we're just not, we avoid it and just medicate, which is not a good thing. If I really sit back and think about it, like why this person is here [on the ward] it gives me more understanding and I could even give them better care… I would want to understand this way of thinking more [TIC], so I can even explain it to the clients and the rest of staff on duty, right now I'm a bit worried I'll get it wrong and ask the wrong question and make everything worse." (Kiara) "I know for care plans its quite personal sort of questions you asked, but trauma feels like a step up for some people. Maybe because it's so personal, I know we already ask personal questions, but it's not so much like about what's going on in your mind more like physical stuff." (Kelly) "If it [Psychological understanding and working] was talked about more then maybe we'd all feel more confident talking about it and working with it too, and then it might even push people to think that talking to people and asking about how they're feeling is actually part of their role, and not something to be avoided while focusing on their physical health. It's like it's ok to get involved in this, it's what we should do, and not just you know, more like for the Psychologist, who only comes on hour every three weeks." (Mia)
	Generational Staff Divides	"It is a culture people don't see training as priority unless it's mandatory, unless it's in their contract, you know, I see it where I'm working at the moment… they start questioning why is this mandatory? Is this part of my contract? Did I apply for this...so it's a cultural thing, especially those who have been working for many years and not had this sort of new way of thinking, where there's a lot of trainings put in place to improve the service, they will stick to their ways…there's people who have worked for many years

		that have not had this provision before and they're just coming to work do the same thing, go back and not really invested in improving the service." (Pamela) "And that's just the culture, isn't it? That's just how they see things, you know. If I must, I'll go. But they're not, you know, not really invested. They don't want things to change, they don't want to grow, they want to carry on doing the same thing with minimal effort and get paid." (Deborah).
Team Dynamics and Cultural Barriers	Poor Treatment of Staff	"The like short version of that was, I filed a bullying complaint against [senior team member]. And then like nothing happened, it continued to escalate multiple times and then I said this bullying is now at the point of discrimination and I don't know if it's my race, my nationality…but she is clearly discriminating against me. And then a few hours later, I get a phone call and I moved off the ward." (Deborah) "There is just not enough time to do everything, it's so fast-paced…to be honest, I tend to read about the patients on my break, when I'm on my break, I just log on and try and read about their history because from my experience, there's no way you can sit in that office to read because the door is always knocking and something urgent that you need to deal with it always happening." (Kiara) "I'm very busy and I find it hard to reply to emails that aren't essential, apologies I didn't get back to you about this interview. This job, and any inpatient working, makes it hard to engage with new things, even if you really want to. You're just in overdrive getting the essentials done." (Richard) "Especially for clinical support workers. There's one girl on [ward name] actually, she was physically abused by one of the patients and had her hair pulled and had scars and everything, you know, she was off for a few days, but she's even bank, which makes it worse because she has to work, there's nothing in place to support her, no proper appreciation. There's no structure in place where maybe someone senior can come and visit. Sit down, reassure them or give them some sort of a nice wellbeing break…You know, you have to deal with that traumatic event by yourself" (Pamela) "They have been highly aggressive to staff members. Uh, pouring hot drinks on them, punching them, kicking them, whatever else that they've done." (Natalia).

		"In the beginning, they treated me, excuse my expression, like c**p, you know? And even [other employee name]. This is just the culture…I just thought you cannot talk to me this way…don't treat me that way because that's wrong." (Natalia) "You can kind of go back to the cr***y conditions on [ward name], where you know it was frequently not well staffed and some staff could go and do what they want while others do the majority of the tasks and we're working really hard. And so, what happens then is patient care suffers right, and it's hard to provide trauma informed care, or any quality care, when you've got half of the staff sitting around giggling collecting a pay check for doing nothing and the other staff are overly burnt out." (Deborah) "But of course, we have some other issues, which is finances for a lot of people, and Inflation and worries about salaries and long term issues and maybe a bit of burnout, you know, for staff that are consistently firefighting." (Natalia)
	Management Disconnect	"Yeah, the other day we [managers] were told we now have to do one shift a week in numbers, which is fine, I agree with it. I now have the issue is when you're telling me I can't do weekends and it can't be a late shift, it can only be an early shift between nine to five. I said OK, but you told me that I have to support my staff and give them flexibility. But what about me? I just said, yeah, I'm just letting you know, I've got kids… it doesn't sit right with me at all. And I think it frustrates me because I'm not like that with my team. So if I'm not like that with them, why should I now tolerate anything different for myself?" (Aleysha). "Just everything's like tickbox. And as long as everyone looks great, but they [senior management] don't care about the people." (Aleysha) "I just feel like those at the top are so out of touch, they probably won't ever see or hear of the emails discussing the trauma people experience. They should personally be attending meetings with people who have been affected so they can really appreciate their experience and see what they need to change." (Pamela) "Yeah, like they will encourage people to attend and be like yeah this is good for practice blah blah blah, but the thing is they don't actually give you the time to attend, so you don't attend, you can't do two things at once and you can't let the team down, so you just do your job and miss out." (Kiara)

		"I've seen some managers have different journeys. They come here straight out of uni…they go from band 5 to 6, then ward manager, then matron, and you see them changing, you think you never used to really communicate with me like that… how they now treat patients and treat staff will be very different because maybe they are looking at the numbers now and that's more important, cus I feel like the higher you go, slowly you come into the business side, and it goes from seeing a human to seeing "1"… We forget it's healthcare but it's a business…The higher you go the more out of touch you become with what's actually happening." (Kelly) "Yeah, yeah, leadership definitely has to be invested in it [training], and I think you can tell they just aren't. They don't care about staff members development; they just want bodies on the floor so the ward can keep going". (Mia) "Sometimes I think people are so behind their screens and they've spent a lot of time away from clinical practice. Umm, they're now focused on targets. Yeah, they're roles have now changed. They just expect things to happen immediately and don't understand things take time or need additional support to happen." (Aleysha).
	Short-Term Focus	"My understanding on two of the wards is that this [reflective practice] has been postponed as a result of limited time and being so stretched, which is they look at the immediate need and forget that if they may go to a reflective practice, they will feel not only reassured, but maybe refreshed and feel like they'll have a different perspective. But you know, when you have your blinkers on, it's very difficult to see." (Natalia, Non-Attendee) "They're [staff] not looking at the longer term picture they are looking to just, well management and a lot of the staff, are looking to just get through the week or even the shift. Upper levels of management might be looking at what the trust can do to improve in 10 years, but everyone else just doesn't have capacity for that." (Deborah) "Yeah. But I will say at least my experience for a lot of nurses and CSW's on the floor. I would say the resistance is not because of any malice. But the resistance is because they are stressed and stretched thin and overwhelmed that they don't think they can handle adding essentially like another task to their list

		and kind of in looking at it as a tick box, not seeing how that trauma informed care approach could lead to a lesser workload in the future. Yeah, they don't realize the trade-off." (Kelly)
	Powerlessness	"I remember [TIC workshop facilitators name] was saying that we shouldn't be scared of like asking people about their trauma. But I think when I did bring that up, people were scared about asking and just avoided it." (Kelly) "So, I mean after [the training] I was keen to do stuff like including considerations of trauma and ACEs in like care plans and stuff like that. That's something that I feel like it's really hard to change the way that's it's done already. You need someone senior to bring that and say, we're doing it differently now." (Mia) "I do think it's hard to kind of communicate it [TIC] with other colleagues. I did try a few times and everyone was just like we don't understand you and you're wasting our time." (Lewis) "If leaders, if people in senior positions are more trauma informed then that would really help us be able to implement it a lot more because it feels like as support workers you don't really have much power to make much change. And especially like from the managers level, I think having that support would really help." (Deborah)
	Rejection of TIC by Leadership	"I saw my manager after we came back from the training and I don't think she found it particularly something she'd be interested in, like implementing, you know. And then if someone really senior thinks like that. You kind of feel like you can't bring that up again or pursue it." (Mia) "It comes back to higher management valuing trauma informed care and valuing well educated staff. The way they act, I don't get the sense that they do, they pretty much rejected all of my trauma informed ideas. The way the ward works we usually had more tasks than we had staff to complete them. And so with this not being a very high priority for management It obviously will not get done." (Deborah)
Lack of Management Support	Inadequate Staffing	"We had the problem with [patient name] where he was supposed to have a one-on-one with the interpreter once a week just so he could have someone to talk to and that rarely got done because they were like we don't have enough staff to do that... having enough staff could mean everyone can also disappear off to a training. If all the charge nurses could make it to your [TIC] training and we actually had monthly supervision with them, then within one month everyone on the team could have a better understanding of it [TIC]." (Mia)

		"It's more management writing enough staff…because I mean I don't know that we're ever gonna fully have enough staff to patient ratio because of the way it's set up now." (Kiara)
	Inadequate Staffing Continued	"And of course, get more staff on the wards, you know, to have some sense of continuity, the difficulty with bank staff is that there is no continuity. I go on the wards and I I don't recognize people. I don't recognize staff because there is such a turnover. And that happened in the summer. There was also a lot of staff that were off as a result of sickness, be it COVID or be it just burnout. It just feels unstable and extra things, like this training, don't seem reasonable to ask of people." (Natalia) "And we were significantly understaffed. We're now getting a whole team back up again. So fingers crossed. But again, don't know how long it's gonna take, so we're relying on bank to cover, it's a mess, so we just can't prioritise training." (Aleysha) "So many people have left. More than 87% of the nurses on [ward name] have left. Everyone is new or completely burnt out." (Natalia)
	Procedural Changes	"I think it's important for everyone, for senior management, to know what it's really like working on the wards, and to ease off on the amount of paperwork expected of nursing. If staff were also paid more and had better working conditions then we'd also need less agency staff, and we'd retain staff for longer. Retention is such a big issue, there's a constant turnover which makes it hard to create like a good team dynamic." (Richard) "I think it's the culture. I feel like people in [hospital name] don't understand the benefit of training I think, because it never used to be like that in my previous hospital, but even if there's training set out, other people don't understand that this is actually for you…Yeah, it's more like I can't go cus we're short staffed. But actually part of shift coordinating and allocating and delegating is knowing what other things you have coming up and actually planning accordingly." (Aleysha) "Then we don't review it and it's just there. And then ten years down the line, we say we just do it because we do. It's just tradition. And if it's a change that doesn't make sense or doesn't fit in with everyone's way of thinking it feels like a lot. People are more receptive when they understand it and it's introduced in small steps, that don't overwhelm them." (Aleysha)

		"UM, maybe the manager ensuring that I have time set aside for it. So for people to be on board... As long as everyone's on board … mainly the manager understanding…This is important as consultants will see that as wasted time especially if the discharge flow is very high. In terms of the pressure, you know, getting new ones admitted, so they see that as priority… So, you could be every week that I'm having to cancel the training. Or am I able to really set aside because people understand the benefit of the training." (Pamela) "I guess if it's, if it's not protected in in their schedule, it's not going to happen. And maybe one of the things that ward managers can do is just give them protected time. It's either like for us continuing professional development or just development of any kind, but if there is no protected time, I don't think it's going to happen it." (Natalia)
	Lack of Support for Psychological Working	"I think I've always purported to have behaviour support on wards. You know, I've worked alongside behaviour support specialist who do nothing but behaviour work. I think they have an important place on wards, especially for people that have had maybe forensic histories and whose violence and aggression requires staff to put them on one to one or isolate them because they have attacked staff on the wards." (Natalie) "I would say to debrief. It is, you know, part of the process that we should be debriefing, but I think we've lost the skills on how to debrief so it's not as effective, you know, unless something serious has happened. Where you definitely have to document everything, you know. You had the debrief, so I think having effective debrief will help. You know, maybe if there was a sort of a guide that can help you do it in a trauma informed way." (Pamela) "Uh, maybe if there was a phrase we can add to this official guide to be like, how does everyone feel? What do we know about the patient? What about other patients that observed this? Do they have any trauma in the past? Do we have to go and speak to them? Maybe a little prompt, something like that will make it more effective. So that kind of almost like a structure in place, so people can just go and get the manual and read it out loud." (Natalia) "They know that patients have very troubled pasts, but it's hard to ask people about that, we don't want to open up a can of worms we can't deal with… it's not what we do or prioritise." (Richard)

Awareness of the role of Trauma	The Role of Childhood & Psychosocial Factors	"It just highlighted how important childhood is and how life stressors can kind of affect things and stuff like that. So it just makes you think like there's lots of things that contribute to like mental health or even just like us maybe not feeling 100%." (Kelly) "I think I remember you gave us some lists of traumas that most people well, a lot of people, might experience in their lives, like death of a spouse or things like that. And I think knowing people in my life that might have gone through things like that, especially like family, I think it did make me reflect on how, yeah, how they sometimes act, how they sometimes snap at you and how it might link into trauma. Also, you're thinking like or what's happening in my life as well, I don't know. Like I've also had. I have like social anxiety." (Mia) "It just gave me a different viewpoint, you know, sometimes you won't think too much of why people are here and stuff like that. And like you don't really have time to look into why people are here or what happened before in their life for them to be here, like what's your story? I'm asking these questions now and trying to figure out what happened to you for you to get to this point." (Lewis) "I think it was good to understand that trauma actually is all around us every day and it's just not the people that you care for, it's the people you work alongside. Obviously, everyone has their private life, but your colleagues rarely ever say ohh years ago I was held down and now I've started this new job and now I have to hold someone down and this really affects me. So, yeah for me it's a good insight to have. Yeah. It really good insight." (Deborah)
	Trauma's Impact on the Body	"I think definitely for people that get agitated really easily. I think at the time we discussed the patient actually in the training he got into fights a lot with other patients and staff. He just seemed like to really easily get worked up about things and like hearing about the biological side, how it's affected like the development of these physical systems and it's like so easily triggered by different things happening around them, that was good to have that sort of reminder. And I think I tried to keep that in mind now when I see patients like that, I try to be a bit more understanding and patient." (Lewis) "I do think it's really important to think about how past events have affected…how it's like currently affecting someone and kind of shapes their perceptions and maybe unknowingly, you know that biological response. Yeah, like it makes you more understanding of things that you see that it doesn't

		make sense to you because you don't react that way. But of course, you don't have the same history." (Kelly)
Awareness of TIC Principles	Awareness of Re-traumatisation	"She's [client] smashed her forehead wide open and I was holding the head for an hour and then just looking at the Blood and everything. And she was just screaming. Everyone was just holding her down was horrible. It was so bad, that affected me quite a bit. I felt so uncomfortable doing it, and the person that was holding the arm kept on saying to me ohh you need to make sure you're holding her tightly, so she doesn't bite me and stuff like that. I came out crying when we finished. It was really horrible. I still think about it and get upset and then I have to see her [client] every day." (Kiara) "I know I'm more aware of being and providing trauma informed care and trying to I guess infect others with that same Trauma informed care approach. And so, I mean in the long term it would obviously be helpful if the whole trust was providing that. Umm So it would help break some of those Traumatizing things that happen when you're involved with the system." (Mia) "I'm definitely talking about trauma and not wanting to like re-traumatise people a lot more now I've noticed. There is one client who has such a dark history and I'm seeing now that people [other staff members] just want to shove it into a box and do the same thing we always do, but now I'm like no, this is just going to be a repeat of last time and make them worse. So now I'm like what can we do differently that might stop that?" (Deborah) "The people [clients], you know, they have to be asking for every little thing. They don't have their belongings, and then we're loudly knocking at 7:00 AM or something asking for medication and turning on their lights. You know, it's like to think if that happened to you like, I would be very irritated as well. And I might snap at people and. And with the training like I can now think that yeah, might be retraumatizing something in the past. Yeah. So that's something new that I think I gained from the training." (Lewis)
	Awareness of the Principles of TIC for Clients & Staff	"Uh, I keep saying that because it's such a massive thing that I noticed just people like opening the door and not knocking and or just being more polite when you can't do something or taking the time to give your reason even though you know that maybe half the time they react in a way that's upset, but as long as you've given a reason, that's better than just sort of brushing them off. Yeah, I think those little things. They really build up I think the thing about including it in care plans would be good." (Kelly)

		"Yeah, especially with people who have EUPD I mean, I find that they get a bad rap and are kind of marginalized, what they're doing is just typical EUPD and people say it's just a cry for attention or whatever, and it's like well but we also know that a lot of people with that diagnosis also have a lot of trauma in their background so how can we give them power? How can we acknowledge that past trauma and help them maybe not fall into these same things and instead of just brushing it off as EUPD like maybe actually call it PTSD and empower them to better their lives?" (Deborah) "We can all think of like the stereotypical physical or sexual verbal abuse right. But then just like even getting into the power differential about being sectioned could be quite traumatic just taking the time to acknowledge that and look at the not overt causes of trauma was super helpful. Like they have to eat the ward food, and eat it when we tell them, take medication when we tell them, and if they don't, we threaten to call the team, there is just no freedom or choice and I'm trying to consider these things when talking to people." (Mia)
Changes to Clinical Practice	Improved Understanding of Patients Needs	"The power differential one, I forget the exact name [Power Threat Meaning Framework], but I use that like 2 weeks later. We had someone who was had gone through a lot of trauma and they wanted me to talk to her and so I was like ohh well what if we use this Trauma informed care asking about the power how what things was how she survived instead of like what happened." (Deborah) "Yeah, So I try to be more understanding because when I don't, if they just come on the ward and it's just medication… I need to go and read about his risk and his history, if not then I'm not really aware of why he's behaving like that. Reading through everything it makes way more sense. I can see where they're coming from, why they're behaving that way. And I'm more patient with them and understanding." (Kiara) "I think before we had the session most times I will just go in and I would just treat the patients from just the way they were behaving. Most of the time they're very abusive and you can't really say what you're actually thinking. I'd get really frustrated, at times I'd go, sit down and cry, but it's actually helped, like going through everything that you talked about that has is helped me a lot. I don't just go by what they say to me, I do a bit of digging. So when I go on the floor and hear what they're saying I don't really take it to heart like I used to. So in that aspect It's helped me quite a bit." (Kelly)
	Improved Relationships	"I think my issue has always been not giving them that time to understand them. So this has helped me to give them that time to just sit with them somewhere for 20 minutes. for them to talk. And strangely

	with Clients & Colleagues	enough, most of them, especially the younger ones, when they come in, they tend to come to me a lot to talk…I will sit there even though I don't have that much time. They will talk… A lot of them, they feel comfortable talking, they'll say I've never spoken about this to anyone, but I feel more comfortable talking to you. Yeah, it actually makes me feel as if I'm doing my job properly, that someone can actually feel comfortable coming to me, approaching me to talk about their experience and what's going on. And for them to feel that comfortable. I feel it's actually a real privilege and I really appreciate it." (Kelly) "You can avoid that person in an hour's time, trying to throw a chair at you, you know, let's work all together, like we're here to work for their needs and put that first, it does work" (Lewis) "I think I'm more understanding, I give them time, I talk to them more. I actually give them that quiet time now, I know they need time to talk, and I try to engage with them." (Kiara) "I think it is just taking the time to reflect on the way they're talking to me and if they're being rude or getting quick to be angry about what might seem little. I think as well not only thinking about like past trauma but also thinking about the environment that we're in. I think a lot of people, they're quite irritated a lot of the time and just understanding that this is a difficult environment. This does relate to past trauma. They don't have power currently, and then that can sort of remind you of past experience." (Mia)
	Changes to use of Restraint & Restrictive Practice	"I try to keep myself neutral, you can't always help it you know, you do get irritated but I try to own up to it, you can get prideful sometimes, especially if someone's getting really agitated, but I just try to remind myself it's not personal, it's this environment, it's mental health, it's their stuff, so I can keep my cool." (Lewis) "We still have to go on response to other wards, so that's the same, but here I've noticed there are less restraints happening, for me I'm just not doing them as much." (Kiara, Attendee) "Restraint feels a bit wrong to me. Especially yeah when you think of trauma informed care as well, you feel really bad now that like putting your hands on someone and forcing them into like seclusion for example... That's unimaginably horrible. So yeah, it's quite upsetting, you're generally not aware of people's history that much as well. Which I mean, I think you can kind of distance yourself more in that

		way. So I don't really know if they've had some experience in the past of the police. I think a lot of people might have had experience with police, like breaking in and manhandling them as well. And but I don't know, like in childhood, if they've had some sort of abuse or something. Yeah, I'm now thinking about that when restraining because I'm now aware of it, but I don't tend to get involved in restraint very much... I try to avoid it now." (Mia) "So, I'm not put in that position of actually physically having to touch someone that much anymore. Just because now I just feel like I prefer all the verbal de-escalation, I like it and it really does work, so restraining is literally the last resort. For others it's their go to, but I'm good with the talking, sometimes it doesn't work and those steps have to be taken, but I'm not in a rush to take those steps anymore." (Kelly) "Just seeing like, this whole scene unfolding in front of me, I think to myself, imagine I'm unwell and on this ward one day, and I get frustrated or angry, you know, that's how I would be treated. You know, I would be taken down, and there would be no consideration of like my background or where I work or who I am or that I have a bad knee, it would just be like you're aggressive and non-compliant. And I'm gonna be taken down. This really frightens me." (Deborah)
Desire for further TIC Training/Changes	Identification of a Systemic Problem	"If its unsafe we're not discharging patients, and I don't care what they [senior management] say, because there's no point in being a hospital and being caring and kind and whatever and then like at the point of discharge chucking them onto the street. No. They'll be right back here in a few days and the cycle continues". (Alesyha) "It was kinda weird, but it helped a lot because I went back on the wards not just seeing patients as people who are unwell and being rude but as people who actually need my help, and a lot of my colleagues, including myself sometimes, we actually need to take time to get a better understanding of where they're coming from. So we can learn better way of acting towards them. Because a lot of us, I have a few colleagues in mind, have a lower threshold when it comes to patients, we don't have that much patience. So I would recommend all my colleagues to go to the workshop because it will give you more understanding and you'll have less problems." (Kiara) "I think everyone's attitude and behaviour can be so much better. I don't know whether it's just the way they are or whether they are aware, but I think we can do better. And in terms of I don't know, speaking

		to people, interacting with them much better, we're just not there yet, and it concerns me now that I'm more aware of it." (Mia) "It was good to sort of reflect on how we can apply it more to this sort of setting, because it's, I don't know, something's really missing and it gets quite frustrating working here, something needs to change at every level for us to actually be providing quality care." (Deborah) "For me personally, not every staff members want to be there, or work in a mental health service. I think a lot of them are money focused, so it's not so much on the service. So, their attitude, their approach to work is different. Yes, they may have those odd patients that they build a good friendship with, but that's just by chance. They're not looking for it. So that's been a culture for many years, which is sad. But that's just the reality. And to be honest, I did see myself falling into that trap." (Pamela)
	Self-initiated Learning about TIC & Trauma	"After the training I actually took some time off, some annual leave, I realised I was so tired and hadn't stopped and I needed a proper break, and I went online to try and see, like, to learn more about trauma and some other stuff in patients lives. Then going back to work it kind of made me feel like a new person, like I had new energy and a different objective, which wasn't so punishing, you know?" (Deborah) "I did find it very interesting. Ohh in like future roles I'll carry it in my mind, yeah. But also for my own issues, the booklet you gave out, I went on their website, and started reading about EMDR and talking about what I've seen, and I'm thinking I might try and organise it for myself." (Kiara)
	Unsuccessful Attempts to Implement TIC	"I did try a few times, and everyone was just like we don't understand you and you're wasting our time." (Lewis)

Appendix N – TICS-10 Average Comparisons

TICS-10 Subscale	**Hales et al., (2019)**	**Kusmaul, Wilson, & Nochajski (2015)**	**Current Study**
Safety	3.60	4.05	5.6
Trust	3.34	3.78	4.6
Choice	3.23	3.75	5.5
Collaboration	3.23	3.61	4.65
Empowerment	3.35	3.88	4.56

Appendix 0 – Participant Demographics for TICS Norming

Participant Characteristics	**Hales et al., (2019)**	**Kusmaul, Wilson, & Nochajski (2015)**
N	1,128	282
Country of Completion	America (Western New York)	America
Participant Role	Staff Members	Staff Members
Service of Employment	A single Behavioural Health Department Located in a public hospital in Western New York	Various Inpatient and Outpatient Mental Health & Alcohol Dependency Services
Sex		
Female	621	210
Male	381	71
Other	126	1
Race		
Caucasian	811	262
African American/Black	106	20
Biracial/Multiracial	18	Not Reported
Other	63	Not Reported
Missing	156	Not Reported
Average Age	42	44.36
Average years in role	Not Reported	16.75

Appendix P – End of Study Summary Report

The need for, feasibility, and impact of Trauma Informed Care (TIC) workshops, with mental health inpatient staff

Background

Studies have identified mental health inpatient settings to be medicalised (Chatterjee, 2022), hierarchical (Eaton, 2017), and quick to use restrictive practices (Bloom & Farragher., 2011). These practices can be traumatising for clients and staff (Butterworth, Wood, & Rowe, 2022), many of whom may have already experienced trauma (Gibson et al., 2016, Merrick et al., 2017). It can be hard to move away from these practices (Raphael, 2021), considering service pressures (Kiely, 2021) and staff burn-out (Johnson et al., 2018). Trauma Informed Care (TIC) is a new way of working which aims to acknowledge and reduce the impact of trauma (Becker-Blease, 2017). Studies have found benefits from introducing TIC in inpatient settings, such as reduced restrictive practice (Azeem et al., 2011, Cations et al., 2021), reduced challenging behaviour and PRN medication use (Keesler & Isham, 2017), and increased quality of care (Brophy, 2016, Hales et al., 2019).

However, many studies have come across barriers to introducing TIC, such as resistance to change (Isobel & Edwards, 2017), lack of leadership support (McEvedy et al., 2017), understaffing (Conners-Burrow et al., 2013), and over-reliance on coercive practices (Bloom & Farragher, 2011). Moreover, the research base quality has been questioned (Almalki, 2016), with many trials using unvalidated measures and complex organisational change projects (Aremu, 2018), further empirical evidence is therefore needed (Valenkamp et al., 2014). The present investigation aims to examine the current culture and practices within mental health inpatient wards in relation to TIC, to gain a deeper understanding of the feasibility of introducing TIC in these settings, and understand the potential effects of

introducing staff TIC workshops on individual practice and wider teams.

Methodology

31 mental health inpatient staff from a variety of professions participated in this mixed methods study. Participants completed 4 quantitative measures assessing their awareness and attitude towards Trauma Informed Care (TIC), as well as their recent involvement in restraint and restrictive practice. Participants were then invited to attend one TIC workshop. Following the workshops, 10 semi-structured interviews were conducted with attendees and non-attendees to understand the conceptual and practical barrier to introducing TIC in these settings. Quantitative measures provided descriptive statistics and interviews were analysed using reflexive thematic analysis (RTA).

Results

Quantitative measures revealed average attitudes towards TIC (ARTIC-45; Baker et al., 2016), partnered with below average personal and systemic support for TIC, and below average levels of trust and empowerment (TICS-10; Hales et al., 2019), possibly indicating systemic challenges in integrating TIC into clinical practice. 29% of participants had been physically assaulted in the last two months, most of these assaults were severe (SOAS-R; Nijman et al., 2005), requiring extreme responses and producing detrimental consequences for staff and clients (ATACKS; Bowers et al., 2002). The RTA led to a thematic map, with the need for trauma-informed change and acknowledgement of a systemic problem appearing to be central themes among staff. The analysis indicated several cultural and organisational barriers to TIC training, including lack of staffing and leadership support. Workshop attendees reported positive impacts, such as improved TIC knowledge, improved relationships with clients and colleagues, and reductions in restrictive practice. Many

attendees also reported a desire for further TIC training and a cultural move towards TIC.

Clinical and research implications

Findings suggest that severe and detrimental assaults, alongside a lack of TIC-awareness, knowledge, and even counter-TIC practices, reflect a TIC intervention need. This need is further emphasised by the positive impacts identified from the training. However, several barriers to introducing TIC suggest TIC workshops on their own may not be enough to create a TIC-cultural change. Individual services may therefore benefit from reviewing their barriers and needs and designing their intervention accordingly. Alternative, or supplementary TIC interventions may include follow-up TIC workshops, TIC-debriefs, prioritising psychological training, providing time for staff to read client histories, and ensuring equal workload distributions. TIC training could be made mandatory for all individuals within an organisation to ensure a successful cultural shift and inclusion of TIC in policies and procedures. Of paramount importance is the support of the organisation's leadership and management, this should be secured prior to any TIC intervention.

Further research is needed to investigate the feasibility and impact of introducing TIC using larger and more diverse samples of mental health professionals. This will provide more power and therefore increase validity and reliability in any potential findings. Larger samples of various mental health professionals may also support the effective comparison between professions, which could in turn support the adapting of training to specific professional groups. The inclusion of a pre-post comparison as well as multiple follow-up time frames would also support the identification of trauma-informed change following a TIC workshop for staff. Findings would be further strengthened by the inclusion of multiple sites or organisations, as well as the inclusion of a control arm and randomisation, heralded as the

gold standard in research (Hariton & Locascio, 2018). Measurement of client outcomes pre and post staff TIC workshops may also support the identification of client benefits from TIC working.

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Appendix Q – Author Guideline Notes for Contributors

Journal of Psychiatric and Mental Health

i. Original Research
Word limit: 5,000 words maximum, excluding abstract and references.
Abstract: 200 words maximum; must be structured under the sub-headings: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice.

Accessible Summary: 250 words maximum; the purpose is to make research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. The Accessible Summary should be written in straightforward language, structured under the following sub-headings, with 1-2 bullet points under each: What is known on the subject; What the paper adds to existing knowledge and What are the implications for practice.

Description: The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing.

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that-in 100 maximum, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.
Reporting Checklist: Required - see **Section 5**.

4. PREPARING YOUR SUBMISSION

Cover Letters
Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript
The manuscript should be submitted in separate files: title page; main text file; figures; COI form.

Title Page:

The title page should contain:

i. A short informative title that contains the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips).

ii. A short running title of less than 40 characters
iii. The full names of the authors
iv. The authors' institutional affiliations at which the work was carried out
v. Corresponding author's contact email address and telephone number
vi. Acknowledgements.
vii. Ethical statements.

The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Authorship
For details on eligibility for author listing, please refer to the journal's Authorship policy outlined in the Editorial Policies and Ethical Considerations section.

Acknowledgments
Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File
The main text file should be presented in the following order:

i. Title, abstract and key words;
ii. Main text;
iii. References;
iv. Tables (each table complete with title and footnotes);
v. Figure legends;
vi. Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

Style Points

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

Abstract
Abstracts and keywords are required for some manuscript types. For details on manuscript types that require abstracts and/or keywords, as well as how to prepare them, please refer to the 'Manuscript Types and Criteria' section.

Keywords
Please provide up to seven keywords When selecting keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at **https://www.nlm.nih.gov/mesh/**.

References

For details on references please refer to the 'Manuscript Types and Criteria' section.

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article
Beers, S. R., & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry,* 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Book
Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document
Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from http://www.youtube.com/watch?v=Vja83KLQXZs

Tables
Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figure Legends
Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Figures
Although we encourage authors to send us the highest-quality figures possible, for peer-

review purposes we are happy to accept a wide variety of formats, sizes, and resolutions. **Click here** for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white.

Guidelines for Cover Submissions
If you would like to send suggestions for artwork related to your manuscript to be considered to appear on the cover of the journal, please **follow these general guidelines**.

Additional Files

Appendices
Appendices will be published after the references. For submission they should be supplied as separate files but referred to in the text.

Supporting Information
Supporting information is information that is not essential to the article but that provides greater depth and background. It is hosted online, and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc. **Click here** for Wiley's FAQs on supporting information. Note, if data, scripts or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points
The following points provide general advice on formatting and style:

- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website at www.bipm.fr for more information about SI units.
- **Spellings:** should conform to those used in the Concise Oxford Dictionary.
- **Footnotes:** should be avoided.

Wiley Author Resources

Manuscript Preparation Tips
Wiley has a range of resources for authors preparing manuscripts for submission available **here**. In particular, authors may benefit from referring to Wiley's best practice tips on **Writing for Search Engine Optimization**.

Article Preparation Supports
Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our

resources for **Preparing Your Article** for general guidance about writing and preparing your manuscript.

Human Studies and Subjects

For manuscripts reporting medical studies involving human participants, we require a statement identifying the ethics committee that approved the study, and that the study conforms to recognized standards, for example: **Declaration of Helsinki**; **US Federal Policy for the Protection of Human Subjects**; or **European Medicines Agency Guidelines for Good Clinical Practice**.

Images and information from individual participants will only be published where the authors have obtained the individual's free prior informed consent. Authors do not need to provide a copy of the consent form to the publisher, however in signing the author license to publish authors are required to confirm that consent has been obtained. Wiley has a **standard patient consent form available** for use.

Appendix R – Anonymised Sections of a Coded Transcript

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