

# Intellectual and Developmental Disabilities

## Assessing Alignment between Intellectual and Developmental Disability Service Providers and Trauma-Informed Care: An Exploratory Study

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### **Abstract**

People with intellectual and developmental disabilities (IDD) are disproportionately impacted by potentially traumatic experiences, however, organizations serving this population have lagged in their integration of trauma-informed care (TIC). Trauma-informed care is a systemwide response to the pervasiveness of trauma that frequently requires an organizational shift that is rooted in staff training. Using an online state-wide survey, the present study examined beliefs and training among IDD service providers. Responses from 288 service providers suggested some alignment among beliefs and staff training content with TIC principles. Although the findings indicate a foundation for TIC, intentional efforts are needed for IDD agencies to more fully embrace TIC.

*Keywords:* Intellectual disability, trauma, trauma-informed care, disability services

People with intellectual and developmental disabilities (IDD) are disproportionately impacted by potentially traumatic events; however, organizations supporting people with IDD have lagged in responding to this knowledge with the integration of trauma-informed care (TIC). Trauma-informed care is a system-wide response to the pervasive nature of trauma and its impact among both those receiving and those providing support and services. Although TIC necessitates staff training and often requires a shift in organizational culture, which can be daunting, alignment between current staff beliefs and organizational practices with TIC can ease the burden. This study explores the congruence of service providers' beliefs and organizational training with TIC across IDD organizations in a Midwestern state.

### **Increased Vulnerability and Trauma**

Trauma results from “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (Substance Abuse and Mental Health Services Administration, 2014a). Extensive research has noted increased vulnerability among people with IDD to potentially traumatic events and trauma sequelae (Daveney et al., 2019; Mevissen et al., 2016; Nixon et al., 2017). Although people with IDD may be 3 to 6 times more likely than the general population to be abused or neglected (Hulbert-Williams et al., 2013), prevalence studies for trauma often demonstrate some variability in rates and sample characteristics. For example, Lapshina and Stewart (2021) noted that 65% of children with IDD and mental health conditions experienced at least one potentially traumatic event. Scotti et al. (2012) noted that upwards of 70% of people with IDD experienced at least one traumatic event during their lifetime, with multiple experiences most common. More specifically, several studies have examined post-traumatic

stress and identified prevalence rates ranging from 10% to more than 40% (Daveney et al., 2019; Mevissen et al., 2020; Nieuwenhuis et al., 2019).

For people with IDD, their level of risk is influenced by the intersection of disability and sociodemographic factors (e.g., race, gender, and socioeconomic status; Parry-Carter-Long, 2016), as well as historic and contemporary experiences. These experiences include institutionalization, separation from caregivers, invasive and nonconsensual medical procedures, behavioral practices of seclusion and the use of physical restraints, sexual and financial victimization, interpersonal violence and bullying, psychological abuse, and physical and emotional abuse and neglect (Austin et al., 2016; Byrne, 2018; Wigham et al., 2013; Woodman et al., 2014). In addition, various sources have highlighted the potential for harm to occur within formalized systems of support like day and residential services (Collins & Murphy, 2021), as well as public services such as law enforcement. For example, Perry and Carter-Long (2016) noted that, broadly, people with disabilities were more likely to experience police violence and comprised 33% to 50% of people killed by police interventions.

Adverse experiences for people with IDD are often compounded and exacerbated by their cognitive functioning and communication skills, reliance upon others for support, caregiver expectations to be compliant, repeated loss over time, frequent changes in living arrangements/housing, and having few natural supports (McGilvery, 2018; Mevissen et al., 2016; Skelly, 2020; Wigham & Emerson, 2015). These collective factors can compromise an individual's resilience and ability to cope with distress (Woodman et al., 2014). In addition, various risk factors associated with post-traumatic stress (e.g., low socioeconomic status, low educational attainment, and lower IQ) are prevalent among people with IDD (Brewin et al., 2000; Ozer & Weiss, 2004).

Beyond the often cited psychological and emotional toll of trauma, it is important to acknowledge the longitudinal and insidious effects of trauma. More than two decades of research in the broader population has linked the impact of adversity, particularly in childhood, with poorer health outcomes and chronic disease in later life (Hughes et al., 2019; Santoro et al., 2018). For example, adverse childhood experiences, such as abuse and neglect have been associated with heart disease, cancer, diabetes, overall poor health, and depression (Felitti et al., 1998; Chapman et al., 2004). Notably, however, the link between trauma and physical health is often overlooked in the lives of people with IDD (McNally et al., *under review*).

Further, people with IDD may struggle to recover from trauma. Trauma responses may be expressed as maladaptive behavior; however, service providers and caregivers often fail to consider the implications of trauma (Scotti, et al., 2012). Similarly, maladaptive behaviors rooted in trauma may result in subsequent distressing experiences, such as physical restraint (Barol & Seubert, 2010). In addition, people with IDD often lack autonomy in accessing treatment services and can struggle with communicating their experiences and emotions to others (Skelly, 2020). Also, service providers may lack expertise in trauma, as well as access to validated assessment tools and evidence-based trauma-specific interventions (Vervoot-Schel et al., 2018; Kessler, 2020c). Thus, trauma often goes unrecognized, with symptoms misattributed to other diagnoses (i.e., diagnostic overshadowing) and, as a result, untreated (Daveney et al., 2019; McNally et al., 2021).

### **Service Delivery in IDD Agencies**

Direct support professionals (DSPs), clinical specialists, and other paid providers can be instrumental to advancing the quality of life for people with IDD. Relationships with providers can be particularly salient, especially for individuals with few natural supports (Disley et al.,

2009; Scheungel et al., 2010). However, the quality of their interactions is influenced by staff-related factors (e.g., personal experiences, level of training, and compensation) and characteristics associated with IDD (e.g., cognitive abilities, verbal communication, and types of behavior). Although rarely represented in the literature, additional insight regarding staff-client interactions can be obtained by applying a trauma-lens.

Extensive research has examined aggression and other behaviors among people with IDD, however, there has been limited inquiry regarding staff perception of such behaviors. As noted earlier, perception or *experience* of an event is an important consideration to understanding trauma (SAMHSA, 2014a). Hensel et al. (2014) noted that staff exposure to aggressive behavior could be perceived as traumatic and lead to symptoms associated with post-traumatic stress. Further, those working in the helping professions, like DSPs, have higher levels of adversity and trauma in their personal lives (Howard et al., 2015; Keesler, 2018). Earlier research conducted by Strand et al. (2004) noted that 14% of staff working in group homes and day programs admitted to using violence toward adults with IDD and 35% had been implicated in or witnessed such violence. Although further research is required to understand the impact of trauma on staff-client interactions, the broader literature has identified various considerations stemming from prior trauma that can influence relationships, including impaired selfcare, challenges with developing healthy relationships, and elevated risk for perpetrating violence (Herman, 1992; Levenson & Grady, 2016).

**Training.** Training is critical for all staff, as it orients them to their organization and can provide direction and hone skills with how best to support people with IDD. Although research has rarely considered training holistically and inclusively of all roles within agencies that support people with IDD (Friedman, 2018; Hewitt, 2014), the importance of training for DSPs has been

linked with improved life experiences for people with IDD, as well as increased staff self-efficacy and longevity (Britton Laws et al., 2014). In contrast, the interaction of limited staff training and supervision, low pay, and exposure to aggressive behavior has been associated with high rates of burnout and fatigue among DSPs, lower quality of care for people with IDD, and discontinuity in care (Friedman, 2018; Hewitt, 2014).

Yet, despite the complexities of direct support work and its intersection with health and wellbeing for people with IDD, the requirements and training for DSPs are often limited (Lunsky et al., 2021). In the United States, the federal government has few required qualifications, including a high school diploma or equivalent, a driver's license, and the ability to pass a criminal background check with no felony convictions (Hewitt, 2014; Wachino, 2016). In addition, few states have training guidelines, often leaving individual agencies responsible for creating their own standards and trainings (Friedman, 2018; National Direct Service Workforce Resource Center, 2013).

Over the past decade, researchers and practitioners have advocated for competency-based trainings and have linked them with increased capacity and competency among DSPs (Bogenschutz et al., 2015). For example, the National Alliance of Direct Support Professionals (NADSP) has made considerable strides in establishing training competencies in 15 areas, including empowerment, assessment, networking, crisis prevention, and health and wellness. However, these competencies demonstrate limited consideration of mental health, despite the increased risk of dual disorders among people with IDD and their increased vulnerability to adversity and trauma sequelae (Munir, 2016). As research in this domain increases, it is important for trainings and competencies to reflect advances, developments, and the acquisition of new knowledge as it pertains to promoting wellbeing for people with IDD. Further, while



emphasizing competencies may be beneficial, emerging research has highlighted the importance of considering the impact of organizational environment on the consistency with which staff and management implement these competencies (LoPorto, 2019).

While organizations provide a context for service delivery and for the intersection of staff and client experiences, staff and clients often experience a parallel process - staff contend with personal stressors as they support clients in distress. In addition, staff are challenged as they respond to organizational demands *and* address client needs (Bloom, 2010). From a theoretical perspective, social ecological theory posits that human behavior and wellbeing are influenced by the bidirectional and mutually influencing relationships among intra-/inter-personal, organizational, and community systems (Stokols et al., 2013). Therefore, while enhancing staff training can offer improved experiences for staff and the people with IDD that they support, efforts can also be made to bolster the broader system and organizational culture.

### **Trauma-informed Care**

In 2014, Keesler called for IDD organizations to integrate TIC as a response to the needs and experiences of people with IDD and the challenges associated with sustaining a viable workforce (e.g., high staff burnout). Trauma-informed care is a total-system approach and model for organizational culture that seeks to prevent re-traumatization and promote healing through interactions that are guided by principles of safety, choice, collaboration, empowerment, and trustworthiness (Fallot & Harris, 2009). Further, TIC emphasizes the importance of “recognizing, understanding and responding to the effects of trauma” and “the physical, psychological and emotional wellbeing of survivors to build a sense of control and empowerment” (Williamson & Qureshi, 2015, p.1).

Trauma-informed care requires a shift from solely focusing on treating the individual client to changing the system within which services are provided (SAMHSA, 2014a). To guide organizations in creating this change, SAMHSA (2014a) has identified ten implementation domains based on the organizational change literature and previous models for adopting TIC. These domains include: *organizational leadership* – to support and invest in TIC; *financial resources* - to support and sustain trauma-informed care; *policy* – to ensure policies reflect the principles of TIC; *engagement* – to involve people receiving services in all levels of organizational operations; *cross-sector collaboration* – to address and support complex client needs; *screening/assessment and treatment* – to assess for and treat trauma, or to refer identified clients to qualified professionals; *physical environment* – to provide a safe and collaborative space for staff and clients; *training and workforce development* – to ensure that all employees are trained in TIC and that systems are in place to support staff with trauma histories; *progress monitoring and quality assurance* – to assess, track, and monitor the implementation of TIC principles; and, *evaluation* – to measure implementation of TIC and evaluate its efficacy.

In the general population, TIC has been associated with improvements for clients and staff, including decreased use of restraints (Azeem et al., 2011; Bloom & Farragher, 2011), increased treatment retention rates, improved organizational culture, and increased staff satisfaction and retention (Hales et al., 2019), and decreased staff burnout (Handran, 2015). Further, training on TIC has been critical to increasing staff knowledge and promoting alignment among staff attitudes and behaviors with the philosophy of TIC (Purtle, 2020). Although TIC has advanced in the general population, it has lagged among IDD service providers. This is concerning given the reciprocal risk between IDD and trauma, as well as the association of disabilities with increased stressors (e.g., health, social, and financial) that can diminish access to

resources for coping and overcoming adversity (Wilson & Severson, 2012). While the positive benefits of TIC have shown benefits in other sectors [e.g., community mental health (Muskett, 2014) and child welfare (Bryson et al., 2017)], there is limited research on the impact of TIC on people with IDD (McNally et al., 2021). In 2017, Keesler and Isham noted that trauma-informed care was associated with increased adaptive behavior among individuals with IDD and favorable work experiences among staff in a day program. Further, research with IDD providers has noted practices that align with TIC (e.g., empowering staff to make a positive difference through their daily work), particularly among DSPs and has linked these practices with subsequent increased job satisfaction and decreased compassion fatigue (Keesler, 2020a, 2020b).

Emerging evidence suggests that IDD organizations face various challenges in moving forward with TIC, including a lack of training and limited understanding of TIC (Rich et al., 2020). However, this study only focused on the responses of organizational leadership, and, although leadership is critical to TIC, they can have a different perspective than direct service providers (Silver Wolf et al., 2014). As such, scholars have advocated for further efforts to understand, conceptualize, and integrate TIC within IDD services (Cook & Hole, 2021). McNally and colleagues (2021) noted that “a more systemic and holistic approach of TIC” within the IDD sector is needed (p. 944).

### **Study Purpose**

Trauma-informed care has potential to enhance IDD services, yet it requires commitment and change across an organization. Training and workforce development are fundamental to this change. Although organizational change can be daunting, it can be facilitated by building on existing organizational knowledge, beliefs, and practices that already align with TIC (Boulagouas et al., 2021; Branson, 2008; Lönnqvist et al., 2009). This exploratory study aimed to

build upon prior research that identified barriers to TIC in IDD services (e.g., limited understanding of TIC and lack of training; Rich et al., 2020); to understand potential alignment between the current state of IDD services and TIC to facilitate its implementation; and, to create potential strategies for advancing TIC in the IDD sector. More specifically, the purpose of this study was to administer a state-wide survey to answer the following research questions:

- (1) To what extent are providers aware of trauma and familiar with TIC? Are there differences by staff role?
- (2) What topics and skills that align with TIC are included in organization's training?
- (3) Do organizations provide training on TIC? What are the perceived challenges or barriers to implementing TIC?

### **Methodology**

Through purposive and snowball sampling, this online survey study examined a cross-section of IDD service providers in one midwestern state.

### **Survey Instrument**

The survey was developed by the first and second authors, with items informed by the peer-reviewed literature, SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014a), extensive practice experience, and in consultation with other researchers and practice experts in IDD. Descriptions based upon SAMHSA's (2014a) conceptualization of trauma and TIC were provided in the body of the survey to promote validity of responses.

The survey included 8 demographic items and 24 items across four domains (i.e., trauma and IDD, staff training, trauma and employees, and organizational efforts with TIC). Descriptions of these domains and sample items are presented in Table 1. Response options to survey items included 5-point Likert type scale (e.g., 1 “*strongly disagree*” to 5 “*strongly*

*agree*”), multiple choice, and open-ended responses. The survey was uploaded to Qualtrics, an online survey platform, and beta-tested with six respondents which included doctoral students and representatives from the IDD service sector (i.e., DSPs, clinician, and an executive leader) to review layout, content, and language, as well comprehension and feasibility. Minor revisions were subsequently made to simplify text and response option categories. The survey took approximately 10 minutes to complete.

### **Data Collection**

After being reviewed and approved by the primary researcher’s university Institutional Review Board, a recruitment email with the survey link was widely distributed through various state-level entities (e.g., professional membership for IDD organizations) and through outreach to individual IDD provider agencies across the state. All stakeholders were asked to share the email and survey link within their own organization and with other networks that could reach additional IDD providers. Inclusion criteria required survey respondents to be at least 18 years-old, able to read and understand English, and be employed by an organization that provides services to people with IDD within the respective State. All levels of personnel, from DSPs to leadership, were eligible to participate. The first page of the survey provided study information and respondents indicated their consent by electronically endorsing their agreement with the information and desire to proceed with the survey. Respondents were eligible to receive an incentive (i.e., random drawing for 1 of 20 gift cards in the amount of \$25) by providing their contact information via a separate link at the end of the survey. Data collection lasted for a period of approximately four months.

### **Data Analysis**

Survey data were exported from Qualtrics into SPSS Statistics Version 26 for data management and analysis. All non-missing data were analyzed; less than 4% of data was missing. Data for demographic items were analyzed using frequency counts. Data from Likert scale items were analyzed using frequency counts and, where appropriate, between group differences by staff role were examined using one-way ANOVA and post hoc comparisons (i.e., Tukey HSD test).

## **Results**

### **Sample**

The sample was comprised of 288 respondents. Of these, 270 respondents identified their organization's name, thus representing 53 unique provider agencies across the State. Descriptive information for the sample is presented in Table 2. The majority of respondents identified as Women ( $n = 248, 87.6\%$ ) and Caucasian ( $n = 266, 92.4\%$ ). Respondent age ranged from 19 to 79 years-old with a mean age of 41.75 ( $SD = 12.74$ ). Approximately 39% of respondents held a graduate degree ( $n = 112$ ) and 20.8% ( $n = 60$ ) a bachelor's degree. Most respondents were either DSPs (35.6%) or served in clinical roles (34.2%), and many (71.9%) had been employed with their current organization for more than 2 years. Although not presented in the table, slightly more than half (57.5%) had worked with people with IDD for more than 10 years.

### **Awareness of Trauma and Familiarity with TIC**

The first research question sought to ascertain service providers' understanding of trauma and familiarity with TIC. Table 3 presents the proportion of respondents from the total sample and by staff role who *agreed/strongly agreed* with the items exploring trauma among people with IDD and staff.

**Trauma among people with IDD.** Across staff roles, more than 93% of respondents agreed with the impact of trauma, association of trauma and challenging behavior, triggers, and the importance of knowing if someone experienced trauma. Two items demonstrated greater response variability and were examined further using one-way ANOVAs (i.e., “People with IDD are more likely than others without disabilities to experience trauma.”; “My organization strives to determine if the people we support have experienced trauma.”). Significant differences were noted by staff role for level of agreement with increased likelihood of exposure to trauma among people with IDD [ $F(4, 279) = 5.218, p < .001$ ]. Post hoc comparisons using the Tukey HSD test indicated that DSPs ( $M = 3.90, SD = .878$ ) agreed less than clinical staff ( $M = 4.32, SD = .622, p < .01$ ), program directors/managers ( $M = 4.31, SD = 1.00, p < .05$ ), and leadership ( $M = 4.48, SD = .770, p < .05$ ) that people with IDD were more likely to be exposed to potentially traumatic events. No significant differences were noted by staff role for organizational efforts to determine if clients experienced trauma ( $p > .05$ ).

Two survey items, not presented in Table 3, queried respondents further regarding common practices related to the inclusion of trauma-specific content in support plans (i.e., person-centered individualized support plans and/or behavior plans) for people with IDD. Slightly more than half of all respondents (51.4%) indicated that support plans *often* or *always* included information about any trauma the person might have experienced. Similarly, 52.7% indicated that if a person with IDD had experienced trauma, their support plans *often* or *always* provided strategies for how staff could help them.

**Trauma among employees.** More than 92% of the total sample agreed that employee trauma can impact their job performance and be triggered by challenging behavior, and that agency support for employee wellbeing is important. However, less than 81% of the total sample

agreed that the work environment influenced job performance and that employees may have experienced trauma.

One-way ANOVAs were conducted to further examine several items with modest variability in responses (i.e., “Employees at my organization may have had traumatic experiences.”; “Employees who have experienced trauma can be triggered by challenging behavior.”; “The work environment influences how an employee does their job.”). Although no significant differences were noted by staff role for level of agreement regarding employees having had traumatic experiences ( $p > .10$ ), significant differences were noted by staff role for level of agreement regarding the potential for employees to be triggered by challenging behavior [ $F(4, 275) = 3.80, p < .01$ ]. Post hoc comparisons using the Tukey HSD test indicated that DSPs ( $M = 4.33, SD = .817$ ) agreed less than clinical staff ( $M = 4.64, SD = .620, p = .017$ ) and program directors/managers ( $M = 4.73, SD = .712, p = .008$ ). In addition, significant differences were noted by staff role for level of agreement regarding the influence of the work environment on employee job performance [ $F(4, 276) = 2.650, p < .05$ ]. Post hoc comparisons using the Tukey HSD test indicated that DSPs ( $M = 4.00, SD = 1.31$ ) agreed less than leadership ( $M = 4.72, SD = .737$ ), with differences trending toward statistical significance ( $p = .053$ ).

**Familiarity with TIC.** Slightly more than one-third of respondents were *very to extremely familiar* with TIC (34.8%) or *slightly to not at all familiar* with TIC (37.3%). Means and standard deviations for familiarity with TIC by staff role are presented in Table 4. A one-way ANOVA was conducted to examine potential differences in familiarity with TIC among the five staff roles (i.e., DSP, therapist/clinician, director/manager, senior management/executive leadership, and ancillary support staff). ANOVA results revealed a statistically significant difference in familiarity with TIC ( $F(4,275) = 6.38, p = <.001$ ). Post hoc comparisons using the



Tukey HSD test indicated significantly ( $p < .001$ ) higher familiarity with TIC among therapists/clinicians and directors/managers than DSPs.

### **Alignment between Staff Training and TIC**

The second research question sought to examine the alignment between content in staff training and TIC. Survey respondents were asked to endorse various topics and skills from a prescribed list that they believed were included in their employee training. Table 5 presents the proportion of staff who endorsed each topic as included in their employee training. For items in the *General* domain, abuse and neglect was most often endorsed (88.5%) as being included in employee training, however, items related to trauma were endorsed by slightly more than 50% of respondents. For items in the *Principles of TIC* domain, both physical safety and the provision of choices were most often endorsed by the total sample (87.5%). In contrast, emotional safety (76.0%) and empowerment (71.2%) were among the least often endorsed.

### **Organization Efforts and Challenges with TIC**

Finally, the third research question sought to identify if agencies provided staff with training specifically on TIC and, if training was provided, what challenges or barriers to implementing TIC were identified. A single question queried respondents regarding the provision of training on TIC at their agencies. The frequencies for responses are presented in Table 6. Of the 277 providers who responded, 17.3% ( $n = 48$ ) noted that their agencies provided training on TIC. Of these 48 providers, less than half (41.7%) indicated that the training was required for all staff.

Through skip logic, those who indicated that TIC training was provided were queried further about any challenges that were encountered at their organization with integrating TIC. From a list of factors, respondents were asked to select those that they believed were challenging

to their organization. The following were most often endorsed: staff turnover (52.1%), lack of time (39.6%), cost (25%), and a lack of training materials/trainers (25%). Additionally, 10.4% (n = 5) were unsure and 6.3% (n = 3) reported that they did not encounter any challenges to using TIC.

The final survey question asked respondents if they would like to learn more about TIC. Of the 283 providers who responded to this question, 74.2% indicated *yes*, 10.2% indicated *no*, and 15.5% were unsure.

### **Discussion**

This study sought to understand awareness of trauma and familiarity with TIC among IDD service providers, to identify areas of alignment between staff training and TIC, and to identify the extent to which organizations provided TIC-specific training and any challenges with implementing TIC. Most respondents endorsed basic factors associated with trauma among clients and staff. However, several areas warrant additional consideration, particularly as DSPs most often had the lowest proportion of respondents in agreement.

More than three-quarters of respondents agreed that their organizations endeavored to determine if clients had trauma histories, however, a little over half indicated that clients' plans included information regarding client trauma and corresponding support strategies. Rich et al. (2020) conducted similar research and noted that about 66% of respondents believed their organizations did a "good job" identifying and responding to client trauma. The discrepancies in findings, however, may be attributable to sample differences as Rich et al. (2020) focused on leadership and the current sample, all levels of staffing, including clinicians who are most often involved in developing support plans.

Similarly, approximately 78% of respondents agreed that employees at their organization may have experienced trauma. According to the philosophy of TIC, it is prudent to approach *everyone* as if they have experienced trauma given its pervasiveness and lasting impact (SAMHSA, 2014a). Likewise, about 81% of respondents agreed that the work environment influenced job performance. Across sectors, research has supported that impact of work environment on employee experiences (Keesler, 2020b; Lee & Jang, 2020; LoPorto & Spina, 2021). Given that TIC is a model for organizational culture, it may be important to foster employee recognition of the potential positive contribution of trauma-informed initiatives to the work environment *and* their performance.

Slightly more than one-third of the sample indicated that they were very familiar with TIC. A few studies that have queried respondents in IDD services about TIC suggest comparable findings. For example, in a national study of leaders in IDD organizations, Rich et al. (2020) found that 24% of respondents agreed that their staff understood TIC. Similarly, in an international qualitative study among IDD service providers, McNally et al. (*under review*) noted that all staff endorsed the need for TIC training. In the present study DSPs demonstrated the least familiarity with TIC, while clinical staff were the most familiar. Lower familiarity among DSPs is of particular concern given that they have the most direct contact with people with IDD and the quality of support they provide impacts the wellbeing of people with IDD (Friedman, 2018). Further, although familiarity among particular roles such as therapists and clinicians are likely associated with their advanced level of education and experience, the use of TIC is not predicated upon experience or education, but rather accessible training (Purtle, 2020).

Training is an integral part of general staff preparation and organizational inculturation, as well as TIC initiatives (Purtle, 2020). The results indicate that organizations provide some

training on content that is foundational to TIC (e.g., abuse and neglect) and aligns with TIC practices (e.g., ensuring physical safety and providing choices). This is similar to previous research that noted organizations often engaged in some practices that aligned with TIC but did not identify them as trauma-informed (Wolf et al., 2014). Considerable variability was noted among the topics covered in staff trainings. Although differences between staff roles might be attributable to recall bias and proximity to training (Althubaiti, 2016), overall trends suggest that certain topics are covered more often than others.

Perhaps most notable were the differences in endorsement of abuse and neglect, historical treatment, and trauma (i.e., prevalence/impact and responding to trauma). Understanding the trauma that many people with IDD have experienced throughout history (e.g., institutionalization) is critical to ensuring that current systems do not perpetuate harmful practices. Yet, the literature continues to note the use of punitive and compliance-oriented practices by paid caregivers (Collins & Murphy, 2021). Further, content explicitly on trauma appears to be far less often included in training than abuse and neglect. Although every effort must be made to prevent incidents of abuse and neglect, trauma goes beyond the event or conditions to an appreciation of the person's experience and the effects of the event (SAMHSA, 2014a). The lack of emphasis on trauma may be influenced by historical perspectives that people with IDD are different from the general population and are not psychologically impacted by adversity (Conrad, 2018; Shapiro, 2018).

Although there is some alignment between current training content and TIC, organizations do not appear to be delivering content or engaging in practices through a trauma lens or framework. Less than one in five respondents indicated that their organization explicitly provided TIC training. As awareness of trauma among people with IDD expands, additional

strategies are needed at the system-level to implement TIC across and within agencies (Cook & Hole, 2021). Despite the availability of formal TIC curricula, many organizations engaged in TIC initiatives implement their own in-house trainings (Purtle, 2020). Despite the lack of consensus regarding what content is most important and the extent to which trainings should be tailored for different populations, common elements to TIC trainings include creating a common understanding of and language around trauma, promoting safety and reducing risk of re-traumatization, and facilitating strategies to promote staff wellness (Purtle, 2020).

Respondents from organizations engaged in TIC trainings most often cited staff turnover as a barrier to implementing TIC. This is consistent with prior research among leadership in IDD services that noted staff turnover as a significant barrier to TIC (Rich et al., 2020). Staff turnover, especially among DSPs, has been identified as an ongoing challenge in the IDD service sector (National Core Indicators, 2019). In contrast however, the utilization of trauma-informed practices has been associated with increased job satisfaction and decreased burnout among DSPs (Keesler, 2020b). Although high staff turnover can create organizational strain, as well as challenges for training, it is important for providers to identify TIC as systemwide approach with multiple domains for implementation. As such it requires both top-down and bottom-up efforts (Cook & Hole, 2021; SAMHSA, 2014a). Thus, *some* progress toward TIC is plausible.

### **Limitations**

The results of this exploratory study provide preliminary insight regarding the perspectives of service providers and the content of staff training as they relate to TIC. Given the nature of exploratory research and current study design, several limitations are noted. Data were collected from respondents in one Midwestern state, and as such, the results might be influenced by state-specific policies and therefore not generalizable. The survey was administered during

the spread of COVID-19 which has had unanticipated and profound effects on research (Omary et al., 2020). Anecdotal evidence indicated that recruitment efforts and response rates were slowed as organizations focused on the health and safety of clients and staff and were often operating in crisis mode due to extensive staffing shortages. To counter the impact of the pandemic, and to ensure an adequate response rate, purposive and snowball sampling were implemented, and all IDD service providers were eligible to participate in the study. Despite its benefits, snowball sampling presents with inherent risks, including selection bias (Parker et al., 2019). Thus, the results may not accurately reflect the breadth of attitudes and practices among IDD organizations across the state.

In addition, some data points (i.e., content of staff training) may have been better collected from specific contacts within an organization (e.g., training coordinator); however, analyses demonstrated trends in training topics that were consistent across respondent roles. Although the survey asked respondents about the provision of staff training on trauma and TIC at their organization, training alone is often insufficient in fulfilling the extensive change efforts necessitated by TIC (Purtle, 2020). Further, only respondents who indicated that their agencies provided training on TIC were asked about challenges with integrating TIC. It is important to also consider barriers that prevent agencies from offering any training on TIC or from fully integrating TIC across their organization practices.

### **Implications and Strategies for Advancing TIC**

The current study focused on TIC as a system/organizational level response to trauma, rather than the individual level, which has often been the focus in the IDD literature (Cook & Hole, 2021). Although the results suggest some alignment among current perspectives and training with TIC, more concerted efforts are needed to fully integrate TIC and to reduce

variability and foster cohesion among staff across all roles in an organization (Melnyk et al., 2010). Further research is warranted to identify additional areas for training that may be specific to working with the IDD population, as well as practices related to workforce wellness which are often part of TIC training and initiatives (Purtle, 2020). Likewise, future research should examine the extent to which TIC training is translated into practice, and the strengths and challenges associated with integrating TIC among IDD organizations.

Challenges for IDD organizations to adopt TIC include a lack of state-level guidance, staffing shortages, a lack of resources, and cost (Rich et al., 2020). Although it is important to acknowledge these considerations, they should not present a hard stop to organizations moving forward with TIC. Fundamentally, professional membership organizations for IDD service providers can mobilize resources to provide direction for organizations and, along with leaders within the IDD sector, lobby for the inclusion of TIC within state-level directives for client care. Further, the results of this study indicate a foundation for advancing TIC amid current training efforts; this should help allay budget and staffing concerns. Free and publicly available resources on TIC and IDD services can be found online (e.g., Galindo, 2020; Marcal & Trsifoso, 2017; and National Child Traumatic Stress Network, 2015). Likewise, SAMHSA (2014a, 2014b) provides an implementation framework and strategies (although not specific to IDD) to support organizations in navigating the shift toward TIC, as well as viable strategies without undue financial burden (e.g., fostering administrative commitment to TIC, using principles of TIC to develop a strategic plan, and reviewing/updating mission and vision).

### **Conclusion**

Trauma in the lives of people with IDD is a salient concern for service providers that warrants a multi-faceted response. As a systemwide response, TIC promotes a common approach

within an organization that understands trauma and is grounded in principles of safety, choice, collaboration, empowerment, and trustworthiness. The results of this study are a promising foundation and provide some direction for change in the IDD sector. Although staff understanding and training are only part of the organizational shift toward TIC, they are significant factors that can increase the success and decrease the burden of such initiatives. It is encouraging that the results of the present study demonstrate a promising foundation as IDD agencies strive to shift toward becoming fully trauma informed.



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Table 1

*Trauma-informed Care Survey*

<b>Domain</b>	<b>Description</b>	<b># of Items</b>	<b>Item Examples</b>
Trauma & IDD	Awareness of the impact and expression of trauma among people with IDD	8	“Trauma can have a lasting impact on the wellbeing of people with disabilities”
Trauma & Employees	Beliefs surrounding the potential impact of trauma on employee wellness and performance	5	“Trauma can influence how employees perform their work responsibilities”
Employee Training	Identifying TIC-related topics and skills that are included in employee training	2	Which of the following are INCLUDED in employee training at your organization? (e.g., how to respond to trauma- things we can do to help people with disabilities heal from trauma)
Organizational Efforts with TIC	Assessing familiarity with TIC and the nature and status of its implementation within organizations	8	What statement BEST reflects trauma-informed care at your organization? (e.g., “TIC is not talked about” to “My organization provides TIC training and evaluates our use of TIC”)

Table 2

*Descriptive Statistics for Respondent Demographics*

<b>Characteristic</b>	<b>n (%)</b>
<b>Gender <sup>a</sup></b>	
Man	32 (11.3)
Woman	248 (87.6)
<b>Race/Ethnicity <sup>b</sup></b>	
White/Non-Hispanic	266 (92.4)
<b>Education</b>	
High School/GED	35 (12.2)
Some College	49 (17.0)
Associate degree	32 (11.1)
Baccalaureate Degree	60 (20.8)
Graduate Degree	112 (38.9)
<b>Staff Role</b>	
Direct Support Professional	101 (35.6)
Clinical Staff (therapists, clinicians, etc.)	97 (34.2)
Program Director/ Manager	49 (17.3)
Leadership (senior management, executives, etc.)	25 (8.8)
Ancillary (benefits specialists, case managers, etc.)	12 (4.3)
<b>Years with Organization</b>	
< 1 year	42 (14.6)
≥ 1 year but < 2 years	37 (12.8)
≥ 2 years but < 4 years	49 (17.0)
≥ 4 years but < 6 years	39 (13.5)
≥ 6 years but < 8 years	31 (10.8)
≥ 8 years but < 10 years	28 (9.7)
≥ 10 years	60 (20.8)

*Note.* (N = 288). <sup>a</sup> Nonbinary (n = 3; 1.1%); <sup>b</sup> African Americans, Hispanic, etc., n = 22; 7.6%.

Table 3

*Service Providers' Endorsement of Trauma and Trauma-related Factors*

Item	Proportion "Agreed/Strongly Agreed" (N = 288)					
	Total	DSPs	Clinical	Manger/ Director	Leadership	Ancillary
<b>People with IDD <sup>a</sup></b>						
People with IDD are more likely than others without disabilities to experience trauma.	87.2	77.2	93.8	87.8	92.0	100
Trauma can have a lasting impact on the wellbeing of people with IDD.	98.9	98.0	97.9	100	100	100
Challenging behavior among people with IDD might be related to past trauma.	97.5	93.1	97.9	100	100	100
People with IDD who have histories of trauma can be triggered (e.g., reminded of past danger) by how staff interact with them.	98.2	97	99.0	100	100	100
Knowing if a person with IDD has experienced trauma is important in determining how we support them.	98.9	99	99.0	100	100	100
My agency strives to determine if the people we support have experienced trauma.	78.1	73.3	86.6	73.5	84.0	66.7
<b>Employees</b>						
Employees at my agency may have had traumatic experiences.	77.6	68.3	75.3	77.6	84.0	83.3
Trauma can influence how employees perform their work responsibilities.	96.8	92.1	95.9	98.0	100	100
Employees who have experienced trauma can be triggered (reminded of past danger) by challenging behavior (e.g., aggression) from a person with IDD.	92.2	84.2	94.8	95.9	88.0	100
The work environment influences how an employee does their job.	80.8	71.3	79.4	85.7	92.0	100
Agency support for employee well-being (e.g., paid time off, etc.) is important to employees' work performance.	94.7	89.1	94.8	95.9	96.0	100

*Note.* <sup>a</sup> Two items in this domain used a different response scale (i.e., frequency). As such, they are not presented in this table, but are discussed in the corresponding Results section.

Table 4

*Familiarity with TIC*

<b>Staff Role</b>	<b>n</b>	<b>M (SD)</b>
Therapist/Clinician	94	3.31 (1.27)
Program Director/ Manager	49	3.10 (1.26)
Senior Mgmt./ Executive Leadership	25	2.84 (1.25)
Ancillary Staff	12	2.75 (1.55)
Direct Support Professional	100	2.43 (1.24)

*Note.* Response options ranged from (1) *Not familiar at all* to (5) *Extremely familiar*



Table 5

*Topics Included in Employee Training*

Item	Proportion Endorsing Item (n = 288)					
	Total	DSPs	Clinical	Managers/ Directors	Leadership	Ancillary
<b>General</b>						
Abuse/neglect and IDD (e.g., increased risk for being abused and/or not taken care of)	88.5	88.1	84.5	95.9	92.0	100.0
Historical treatment and IDD (e.g., often put into large institutions)	62.5	62.4	58.8	67.3	76.0	58.3
Prevalence and impact of trauma (e.g., People with IDD may experience trauma and be harmed by trauma)	51.7	60.4	43.3	57.1	48.0	41.7
How to respond to trauma (e.g., things we can do to help people with IDD heal from trauma)	50.3	59.4	42.3	53.0	52.0	33.3
<b>Principles of TIC</b>						
Ensuring physical safety (e.g., how to create spaces that keep people safe from bodily harm)	87.5	94.1	82.5	87.8	88.0	75.0
Providing choices (e.g., giving others information and opportunities to make choices)	87.5	90.1	83.5	89.8	92.0	83.3
Collaborating and “doing with” (e.g., working well with others)	79.9	83.2	78.4	79.6	80.0	75.0
Being transparent and truthful (e.g., the importance of being honest; doing what you will say you will do)	77.4	82.2	71.1	81.6	80.0	75.0
Ensuring emotional safety (e.g., ensuring that individuals can share their feelings/thoughts without fear of harm)	76.0	83.2	74.2	69.4	76.0	66.6
Empowering and using a strengths-based approach (e.g., identifying and using a person’s strengths to reach their goals)	71.2	64.4	76.3	71.4	80.0	75.0

Table 6

*Status of TIC Training at Agencies*

<b>Status of TIC Training</b>	<b>N (%)</b>
TIC is not talked about	44 (15.9)
TIC is talked about from time to time	58 (20.9)
People at my organization are discussing/ planning how they might use TIC	55 (19.9)
My organization provides TIC training	33 (11.9)
My organization provides TIC training and evaluates our use of TIC	15 (5.4)
I am unsure if my organization provides training on TIC	72 (26.0)

*Note.* ( $N = 277$ ). 26% ( $n = 72$ ) of respondents indicated *I am not sure* regarding the status of TIC implementation within their agencies. Of these, the majority were DSPs (50%) and therapists/clinicians (26.4%) and worked with their organization less than 1 year (25%).