2-28-2022 1:00 PM

# Organizational Implementation of Trauma and Violence Informed Care

Tanaz Javan, *The University of Western Ontario*

Supervisor: Dr. Nadine Wathen, *The University of Western Ontario*

A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health Information Science

# Abstract

For the past several decades, social and health services have increased their efforts to enhance service delivery and close the 'science-to-service' (or 'evidence-to-practice') gap by implementing effective interventions. At the same time, there has been growing recognition of the prevalence of trauma and violence in the lives of those served and those providing care and the impact of these experiences on service needs and interactions. This study explored the implementation of trauma- and violence-informed care (TVIC), a complex intervention focused on providing safety and choice for service users in the context of their life experiences and conditions, exploring factors that facilitate or prevent successful implementation in health and social services. Following a Pragmatic theoretical orientation, Active Implementation Frameworks (AIFs), an established implementation science model, was used as a guide to study the TVIC implementation process to further understanding of implementing a complex intervention in multiple complex contexts.

The study had two phases. In phase 1, six organizations interested in the implementation of TVIC participated. In-depth interviews were conducted to understand how organizations develop awareness of TVIC and its potential fit for their needs, and what motivates them to consider implementing TVIC. In phase 2, three of the six organizations were invited to participate as cases to explore TVIC implementation across time and learn about the facilitators and barriers of sustainable implementation. Data were collected by conducting interviews with key informants and reviewing relevant documents. Interpretive description methodology guided data analysis and interpretation to elucidate indicators and practical strategies during TVIC implementation.

Findings indicate that TVIC was a good fit for participating organizations interested in enhancing service delivery to meet the needs of individuals experiencing trauma and violence, but not all organizations have the required resources (time, money, etc.) to sustain implementation. In the two case sites able to continue implementation, the adaptability and applicability of TVIC principles were an important feature supporting leader and champions engagement in the implementation process, including providing ongoing support for their staff. Increasing the knowledge and understanding of the impact of exposure to trauma and

violence helped staff understand how to provide care and receive support for their own wellbeing. This study also showed that the implementation of TVIC requires patience, ongoing attention and resources as the integration of TVIC within a complex context creates uncertainty and can be unpredictable. Further, external support from the community and other organizations were key implementation drivers to facilitate moving through the implementation process.

TVIC, while a complex intervention, was successfully integrated by two of the three cases examined, with emerging benefits noted by these organizations. AIFs are robust implementation science frameworks that fit well with the processes undertaken by these case organizations, and these findings will further enhance the AIFs by suggesting new implementation drivers. Implications focused on strategies to embed TVIC into organizational policy and practice are presented.

## Keywords

Trauma, violence, implementation science, complex interventions, active implementation frameworks, interpretive description.

# Summary for Lay Audience

Health and social service enhance their service delivery by implementing new knowledge generated from research into their practice. This study explored how specific service organizations become interested in improving their service delivery by implementing trauma and violence informed approaches in their organizations. Trauma and violence informed care (TVIC) focuses on increasing service provider knowledge about trauma and violence, including structural and systemic violence, and creating safe spaces for clients and service providers to collaborate, building on client strengths and providing them with realistic choices.

This study was conducted in two phases. In phase 1, I interviewed organizations interested in bringing TVIC into their organizations. The interviews clarified how TVIC can support the needs of organizations and what motivates them to integrate TVIC into their service delivery. In phase 2, I selected three organizations as cases and followed their TVIC implementation process across time. Interviews with key informants were conducted, and relevant documents were analyzed.

The key goal was to examine the implementation process to find practical strategies to assist other interested organizations in taking up TVIC. The findings showed that all participating organizations in this study were motivated to implement TVIC to enhance service delivery and provide extra care and support for their staff and clients. External support from the community and others also played an essential role in TVIC implementation. Significant changes and ongoing supports, including funding, are needed to help staff to incorporate TVIC into their practice, and organizations to embed TVIC thinking into their policies and protocols. These findings are important to support other organizations in taking up TVIC, which improves care experiences for everyone involved, and enhances our understanding of implementing complex interventions more generally.

# Co-Authorship Statement

Tanaz Javan completed the following work under the supervision of Dr. Nadine Wathen and the advisement of Dr. Marilyn Ford-Gilboe and Dr. Lorie Donelle. All supervisors and advisors will be co-authors, as appropriate, on publications resulting from the chapters of this dissertation.

# Acknowledgments

I am thankful to my participant organizations and all the representatives. I am grateful for your invaluable contribution and time. Your generosity enabled me to complete this study and learn and grow in the process.

I am deeply grateful to my supervisor, Dr. Nadine Wathen, who helped every step of the way. Nadine, you believed in me from the beginning. You guided me and allowed me to emerge and grow as a researcher. As a trauma and violence-informed supervisor, you supported me and taught me what it takes to bring these principles into our daily lives. Thank you.

I am also thankful to my committee, Dr. Lorie Donelle and Dr. Marilyn Ford-Gilboe, whose generous support and mentorship helped me as a researcher and facilitated my academic growth.

I am thankful to all my colleagues and friends at FIMS and GTV Incubator. Margaret MacPherson and Susan MacPhail, your mentorship, friendship and guidance have been invaluable. James Shelly, you were always present to listen and help generously. Eugenia Cannas, I miss our long conversations, and more than anything, your kind presence and your friendship.

I am thankful to my mother, Shahnaz, for her unlimited love and never-ending support. You taught me to strive and become an independent woman. I am also thankful to my little sister Sanaz for her unconditional love and support. Nana, you always believed in me and encouraged me to keep going.

So many family and friends supported me throughout the completion of this dissertation. Mateo, my dear nephew, your love and your laughs always keep TaTa going. Kristibeth you are my non-Persian sister, being there for me through thick and thin! Roshanak, you listened to all my stories from a distance while reminding me of our childhood dreams and supporting me to keep moving! Melineh you have been my meditation buddy bringing me back to my center. Hailey, Michelle, Shahab, and my other spiritual friends and companions, you all believed in me and supported me. Your presence and friendship kept me focused on the

spiritual principles guiding my life and helped me find my way back in moments of confusion and uncertainty.

# Table of Contents

# List of Tables

# List of Figures

# List of Appendices

# Chapter 1

# 1 Introduction

For the past several decades, social and health services have increased their efforts to enhance service delivery and close the 'science-to-service' (or 'evidence-to-practice') gap by implementing effective interventions. However, dissemination and implementation of new interventions are complex and challenging processes (Greenhalgh et al., 2004). This study aims to understand the implementation process of trauma- and violence-informed care (TVIC), a complex intervention focused on providing safety and choice for service users in the context of their life experiences and conditions, exploring factors that facilitate or prevent successful implementation in health and social services. This chapter will introduce the study by discussing the background and context, followed by the problem statement, research questions, study significance, and an overview of this dissertation.

## 1.1 Background

An estimated 76% of Canadians experience a traumatic event during their lifespan that would meet the threshold for post-traumatic stress, and 8% develop post-traumatic stress disorders (PTSD) (Van Ameringen et al., 2008); these rates are at what would be considered the higher end of traumatic experiences and impacts, globally (Benjet et al, 2016). Exposure to trauma and violence affect individuals in various ways and can leave long-term impacts, including but not limited to poor physical health outcomes, difficulty managing daily activities, and cognitive and emotional impairments resulting from neurobiological disfunctions (Van der Kolk, 2014, Felitti, 1998). The negative impacts of trauma and violence are not isolated or limited to individual experiences or struggles. Systems such as health and social services play crucial roles in helping people access and receive appropriate care. However, many of those working in these organizations, and the policies and practices guiding their work, are often unaware of the long-term impacts of trauma and violence and may inadvertently create harmful environments for those with previous and ongoing trauma who seek care. In addition, our broader society often views

trauma experiences as “in the past” with consequences on a person’s psyche (i.e., “in their head”); this individualistic view of trauma tends to place the responsibility to seek cure and treatment for trauma “symptoms” on trauma survivors. This limited understanding enables retraumatization by building harmful practices – i.e., violence - into care systems (Browne et al., 2012). In addition, there is little awareness of the range and types of trauma, from single acute events, such as natural disasters, to chronic and complex experiences, such as child maltreatment and intimate partner violence. Importantly, many trauma theories also fail to include historic and social events and conditions as trauma and violence. In Canada for example, the devastating and ongoing impacts of Indian Residential Schools, the Indian Act, and the child welfare system continue to traumatize Indigenous Peoples, and intersect with other forms of systemic violence, including policy-induced poverty, homelessness, and racism (Brown et al., 2016). Adding to this complexity is that many behavioural responses to trauma, and emotional and physical pain are themselves stigmatized, especially use of certain substances. These forms of *structural violence* (Varcoe, Browne and Cender, 2014) are sometimes overt and visible, such as policies turning away from service those using substances, or less visible, but no less harmful, such as implicit bias, i.e., unconscious stereotypes and assumptions that people may not be aware of but are embedded in both individual practices, and systems of care, further pushing some people experiencing various forms of trauma and violence into marginalization (Sukhera et al., 2020).

In recent years, trauma-informed care (or practice) (TIC/P) has emerged as an important way to enhance service delivery. TIC/P creates awareness about the long-term impacts of trauma and recognizes the unique needs of individuals with a trauma history. When principles of TIC/P are applied in service delivery, service providers assume that anyone could have experienced trauma. Therefore, a key goal of TIC/P is to create safe environments that prevent retraumatization during care interactions (Harris and Fallot, 2001; Hopper et al., 2010). Understanding the impacts of trauma can help providers understand “non-compliant clients,” reducing judgement and stigma. TIC/P encourages service providers to see symptoms as “responses to particular contexts and circumstances,” shifting the question from “what’s wrong with this person?” to “what

happened to this person?" (Harris and Elliot, 2001 p.13). A key understanding is that trauma-informed approaches are differentiated from trauma-specific services. 'Trauma-informed' means providing service in welcoming and appropriate environments tailored to meet the unique needs of individuals, and this type of care is practiced by everyone in a setting; 'trauma-specific' therapies are delivered by specialized services, with experts treating trauma symptoms at the individual level (Harris and Elliot, 2001). Various adaptations of TIC/P have been developed and applied in different settings, but this study was particularly interested in exploring an important evolution of the concept: trauma-*and violence*-informed care (TVIC) as initially articulated by researchers from EQUIP Healthcare (the short name for Research to Equip Healthcare for Equity) (Browne et al., 2015), a multi-component intervention to enhance equity at the point of care. In the next section, I introduce EQUIP and how TVIC has further evolved both within and outside of this intervention.

### 1.1.1 EQUIP

EQUIP is a multi-component, complex intervention designed to foster the delivery of equity-oriented health care. EQUIP aims to improve organizational capacity to provide responsive care that fits with the diverse needs of clients, especially those who face barriers to accessing care. EQUIP describes and operationalizes three intersecting "key dimensions" of equity-oriented care: TVIC, cultural safety, and harm reduction, with the cross-cutting dimension of tailoring to context (Varcoe et al., 2019). Implementation of EQUIP includes educating staff and implementing necessary organizational policies and practices that shift the culture of care (Browne et al., 2015; Varcoe et al., 2019). EQUIP recognizes that people affected by social inequities and structural violence are more likely to suffer from ill-health and have the least access to health care services. In addition, the distribution of health services is not necessarily tailored to the needs of people or groups with poor health, due in part to fragmentation and under-resourcing of certain parts of the health system (Browne et al., 2012). Encouraging change solely by targeting practice and knowledge of health and social service providers can be beneficial for individual clients/patients at the point of care, but the impact would be limited since many of the barriers to providing optimal care reside at the system level, including

workload, organizational policies and process of care, resourcing, leadership and socio-political considerations; EQUIP therefore emphasizes organizational and policy changes to facilitate equity-oriented care (Lavoie et al., 2018). While all three key dimensions of equity-oriented care interact and overlap, the focus of the present dissertation is on TVIC.

### 1.1.2 Adding the "V"

TVIC expands on the core concepts TIC/P and, crucially, brings an intentional focus on both interpersonal and structural violence, demonstrating the links between them (Ponic, Varcoe & Smutylo, 2016; Purkey et al., 2020; Wathen & Varcoe, 2019); this focus is generally lacking, as will be reviewed in Chapter 2, in TIC/P approaches. Therefore, adding the 'V' to TIC/P highlights the need for structural and cultural shifts in organizations to recognize and address the impacts of structural and systemic violence (and ideally advocate to prevent them) as an explicit way to improve service delivery.

### 1.1.3 Implementation Science

In recent decades, knowledge translation (KT), or linking research to practice, has been an important focus of researchers, practitioners and policy actors (Khalil, 2016) with the aim of reducing the evidence-practice gap. However, moving research-based knowledge to practice is itself a complex task, requiring changes in both research and practice, and the use of strategies such integrated KT, i.e., partnered research that is co-developed by researcher and the ultimate users of new knowledge (Kothari, and Wathen 2013).

As recognition, arising from fields such as evidence-based medicine, of the need to accelerate knowledge uptake to improve health outcomes has emerged, implementation science has become its own field of both practice and inquiry, with the specific goal of examining and guiding how to adopt, assess and sustain interventions in complex settings such as health and social services. Implementation science is defined as "the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into practice" (Eccle and Mittman, 2006, p.1). Research in this area focuses on understanding the implementation process and the facilitators and barriers of implementation to increase fidelity (commitment to deliver the intervention

fully) and sustainably (continuity of using the intervention) of implementation (Khalil, 2016).

### 1.1.4 Complexity theory: Complex interventions and Complex contexts

Many, if not most, interventions are to some degree complex, and implementation settings are themselves complex (Shiel et al., 2008); TVIC, and the sites under investigation in this research are no exceptions. Complex interventions have multiple interacting components that, when implemented, interact with the context of implementation (Hawe et al., 2009). These contexts, such as, for TVIC, health and social services, are complex systems. By definition, a complex system is "adaptive to changes in its local environment, is composed of other complex systems (for example human body) and behaves in a non-linear fashion (changes in outcome is not proportional to change in output)" (Shiel et al., 2008, p.1281). Therefore, the implementation of complex interventions does not occur in isolation from the context of implementation. In fact, complex interventions and complex contexts evolve together during the implementation process (Hawe et al., 2009).

Hawe and colleagues (2015) argue that traditional views of implementation often fail to recognize the importance of these interactions and expect a linear and predictable implementation process, leading many interventions to fail to achieve their intended outcomes. Hawe et al.(2015) suggest that instead of heavily relying on individual-level theorizing, researchers should adopt a dynamic, ecological approach to study complex systems. Researchers need to be aware of both the interaction between components of the intervention and the interactions between the intervention and the context.

### 1.1.5 Active Implementation Frameworks (AIFs)

There are various implementation frameworks in the literature; applied implementation frameworks are particularly interested in understanding the implementation process by explicitly considering the interactions between the intervention and the context (Duda., 2015). Among these, the Active Implementation Frameworks (AIFs) approach is proposed as an appropriate framework for studying the TVIC implementation process because it pays attention to contextual factors and has detailed guidelines on facilitator

activities and core components of practical implementation (Fixsen et al., 2005). AIFs define implementation as "a specific set of activities designed to put into practice an activity or program of known dimensions" and includes five frameworks: usable intervention criteria, stages of implementation, implementation drivers, improvement cycles, and implementation teams (Fixsen et al., 2005, p.5; see Chapter 2).

AIFs assume a non-linear, interconnected process for intervention and a multi-stage framework to demonstrate different points in the implementation. These stages overlap and may reoccur, and activities in one stage may be repeated as the activity in the next stage begins (Metz et al., 2015, Metz & Bartley, 2012). Since each stage includes a set of specified activities and structure that ensures moving to the next stage of implementation, AIFs help make visible how these activities can be contextualized and tailored by an organization based on their specific needs and goals, and consequently how this tailoring could contribute to effective implementation (Fixsen et al., 2009). AIFs are also designed to help determine what an intervention is and what it means to implementers and service providers; clear understanding of the intervention and its principles ensures its full operationalization (Fixsen et al., 2005).

Therefore, this dissertation applied AIFs as a model with which to explore the overarching question of how TVIC is perceived and understood, initiated, and implemented in health and social services with a focus on how leaders and staff engage with, tailor, and deliver their services using a TVIC approach. Specifically, this study was an in-depth analysis of select organizations to understand why and how they implemented TVIC, with specific attention to contextual factors influencing decisions. Up until now, AIFs have been mostly applied to facilitate implementation by providing a map to guide the implementation team. However, the present thesis took a novel approach by applying AIFs as a retrospective organizing framework to understand the implementation process of TVIC in three case organizations in London, Ontario.

## 1.2 Problem Statement

While TVIC has been implemented and studied as a component of EQUIP (Browne et el, 2015; Varcoe, 2019) and, in the past several years in multiple implementations conducted by members of the Gender, Trauma and Violence Knowledge Incubator at Western

University (including some of the cases examined in this dissertation (Wathen & Varcoe, forthcoming), little is known about how TVIC as a distinct intervention is implemented in health and social services and how implementation impacts setting. More importantly, new evidence on how a TVIC implementation process unfolds and what structural and cultural changes are needed to ensure fidelity (commitment to fully deliver the intervention) and sustainability (continuity of using the intervention) (Greenhalgh et al., 2004) would fill important gaps in the literature.

Therefore, this study aims to understand the impact of contextual factors on the implementation process of TVIC in health and social services while paying particular attention to important variations in service delivery across different settings.

## 1.3 Research Questions

The purpose of this study was to understand how and why organizations became interested in TVIC and, for a selected subset, how organizations implemented TVIC, across time, in their specific context. The following research questions (RQ) were asked:

RQ1. How do leaders and staff within organizations come to understand the concept of TVIC for their service context?

RQ2. What structural, cultural, and practical changes are required to implement TVIC, and what factors enable or impede uptake?

RQ3. How does TVIC implementation impact organizations?

## 1.4 Study Significance

This is the first study that explores, using AIFs, implementation of TVIC in health and social services. Findings will help fill an important research gap by providing guidance, using a complexity lens, for TVIC implementation processes across contexts. This study aims to understand how and why organizations choose TVIC as a good fit for implementing changes in their organizations to support more person-centred, and safe, care practices. By exploring the implementation process, this study highlightes the necessary operational and cultural shifts required for providing an enabling context for

TVIC implementation. Furthermore, the exploration of the implementation process clarifies how TVIC evolves as an intervention in different contexts and how organizations contextualize and tailor the TVIC principles to their unique contexts. The results of this study offer practical suggestions for organizations interested in integrating TVIC into their service delivery, as well as advances to our thinking in implementation science.

## 1.5 Chapters Overview

This dissertation is written as a monograph. Chapter one includes the introduction, background, statement of the problem, research questions and significance of the study. Chapter two provides a more extensive literature review on trauma informed approaches, and TIC/P and TVIC implementation. This chapter also describes theoretical approaches and frameworks for the implementation of complex interventions in complex contexts, especially AIFs as an appropriate approach to study the TVIC implementation process. Chapter three includes details related to methodology, research paradigm, case selection, data collection, data analysis and ethical considerations. Chapters four and five apply AIFs to synthesize the findings of the study. Chapter four details the findings addressing the first research question of how leaders and staff come to understand the concept of TVIC, while Chapter five provides findings on the second and third research questions, including a description of structural and cultural changes that took place during the implementation process and how the implementation of TVIC impacted the participating organizations. Chapter six consists of the discussion of findings, limitations of the study, future directions, implications and conclusions.

# Chapter 2

# 2 Literature Review

This study explores the implementation process of trauma and violence-informed care as a complex intervention applicable in a range of complex health and social services contexts. Trauma-informed approaches are built on understanding the impact of trauma on individuals seeking care. In other words, applying a trauma-informed lens requires service providers to recognize these impacts and tailor care toward the unique needs of all individuals. TIC/P originally emerged from mental health and addiction services (Harris and Fallot, 2001a), with numerous variations and adaptations since emerging across different implementation contexts (Wathen et al., 2021; SAMSHA, 2014). More recently, the concept of *violence* has been added to TI/P approaches to recognize the impact of interpersonal and structural violence with important conceptual differences (Browne et al., 2012). This chapter will discuss the origin and development of trauma- (and violence) informed approaches that inform the methodological approaches of this study. I am particularly interested in the implementation of TVIC as a more critically oriented construct that recognizes the impacts of ongoing and historical interpersonal and structural violence on individuals' lives and wellbeing (Ponic et al., 2016). TVIC has been implemented as a component of EQUIP in multiple contexts (Browne et al., 2018; Varcoe et al., 2019), and has been adapted, for example, in teacher education (Rodger et al., 2020) but this is the first study looking at the implementation of TVIC as a distinct intervention in health and social services. TVIC is a complex intervention with interactive components; therefore, when implemented in an organization, it interacts dynamically with the complex context of the setting. To understand TVIC as a complex intervention, I first provide an overview of TVIC as a complex intervention, then review the relevant literature on the implementation of complex interventions in complex contexts.

## 2.1 Trauma and the Impacts of Exposure to Traumatic Events

Trauma can be experienced as a single catastrophic event such as an accident, natural disaster, or an episode of sexual assault, or a series of repeated events such as war, genocide, or abuse/ neglect throughout childhood. Regardless of the type of experience, shock, terror, negative thoughts and affect, shame and isolation are some of the predictable outcomes of exposure to violence and trauma (Van der Kolk, 2014). These outcomes can impact individuals' wellbeing and safety and working through the associated consequences of trauma is sometimes a lifelong journey for survivors.

Feeling unsafe is one of the hallmarks of trauma, particularly when the traumatic events are ongoing and unpredictable. Exposure to constant danger alters brain function to continuously assess threats in the environment. Consequently, trauma survivors often experience hypersensitivity, hyperarousal, hypervigilance, and agitation. Conversely, some may experience numbness and dissociation as ways to cope with the overwhelming nature of these physiological responses – the so-called "flight, fight or freeze" response. These brain responses may also lead people to misinterpret danger and stressful situations, making it particularly challenging to trust others and the environment (Ford-Gilboe et al., forthcoming; Van del Kolk, 2014). Therefore, trauma survivors often experience reactivation or 'triggering.' This refers to reactions to seemingly neutral events that instead lead to re-experiencing the traumatic event. Even well-intentioned behaviours could result in activation or retraumatization (Lanius, Vermetten, Pain, 2010; Lanius et al., 2011). There is well-established evidence of the links between experiences of trauma and violence and physical and mental health outcomes, such as chronic pain, anxiety, depression, and health risk behaviours, including substance misuse (Felitti et al., 1998). These experiences are also highly correlated with poverty and other forms of marginalization (Krieger et al., 2011). The intersection of these factors means that trauma survivors may require additional support, particularly when they seek health and social services.

When service providers become aware of the negative consequences of exposure to trauma and violence, they are more likely to tailor their services to meet the needs of trauma survivors. Indeed, trauma- and violence-informed approaches directly respond to both the very high prevalence of trauma and violence (Van Ameringen et al., 2008) and the need to provide care responsive to these needs (Browne et al., 2012). There are various approaches to trauma- (and violence-) informed care in the literature, and I discuss the most relevant to this study in the following section.

## 2.2 Trauma and Violence Informed Approaches

In most forms of service delivery, there is a lack of awareness about the impacts of trauma and violence on individuals. This lack of understanding often results in the misinterpretation of trauma symptoms – i.e., what trauma "looks like" in a care encounter - and failure in providing tailored services to accommodate the unique needs of those who have experienced or are experiencing trauma and violence (Browne et al., 2012). For instance, the intersection of trauma, violence, substance use, and structural violence such as homelessness and poverty are often ignored by health and social services, and substance use is approached as an isolated problem that counsellors or psychiatrists are best-placed to resolve (Browne et al., 2018; Harris and Fallot, 2001a). Trauma-informed approaches, on the other hand, challenge the dominant pathological view of substance use, and other behaviours that attenuate pain, and encourage service providers to see these, in part, as understandable responses to current and past experiences; importantly, this shifts the question from "*what is wrong with this person?*" to "*what has happened, and is still happening, to this person?*" (Wathen and Varcoe, 2019).

Increasing awareness about trauma and violence does not require organizations and staff to provide counselling and therapy for their clients. Trauma-informed approaches are different than trauma-specific therapies. While the latter address the actual symptoms of trauma and assist clients in developing strategies and coping skills to manage their trauma symptoms, the former is designed to "provide services in a manner that is welcoming and appropriate to the special needs of trauma survivors" (Harris and Elliot,2001a p.5; Wathen and Varcoe, 2019).

While research on trauma-informed care has recently increased, much of this work represents adaptations of TIP for specific contexts or settings that do not add additional theoretical or empirical innovations to the core idea of TIP (Wathen et al., 2021). Many of these adaptations are built on two models that pioneer this field: 1) TIC, developed by Harris and Fallot (2001); and 2) The Sanctuary Model, developed by Bloom (1997). In the next section, I discuss each model's philosophy and theoretical background. I will follow this with an examination of the research on implementation and implementation guidelines.

### 2.2.1 Philosophy and Principles

Maxine Harris and Roger Fallot (2001a) were among the first to advocate for the importance of recognizing the impact of trauma and ongoing violence in the lives of people who seek mental health and substance abuse services. Although TIC was initially developed to foster service delivery for individuals seeking mental health and substance abuse programs, it has been expanded to other settings such as housing support (Bebout, 2001) and inpatient services (Harris & Fallot, 2001b).

The TIC model moves beyond the pathological view of seeing trauma as a single isolated event; it recognizes the far-reaching impacts of trauma on individuals across their life span. TIC views trauma as "a defining and organizing experience that forms the core of an individual's identity" (Harris and Fallot, 2001a, p.13). TIC is based on the recognition that these lifelong impacts create unique needs and requirements for trauma survivors. The framework suggests that service delivery should undergo necessary structural and cultural shifts to accommodate these needs. TIC suggests that "any service delivery, regardless of its primary task, can become trauma-informed by making specific administrative and service level modifications in practice" (Fallot and Harris, 2008, p.6). By implementing structural and cultural shifts, trauma becomes the primary focus of service delivery and becomes centralized (Harris and Fallot, 2008). The authors also distinguish between trauma-specific and trauma-informed services and advocate for a universal understanding of trauma, even and especially among service providers who do not provide trauma-specific services/therapy (Harris and Fallot, 2001a).

TIC encourages agencies to create a culture of trauma informed care (CCTIC) because culture represents "the most inclusive and general level of an agency or program's fundamental approach to its work" (Fallot and Harris., 2015a, p.3). By changing the culture of an agency to TIC, the agency's focus and attention are set on the importance of practicing principles of trauma-informed care. These principles include 1) safety: ensuring the physical and emotional safety of clients and service providers, 2) trustworthiness: providing service by creating clear and consistent practices and maintaining appropriate boundaries, 3) choice: maximizing experience of choice and control for service providers, 4) collaboration: ensuring collaboration and shared decision making between clients and service providers 5) empowerment: recognition of strength and skills of client and creating opportunities for growth (Harris and Fallot 2001a, Fallot and Harris., 2015a).

### 2.2.2 Implementation Guidelines and Tools for TIC

Fallot and Harris (2015b) developed a guideline to implement principles of TIC in an organization. As the first step, an extensive assessment and review of programs and policies are required. These assessments indicate the extent to which knowledge about the impacts of trauma and prevention of retraumatization are embedded in the routines and activities of the organization. TIC recommends asking a series of questions to check and identify potential problems and barriers to practicing TIC principles. For instance, to check for safety, the organization should review whether the first contacts with the clients are welcoming, respectful, and engaging or check to see if the clients get a clear and appropriate message about their rights and choices (Brown, Harris, and Fallot, 2013).

In addition to the assessment, Fallot and Harris have two other recommendations: reviewing written policies and conducting trauma screening/assessment (Fallot and Harris, 2008). Organizations are encouraged to review their written procedures to reduce the risk of coercive practices and eliminate retraumatization. For instance, organizations need to communicate their approach to confidentiality clearly with their clients. This communication should be reflected in their written documents while considering an appropriate literacy level. Staff and client rights and responsibilities also should be

transparent (Fallot, and Harris., 2015 a). Unlike the TVIC the approach used in this study, TIC often recommends universal trauma screening that is often followed by a more in-depth assessment of the impact of trauma. The results of these procedures inform appropriate service planning and, for instance, referral to trauma-specific programs.

A TIC approach also includes implementing structural and cultural changes. For instance, improving new employees' knowledge about trauma and its impacts should be part of the hiring process and included in orientation sessions. New staff should have at least basic information about trauma and learn how to incorporate TIC principles into service delivery (Fallot and Harris, 2008). The authors also developed protocols, self-assessments, and fidelity scales to facilitate TIC implementation for organizations (Fallot and Harris., 2015a; 2015b; 2015c)

## 2.3 The Sanctuary Model

The Sanctuary Model was developed by a team of clinicians led by Dr. Sandra Bloom based on their clinical and personal experiences (Sanctuary Institute, 2021). The Sanctuary Model promotes clinical and organizational changes to facilitate recovery from adversity in safe environments (Esaki et al., 2013). It defines trauma as "an experience in which a person's internal resources are inadequate to cope with external stressors." A traumatic experience could be discrete or ongoing and often intersects with structural issues such as poverty and racism (Sanctuary Institute, 2021. para.5). The Sanctuary Model encourages staff to understand the impacts of trauma and shift their interpretation of what could be seen as "difficult" behaviours instead of "survivor strategies." For instance, the fear expressed by a client in a nonthreatening situation could be reinterpreted as a coping skill developed to provide protection. The Sanctuary Model also encourages cultural changes in organizations. The primary focus of the Sanctuary Model is to create and sustain a safe and non-violent culture in service delivery. The model promotes physical safety (an environment free of any threat to physical wellbeing), psychological safety (elimination of bullying behaviours such as sarcasm, put-downs, public humiliation, etc.), social safety (feeling safe with other people), and moral safety (elimination of moral distress). Creating a culture of safety provides opportunities for

clients to receive the necessary help and enables service providers to offer support (Bloom, 2010).

### 2.3.1 Philosophy and Principles

Multiple theoretical frameworks inform the Sanctuary Model, including

1) Constructivist self-development theory that emphasizes the impact of childhood adversity on self-development (McCann & Pearlman, 1990; Pearlman & Sakvitne, 1995). The Sanctuary Model applies this understanding by creating safe environments in which meaningful relationships can happen (Esaki et al., 2013).

2.) Burnout theory defines burnout as a stress response to an exhausting job. Burnout often arises from emotional exhaustion that prevents the service provider from being available to their clients in need of attention and positive relationships (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001). The Sanctuary Model emphasizes the importance of providing care and structural support for staff to prevent burnout (Esaki et al., 2013).

3.) Systems theory defines a system as interrelated components that are in mutual interaction. In this theory, organizations are also viewed as interconnected subsystems in constant interaction (Bertalanffy, 1974). The Sanctuary Model views organizations as systems that include stakeholders, service providers, and clients, all of which are the primary target of the intervention (Esaki et al., 2013).

4.) The valuation theory of organizational change recognizes that structural and cultural shifts in an organization could be interpreted differently by staff, teams, and the organizations as a whole (Hermans, 1991; Weatherbee et al., 2009). The Sanctuary Model incorporates this understanding to shift and improve organizational culture based on reflecting on the personal meanings shaped by staff, i.e., the organizational actors (Esaki et al., 2013).

### 2.3.2 Implementation Guidelines and Tools for the Sanctuary Model

The Sanctuary Model brings all these theories together and offers the four pillars of Trauma Theory, the SELF Model, Seven Commitments and Sanctuary Toolkit (Sanctuary Institute, 2021).

**Table 1**

***The Four Pillars adapted from the Sanctuary Model: the theoretical framework (Esaki et al., 2013 & Sanctuary Institute,2021)***

| | |
|---|---|
| Trauma Theory | Recognizing the impact of trauma along a vast continuum that includes both discrete events and ongoing, cumulative, and perhaps intangible experiences like racism and poverty. |
| Seven Sanctuary Commitments | Moving away from trauma-reactive behaviours by committing to nonviolence, emotional intelligence, inquiry and social learning, democracy, open communication, social responsibility, growth, and change. |
| SELF | Acronym for the organizing categories of safety, emotion management, loss, and future, used to formulate plans for client services or treatment as well as for interpersonal and organizational problem-solving. |
| Sanctuary Toolkit | These tools, community meetings, safety plans, Self-treatment planning conferencing, team meetings, self-care planning, and SELF psychoeducation are the daily practices for both staff and clients that support an organization's creation of a trauma-informed culture. |

The Sanctuary Model encourages both individual- and organizational-level change and provides tools and strategies to guide cultural shifts. Implementation starts with an overall needs assessment of the organization to identify the strengths and areas for targeted intervention. The organization's leaders then will attend a five-day training session to learn about implementing the Sanctuary Model in their organization (Sanctuary Institute 2021, Yanosy, 2009). A core implementation team should be established after the training, and support and consultation from the institute guide the team for an extra year. Entering the third year, the organization continues to incorporate the model into service delivery. Organizational shifts occur by operationalizing the seven commitments and realigning policies and procedures to support implementation (Esaki et al., 2013). In the final implementation stage, the organization will receive the Sanctuary Certification representing the successful implementation of the Sanctuary Model in the organization (Sanctuary Institute 2021).

The Sanctuary Model has been implemented in various organizations in different contexts and settings such as acute and inpatient care (Bloom, 1997, 1994; 2000), juvenile justice programs (Ford, and Blaustein, 2013; Elwyn Esaki & Smith, 2015), child welfare and (Henry et al., 2011; Hummer et al., 2010). Each year more than ten new sites become certified by the Sanctuary Institute (2021) both in the US and internationally. Various scoping reviews have been conducted on the impact of TIC training and implementation in different settings. Gundacker et al. (2021) reviewed the effectiveness of trauma informed approach curricula for primary care providers. The results indicate primary care professionals reported an overall increase in knowledge about trauma, increased confidence in providing care and improved attitude toward clients with trauma history. O'Dwyer et al. (2020) conducted another scoping review on the implementation of TIC in acute psychiatric inpatient settings. The results showed that TIC encouraged health professionals to reflect on the previous practices (restraint, seclusion, rigid nursing roles) and appreciate adopting TIC as a new approach to care. Becoming trauma informed helped them understand the impacts of their clients' trauma history and show more empathy in response. In addition, TIC principles assisted the health professionals to shift from control to collaboration and allowed for creating safe spaces for positive and

mutual respect between them and their clients. However, the participants also expressed fear and anxieties about implementing TIC principles in their practice because of a lack of organizational support and guidance from senior management. For instance, organizational pressures to follow safety and risk management procedures sometimes interfered with integrating TIC and reducing coercive practices.

Another significant challenge for staff was the variability of how health professionals and management interpreted TIC principles and implemented these principles in their units. For instance, these discrepancies created concerns for staff regarding bed management and particularly the female clients' safety. Creating space for shared knowledge and accountability and questioning the dominance of the biomedical model based on TIC principles empowered nurses to voice their concern about the system. This review points at the importance of organizational structural and cultural changes to facilitate the implementation of TIC. Moreover, implementation of TIC, even in the same type of setting (i.e., psychiatric units) cannot ensure the same interpretation of TIC principles, highlighting the importance of having coaches to guide the implementation process (Fixsen et al., 2005).

## 2.4 Trauma and Violence Informed Care

Compared to the above two models, each with decades of history, TVIC is a relatively new and still evolving intervention that builds on key aspects of those two models. TVIC was initially articulated as part of EQUIP Healthcare (http://EQUIPHealthcare.ca), a multi-competent, complex intervention designed to foster the delivery of equity-oriented health care. EQUIP has three key dimensions: TVIC, cultural safety and harm reduction, all framed by complexity theory and requiring tailoring-to-context (Varcoe et al., 2019). The TVIC component of EQUIP emphasizes the need to create an emotionally, physically, and culturally safe environment that recognizes the impacts of trauma and violence (Browne et al., 2012; Ponic et al., 2016; Levine et al., 2021).

### 2.4.1 Philosophy and Principles

Like TIC and The Sanctuary Model, TVIC views trauma as a multidimensional response (brain, mind, and body) to stressful and overwhelming single or ongoing events. These stress responses can impact individuals' lives throughout their life span, creating unique needs and circumstances. Therefore, the first goal of TVIC is to educate service providers and raise awareness of the impact of trauma, leading to tailoring care and enhancing service delivery.

TVIC also distinguishes between trauma-specific and trauma-informed approaches and encourages service providers to create a safe space to reduce harms from service interactions and increase their effectiveness, rather than treat trauma symptoms (Wathen and Varcoe, 2019).

### 2.4.2 Structural Violence

One key difference of TVIC is its explicit emphasis on violence, particularly structural violence. Like other trauma informed approaches, TVIC is committed to structural and cultural shifts both at the individual and organizational level; however, TVIC emphasizes the 'V' (representing all forms of interpersonal, structural, cultural, historical, and intergenerational violence) more explicitly. This explicit commitment broadens the view of seeing trauma as past experiences that happen to someone, to recognize ongoing forms of interpersonal and structural violence (Wathen, and Varcoe, in press). TVIC acknowledges that interpersonal violence (e.g., child maltreatment, intimate partner violence) and structural violence (poverty, homelessness, racism, and other forms of discrimination etc.) are embedded in society and are in many cases explicit acts or results of policy decisions and non-decisions. Acts of violence, whether interpersonal or structural, can be perpetuated in service delivery settings if, for example, these services (in whole are by individual providers) legitimize violence and harm by offering moral or cultural justifications for them. In other words, "cultural violence makes direct and structural violence look, even feel right - or at least not wrong" (Galtung, 1969, p.291). Interpersonal/direct violence, structural violence, and cultural violence together shape a triangle. Cultural violence is an invariant, a 'permanence,' that normalizes historical

forms of trauma (e.g., the genocide of Jewish or Indigenous peoples) and their intergenerational aspects (e.g., the impacts of Residential Schools on Indigenous communities). The presence of these forms of violence (normalization, justification, denial) in service delivery could lead clients and staff to see repression and exploitation as normal, and eventually not seeing them at all (Galtung, 1969, Varcoe, forthcoming).

Explicit recognition of structural violence, and commitment to addressing it, along with interpersonal forms of violence, in practice has been shown to create significant cultural and structural shifts in organizations. For instance, the implementation of EQUIP in primary health care clinics encouraged staff to learn about structural violence. Consequently, post-training staff challenged the status quo and increased their confidence in handling structural violence that appeared through racism and discrimination. In addition, the dynamic between staff and Indigenous clients shifted because staff members were able to move away from taking a biomedical approach to a client's struggles and recognizing the impact of the ongoing and intergenerational experience of trauma and structural violence, including racism, on their lives (Browne et al., 2018). Changing service delivery by incorporating a universal understanding among and between providers about trauma, ongoing and past violence, and the impacts of these experiences on their clients can prevent systems and services from further traumatizing clients (Levine et al., 2021, Purkey et al, 2020).

### 2.4.3 TVIC Theoretical Framework

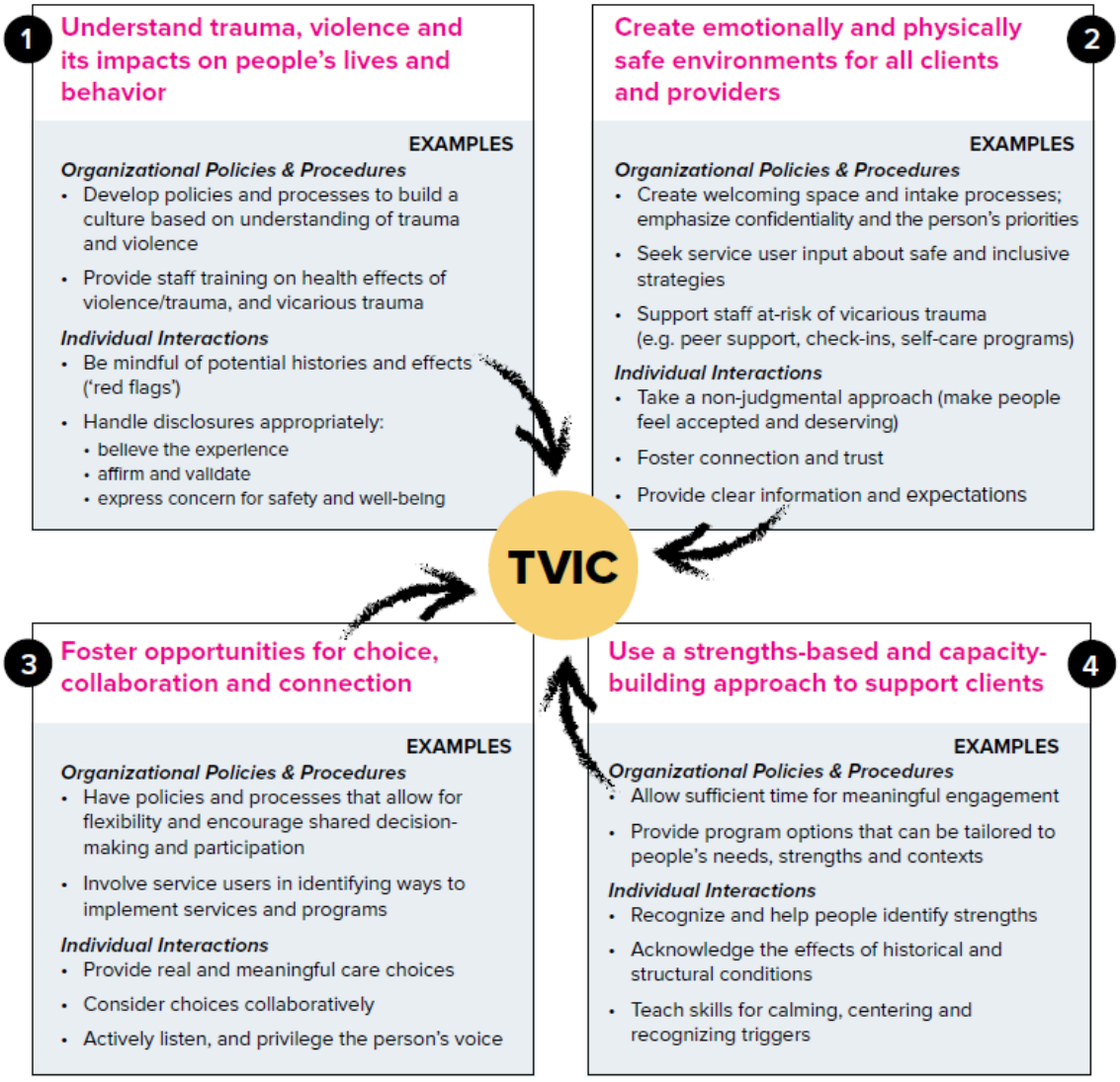
The underlying philosophy of TVIC is a critical theoretical understanding of social justice. As articulated in the EQUIP intervention, inequities in health and social service are a result of structural barriers (Varcoe et al., 2019), and achieving health equity in practice requires recognizing systematic and structural inequities embedded in systems, including explicit and implicit policies and practices that prevent tailoring care to attend to these factors (Browne et al., 2018). The four Principles of TVIC as articulated in EQUIP and subsequent work, aim to improve organizational capacity to provide responsive care that fits with diverse clients needs on two levels: 1) educating and supporting staff, and 2) clarifying necessary improvements in organizational policies and

practices, shifting the culture of care, and facilitating contextually tailored changes in policies and services delivery. TVIC is framed as “universal” in that the intent is to reduce harm, tailor care to an individual’s unique needs, and improve service delivery, regardless of a person’s specific trauma history – in fact, recognizing the very high prevalence of trauma and violence, TVIC explicitly discourages forms of screening that, for example, are featured in the Sanctuary Model (Browne et al., 2015; Browne et al., 2018; Wathen & Varcoe, forthcoming). Moreover, research shows that screening often has no benefits. For instance, in the context of intimate partner violence having a TVIC lens, being aware of the prevalence of IPV, creating a safe environment for clients, and providing options in collaboration with the clients are more likely to ensure individual’s well-being and safety (Wathen, 2020).

TVIC has four main principles (Figure 1), including 1) Understanding trauma and violence, including structural violence, and its impact on people’s lives and behaviour. 2) Creating emotionally, culturally, and physically safe environments for all clients and providers. 3) Fostering opportunities for choice, collaboration, and connection. 4) Using a strength-based and capacity-building approach to support clients (Wathen and Varcoe, forthcoming). Each principle should be implemented on an individual and organizational level.

**Figure 1**

***Principles of Trauma and Violence Informed Care (from Wathen and Varcoe, 2021, used with permission)***




## 2.4.4 Implementation Guidelines and Tools for TVIC

At the time of TVIC implementation in the participating organizations in this study, no implementation guidelines or tools were developed specifically for TVIC

implementation, though workshop materials and other supports, including expert facilitation, were available via the Gender, Trauma & Violence Knowledge Incubator at Western University (http://GTVIncubator.uwo.ca). This gap has become more evident with a recent scoping review conducted by Wathen and colleagues (2021), who examined what validated measures exist to assess the impact of the implementation of TVIC principles in organizations. Most of the existing measures emphasized assessing knowledge and attitudes about trauma and violence at the individual level, the capacity to implement TVIC, staff experiences of vicarious trauma, and client perceptions of care. Less, or no, attention was paid to structural factors such as racism and discrimination, particularly how implicit bias in organizations and among providers can lead to poor care experiences for people experiencing marginalization.

#### 2.4.4.1 Research Findings on Implementation of TVIC

As a newer model, TVIC has fewer evaluated implementation examples on which to draw. The primary source of research on TVIC's impacts comes from the EQUIP implementations in primary and emergency health care, with several other smaller case studies available. Therefore, in this section, I review studies that reported on the results of these implementations.

EQUIP Healthcare has been implemented and tested in four primary health care clinics in Ontario and British Columbia (BC) (Browne et al., 2015; Browne et al., 2018; Ford-Gilboe et al., 2018), and is completing the evaluation in BC emergency departments (Varcoe et al., 2019). The main findings of the primary health care study (Ford-Gilboe et al., 2018), established the link between providing more equity-oriented care, including TVIC, and better health outcomes among patients across time. As noted above (Browne et al., 2018), changes in staff perceptions and practices were an important underpinning of these client pathways – as staff shifted their practices to equity, clients felt more confident in their care, and more able to manage their care needs. Ultimately, clients reported reductions in depressive and trauma symptoms, improvements in quality of life, and even small reductions in pain disability (Ford-Gilboe et al., 2018). Alongside these staff and client level analyses, EQUIP Primary Healthcare investigated how the policy

and funding contexts of each clinic enable equity-oriented, trauma- and violence-firmed care (Lavoie et al., 2018). They identified three fundamental mechanisms that influence the enactment of an equity mandate of these organizations: 1) accountability and performance frameworks; 2) patterns of funding and allocation of resources 3) pathways for new priorities. Even though the clinics participating in the EQUIP primary care study were interested in enhancing the accessibility of their services and addressing social determinants of health for their marginalized populations, their work mainly stayed invisible because these indicators were not embedded in the accountability frameworks required by their funders, usually provincial governments. In addition, most of these organizations faced limitations and significant gaps in their funding, making it difficult to tailor their services to their clients' complex and ever-changing needs. Thus, when the allocated resources are not designed to be responsive to these changes, the clinics cannot adapt. These findings shed some light on facilitators and barriers for operationalizing equity-oriented approaches, particularly in community-based services. However, the actual process by which services take up specific aspects of the intervention was not explored in depth.

Browne et al. (2018), in a related analysis from the EQUIP primary care study, showed that the intervention enhanced staff awareness and confidence in providing equity-oriented health care. The staff found the TVIC component of EQUIP particularly helpful to raise awareness of the impact of trauma and how seemingly non-harmful practices could be retraumatizing. The discussion about trauma and violence also led to conversations about staff members' emotional wellbeing and vicarious trauma. The authors have suggested strategies to enhance the impact of EQUIP, including explicitly integrating harm reduction as a key dimension. In clinics with a high number of clients with substance use issues, providing education on the impact of trauma and violence requires an explicit link to harm reduction as both a philosophy and a set of practices. This finding is significant because it clarifies how the complexity of the context and its interaction with the intervention components could be critical for successful implementation. The TVIC education component of EQUIP was further analyzed in a study by Levine and colleagues (Levine, Varcoe, and Browne, 2021). The findings

indicate that learning about the impact of trauma and violence increased awareness in staff and boosted their confidence to provide care for individuals with a trauma history. This was more evident in staff with relevant social work and counselling backgrounds than physicians and medical office assistants. Education about TVIC also shifted power dynamics by challenging the biomedical paradigm and encouraged a more holistic approach to include the psychological impact of past and ongoing trauma and violence in providing care. Finally, the supportive context of the organization in one clinic acted as a facilitator for the implementation of TVIC. In a different clinic, tension, the existing interprofessional culture, and the power dynamic created barriers in fully embracing TVIC principles. This finding clarifies the importance of an enabling context for the successful implementation of TVIC.

In another study conducted by Wathen and colleagues (2021), similar findings emerged. The authors were interested in understanding the long-term impact of interprofessional education in TVIC on the individual and organizational levels. They also found TVIC education increased awareness in thinking about trauma and violence, encouraging service providers to apply a holistic view and see the "journey" clients had been on before requiring care. This increased awareness also enhanced service delivery by avoiding retraumatization and harm. Changes at the organizational level reported by participants were consistent with the previous study: including creating a more welcoming space, keeping the conversation regarding TVIC going, and being more understanding of clients not attending appointments. The organization also increased care and support for staff to acknowledge the impact of vicarious trauma.

EQUIP has been implemented, since 2018, in three diverse emergency departments (EDs) in BC (Varcoe et al., 2019). While results are still emerging, one key finding is that, even among EDs serving quite different populations, those who report receiving poorer care tend to cluster into specific groups according to their experiences of structural violence, including social determinants of health such as poverty and, their age and gender, and the racism and discrimination they experience (Varcoe et al., under review). This more precise identification of structurally violent conditions and their link to service quality, provides additional evidence regarding how to tailor TVIC is specific contexts.

Even though research has examined the implementation of EQUIP and TVIC, more research is needed to investigate how organizations implement TVIC as a distinct intervention. To further enhance my understanding of the implementation process, I reviewed the literature to understand what implementing complex interventions in complex contexts entails and explore the relevant literature on implementation frameworks.

TVIC has also been implemented in different contexts such as working with Indigenous men (Smye et al., forthcoming); improving educational settings and working with professional teachers for kindergarten to grade 12 (Rodger et al., forthcoming); gender-based violence (Wathen and Carswell, forthcoming) and elder abuse (Macpherson and Wathen, forthcoming).

## 2.5 Implementation

Enhancing health and social services has been the focus of research for decades, but more recently, this attempt has shifted toward incorporating the latest evidence from research into service planning and delivery (Fixsen et al., 2005). The evidence-based movement in service delivery promotes using research-derived knowledge to find ways to improve service outcomes. Even though bringing research to practice is a desirable outcome for both researchers and services, the process of producing and sustaining improvement has remained challenging. There are existing service gaps that are difficult to overcome (Ogden and Fixsen, 2014).

The effort to understand and overcome these discrepancies has resulted in the emergence of the field of implementation science and substantial improvements in researching how best to improve health and social services (NIRN, 2016). Implementation science is defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into practice.” (Eccle and Mittman, 2006.p.1). Implementation science is interested in understanding the interactions between interventions, providers, and contexts at the individual, organizational, and policy/system levels, both within and beyond health care settings (Bauer et al., 2015).

### 2.5.1 Complex Interventions

What makes implementation research challenging is that many evidence-based interventions, especially those with multiple components, are complex, and the contexts in which they are implemented are also complex (Shiel, Hawe, Gold, 2008; Fixsen et al., 2009).

Complex interventions are defined as interventions with several interacting components. Development, evaluation, and implementation of complex interventions require researchers to take specific steps, in stages, and carefully consider each stage's essential functions. However, these stages do not follow a linear pattern (Medical Research Council of the United Kingdom, 2008). In 2008, the Medical Research Council of the United Kingdom (MRC) published guidelines for the design, development, evaluation, and implementation of complex interventions. The purpose of publishing these guidelines was to illuminate the potential constraints inherent in the complexity of implementing these interventions due to their interacting components, which act independently and interdependently (MRC, 2008).

As the first step in developing a complex intervention, researchers are advised to conduct a systematic review of the existing evidence (Hawe, 2015a, 2015b). This evidence can be drawn from available resources such as the health care system, behavioural science, health psychology, and community psychology (Craig et al., 2013; Moore et al., 2015). Developing a robust theoretical framework as the second step is critical to target desired changes and identify a road map to accomplish those changes. This can also be achieved by interviewing stakeholders targeted by the intervention (MRC, 2000; 2008). The third step is modelling the process and outcomes. Through pilot studies and modelling complex interventions, researchers attempt to clarify uncertain aspects of their plan and improve the design of the intervention. Conducting a preliminary process could be helpful to confirm the feasibility of the intervention and evaluate the impact of the intervention (MRC,2000; 2008; 2005; Hawe, 2015). The guideline calls for standardization of interventions, but it also recognizes that the constant and variable

components of interventions need to be identified during the exploratory phase (Hawe et al., 2004).

As discussed in previous sections, TVIC includes multiple components and principles that impact organizations both on the individual and organizational levels; therefore, TVIC is a complex intervention that interacts with the context of implementation. While TVIC was originally examined as part of the EQUIP intervention, it has, as reviewed above, been taken up as a distinct intervention by others, including the present study's participating organizations.

### 2.5.2 Complex Contexts

Successful implementation also requires an enabling context (Fixsen et al., 2005). Even though an intervention may be designed with specific outcomes in mind, it may deviate from its design when adopted by a complex system. This means that the complexity of the system in which the complex intervention is implemented also plays a critical role. Complex interventions are context-level interventions, and their multi-level nature is not limited by having different components (Hawe, 2015).

Hawe and her colleagues (2009) argue that the importance of context has been absent in the complex intervention discourse, which has led many interventions to fail and mislead subsequent research. They posit that instead of over- relying on individual-level theorizing, researchers should adopt a dynamic, ecological approach to studying complex systems, as the setting and structures of the organization add additional dimensions to the complexity of the intervention (Hawe, 2015). An ecological approach recognizes that individuals connect with their social context directly, and this social context has significant impacts on how an intervention unfolds. Producing changes in individuals' lives requires consideration of their social location because "the essential point is that the theory driving the intervention is about the dynamic of the context or system, not the psyche of attributes of the individuals within it" (Hawe et al., 2009, p. 269).

Here the context is defined as "the wider situation surrounding something and how this wider situation confers meaning" (Mclaren, & Hawe, 2005, p.7). Factors such as where

people work or live or the characteristics of the groups, they belong to become relevant to the research, resulting in a more robust multi-level analysis (Mclaren, & Hawe, 2005). When complexity is the property of a system, not only an intervention, it makes that system more adaptive, meaning "the process of change that results as various intelligent agents - from policymaker to patient- who modify their behaviour (including any actions required to implement the intervention) in an effort to improve outcomes relative to their own perspective and objectives" (Greenwood-Lee et al., 2016. p.2). Furthermore, complex systems such as health care tend to behave in a nonlinear phase transition, meaning they change their positions frequently and quickly (Shiel, Hawe, Gold, 2008, p.1281). Thus, the implementation of successful changes in a system depends on understanding the nature and the diversity of the activities taking place within it (Greenwood-Lee et al., 2016). In addition, considering the principal agents and the significance of their roles in a system draws attention to social relationships that shape the system. These social relationships could play a key role in incorporating changes into a system since interventions often create new social roles, bridge existing gaps, and increase and change the dynamics of social interactions (Hawe, 2015a, 2015b).

Implementation of a complex intervention in health and social services requires attention to three features: 1.) the providers' expertise, and how to incorporate the intervention into their daily practices and routines. 2.) recognition of variation among services; and 3.) the dynamic between the complex intervention and the complex system in which it is implemented, "conceived as evolving networks of person-time-place interaction" (Hawe, 2015, p.310). To understand how a complex, context-level intervention such as TVIC is implemented, it is crucial to explore the structures, culture, and relations embedded in the system. It is necessary to examine the implications of these contextual factors on the implementation process, noting that the dynamic relationship between the intervention and the context in which it is implemented adds multiple dimensions to the complexity of delivering the intervention (Greenwood-Lee, 2016). Furthermore, these contextual differences exist both within and between organizations, making it essential to understand the implementation of the interventions in the "real world" environments in which organizations provide different services (Baker, 2011). Therefore, the present study was

interested in understanding the impact of contextual factors on the implementation process of TVIC in social services while paying particular attention to the variation of service delivery across different settings.

### 2.5.3 Implementation Frameworks

Different frameworks have been developed in the implementation science field to study and guide how interventions are taken up by health and social services and what indicators ensure successful implementation (Fixsen et al., 2005). There are three main approaches in the literature to understand the facilitation and adoption of interventions in organizations, including diffusion (letting it happen), dissemination (helping it happen), and implementation (making it happen) (Greenhalgh et al., 2004). In the "letting it happen" or diffusion of innovations approach, an organization often becomes interested in taking up an intervention as "a good idea." The uptake of interventions usually occurs informally; however, their fidelity (commitment to fully deliver the intervention) and sustainably (continuity of using the intervention) are not guaranteed (Greenhalgh et al., 2004). "Helping it happen" or dissemination investigates organizational readiness and system influences and encourages more active approaches such as developing websites and guidelines and providing training to increase the likelihood of using the intervention in service delivery (Greenhalgh et al., 2004). Even though dissemination could be effective and result in higher fidelity and sustainability (Greenhalgh et al., 2008) than diffusion, these are still far behind the "making it happen" or implementation-oriented approaches (Fixsen et al., 2013). To "make it happen", the organizations adapt the innovation to the cultural and structural requirements of the organization and the outcome is the actual use of the intervention and full integration of its components into practice (Greenhalgh et al., 2004). "Making it happen" approaches or applied implementation frameworks aim to address the gap in the literature on understanding the impact of the interaction between complex systems and complex interventions and the implications of these interactions on the implementation process, fidelity, and sustainability (Fixsen et al., 2005; Greenhalgh et al., 2004). Applied implementation science is interested in learning how complex interventions should be implemented to achieve success on specific outcomes (Duda., 2015). The present study was interested in understanding the

process involved in the full integration of TVIC in specific social services; therefore, I applied the Active Implementation Frameworks (AIFs) to explore the implementation of TVIC as a complex intervention in complex social services. Active Implementation Frameworks proposes five frameworks to achieve successful implementation. Furthermore, an enabling context plays an essential role as a container that holds these frameworks and facilitates full integration of the intervention into the context (Fixsen et al., 2005). In the next section, I will describe the AIFs.

### 2.5.4 Active Implementation Frameworks

In 2005, the National Implementation Research Network (NIRN) published a monograph based on an extensive literature review on implementation science (Fixsen et al., 2005). The development of AIFs resulted from synthesized multidisciplinary research on implementation science, including the five frameworks: usable intervention criteria, stages of implementation, implementation drivers, improvement cycles, and implementation teams. The AIFs define implementation as “a specific set of activities designed to put into practice an activity or program of known dimensions” (Fixsen et al., 2005.p.5). These activities take place over time and in multiple stages that overlap and are repeated when necessary (Fixsen et al., 2013). Successful implementations result from interactions between different factors, all equally important. These factors include effective interventions, effective implementation methods, and enabling contexts that ensure socially significant outcomes (figure 2). This approach to implementation is essential because it respects the complexity of implementing complex interventions in complex contexts while adding attention to robust implementation methods. Emphasizing the multiplicity of the interactions between these factors shows the importance and contribution of each factor to successful implementation. AIFs encompass the range of possibilities that could facilitate or prevent the integration of an intervention into a new context, particularly emphasizing the importance of context, broadly defined, as an enabling factor for achieving desired outcomes (Fixsen et al., 2005). Emphasizing the multidimensional nature of enabling factors makes AIFs suitable to study the implementation of complex interventions, such as TVIC, in complex contexts, such as social services.

The five AIFs frameworks cover the “What,” Who When and How of the implementation process:

**What:** Refers to the evidence-based intervention that is teachable, learnable, doable, and readily assessed in practice.

**Who:** Refers to the implementation team(s) accountable for the integration of the intervention into practice, while ensuring equity in each step.

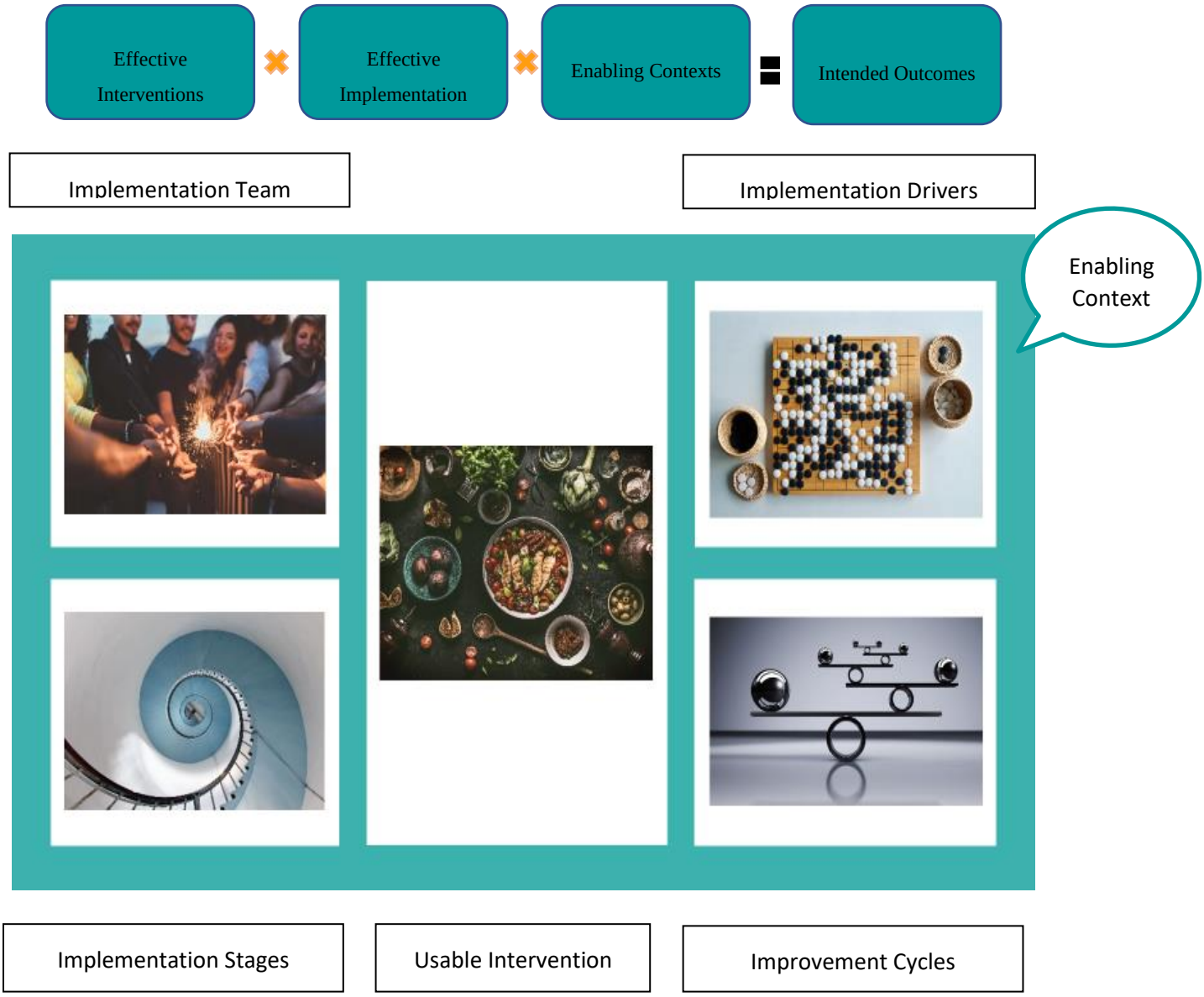
**When**: Refers to the implementation stages in which particular activities occur over time. They are revisited as needed.

**How**: Refers to implementation drivers and improvement cycles that create a system of support for sustainability. (NIRN, 2021, Duda et al., 2014).

In the next section, I provide a summary of each framework.

**Figure 2**

***Impact factors (NIRN, 2016)***



#### 2.5.4.1 Usable Intervention

The first framework of AIFs is concerned with the importance of determining what an intervention is and how it is perceived by implementers and service providers (Fixsen et al., 2009). Organizations must have a clear understanding of the details and components of the intervention to assess the intervention as a good fit. An in-depth understanding of what an intervention offers ensures fidelity and sustainability of the implementation. Fixsen et al. (2013) argue the usability of the intervention should be fully grasped by service providers for effective implementation at the practice level (p.219). AIFs propose four essential criteria for assessing the usability of an intervention. A **clear description of the intervention** is the first criterion for an organization to consider when evaluating its fit. Understanding what an intervention offers and how its implementation impacts service delivery is essential because not every intervention is a good fit for the organization. For an intervention to be fully integrated, its core values and principles should align with the organization's values and principles. Once the description of the intervention is clear, then **program components** should be identified and clarified. These are the critical features of the intervention that, when operationalized, ensure that the implementation progresses (NIRN, 2021). For instance, in TVIC implementation, after developing knowledge and understanding about trauma and violence, the organizations must identify components of TVIC that should be in place to move toward becoming trauma- and violence-informed. Then **operational definitions** of each feature describe how it should be implemented. The operationalization of these components eventually should be assessed to measure **practical fidelity** (NIRN, 2021). For organizations knowing and learning about the core components of TVIC is not sufficient; they must also understand how TVIC principles and values can be operationalized. For instance, learning to create an emotionally, culturally, and physically safe environment as a TVIC principle is an important step; but this should be implemented to change the service culture. This can happen when practitioners, for example, modify intake forms by eliminating questions that potentially retraumatize clients. After implementing necessary changes, the organization should repeatedly assess the effectiveness of the intervention to see if it is used as intended.

#### 2.5.4.2 Implementation Stages

The second AIFs framework proposes four overlapping stages for implementation and is about ***when*** certain things happen during the implementation. AIFs suggest a nonlinear and interconnected process for intervention, implementation, and a multi-stage framework to demonstrate different points in the implementation. These stages overlap and may reoccur, while activities in one stage may be repeated as the next stage begins (Metz et al., 2015, Metz & Bartley, 2012, Fixsen et al., 2005). Each stage includes a set of specified activities and structure that ensures moving to the next stage of implementation.

Stage 1: Exploration and Adaptation

The exploration stage is a crucial step to build a solid foundation for the implementation process. A deep understating of the intervention helps to clarify what to expect and how the result of the implementation could potentially affect the organization. Articulating potential facilitators and barriers will aid the implementation team in anticipating and overcoming challenges. It is the step where an organization identifies the usability of intervention, then assesses if it is a good fit for their organizational needs. Many organizations expect to implement an evidence-based intervention in a "plug and play" manner. This expectation could end the implementation process in its infancy because the organization is not prepared to face the uncertainty and challenges that accompany the implementation of complex interventions. In fact, implementation of EQUIP has been shown to create tensions in the organization regarding structural violence and other related topics such as substance use issues (Browne et al., 2018). Therefore, this stage is crucial in identifying how the intervention could be operationalized in the organization. It is necessary to set realistic expectations by carefully examining the intervention and the implementation process before identifying required resources and potential barriers (Fixsen et al., 2013). Often in this stage, organizations build connections with individuals or groups (coaches and purveyors) to assess the intervention as a good fit. If the organization decides to proceed with the implementation, these individuals will actively work from within to ensure successful implementation with high fidelity and sustainability (Fixsen et al., 2005).

In addition, creating readiness for change in individuals and organizations is an essential step in the exploration stage (Fixsen et al., 2013). Readiness is defined as the willingness and ability of an organization to implement a new intervention and can be viewed as a necessary condition to ensure successful and sustainable implementation (Greenhalgh et al., 2004). It is difficult to determine when an organization is "ready" for implementation because we often do not have empirical tools and guidelines to measure readiness, and readiness is not a stage that an organization reaches; it is a dynamic and multidimensional concept. Readiness is multifaceted because various factors could increase or decrease the readiness of an organization, including motivation (advantage, compatibility, etc.), general capacity (sufficient staffing, effective leadership, etc.), and innovation-specific capacity (human, technical and fiscal resources). It is also dynamic, meaning the level of readiness could fluctuate over the implementation process and requires monitoring (Sassia et al., 2016). In addition, when an organization is not fully ready, it does not necessarily mean the implementation will be unsuccessful. Increasing readiness in the organization is an essential step in the exploration stage to guarantee a successful implementation.

It should also be noted that when an organization identifies a potential intervention, it does not mean that every component will match their needs and readiness; context plays a crucial role in implementation logistics. Therefore, during exploration and adaptation, organizations need to outline the intervention components required to assess suitable aspects; and they need to decide whether sufficient fidelity can be achieved, ensuring the realization of anticipated benefits. Clarifying the details of an intervention is an essential step because it could help the organization use the intervention effectively and shift important, pre-identified outcomes. Mapping the intervention's core principles and strategies with desired outcomes and expectations, and committing to intervention fidelity, must underpin implementation. This means that organizations need to consider the potential fit between the target population, the organization, and available resources, with the program's key principles, underlying theories, and the proposed model. Furthermore, potential barriers such as funding streams, staff patterns, and required organizational, cultural, and structural shifts require examination (NIRN, 2021).

Stage 2: Installation

The installation stage begins with deciding to proceed with the implementation of the intervention. Organizations need to create and acquire resources to shift the practice in alignment with the new intervention's principles, as they ensure that financial and human resources are available. In this stage, implementation drivers will be developed and established. These implementation drivers include competency drivers, organizational drivers, and leadership drivers (each one will be discussed in more detail in upcoming sections). Assistance from purveyors and coaches is essential in this step for increasing knowledge, skills, and competency in staff and leaders who are expected to apply new principles (Bertram et al., 2015). The establishment of implementation drivers also helps to reduce the conflicts between the new intervention with the existing infrastructure. Organizations could avoid confusion and less effective implementation by evaluating and repurposing previously developed programs and routines that may interfere with the new intervention (Bertram et al., 2015). In this stage, organizations often create data systems to receive feedback from service providers, clients, and administrative systems to assess the impact of applying the new intervention in practice; this informs further decision-making.

The importance of the installation stage sometimes is overlooked during implementation, and this can impact fidelity. Therefore, organizations should be aware that planning and building necessary structures will facilitate the later stages of implementation and ensure a confident implementation of the new intervention.

### Stage 3: Initial Implementation

This stage can often bring a sense of excitement and enthusiasm to use the new skills learned in the installation stage are applied. Despite this, challenges could also arise since it can be hard to change already set ways of doing things and effectively incorporate change (Bertram et al., 2015). Challenging the status quo and existing power dynamics, coupled with implementation complexity, creates disruption (Browne et al., 2018). Attention to equity in implementation- is also encouraged to ensure equitable outcomes for everyone (NIRN, 2021). In this stage, coaching and supporting providers are critical to helping them move through the awkwardness of navigating new ways of providing service. In this stage, often, barriers and obstacles for implementation start to emerge.

Therefore, it is essential to have structural support to identify and learn from mistakes and approach these challenges systematically. Support from leadership in addressing these issues is critical because their participation in the process creates top-down accountability (Fixsen et al., 2013).

Stage 4: Full Implementation

Full implementation occurs when practitioners are comfortable providing high-quality service aligned with the new intervention principles, and these new practices become the standard (Bertram et al., 2015). At this point, implementation drivers are fully established, supported, and then regularly evaluated for improvement. Evidence of evaluation shows improvement of practice and increased client satisfaction and other key outcomes (NIRN, 2021). The complexity of the intervention plays a sizable role in the speed of implementation. For context, implementing TVIC has taken more than 5 to 6 years in a local mental health agency (S. MacPhail, personal communication). The TVIC committee in that organization continues to be actively engaged in creating necessary changes.

It should be noted that without careful development and repurposing of available resources and establishment of implementation drivers, full implementation could be delayed, and the implementation process may need to revisit previous stages (Fixsen et al., 2013). The implementation team also plays a crucial role in the sustainability and fidelity of the intervention. The support and coaching provided by the implementation team is a facilitating factor for full implementation.

#### 2.5.4.3 Implementation Drivers

Implementation drivers or core implementation components refer to *how* to implement an intervention and are “the building blocks of the infrastructure needed to support practice, organizational and system change” (Metz et al., 2015, p.416). They are the interactive process integrated into the system to maximize the influence on the fidelity of providers’ behaviours and organizational culture (Fixsen et al., 2009). There are three different types of implementation drivers: *competency drivers, organizational drivers, and leadership*

*drivers*, and each includes structural factors and activities to ensure high fidelity and sustainability of the intervention.

A) Leadership Drivers

Leadership is a fundamental driver for successful implementation. Leader support and engagement with the implementation process enable forward movement, especially when there is tension and resistance in staff. Leadership as a driver in AIFs is more about the roles that leaders play rather than their status and authority. The implementation process takes time and is a long and sometimes exhausting process. Therefore, leaders are encouraged to build connections with staff, listen to their concerns, and resolve problems (NIRN, 2021). Leaders' ability to apply appropriate strategies when facing technical versus adaptive challenges could prove essential in the implementation process. Technical challenges are more well-defined problems and usually have a clear path to a solution (e.g., changing staff schedules). In contrast, adaptive challenges could be defined from multiple and sometimes competing perspectives, constituting multiple viable solutions (e.g., when a new intervention creates resistance in some staff). Leaders should distinguish between the two, as it has been shown that mistaking one for another can impact leaders' ability to support both staff members and ensure the sustainability of the outcome (Bertram et al., 2015; Duda, 2015).

B) Competency Drivers

Competency drivers mainly focus on the facilitator mechanisms enabling providers to improve their ability to deliver the desired outcomes. The four competency drivers are *staff selection, training, coaching, and fidelity* (Fixsen et al., 2009; Metz et al., 2015).

AIFs give particular attention to the selection of staff who are qualified to carry out the intervention. Qualification includes compatible academic background and practice experience, but other factors such as willingness to learn, commitment to moral values and social justice, good judgment, and empathy also play crucial roles. Staff selection is not an isolated process as it intersects with more contextual factors such as organizational financing, the demand of time and skill, the availability of staff, union, and other human resources considerations, and so on (Fixsen et al., 2005; 2009).

Full integration of an intervention can depend on service providers' ability to know when, how, where, and with whom they should apply their new skills and approaches. To achieve this, pre-service and in-service training may be helpful mainly if they are not used alone (Duda, 2015). For instance, workshops and training could provide background information, theory, philosophy, and knowledge of key principles of the intervention. However, participation in skill-building sessions could also help providers practice their newly learned skills while receiving feedback (Metz et al., 2015).

Ongoing coaching and consultation are other necessary steps for effective implementation. While initial training can teach new skills to providers, ongoing coaching or facilitation provides a more tailored approach based on the importance of the contextual factors of each organization, such as the type of services delivery and client needs (Fixsen et al., 2009). Coaching also can offer encouragement and improve motivation for staff to apply their new skills (Metz et al., 2015).

Evaluation of staff performance and application of the new skills in the organization could also provide valuable insights to continue practicing new skill sets. It could also be beneficial feedback for providers (Metz et al., 2015).

C) Organizational Drivers

Organizational drivers are core components that ensure structural and cultural change, including decision-support data systems, facilitative administration, and systems interventions (NIRN, 2021). Decision-support data systems evaluate the implementation progress in the whole organization and inform decision-making by the implementation team. Data related to quality assurance, fidelity, and outcome should be reported frequently, centring on service providers' experience with the intervention (Fixsen et al., 2009). Results could be shared within a user-friendly decision support data system to facilitate decision-making at the policy and practice levels in the organization (Fixsen et al., 2013). Facilitative administration, as another core component of implementation driver, applies the data to inform decision-making. Organization leaders use the available data to facilitate intervention and provide supportive and complementary resources (NIRN, 2021). Facilitative administrators pay attention to the procedural, cultural, and

structural aspects of an organization. They keep them aligned with the desired outcomes of interventions that involve breaking down barriers (Fixsen et al., 2009). For instance, effective interventions could occur through interactions between health and social service providers with their clients. Ensuring the integration of the intervention into service delivery requires the administrator to make sure that service providers are confident in applying their new skills and that they have what they need (Metz et al., 2015).

Finally, system interventions refer to strategies used to provide external resources, such as financial and human resources, needed by an organization to support staff and ensure a successful implementation. The principles and values of the intervention should be integrated into all the implementation drivers. If there is a lack of competency in one driver, it should be compensated (NIRN, 2021). For instance, if new staff did not receive any knowledge and training for TVIC, the organization should compensate for this lack by providing ongoing training for new staff.

#### 2.5.4.4 The Improvement Cycles

Continuous improvement is another important aspect of implementation. Experiencing implementation barriers such as lack of buy-in, inadequate training, lack of communication, and ineffective coaching is a natural occurrence during the implementation process. The AIFs apply Deming's (1986) Plan-Do- Study- Act (PDSA) improvement cycle to overcome these barriers. The implementation team identifies the existing barriers using multiple data sources while ensuring an equitable approach by including every concerned voice. In the Do phase, the plan will be carried out again by representing diversity in testing. Measures for process monitoring will be administrated, and data will be collected in the Study phase. Data in this phase should be gathered from multiple and diverse sources while paying attention to the contextual factors. In the Act phase, based on the data collected during the study phase, the appropriate modification will be applied to improve implementation (NIRN, 2021).

#### 2.5.4.5 Policy-Practice Feedback Loops

Another important stage in the implementation process is connecting practice to policy. The PDSA cycles are often developed to manage challenges on the practice level,

whereas the practice-to-policy feedback loops are designed to improve the implementation on a larger scale (NIRN,2021). The policy-practice feedback loops engage stakeholders and decision-makers to be informed about emerging barriers. Systematic barriers often prevent providers from fully integrating intervention principles into their practice (Fixsen et al., 2013). Therefore, as part of the implementation process, the implementation team communicates feedback based on practice experiences to decision-makers to ensure continuous changes and improvement (Metz et al., 2015). The policy-practice feedback loop must be applied to every level in an organization to ensure that the structural changes are built to support effective implementation and services changes (Metz et al., 2015).

#### 2.5.4.6 Implementation Teams

Often implementation in organizations ends with providing baseline training and referral to other online resources. The service providers are left to apply the new skill into practice with no further support. The dissemination approach rarely reaches full implementation. Thus, developing an implementation team is necessary to create accountability and provide active support in the organization. Having an implementation team complements the strategies developed by leadership and builds local and internal capacity during the implementation process. This team "provides an internal structure to move selected programs and practices through the stage of implementation" (Metz et al., 2015; p.417).

In addition, the weight of implementation usually is carried by one or two champions in organizations, decreasing the chance of fidelity and sustainability. When an implementation team is present, keeping the implementation alive will be divided among multiple individuals and various departments, increasing the likelihood of reaching the desired outcomes. (NIRN, 2021; Metz and Bartley, 2013).

**Table 2**

***Implementation team core competencies and functions (NIRN, 2021)***

| **Basic Functions of Implementation Teams** | **Ideal core competencies of an Implementation Team** |
|---|---|
| • Increasing collaboration and readiness<br>• Analyzing the strengths and needs of the organization<br>• Selecting innovations based on identified needs and root causes<br>• Installing and sustaining the implementation drivers (e.g., coaching, training, data systems)<br>• Assessing and reporting on fidelity, capacity, and outcomes<br>• Ensuring equity in the implementation<br>• Utilizing system change best practices<br>• Building linkages with external stakeholders, and partners<br>• Problem-solving and promoting sustainability | • Engage, collaborate, and build relationships with leadership and stakeholders<br>• Build effective teams through development and management<br>• Facilitate change through implementation, training, and coaching<br>• Analyze data for informed decision making and support complex change<br>• Understand the components of the selected program or practice, and the connection to outcomes |

### 2.5.4.7 Application of AIFs

AIFs have continued to develop into multidimensional frameworks and have been applied to various contexts in implementation research. For instance, Metz and colleagues (2012; 2014) applied the AIFs to improve service delivery for children and families involved in the child welfare system. Implementing AIFs as a framework enabled the implementation team to overcome organization and system barriers. Furthermore, the result of this study indicates that building active implementation teams and cross-sector leaders could increase the chance of a successful implementation.

More recently, AIFs have been used to implement effective and efficient pharmacy services in primary care to optimize medications outcome and improve patient health (Blanchard et al., 2017). While the components of AIFs were contextualized, applying the AIFs to frame and guide the implementation allowed the project team to achieve

desired outcomes, including successful implementation of the intervention and development of transferable implementation strategies and tools for similar contexts (Blanchard et al., 2017).

In a more recent study, AIFs were utilized to implement an intervention designed for working with youth with challenging behaviours. The authors suggested that applying the AIFs for guiding the implementation improved the process in multiple ways. The stage-based rather than time-based approach of AIFs was helpful because it respected the pace and speed of implementation and provided a guide for activities that needed to occur in each stage. In addition, AIFs assisted the implementation team in designing and developing training. AIFs also encouraged coaching at each stage to support staff in adopting the intervention. The establishment of implementation drivers and a policy-to-practice loop was another implementation support provided by AIFs that increased intervention fidelity. Monitoring intervention fidelity assisted the implementation team with identifying barriers and plans to overcome them (Pollastri, 2020).

AIFs have also been proposed to aid the implementation of an education program designed for young adults with an autism spectrum disorder. Given the complexity of working with autistic adolescents, a program that is comprehensive and inclusive is needed. However, implementing such programs requires frameworks and tools that support the implementation of a complex intervention in a complex context. AIFs were proposed as suitable frameworks to achieve this (Odom et al., 2014).
In the present study, the AIFs approach was proposed as an appropriate framework for studying the TVIC implementation process. AIFs pay attention to contextual factors and have detailed guidelines on facilitator activities and the core components of effective implementation.  Therefore, this study applied AIFs as a roadmap to explore the overarching question of how TVIC gets understood, initiated, and implemented in community-based social service organizations with a focus on how leaders and staff engage with, tailor, and deliver their services using a TVIC approach. Specifically, this study engaged in an in-depth analysis of select organizations to understand why and how they implement TVIC, with specific attention paid to contextual factors influencing decision-making.

# Chapter 3

# 3 Approach to Inquiry, Methodology, and Research Design

Multiple case study design was used to explore the implementation of TVIC in select organizations in London, Ontario, Canada. This study intended to understand how health and social service organizations become interested in TVIC implementation and what it would take for them to become trauma- and violence-informed. Multiple case study was a good methodological fit; it permitted me to explore and compare the TVIC in different cases and contexts (Yin, 2014). Multiple case study is a rigorous research method that is flexible and permits creativity in study design (Houghton et al., 2015).

In this chapter, I will present my research questions first and then my positionality as a researcher. Then I will provide an overview of multiple case study and interpretive description, discuss my rationale for, and approach to, using these methods, and outline how Active Implementation Frameworks (AIFs) provided the overarching framework for interpreting study findings. In the last section, I will detail my study's procedures. I will end the chapter by discussing the ethical considerations and rigour of the study process.

## 3.1 Research Questions

The purpose of this study was to understand how and why organizations become interested in TVIC and, for a selected subset, how organizations implemented TVIC in their specific context. The following questions were asked:

RQ1. How do leaders and staff within organizations come to understand the concept of TVIC for their service context?

RQ2. What structural, cultural, and practical changes are required to implement TVIC, and what factors enable or impede uptake?

RQ3. How does TVIC implementation impact organizations?

## 3.2 Researcher Positionality

Doing research starts with making assumptions about the outside world and using these fundamental beliefs as the philosophical ground for conducting research. Various schools of thought and research disciplines have developed methods and tools based on differing philosophical assumptions to guide researchers in the study process. Kuhn (1970) introduced the term *paradigm* to refer to shared beliefs and philosophical assumptions among a community of researchers regarding the nature of reality and knowledge production. In other words, paradigm refers to the researchers' worldview of reality defined by a specific scientific school of thought. Every paradigm offers a framework and multiple tools for conducting research and engaging in scientific inquiry (Morgan, 2014a).

Paradigms have different perspectives on ontology (how reality is defined), epistemology (how knowledge is created), and methodology. Researchers situate their philosophical assumptions about the nature of reality and knowledge production underlying their motivation to perform an inquiry. In this section, I will explain my philosophical beliefs, connecting them to the philosophy of pragmatism as the paradigm of use.

### 3.2.1 Pragmatism

William James first mentioned pragmatism in 1898 in a public speech. He developed the early concepts of pragmatism through his collaboration with Charles Sanders Pierce. However, what is called pragmatism today is very different, and pragmatism has continued to evolve. There are various adaptations of pragmatism; for the purpose of this research project, I stayed close to Deweyan pragmatism as an influential and research-oriented approach in social science (Morgan 2007).

Deweyan pragmatism (so named for American philosopher and psychologist John Dewey, who articulated pragmatism as a theory of social inquiry) has been discussed primarily as a problem-solving paradigm, mainly interested in what could work in a particular context. As the word *pragma* (meaning action) suggests, pragmatism is an action-oriented philosophy interested in practical outcomes of knowledge (Morgan,

2014b). I found the philosophical assumptions of pragmatism very aligned with this research project's purpose, as it was focused on understanding how the implementation process of TVIC could work in health and social services and what actions were taken in organizations that facilitated or prevented a successful implementation.

For pragmatism, the world is not static. It cannot be stopped and observed; it moves and changes through our interactions with it. Pragmatism rests on the argument that meaning cannot be assigned to an event before the event occurs (Denzin 2012; Morgan 2014a). Dewey was not interested in adopting a dualistic view of establishing the nature of truth. Instead, he "both acknowledges that perception is not a passive registration of the world outside but an active construction *and* that this construction 'refers' to reality -- or, to put it more precisely: that this construction *is* real "(Vanderstraeten & Biesta, 1998, p. 9). For Dewey, it is the essence of human experience that matters. Even though different experiences could potentially construct different realities, getting stuck defining what truth means in each context only adds to the complexity of research. The process of inquiry for Dewey contains what Morgan (2020) calls a dual process of reflection "first on the nature of the problem itself and then on the likely consequences of acting on the potential solution" (p.66).

Dewey's epidemiological work is embedded in transactional dualism, suggesting individuals and the world around them are in constant interaction through which knowledge is produced. The belief system shapes and evolves based on how we experience the world around us and interact with it. In other words, individual beliefs translate into actions, and consequently, the results of performing these actions could confirm or modify these prior beliefs. Habits are shaped through trial and error when we learn what works and what doesn't work in a practical context. This is how knowledge is generated, and learning happens. For Dewey, the metaphysical dualism of realism and relativism becomes irrelevant because the inquiry is treated as a daily experience performed by individuals when their habitual tendencies and behaviours fail to generate the desired outcome. Therefore, "the ultimate issue is not the truth or falsity of a belief but rather the consequences upon that belief" (Morgan, 2020, p. 66). For Dewey, research is a more structured and dedicated way of doing the same thing.

Moreover, even though pragmatism's philosophical assumptions are based on "what works," when we get past the emphasis on this practicality, we can see that pragmatism is also mindful of knowledge's context dependency. The interaction between beliefs and actions does not happen in isolation; their specific context directs these interactions. Even though prior experiences shape and inform actions in a situation to a certain extent, a similar outcome is not guaranteed. It is not just the sum of actions that matters; it is also essential to understand the required actions in the context. It is always possible that the same set of actions fail to produce the same result because all experiences are "both historically and culturally situated… [meaning] reasoning from past experience can only be fallible and probabilistic" (Morgan 2014a, p.2). Studying the implementation process of TVIC also invites us to explore the interaction between the intervention and its components within the context. This study was interested in understanding the "real world" implications of implementing TVIC as an evidence-informed intervention because interventions can evolve absent adequate knowledge about their implementation in different contexts. In other words, it is through the implementation that it becomes evident whether an intervention works or not. TVIC could evolve and be reshaped by interacting with its context, and through this interaction, the enabler factors that could facilitate this interaction also can become clear.

Another aspect of Deweyan pragmatism that was interesting to me was that pragmatism emphasizes the importance of context but refuses to choose between two extremes where the subject of inquiry is either entirely context-dependent or universal. Pragmatism recognizes the importance of a specific setting and seeks to understand how the outcomes of actions in a context can inform the best sets of actions in another context (Morgan, 2014b). Therefore, even though the results of this study are context-dependent, certain aspects of the findings could inform future organizations interested in implementing TVIC, and knowledge generated by this project could be applied to other contexts.

## 3.3 Research Methodology

### 3.3.1 Multiple Case Study

Multiple case study design, as described by Yin (2002), was used in this project. Yin's approach was aligned with my point of view and the purpose of this study for the following reasons: Yin (2002) defines a case study as exploring "a contemporary phenomenon (the case) in depth and within its real-life context, especially when the boundaries between a phenomenon and context are not clear, and the researcher has little control over the phenomenon and context" (p.13). Yin (2014) views case study to "cover contextual conditions" hence, the case study is a deliberate attempt to describe the case and the setting of the case concerning contextual factors (Cresswell et al., 2007). The case study design is well suited for responding to research questions that address the "how" and "why" aspect of studying a phenomenon because these questions are more exploratory and they "deal with the tracing of operational processes over time" (Yin, 2014, p.10).

The purpose of this study was to explore how TVIC was understood among health and social service organizations. It was also concerned with how it has been implemented, and what the contributing factors were in the process. Therefore, Yin's focus on contextual factors was helpful to illuminate what this study hoped to achieve. Other case study designs, such as Stake's approach, which views a case "as an object rather than a process" (Stake, 1995), are more appropriate to study specific programs or people rather than investigating events and processes (Yazan, 2015).

Moreover, Yin (2014) provides researchers with precise and well-structured strategies to design and conduct a study. He defines design as "the logical sequences that connect the empirical data to a study's initial research questions and ultimately, to its conclusions" and suggests explicit methods on how the research questions should inform the study design (Yin, 2002, p. 20). For Yin, the design's primary purpose is "to avoid the situation in which the evidence does not address the research questions" (Yin, 2014. P.26). Stake, by contrast, takes a more flexible approach toward study design (Stake, 1995). The base of this flexibility stems from his interest in the notion of "progressive focusing" borrowed from Parlett and Hamilton's (1972) assumption that research moves through stages that

clarify the problems and cannot be strategized in advance (Yazan, 2015). Even though this flexibility could be desirable for some researchers, it might confuse novice researchers because it creates uncertainty and ambiguity. Even expert researchers may need a roadmap that clarifies the steps in each stage of the research and how to navigate through a proposed timeframe (Yazan, 2015). Therefore, Yin's approach was more helpful for the purpose and scope of this doctoral dissertation study.

### 3.3.2 The Multiple Case Holistic Approach

Yin (2014) proposes four types of designs that could be applied for selecting cases, including single holistic designs, single embedded designs, multiple holistic designs, and multiple embedded designs. All these designs are interested in analyzing "the contextual condition in relation to the case" (Yin, 2014, p 14). A multiple case study is preferred when choice and resources allow it because the chance of doing a rigorous case study increases compared to the single case model, which is more vulnerable to limited analytical benefits (Yin 2014, Hawe 2009). In addition, single case studies are more suitable for extreme and unique cases that deviate from norms or for longitudinal studies interested in investigating the phenomena of interest over time (Yin, 2009).

Multiple case study is particularly suitable for understanding the uptake and implementation of interventions in diverse and complex contexts, allowing the researcher to explore a phenomenon both within each organization or "case" and across organizations/cases (Yin, 2014; Baker, 2011). Therefore, multiple case study was used to explore the overarching question of how TVIC gets understood, initiated, and implemented in community-based service organizations, focusing on how leaders and staff engage with, tailor, and deliver their services using a TVIC approach. Specifically, this study was interested in an in-depth analysis of select organizations to understand why and how they implement TVIC, with specific attention to contextual factors that influence decisions.

Lastly, the design of this study was holistic in contrast to the embedded design. In an embedded design, subunits of analysis would be selected within an organization, whereas in the holistic approach, the entire organization would be the unit of analysis. Since this

study was interested in the implementation process of TVIC across the whole organization, a holistic approach was more suitable (Yin, 2014).

### 3.3.3 Interpretive Description (ID)

Unlike other qualitative methodologies such as grounded theory and phenomenology, the multiple case study does not guide techniques and strategies for data analysis (Houghton 2015, Yin, 2002). Researchers conducting multiple case studies often work with a complex set of data involving both within (rich understanding of each case) and between case (finding similarities and differences between) analysis (Yin, 2018). To conduct a rigorous study, the researchers need to justify the analytical decisions made during the study process. The absence of clear guidance for data analysis could make analysis challenging, particularly for novice researchers (Houghton 2015). I applied interpretive description (ID) as a complementary approach to compensate for the lack of clear guidelines in multiple case study.

I chose ID because its principles and underlying philosophy were aligned with pragmatism and multiple case study as my methodology. ID is interested in ways of knowing that relate to the so what of the research process (Thorne, 2014). ID is applied and interpretive; deviating from traditional descriptive approaches by explicitly aiming to generate practicable knowledge. The importance of the applicability of research findings is also critical to the action-oriented philosophy of pragmatism (Thorne et al, 2004). Like pragmatism, ID is not interested in generating "an entirely original and coherent new truth," it is a "critical examination with the methodological guidelines" for understating the intended applications (Thorne et al, 2004, p.7). ID also encourages researchers to seek "expansion on that prior knowledge for some defensible purpose" and looks at data analysis as a "dialectic of inquiry along the lines of: What else might be happening here? What might we be missing? How else might we be thinking about this phenomenon? What other interpretive lenses might add value (or depth, or perspective) to what I am able to discern to this point?" (Thorne et al, 2004, p.15).

For ID, multiple constructed realities are "complex, contextual, constructed and ultimately subjective (Thorne et al., 2004, p.5). ID is interpretive, but Thorne emphasizes

the applied nature of interpretive research, providing direction in the interpretation process. The direction the researcher takes is "on the basis of informed questioning, using techniques of reflective, critical examination and which ultimately guide and inform disciplinary thought" (St. George, 2010; Thorne et al., 2004. P.6). This approach is what Holstein and Gubrium (2005) call "interpretive practice." It is concerned with "hows and whats of social reality" and curious about "how people methodologically construct their experience and their world, and in the configurations of meaning and institutional life that inform and shape their reality-constituting activity" (Holstein & Gubrium, 2005, p. 343). The results of the interpretive process are most valuable when it has application potential and informs practitioners, extends their available insight for practice decisions, and enables sense-making in the complex real world of practice (Thorne, 2004). This perspective was aligned with my intention to find indicators and practical strategies that ensure successful TVIC implementation. I engaged in an exploratory process with participating organizations to understand how they perceive TVIC and how they implement this way of thinking/behaving to their complex contexts. The multiple case study as a methodology is also interested in shedding light on the how aspects of the research process, bringing multiple case study and interpretive description together; this enhanced my ability to dive into my data to gain applicable insight for practice.

Also, ID is not prescriptive and encourages researchers to move beyond limitations imposed by adhering to one specific method. By using multiple approaches to data collection, researchers have the freedom to explore the research questions, and emerging answers, in more depth. Therefore, using ID as a tool for data analysis did not interfere with other methods I used. In the final step, I applied AIFs (see Chapter 2) as a lens through which I synthesized the findings in the established knowledge base. I will further explain this process in the upcoming sections.

## 3.4 Selecting Cases

Purposeful sampling was used in this study to select participating organizations. Purposeful sampling in qualitative research design has been widely used because it helps researchers identify and select cases that pertain to the phenomenon of interest. In addition, choosing information-rich cases ensures the effective use of limited resources

(Patton, 2002). This sampling method has also been extensively applied in implementation research design to develop a comprehensive understanding of select cases (Palinkas et al., 2015). Purposeful sampling leads researchers to work with both knowledgeable and experienced organizations, who are, more importantly, also willing to participate in a reflective manner (Bernard 2002).

Purposeful sampling is also aligned with what Yin (2014) recommends for selecting cases, i.e., that case selection procedures in multiple case studies should not be compared to sampling design in quantitative studies. Even though selecting multiple cases may resemble replication in sampling design, the underlying rationales for multiple case studies are different, and the researcher is looking for maximum variation. In addition, case studies are not suitable for investigating the prevalence of a phenomenon in a pool. Instead, each selected case should represent the phenomena of interest concerning its context (Yin 2014).

While purposeful sampling approaches are focused on identifying similarities and differences in the phenomenon of interest, different types of purposeful sampling could also serve other purposes (Palinkas et al., 2015). Some of these strategies, such as *maximum extreme case sampling*, are used to include a more extensive range of variation; and some of them, such as *monogenous sampling*, are used to narrow down the differences. *Emergent sampling* is often used to do both because the range of variation may not be well-known at the research project's outset. For theoretical saturation to occur, sampling and resampling of the new insight emerging from the data analysis are often recommended (Palinkas et al., 2015).

Even though emergent sampling is a useful technique, multi-methods sampling takes sampling methods further and allows new cases to be selected after data collection begins. It provides the researchers with an opportunity to choose other information-rich cases. In addition, *multiple stage sampling* aims to measure both the depth and breadth of understanding. In this method, in each stage, researchers choose different cases to capture both variation and similarity (Patton, 2001). Selecting cases in multiple case studies follows the same rationale. To decide how many cases are required in each category, Yin (2014) suggests that researchers make a discretionary decision rather than a formulaic one based on the desired certainty they would like to draw from the results. Furthermore,

even though case selection occurs at the onset of the study, it is open to change. Important discoveries could produce new insight during a study that may require reconsidering case selection and choosing alternative cases.

This study was interested in exploring TVIC implementation in local organizations in the community. Therefore, purposeful multiple-stage sampling was chosen as the method of sampling; this method of sampling allowed for choosing interested organizations while paying attention to the richness of the case. As the study progressed, more organizations became interested in taking up TVIC. Purposeful multistage sampling also created opportunities to add another information-rich case (the police service) in later stages of the study. In the section below, I provide the details of choosing cases in this study.

## 3.5 Recruitment

### 3.5.1 Phase 1

In the first phase of sampling, organizations interested in the implementation of TVIC were identified and then selected (sampling for similarity). The purpose of this sampling stage was to understand how organizations come to understand the concept of TVIC for their service context and if they were engaged in the implementation of TVIC. It was important to explore this because a successful implementation requires an in-depth understanding of the core intervention components. It ensures that the intervention is fully operationalized in the context before the implementation (Metz et al., 2015). The purpose of this stage was to clarify how a diverse group of organizations had been introduced to TVIC and what TVIC meant to them concerning their unique context and service delivery mandates (first research questions).

Led by Western's Centre for Research on Health Equity and Social Inclusion (CRHESI), in 2017 Western researchers and community organizations launched an effort to make London, Ontario, a "TVIC Community." To initiate the conversation, CRHESI convened a meeting in November 2017 of 25 interested health and social service organizations to discuss TVIC and its applicability to various community services. This meeting provided an opportunity for me to identify organizations interested in TVIC implementation. In the first phase, the CRHESI Steering Committee was asked to distribute an initial

recruitment email (Appendix A) to organizational representatives who had attended the November 2017 meeting. In the email, the representatives were invited to contact me if they were interested in participating or wanted more information. A one-page study summary was also attached (Appendix B). A reminder email was sent when necessary (Appendix C). Nine organizations consented to a brief interview, designating one person to complete it (N = 9). A Letter of Information/Consent (Appendix G) was sent to interested organizations and, upon consent, they were enrolled in the study. In this phase, a 20–30-minute interview (Appendix E) was conducted with the executive director or a representative of the organization (see below).

**Table 3**

*Participating Organizations in Phase one*

| | # | Type of Services | Stages of Implementation | Participants | Data |
|---|---|---|---|---|---|
| Phase 1 | 9 | - Settlement Agency<br>- Interpretation and Translation Service<br>- Employment Agency<br>- Public Health Unit<br>- Community Health Centre<br>- Police Service<br>- Mental Health Service<br>- Gender-based Violence Service<br>- Literacy Information Service | Exploration (Similarity) | ED, Coordinators, Managers | Brief Interviews Reflective Notes |

### 3.5.2 Phase 2

The first phase interviews with participating organizations provided the opportunity to estimate where each was in the implementation process. In phase two, the sampling focused on variation to identify and then select organizations in different implementation stages (Yin 2014). At the outset of the study, two organizations (a settlement agency and an interpretation and translation agency) presented in different stages of TVIC implementation (initial implementation and installation, respectively); they were invited to participate in the case study (sampling for variation). Several months later, another organization in the exploration stage of the implementation (a police service) showed interest in participating in this study. As per the above procedures, a short interview (phase one) was conducted, and then the organization was added to the list of selected cases for phase two.

In all three organizations, an email (Appendix F) was sent to the person interviewed in phase one, accompanied by a request that they consider organizational participation. Organizations indicating interest were provided with a Letter of Information/Consent (Appendix G) and, upon consent, enrolled in the study. Participation in this study was open to all staff involved in the implementation of TVIC within each organization. Organizational leaders were provided with sample text (Appendix H) that they could use to inform individual staff about the research and emphasize that participation in the study was voluntary. I participated in introductory meetings in the settlement agency and the police service on different days to make myself available to meet and discuss the study's details with the staff. Interested participants in these meetings were able to provide their contact information to participate in the study. I could not join the TVIC meetings in the interpretation and translation agency because the implementation did not progress due to financial constraints (reported below). To summarize, the organization was first invited (and consented) to participate as a case, after which key individuals were invited (and consented) to provide insights into the implementation process, as described below.

**Table 4**

*Participating Organizations in Phase one*

| | # | Type of Services | Stages of Implementation | Participants | Data |
|---|---|---|---|---|---|
| Phase 1 | 9 | -Settlement agency<br>-Interpretation and Translation<br>- Police services | Initial implementation<br>Installation<br>Exploration | ED, Coordinators, Managers | Brief Interviews<br>Review of documents<br>Field observations<br>Reflective Notes |

## 3.6 Data collection

The select organizations were the primary unit of observation, or "case," and data were collected from multiple sources to enhance credibility (Yin, 2014). Multiple data sources are used in several case study designs to improve the quality and credibility of data. The data collection took a holistic approach to understand the big picture by putting pieces together (Baxter & Jack, 2008). The case study design relies on exploring various evidence such as documents, artifacts, interviews, and direct observation, which gives this design unique strengths and abilities to explore the phenomenon from multiple angles (Yin, 2014).

The sources of data collection for this study included a) a brief interview (stage one, Appendix H) and in-depth (stage two, Appendix I) interviews with key informants (leaders and staff; Appendix L; b) reviews of existing and archival documents; C) field observation (Field notes, Appendix N) and reflective notes.

A) Semi-structured Interviews

Phase 1: Following informed consent (Appendix D), brief semi-structured interviews (20-30 minutes; Appendix E) were conducted with those who attended the CRHESI meeting or their proxy. These short interviews were analyzed to understand initial thinking and status regarding TVIC implementation and to identify case organizations for the phase 2. All the interviews were audio-recorded, with the participant's permission, de-identified, and transcribed by me.

Phase 2: Following informed consent (Appendix I), in-depth semi-structured interviews (Appendix L) were conducted, each approximately one hour in length at a time and place convenient to consenting participants. Two to six participants were interviewed per organization, depending on organization size and stage of TVIC implementation. Since my participation in the implementation process was limited to observation and occasional comments (when asked), these interviews explored specific implementation strategies, enablers, and challenges, deepening my understanding of TVIC uptake and implementation. After the first round of interviews, staff who were part of the implementation team were identified and interviewed. If something was unclear and more information was needed, participants were invited for subsequent interviews to assess the implementation process as it unfolded. An email (Appendix M) was sent to these individuals as an invitation to participate in subsequent interviews.

At the beginning of each interview, participants were provided with a letter of information, and informed consent was obtained (Appendix I). All the interviews were audio-recorded with the participant's permission, de-identified, and transcribed by me.

B) Document Review

Relevant documents were reviewed to develop an in-depth understanding of structural and cultural shifts due to the implementation of TVIC. In each organization, relevant non-confidential documents, such as meeting minutes, board or operational policies, practice guides or protocols, and assessment forms were requested for inclusion in the data set for each case.

C) Field Observations and Reflective Notes

Field observations (Appendix N) were conducted by assessing the physical environment and the general milieu (public spaces) to examine changes associated with the implementation of TVIC. I also asked to participate in staff meetings, training sessions/workshops that were relevant to TVIC implementation. Participation in these meetings provided an opportunity to observe how staff members and leaders work together to tailor components of TVIC for their context and client/patient needs. Organization leaders were provided with sample text Appendix J) that they could use to inform staff about the research and remind staff that a researcher would be present at a forthcoming meeting or event. No identifying information was collected or recorded at these meetings. A Letter of Information/Consent (Appendix K) was also prepared for recording data in meetings and workshops but never used.

Field notes were taken before and after observation sessions to explore the impact of the relationship between the researcher and participant/setting (Morse, 1989). These field notes were recorded as voice memos to help me with my thinking process and the development of new insight.

For all interviews, participants had to be 18 years or older, able to speak, read, and consent in English, and a staff member or leader of a participating organization.

## 3.7 Data analysis

As noted above, multiple case study is a suitable methodology for exploring implementation, but it does not provide methodological guidance for data analysis (Houghton, 2015, Yin, 2002). Since I applied Yin's multiple case study methodologies, I relied on his general approach to qualitative data analysis, including compiling, disassembling, reassembling, and interpreting (2016). I also used ID to inform my coding strategies, find patterns and interpret the findings. The disassembling, reassembling, and interpretation were done separately for each phase, but each followed the process described below.

### 3.7.1 Analysis of interviews, documents and fieldnote observations

From Yin (2016), the first stage in data analysis is compiling, referring to organizing data in a systematic way that facilitates data analysis. I started compiling my data using computer-assisted qualitative data analysis software (CAQDAS), Microsoft Office, and QSR NVio12 (REF). I categorized my data into two phases of the study, and under each, I stored relevant interviews, documents, and field notes (voice memos). At this stage, I also refamiliarized myself with my data by reviewing my field observations, meetings note, and via the process of transcribing my interviews, adding margin notes for new insights. After completing transcription, I again listened to the interview audio files before adding the text to NVivo. In this stage again, I created memos and annotations in NVivo emphasizing within and between case analysis (Bazeley and Jackson 2008; Houghton et al, 2015). I used NVivo's tools and options for coding, retrieval, creating memos, etc. where appropriate to enhance rigour (Bringer et al., 2004).

In the second stage of data analysis, disassembling, data should be broken down into smaller fragments. This often happens through assigning new labels or "codes" (symbolic meaning) (Yin., 2014). The coding process engages the researcher in deep thinking about their data and initiates the interpretation of data's meaning as a heuristic method of discovery (Miles et al., 2014). NVivo facilitated coding by allowing me to create parent nodes, child nodes (subcategories) and eventually develop "tree nodes" to see the hierarchical relationships between them. The tree nodes helped clarify my conceptual understanding and identify patterns in the later analysis stage (Bazeley and Jackson 2013).

After reviewing the research questions (Yin, 2014), I started the first round of coding, using short phrases or words used repeatedly by participants to create a codebook (Miles et al., 2014). For instance, many participants used terms such as "awareness" or "becoming aware" to describe their learning experience about TVIC. They also emphasized TVIC validated their experiences ac service providers. I used awareness and validating as codes to capture these ideas.

For the second round of coding, I again listened to the audio recording of my interviews and re-reviewed the documents, using holistic coding to apply a single code to a large data unit (Mile et al., 2014). The second level of coding was informed by interpretive description (Thorne, 2004). For instance, applying the ID lens assisted me in paying attention to what motivated organizations to move beyond TVIC baseline training and engage in the implementation of TVIC. This approach also helped me capture a sense of the overall content of my data and develop some ideas about the possible emerging categories. Table 5 below represents examples of some of the first level and second level coding.

**Table 5**

***Examples of the First Level and Second Level Coding***

| Words from interviews | In vivo (initial) coding | Holistic (secondary) coding |
|---|---|---|
| You got to think about things in terms of awareness, awareness raising first and foremost. | Awareness | Perception of TVIC |
| I think there's been a lot of awareness and reflection, which are all good things. | Awareness | Perception of TVIC |
| That was validating for some people that I think we do this, but they didn't know what it was called. | Validating | Perception of TVIC |
| Highlighted things that we had seen good workers already doing, but it was putting language and some consistency around those interventions. | Validating | Perception of TVIC |

I recorded new insights and ideas as analytical memos during the coding process (Yin, 2014). These memos were very helpful in the later stages of analysis, providing a multidimensional view of insights emerging from my coding.

In this stage of analysis, Yin (2014) suggests reassembling the data by looking for patterns by examining ideas and insight developed in the previous stages. I began this stage using questions about different events and recorded experiences in the database. I examined how the emerging patterns relate to the research questions and the similarities and differences between cases. The ID lens prompted me to consider how the implementation process progressed in each participating organization. I examined tree nodes to find patterns. These hierarchical arrays represented the data with the most concrete concept at the bottom end of the hierarchy and abstract concepts at the higher levels. The hierarchical array also pointed at different groups and the relationships among them. Yin (2016) also suggests using matrices as a valuable tool in articulating patterns. Matrices are often tables with rows and columns that could organize data to see how the different dimensions of data interact and find relationships between and among categories of data (Agnes, 2000; Averill, 2002). I found matrices particularly useful for both within and between cases analysis. I used Yin's narrative arrays (including direct quotes from data) as a strategy to explore similarities and differences between cases. For instance, in one of the developed matrices, I had organizations categorized in one column, the interviewee's role, and their responses regarding their understating of TVIC in the subsequent columns. Then I colour-coded the responses with the four main TVIC principles in mind. It was a very useful way to visualize the data and see how TVIC principles were embedded in each organization's understanding of TVIC.

In the next stage of analysis, the researcher engages in the process of interpretation (Yin, 2016). I applied ID to engage in what Thorne calls moving from pieces to patterns (Thorne, 2008). After a long period of immersion and distance from the data and critically reviewing every aspect of it, I emerged from the reassembling stage with some tentative ideas and patterns that captured the bigger picture. These themes and patterns shed light on what was involved in the implementation process in each organization. The

final step in this process suggested by ID was to contextualize the results in the established knowledge. I applied AIFs to achieve these.

### 3.7.2 AIFs: synthesis

As the last step, I used AIFs as the overarching conceptual lens to map themes and patterns from the data with what these frameworks suggest for a successful implementation. This approach was aligned with the ID suggestion for generating useful and applicable results. For instance, I explored whether structural and cultural changes in the participating organizations were parallel with AIF implementation stages. AIFs were also used to clarify contributing factors to a successful implementation. The implementation drivers in each organization were identified, and their importance in a sustainable implementation was assessed. Although using AIFs provided an interesting framework to look for facilitators and barriers of TVIC implementation, I also attempted to go beyond the limitation of these frameworks and identify other factors that are equally important in the implementation process but haven't been discussed in the AIFs.

## 3.8 Ethical Considerations

Ethics approval was obtained from the University of Western Ontario Research Ethics Board (REB 111905R2). Participation in the study was voluntary, and informed consent was obtained from both organizations and individuals (see Appendix O, Example Letters of Information & Consent: Appendix G, Organizations and Appendix I, Individuals).

## 3.9 Trustworthiness and Authenticity

Trustworthiness and authenticity of the study and its findings were ensured by meeting the criteria proposed by Schwandt, Lincoln, and Guba (2007) including, credibility, transferability, dependability, and confirmability.

Schwandt t al. (2007) suggested multiple criteria for aching credibility. Prolonged engagement and persistent observation were achieved by spending more than three years in the field with the participating organizations, attending meetings, reviewing key documents, and observing the development of their thinking about TVIC and progression

of TVIC implementation. Triangulation was achieved by collecting multiple data sources and cross analysis to ensure the confirmation of findings. In addition, different perspectives and points of view were gathered to present a complete picture of TVIC implementation. Informal and formal peer debriefing was conducted through various ongoing discussions with my dissertation supervisor and committee members, colleagues, and experts in the field. Member checking was achieved through collaboration with the participating organizations to present the findings in a conference and three book chapters.

Transferability, via "thick descriptive data," (Schwandt et al., 2007) was achieved in the Findings chapters by providing concise and appropriate details of the context. Direct quotes were included to enable alternative interpretations.

An external audit is required for achieving dependability and confirmability. Schwandt et al. (2007) suggest "that part of the audit that examines the process results in a dependability judgment, while that part concerned with the product (data and reconstructions) results in a confirmability judgment" (p.19). I used different tools to enhance the dependability and confirmability of this study; the former by outlining and providing recognizable details about decisions made throughout the data collection and analysis, and the latter by using audit trail and reflexivity. I recorded memos (audio and text), kept a reflective diary from the beginning of the data collection, and continued throughout the data analysis. I recorded how decisions were made through the process of study. These reflective notes also assisted me in developing final themes and patterns. In addition, meetings with my dissertation supervisor and committee members were recorded, and notes were taken to keep track of the study progression. NVivo complemented the process by allowing for running different queries. For instance, running text or concept queries helped ensure that the selected concepts were not limited to one interview and reflected in other interviews and documents.

# Chapter 4

# 4 Findings (part A)

This study includes two phases. In this chapter, I will present the findings of phase 1, and in the next chapter, I will discuss the findings of phase 2. In phase 1, I interviewed representatives from nine organizations in London interested in the implementation of TVIC and explored their understanding of TVIC and its link to implementation. Based on the AIFs, implementation includes four stages. The first, exploration, is a crucial step to build a solid foundation for the implementation process. A deep understating of the intervention helps clarify what to expect and how the implementation could potentially affect the organization. Articulating potential impacts, facilitators and barriers will aid the implementation team in anticipating and overcoming challenges. Many organizations expect to implement an evidence-based intervention in a "plug and play" manner. This expectation could end the implementation process in its infancy because the organization is not prepared to face the uncertainty and challenges that accompany the implementation of complex interventions. Therefore, this stage is crucial in setting expectations through careful examination of the intervention, the implementation process, required resources, and potential barriers (Fixsen et al., 2013). Organizations can then build connections with individuals or groups (purveyors) who represent the intervention and actively work with the organization to ensure successful implementation with high fidelity and desired outcomes (Fixsen et al., 2005).

## 4.1 Usable Intervention

In addition, when an organization identifies a potential intervention, it does not mean that every component will match their needs; context plays a crucial role in implementation logistics. The exploration stage includes adaptation considerations, and organizations need to outline the intervention components to assess the suitable aspects; they will then decide whether they can achieve sufficient fidelity to realize anticipated benefits. Clarifying the details of an intervention is an essential step because it can help the organization to use the intervention effectively and shift important, pre-identified outcomes. Mapping the intervention's core principles and strategies with desired

outcomes and expectations, and committing to intervention fidelity, must underpin implementation. This means organizations need to consider the potential fit between the target population, the organization, and available resources, with the program's key principles, underlying theories, and the proposed model. Furthermore, potential barriers such as funding streams, staffing patterns and required organizational, cultural, and structural shifts also need to be examined.

The exploration stage includes:

- Identification for the need for change (Assess needs)
- Learning about possible interventions that may provide solutions
- Learning about what it takes to implement the intervention effectively
- Developing stakeholders and champions
- Assessing and creating readiness for change
- Deciding to proceed

This section provides a comprehensive picture of the exploration stage among the five included organizations. Five out of the nine participating organizations were in the exploration stage and were included in this chapter (see table 6). Three of the organizations who were assessed to be in the later stage of implementation and, more concerned about sustainability and fidelity of the intervention, were excluded from this chapter. The last organization acted more as a link between organizations in the community that needed training on different subjects and training facilitators. They were familiar with TVIC training, but the implementation of TVIC was irrelevant to their context. Therefore, they were also excluded.

Participants in this phase were executive directors and managers. Besides interviews, reflective insights gathered from memos, field notes, and meeting minutes informed this analysis.

Findings are presented according to the following themes:

1) Motivation for implementation

2) Introduction to TVIC

3) Perception and understanding TVIC

**Figure 3**

***Phase 1-The Exploration Stage***

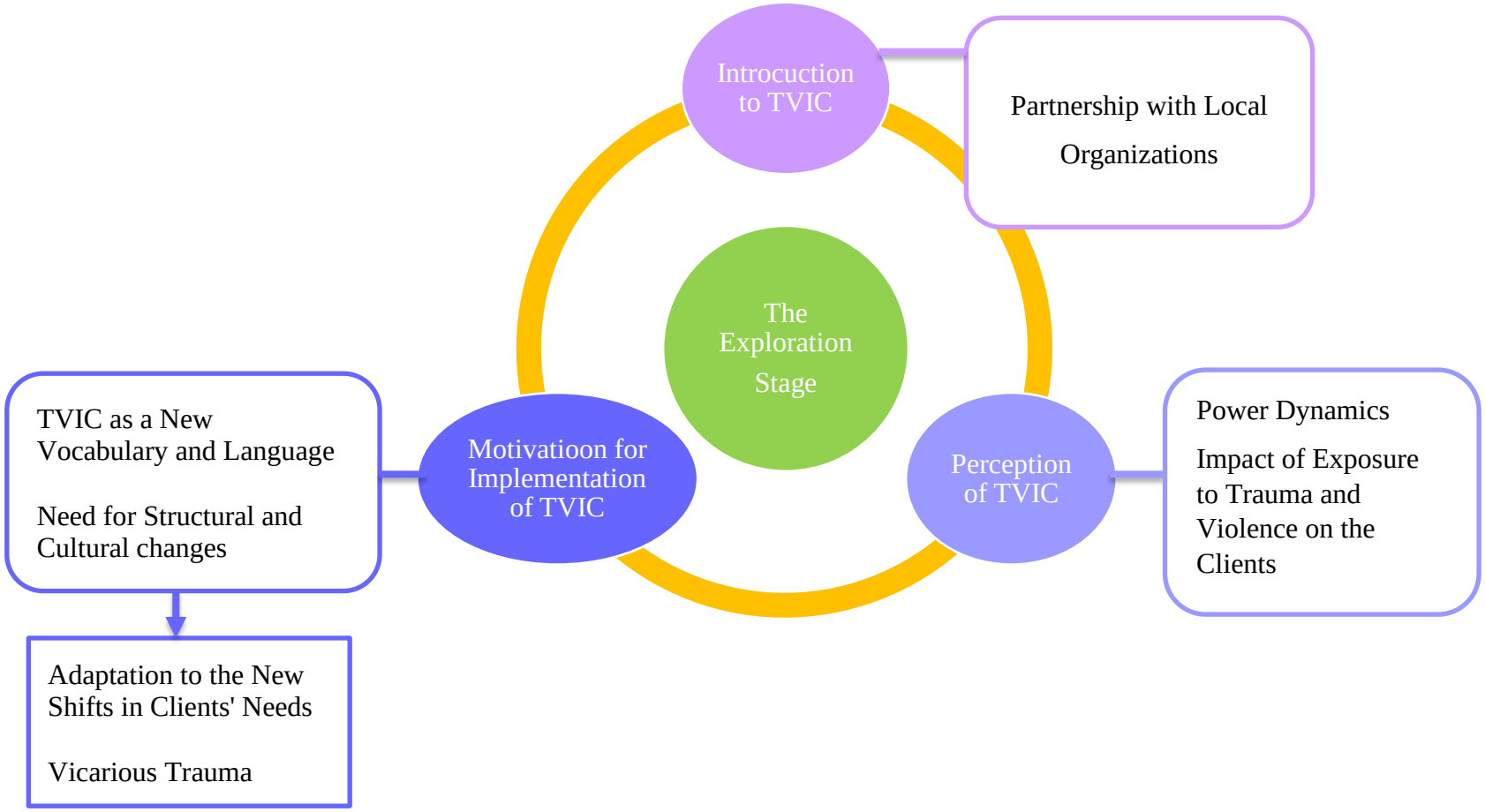


**Table 6**

***An overview of the participating agencies serving as cases for this part of the study*.**[1]

| Type of Organization | Participant Pseudonym & Role |
|---|---|
| Settlement Agency: facilities resettlement for newcomers and refugees | Kent, Executive Director (ED)<br>Sally, Capacity-building coordinator<br>Kia, Project and administrative coordinator<br>Jain, Wellbeing counsellor |
| Police Service | Bob, Superintendent of the corporate division<br>Roy, Administrative Sergeant<br>Sam, Administrative Sergeant of the Human Resource<br>Karen, Former police officer and Consultant (assisted the implementation team) |
| Translation and Interpretation agency: provides translation and interpretation services to the community | Anita, ED<br>Linda, Agency's training coordinator (her role should not be confused with the TVIC trainer) |
| Public Health Unit: provides public health services | Leila, Team Leader |

[1]Pseudonyms are used throughout to protect participant identity

| | |
|---|---|
| Community Health Centre: provides primary health care and community outreach services | Paul, Exertive Director (ED)<br>Anna, Director |
| Employment Agency: providing opportunities for employment | Kim, Coordinator |
| Gender, Trauma , Violence Knowledge Incubator | Sophia, TVIC Coach and Purveyor |

First, I will outline the factors that motivated organizations to become aware of required structural and cultural changes. Then I will discuss how these organizations were introduced to TVIC. To make the connection between motivational factors and their perception of TVIC more clear, I will analyze their understanding and perception of the TVIC principles.

## 4.2 Motivation for Change and Exploring TVIC as a Solution

Different motivational drivers could inspire an organization to implement change. In this section, I will discuss factors that motivated participating organizations to seek change. These factors were categorized into 1) need for structural and cultural changes and 2) TVIC as a new vocabulary and language.

### 4.2.1 Need for Structural and Cultural Changes

Overall, all the organizations in this study were interested in bringing implementing change. This interest mainly stemmed from encountering systematic challenges that prevented the enhancement of their service delivery. These systematic challenges could be categorized into 1) adaptation to the new client needs 2) staff well-being.

#### 4.2.1.1 Adaptation to New Client Needs.

For many organizations, structural and cultural shifts had become a priority to adapt to changes that were taking place in the community. New populations of refugees were joining the

community and an increase in poverty, addiction, and housing issues, to name a few, pushed more and more people to the margins. Anna, the director of a community health centre, believed that the culture and structure of her organization needed to adapt to these new realities. Anna said:

Our system isn't working … even though the system looks perfect from a North American white way of doing things. This is not north London, like people who are homeless cannot carry a card with them to be reminded of their appointments.

For Anna, the organization needed to change to recognize the reality of their clients' lives. There was a lack of cultural competency and flexibility in the system, which was operating based on a dominant "white middle-class" view, and was therefore unable to accommodate clients' unique circumstances, diverse backgrounds and needs. This lack of awareness prevented implementing change in the organization. She said:

> We were not reflecting on our system structures, processes [and] policies to accommodate to change that's in our hands to change, that's the easiest thing to change, so we were trying to fit the reality of the sidewalk as homelessness increased, drug addiction increased as the weather got colder to some policies we designed years ago based on the needs of a team that didn't exist in that configuration.

For Anna, if the required changes were perceived as a priority to improve the system, they were more likely to occur. However, the organization relied on policies and procedures that were out of touch with the current circumstances. The structure and policies created years before and based on other priorities now turned into barriers for implementing change. Anna believed the operationalization of TVIC, particularly at the policy level, could foster these changes by providing a new lens. She said "you don't want to manage in a way that there is a distance between your perceptions of reality and your team's perception of reality so this [TVIC] was something that we could all gravitate and create a shared reality". Anna felt that by implementing TVIC and increasing the awareness among staff of the health impacts of trauma and violence, the gap between different priorities in the organization could decrease. This shared understanding could lead to creating a match between service delivery and client needs. Therefore, the

leadership of the organization believed that TVIC could create a path toward structural and cultural shifts that were necessary for the organization.

Other participating organizations also felt that TVIC could become the vehicle of systematic organizational change. I interviewed Kim, one of the coordinators of another agency in the community that focused on providing opportunities for people facing barriers to employment. Kim emphasized that the agency's executive director was interested in becoming trauma informed because their organization needed to shift its current view of service delivery. Kim said:

> It is her [the executive director's] thought and vision to have the career centre be trauma informed and have the employment coaches work from the perspective of trauma informed. I mean at [organization's name] my boss has been very interested in trauma informed approaches and she wants to really focus on the career centre downstairs, so anything from when people come into the front desk, how even those individuals can work from a trauma informed perspective.

Agency leaders envisioned structural changes on all levels of the organization and hoped that TVIC implementation could create the opportunity for staff to apply new ways of thinking. Due to the nature of their service delivery, clients were often frustrated and in immediate need of finding employment. If unemployment was judged by staff as a lack of motivation and determination among clients, this indicated a lack of understanding of clients' reality and could be a barrier to providing appropriate services. But awareness of people's struggles could evoke a sense of compassion in the coaches. Kim said:

> We all go through really hard painful moments in our lives and just being more compassionate. There are lots of individuals who come in who are frustrated or angry or you know, operating from a different place and I think automatically people think oh they're just messing our resources or oh they are so ignorant.

Making connections with the clients and understanding how dealing with trauma and structural violence could lead individuals to marginalization and, in this case unemployment, could reduce

judgment and frustration among service providers. Therefore, implementing an intervention such as TVIC could enhance connections between service providers and clients.

Additional factors, such as the arrival of a new population of refugees and newcomers, made cultural and structural changes a priority for other organizations. The settlement agency had a long history of working with refugees; however, attending to the unique needs of highly traumatized individuals created new challenges beyond their expertise. Therefore, the organization started to investigate new ways of service provision and TVIC seemed to be a good fit. The executive director of the centre (ED), Kent, said:

> The TVIC approach is the best that we could do to engage our whole organization in a transformative journey, to really build that capacity to support clients with high trauma. Refugees come from warzone countries, refugees who have been through occurrences that, you know, we cannot even imagine.

Kent framed the implementation of TVIC as a transformative journey because creating structural and cultural changes in an organization takes time, a lot of self and team reflections, extra effort and resources. Nonetheless, TVIC could help the service respond to the uncertainty around working with new refugees, particularly Yazidi refugees with extreme levels of trauma. The organization was interested in increasing their knowledge about the health impacts of trauma and violence to improve staff skills. TVIC could also enable the organization to build new resources and increase its capacity to aid staff in providing adequate and appropriate services for their clients. Sally, the capacity-building coordinator of the organization, also believed the arrival of the Yazidi population created a unique circumstance for the centre to bring new changes into the organization. Sally said:

> It was good timing considering who our clients are. We have a huge subset of refugee population which the center always had in its 50 years history but recently the arrival of [the] Yazidi population which have extreme extreme trauma, sexual violence, human rights violation, so I think it was a new type of resettlement for the center. There is something distinctively different about this resettlement effort, given their pre-migration

> experiences. The resettlement became incredibly challenging just because of the extreme amount of trauma and then also to go through the resettlement period.

Sally's evaluation of the organization's ability to accommodate the Yazidi population is compatible with that of her ED, Kent. She also believed the needs of the Yazidi population were unique due to the nature of their pre-migration circumstances, and the organization required extra help despite years of experience working with refugees from around the world. Many of the Yazidi women had been captured, tortured, and sexually assaulted prior to their arrival. Many of them also had to leave their loved ones behind, making resettlement even more challenging. Therefore, the usual routines of resettlement in the agency were inadequate to meet the needs of these individuals, and extra resources and new approaches to supporting their re-settlement were required.

#### 4.2.1.2 Vicarious Trauma: Attending to Staff Need for Support

Providing care and support for staff was another motivating factor for many organizations. The compassion fatigue and vicarious trauma associated with working with highly traumatized clients led to feelings of burnout and prompted many organizations to provide extra support and care for their staff. Leaders believed that the implementation of TVIC was one way to commit to a culture of safety and well-being for staff. I interviewed one of the directors of a public health unit division focused on providing preconception, prenatal, and postpartum services. Nurse practitioners at the Nurse Practice Council became interested in bringing TVIC to their organization because they were aware of the insufficiency of their training in working with trauma and violence. They approached their team leader, Leila, to provide extra resources and training. Leila said:

> So that training [TVIC] was born out of two separate incidents that happened at the same time. Somebody on the Nursing Practice Council brought forward TVIC and indicated that this was something that the nurses were discussing and wanting to know more about, wanting more support in their practices and so at the nursing practice council, we talked about the values that will bring and what kinds of opportunities we might be looking at to provide some education and support for our staff.

The team collectively decided that TVIC was an appealing option for the organization to provide extra training and resources. Other managers of the division further supported this request and stepped forward to discuss similar needs and challenges. Leila the team leader said:

> Also, the managers within the division, so that's this division that's prenatal, postpartum and early years which TVIC has a huge impact on that. They came forward to the leadership team, to me and said you know this is something that we are feeling we need to build capacity for; people need to have a better understanding of this.

These requests came to the leadership around the same time, indicating the urgency of attending to the needs of the staff and providing adequate support for them. The prevalence of trauma and violence among clients was significant and structural and cultural shifts became necessary to tailor service delivery to clients' needs. Building capacity and support for staff was coupled with recognizing that organizational policy and procedures required re-evaluation and perhaps revision; therefore, TVIC became increasingly perceived as a good fit for the organization. Leila, the team leader said:

> Then the third thing is what I've also already referred to, which is this realization that we need to re -look at our policy that are related to domestic abuse and which is what we called at the time and get a better understanding of what direction we need to go related to IPV [intimate partner violence].

Other related issues, such as domestic violence and interpersonal violence, required structural changes in the organization. Since TVIC specifically addresses recognizing and responding to both structural and interpersonal violence, the organization became more interested in TVIC implementation to support their staff around these issues.

The settlement agency was also interested in improving staff well-being by providing extra resources and training for the organization; TVIC was seen as a viable option. Kent, the ED of the settlement agency, said:

> We should invest in our human resources, in our people, in our staff and make tangible investments in the staffs' well-being so they could provide better service to clients so it

> [TVIC] is key for our success which is supported by the board and then the management team.

Working with Yazidi clients was challenging for many staff at the settlement organization. The trauma stories were difficult to listen to, let alone to provide care. Many of the staff had been refugees themselves, with their own trauma histories. Therefore, working with clients with high levels of trauma was both difficult and re-traumatizing/triggering. The organization's leadership recognized that TVIC, with its emphasis on vicarious trauma and debriefing, was a good fit and an informative intervention for the organization to support staff. Kent said:

> Vicarious trauma concern grew out of that [arrival of the Yazidi population] and we definitely needed something to do and we wanted to do something that's effective.

Sally, the capacity-building coordinator and one of the champions of the TVIC implementation at the settlement agency, was also aware of the additional stresses associated with working with Yazidi refugees. She said:

> Going through this resettlement process with this community and trying to figure out, you know, what our role within it is, you know we need to be more trauma-informed and we are also not a mental health agency so the principle of trauma and violence informed care really works for us because it is not trauma specific services.

In addition, she recognized that her staff do not need to be experts in counselling and therapy; therefore, trauma-specific approaches were not what the organization was after. The staff needed to understand trauma, its health and others impacts, and the intersection of these difficulties with the structural violence embedded in the settlement process.

Serving the Yazidi refugees was also a challenge for the community health centre. They were aware of challenges arising from working with this population. Paul, the ED of the community health centre, said:

> We just create safety through flexibility and recognize that it's a reality of our work. Particularly I think being mindful of some of the providers that are working with

> populations like the Yazidi people, being very mindful from the very beginning that some of our folks were going to struggle working through that and they have such awful awful awful stories.

The traumatic events endured by the Yazidi refugees were still very alive and present. A lack of knowledge about vicarious trauma could result in significant and rapid feelings of burnout for the staff. Therefore, the community health centre tried to support their staff with enough flexibility and care such as extra days off, flexible hours, peer support and other resources. Anna, director of the community health centre, said: "we were aware of how our culture needed to change and this [TVIC] gave us a tool."

Implementation of TVIC became more desirable for the community health centre because it gave them a specific strategy to foster changes in the organization. Difficulties associated with the arrival of the Yazidi population were not limited to the settlement agency and the community health centre. Another organization in the community that provided interpretation and translation services also faced similar challenges. The Yazidi refugees' pre-immigration life and circumstances resembled the experiences of their own staff. These similarities brought back unresolved trauma histories. Linda, the training coordinator of the interpretation agency, said:

> So it took us awhile but we realized that interpreters who were being asked to sit in these situations, that were very tough for them at times, would bring up their own experience in a lot of ways with the recent group of Syrian refugees. We realized that interpreters that precisely were being asked to be in those rooms and interpreting situations that were very similar to their own and so how are interpreters coping with that?

Even though many service providers encounter similar issues working with highly traumatized individuals and groups, the interpreters face a unique challenge because they use the personal noun "I" when engaged in translation, hence embodying the story they were telling. This unique circumstance could bring back both previous traumatic events and magnify the fear and stress associated with the client's current experiences. Therefore, the interpretation session could quickly become very traumatizing for the interpreters, jeopardizing their ability to continue the

session. Linda went on to say: “They need to be aware that there might be something in me that could be triggered based on what I have experienced.”

Implementation of TVIC for the interpretation service seemed to be the right step toward creating awareness about the underlying mechanisms of trauma and its health and other impacts, Linda said:

> Why is it important to look at your trauma? What it can do in you if it is not something you work on. Right? The physical implications for an individual, so that is where I think interpreters will benefit from hearing about it. You should not be pushing it aside. You should not be thinking, oh I am strong I can deal with anything. Well yes. I can tell about your strength but you may want to look into that, right?

As I heard from those that I interviewed in many other organizations, there remains a perception that showing symptoms of vicarious trauma is associated with weakness. This view usually blinded the organization to the devasting consequences of exposure to trauma and prevented staff from seeking help. Linda from the interpretation service was interested in shifting this dominant narrative out of concern for her team’s well-being. She believed the implementation of TVIC could change the cultural narrative around working with trauma and motivate interpreters to feel supported when advocating for their own well-being.

The police service also saw the benefits of TVIC as a way to address problematic organizational culture. Specifically, police leaders wanted to implement TVIC to help shift mental health-related narratives in a culture that encouraged members to toughen up when encountering difficulties. Bob, the superintendent of the corporate division, said:

> I think there was really two different ways that we came became interested in trauma and violence informed practice and I think the first one was a recognition that our members, their mental health and well-being was being seriously impacted in some cases through exposure, vicarious exposure to violence and trauma and so there was a recognized need to learn more about that.

The focus of the implementation of TVIC for police was to inform staff about the impacts of trauma and violence and provide staff with care and support. The organization was confident that learning about trauma and violence would also enable staff to become more aware of the prevalence of trauma and structural violence in the community and apply the TVIC principles in their service delivery.

### 4.2.2 A New Vocabulary and Language

In the AIFs Exploration stage, organizations also examine whether the new intervention could be operationalized and would be acceptable to staff. For many organizations in this study, TVIC could provide an evidence-informed best practice model to which staff could relate. In addition, for the leaders of the organization TVIC implementation could potentially offer a new vocabulary and enable communication in the organization in new ways.

Anna, director of the community health centre explained how implementing small changes that could benefit their clients faced resistance. For instance, when she tried to make a small change in their schedule to open the entrance doors for clients earlier than usual, especially during winter, her staff resisted the change. Paul, the ED of the organization, described keeping the clients outside in the cold as a form of structural violence, validating and affirming Anna's request. Anna said:

> So, I'm explaining this to Paul where I'm sharing my grief over my inability to do this, and Paul says you know this is structural violence and I'm celebrating not because we are practicing structural violence, but I think this might just be the word and it's exactly what allowed us to move this forward once we named it locking people out on the sidewalk.

There was a sense of validation for Anna that her request for change was, in fact, targeting a form of violence embedded in the organization's structure. A TVIC lens allowed the problem to be understood and named in a new and powerful way. By providing a framework and much-needed vocabulary, TVIC created movement in the organization and increased the readiness for change in staff. Anna said:

> How the academic academizing [of] the concept is making a big difference because it's work we've done for years, but when the academics started dealing with it as with everything else that we have done in our lives then they give the vocabulary to address certain things in a more formalized way.

TVIC's proven-effective and clearly articulated principles and strategies also "academized" and provided scientific evidence for the leadership to manage and direct the organization in a more structured way.

## 4.3 Introduction to TVIC

In the previous section, I discussed the motivational factors that sparked an interest in organizations to implement TVIC. In this section, I discuss enabling circumstances that could initiate or perpetuate implementing TVIC in the exploration stage.

### 4.3.1 Partnership with Local Organizations

In this study, all of the organizations interviewed were introduced to TVIC through various kinds of relationships with other local organizations, and/or with Western University. Many of the organizations attended the meeting convened by the Centre for Research on Health Equity and Social Inclusion (CRHESI) (discussed in the Method chapter) held as one step in making London, Ontario a trauma- and violence-informed community. The meeting acted as an introductory session for some organizations, and for others was an opportunity to engage in further conversation about the implementation of TVIC. These conversations mainly involved partnering with those who were pioneers in the implementation of TVIC. Also, some organizations connected to our team of Western University researchers and showed interest in participation in the present study. For instance, the executive director of the community health centre, Paul, was introduced to TVIC for the first time at this meeting and brought the idea back to the centre's leadership team. As Paul, the ED of the community health centre said: "I went to a TVIC workshop and so that's how I became aware of it then I came back and talked to Anna".

The public health unit had their first TVIC training by researchers from Western's Gender, Trauma & Violence Knowledge Incubator (GTV Incubator) prior to the CRHESI meeting;

participation in the meeting confirmed TVIC as the right fit for the organization; as Leila, the team leader at the public health unit, said "a confirmation and then and also some, you know, conversations with you about the potential for this research study and the intention as an organization to be looking at that [TVIC implementation]". The CRHESI meeting also provided an opportunity for me to discuss my research project with the interested organizations to investigate the implementation of TVIC further. The settlement agency also indicated that their interest in the implementation of TVIC was initiated at the CRHESI meeting. Thus this meeting initiated the settlement agency's exploration stage, prompting them to contact our team of TVIC experts at Western University. They also partnered with a local mental health organization in the community, which has pioneered the implementation of related trauma-informed approaches in London. Kent, the settlement agency's ED, said:

> It was just the confirmation of what I was looking for. I was aware of the [mental health organization's] journey, so we were interested in working with them to do what they did. And even before, the meeting that was just a confirmation that we really need to engage as soon as we can.

The settlement agency had a long-term partnership with the mental health organization, and the person who had championed their trauma-informed work. Sophie was well known in the community, and a founding member of the GTV Incubator – precisely to bring academic research and thinking to what community experts saw as a huge need in their services, especially the need for people to provide training and implementation facilitation. The settlement agency was interested in modelling the success of the mental health organization's TVIC implementation - knowledge based on community relationships and trust. When Kent, the settlement agency ED, saw the same concept [TVIC] championed by the researchers from Western University, this added to the validity and credibility of TVIC as a good fit for his organization.

Partnership with the mental health organization was not limited to the settlement agency. Police services also were introduced to TVIC through their partnership with the same organization. Bob, the superintendent of the corporate division said:

> We became aware of the activities of [mental health organization] in regard to violence and trauma informed practice, and that's where we learned a little bit about it and how it would be maybe a good fit for our police service.

The mental health organization, led by Sophie, was open to sharing their experience and expertise with other local organizations and guiding them through the implementation process, creating a unique opportunity for organizations interested in implementing TVIC.

There were other local committees and programs in the community interested in related goals, such as reducing violence against women and children. Most of the organizations in this study were active participants in these committees and were introduced to TVIC through their involvement. For example, the translation and interpretation agency was introduced to TVIC through their involvement with local organizations to reduce violence against women and children. The executive director of the agency said: "I'm an active member of the executive committee of the London Coordinating Committee to End Woman Abuse so trauma and violence informed conversations happened at that table". This agency also later partnered with the mental health organization to initiate a TVIC implementation.

## 4.4 Perception and understanding TVIC

In this section, I will discuss the organizations' perceptions and understandings of TVIC in relation to implementation considerations. Two overlapping themes emerged from the analysis: 1) understanding the impact of trauma and violence on clients; and 2) power dynamics.

### 4.4.1 The Impact of Trauma and Violence on the Clients

The organizations leaders interviewed in this study were aware of their clients' challenges, but TVIC enhanced their understanding and shifted their thinking regarding how to provide care for everyone, especially those with trauma and violence experiences. For instance, the settlement agency had been working with refugees and newcomers with severe trauma for a long time. Still, they remained uncertain about distinguishing between trauma-specific approaches and establishing a safe system mindful of the health impacts of trauma and violence across all clients and providers. TVIC offered a universal approach to trauma and violence suitable for everyone,

without the requirement of expertise in trauma therapy. Sally, the settlement agency coordinator, said:

> I think I understand it [TVIC] as a universal approach and something that anyone and everyone can do. I think that is usually the way that I explain it and working with [the mental health agency] and a lot of stuff that we have done with them it is just the difference between being trauma informed and trauma specific. It helps people switch from having to figure out people's diagnosis or things like that, so just to be using some of those principles that can be incredibly effective and removes that sort of feeling that you have to sort of be everything and do everything. It is a tool.

TVIC thinking allowed staff to be comfortable with their uncertainty about trauma and eliminated the need to "cure" trauma symptoms. Staff learned effective strategies and helpful tips for approaching trauma that could be applied in moments of tension or uncertainty, such as understanding dissociation and lack of affect as trauma-related symptoms rather than perceiving clients as ungrateful and demanding. Consequently, integration of TVIC in practice enabled staff to reinterpret the notion of "difficult clients" and be more open to approaching their clients with compassion.

TVIC principles also created awareness about the implications of normalized and well-established behaviours and practices that could fundamentally be harmful. Anna, director of the community health centre, said:

> Allowing the system to impose on whether someone gets served or not so anyone like a middle-class middle whatever, white man being terrified that they are infected with something and they are married with children, and I don't know they may be even the priest so how does confidentiality look like when we yell [in the waiting area] who are you here to see?

TVIC encouraged each organization to review its established practices with a new lens. Sometimes what the organization viewed as functional actually did more harm than good, and the question became "functional for whom (staff, the organization, the system, or service users)?". Also, some organizations learned about the lingering impacts of exposure to trauma and

violence and their sometimes-invisible presence in their client's lives. Paul, the ED of the community health centre, said:

> My understanding is that the appreciation that we are serving people's life stories that the way that we provide care could revictimize people based on whatever their life experience is being very mindful in how everything from how we greet people at reception to how we provide care, being mindful that we could trigger experiences that are very traumatic based on violence either violence for individuals or based on violence of the system and how the system has interacted with people.

TVIC thinking highlighted the importance of looking at the bigger picture when providing care, rejecting the dominant reductionist view of breaking people down to their symptoms or body parts. Understanding the impact of trauma and violence as an embodied experience with broad physical, mental, and psychosocial impacts enabled Paul, the ED of the community health centre to move beyond the visible issues and be mindful of the whole story. These life stories usually included both experiences of traumatic events and a life journey of dealing with structural violence such as racism, discrimination and stigma. Paul believed this reality should inform service delivery on every level of the organization to reduce the possibility of re-traumatization, and improve client care experiences and outcomes, by taking a client-centred approach. He said "It requires us to really put the people we're serving at the centre and being very mindful of how we are practicing in a way that doesn't do more harm than good".

Being a nurse and having a public health lens, Leila, the team leader at the public health unit, saw a close connection between the concepts of person- or client-centred care, and TVIC. She said "I think I see a very strong interconnection with client-centred or person-centred care which has been something that has been a strong focus within public health for some time so that's a very easy connection for us to make". Leila also believed it is essential for staff to have a fundamental understanding of multilevel health impacts of exposure to trauma and violence in their interactions with clients. She said:

> From my perspective trauma and violence informed care in public health is about ensuring that we have a solid understanding of trauma and its incidence, its effects, the types of trauma, that we understand how it can influence people in the decisions they make in their lives and that we have a strong understanding of how it impacts their health at all levels whether it's physical, emotional, spiritual.

Clients with a trauma history are more likely to see things as threats and their priority is safety. Leila believed that increasing staff knowledge of trauma and violence could change the interpretation of clients' behaviours and make it easier for staff to see alternative explanations.

Anna, director of the community health centre, urged her staff to expand their views on trauma and violence even further by encouraging them to see beyond their initial presumptions. She said:

> Sometimes trauma and violence are easy to assume because of historical concepts or the experience of the person coming from another country, so we know when a refugee who comes from a war country then there is an assumed knowledge even though we really don't know how that [trauma] changes an individual or their perception of the reality and that's what we're most interested in.

Anna, director of the community health centre, was aware that exposure to trauma and violence is experienced differently by different people and leaves unique invisible markers on their minds and bodies. Therefore, she was interested in basing service delivery on recognizing these unique needs rather than "assumed knowledge." She said, "it is not whether we think we're right or we do the service right. It is how it's perceived given where the person is at" Providing care meant pushing beyond established care protocols and tailoring care to the particular needs of an individual by demonstrating a willingness to attend to "what is not in front of us."

Anna also emphasized that there are presumptions that are harder to detect for clients that she called "the less obvious". She said:

> A person who is dealing with addictions, it's obvious. A person with mental illness of course often is more visible, a newcomer, an immigrant is more visible, and they usually

> have an interpreter with them. There is that gray that we need to do to develop some organizational wisdom to reflect on the gray.

Looking at someone with an addiction problem and assuming they have experienced trauma and violence is essential. But what Anne is pointing at here is how TVIC could broaden this understanding even further by encouraging the system to be more sensitive to the gray area. Anna said:

> An example of the gray area would be a white woman speaking perfect English dealing with excruciating poverty, no shoes for the kids to go to school, was beaten the night before and you have no idea because there is no sign. As a system I think we were used to signs and symbols and not reflection, so how can our approach be naturally sensitive and flexible to accommodate for that?

For Anna the less obvious and the gray area referred to circumstances that were more difficult to detect and could go unnoticed. Having a TVIC lens meant being able to 'see' trauma and violence when there are no obvious signs. When TVIC is implemented in an organization as practicing 'universal precautions,' providers don't require specific trauma or violence disclosures from clients to treat them with respect, safety and compassion. The requirements for providing appropriate care are already embedded in the system to cover the obvious, the not obvious, and the gray area in between.

Finally, Leila from the public health unit believed TVIC encouraged organizations to take a strength-based approach and promoted client participation in service planning. She said:

> We then take that understanding [of TVIC principles] to inform and influence how we engage with people, how we work together to help them identify their strengths and work at whatever area we're working with them. It impacts our messaging, it impacts the interventions that we choose, how we choose to do those interventions, where we choose to do [them].

Implementation of TVIC was seen as a way to shift the interaction with clients at every step from the moment of greeting them on arrival (or even before, in how the arrival area was prepared, or

when the door was unlocked). TVIC did not prescribe a formula to be applied for each client, rather it encouraged creativity and openness to listen to client's needs, trust their strength and resiliency, and engage them in shared decision making.

### 4.4.2 Power Dynamics

Improved knowledge about the impact of trauma and violence on individuals encouraged organizations to investigate the power dynamics between service providers and clients. Even though service providers intended to help, a lack of awareness about the implications of harmful normalized behaviours increased the possibility of client re-traumatization. Anna, director of the community health centre challenged even benevolent behaviours, such as certain expressions of sympathy, versus authentic empathy. She said:

> It is a different kind of empathy. We use empathy all the time… there's always that privileged educated, often white provider in a formal system that has a good payroll, and I think even though empathy is used as a term in this work for us empathy had to be challenged because this kind of empathy required the provider to have the humbleness and the capacity to reflect on what they're doing not being right because we are a culture of professional, registered professions, and this way of working challenges that sometimes because it's the only way you can be received by a person that is vulnerable.

Anna suggested that the notion of the service provider as the expert should be questioned even when expressed with good intentions. She believed that when providers hide behind their professional credentials and fail to acknowledge the expertise of clients in their own lived experiences, and coping strategies, this can be very disempowering, and potentially re-traumatizing, for clients, especially those with experiences of poor service in health and social care systems. However, when providers were ready to examine their own position of power and shift to a shared or balanced approach, including active listening and authentic choice and control for clients, they could create a safe environment by being open to alternative ways of providing care tailored to clients' needs. Sally, in the settlement agency, also comments on how understanding TVIC could help providers to shift their judgmental attitudes about clients and understand them better. She said:

> There are a few components. One … is [that] our approach should be trauma informed. That means starting with the language not to re-traumatize the clients starting with rather an understanding than a judgment, starting with the fact that you know humans sometimes have the tendency to blame the victim. If you meet a client who behaves in a certain way, we could also think perhaps the trauma is the reason why the client behaves that way. It's not necessarily that the client is just being obnoxious with our staff.

For Sally, TVIC meant finding alternative explanations for an otherwise difficult encounter with a client and encouraging providers to review their interpretation of the situation considering understanding trauma and violence, and their own power in these interactions. Kia, a manager working in the settlement agency, explained a challenging situation in which looking through a TVIC lens changed his interpretation of his client's behaviour. He said:

> When it comes to housing, it is getting really challenging to find apartments and houses for our clients to live in, right? Especially for large families it is very hard. I mean the rents are going up but also you cannot find any 3-bedroom places big enough to fit a family of eight, a family of nine, right and so the housing aspect of the work we have done has become really contentious because sometimes clients come back and they say they feel like they are being forced to take this unit that they did not really like because they want to live closer to their relatives. Let's say I'm just giving an example, OK? This place might be a good fit for them but like they sometimes they come in with so many requirements and they are very demanding too, right, but in this case like what is the best thing to do, do you get the work done and say no this is the place that we found. Unfortunately, you have to move out then because if you do not move out you cannot stay upstairs [the temporary resident] anymore because you have to make space for other people and, yeah, you cannot stay in the temporary condition but so, like, this obviously has an effect on the emotional well-being of the clients. There's like this kind of balance you have to go through when you're providing these services that the clients do not feel like they're being forced into taking an option that they do not really want, so these are kind of like I'm not saying that you're doing it wrong you're doing it right? I'm just saying that this is one of the complex issues.

When applying a TVIC approach, Kia was able to look at anger and frustration shown by clients as their need for safety. He was aware that experiencing trauma could leave individuals feeling unsafe; therefore, separating family members could have devastating effects on the well-being of his clients. He was also aware that resettlement routines such as temporary residences and housing issues were structural violence imposed on him and his clients by the system. He was willing to let go of his position of authority and work with his clients to find more accommodating alternative options.

Linda, in the interpretation and translation agency, also talked about these power dynamics. The interpreters had a unique position as they were the only people who could understand both sides of the conversation; therefore, they created the link between the client and the service provider. Linda said:

> We always tell the interpreters … that they have to understand, that they have to really digest the idea that in that room, they are the only person that understands absolutely everything happening. How I could be, again going back to that power dynamic, how I may be in a position to abuse if I am not careful with my place here. Right? We always want the interpreters to be quite aware and realize the singularity and the importance of their role.

Interpreters had a unique and powerful position that could be abused if they were not aware of these dynamics. Interpreters were the voice of their clients in a courtroom, in the hospital, and in a therapist's room, and any biased translation of information could jeopardize their client's well-being. Therefore, confidentiality and protecting client information were crucial to building a trusting and safe relationship with clients.

## 4.5 Synthesis of the Exploration Stage

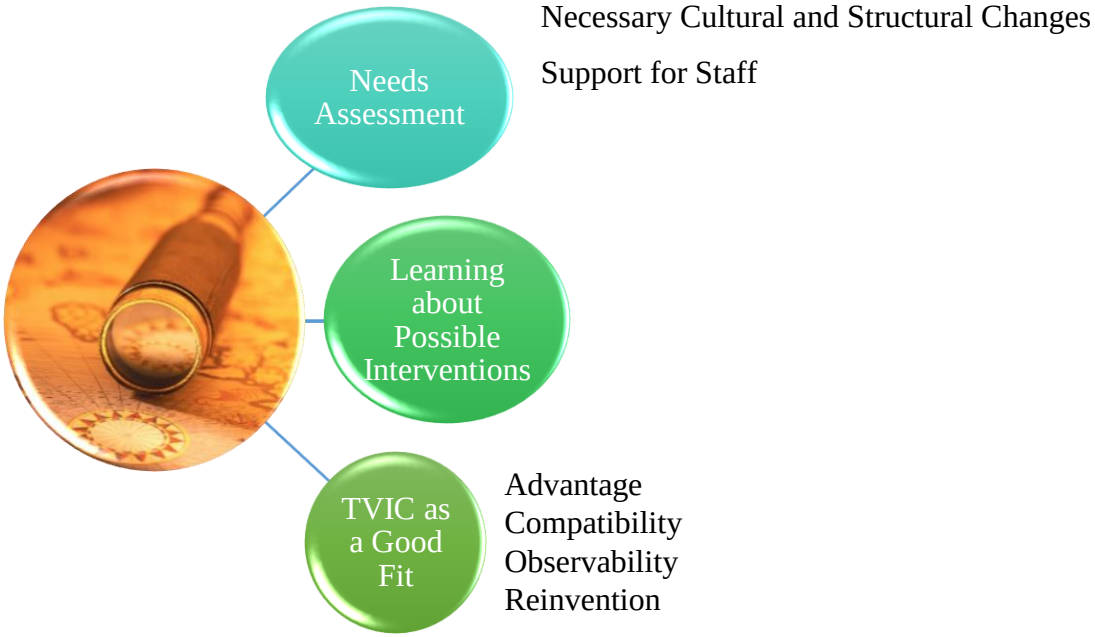
The exploration stage discussed in the AIFs is an important stage for organizations, as it determines whether they decide to proceed with implementing a new intervention. In other words, one of the main goals of the exploration stage is to determine the needs of the organization, find an appropriate evidence-based intervention that supports the desired outcomes,

and assess the required resources to enable the implementation drivers required to support the implementation process (Fixsen et al., 2013).

Since I mainly had one interview with the organizational leaders who participated in this phase of the study, the results do not cover all the main activities of the exploration stage. However, the findings provide valuable information on understanding how organizations engage in the exploration stage, particularly how these specific organizations identified their needs, learned about TVIC, and evaluated it as a good fit for their organization.

**Figure 4**

***Summarizes these key steps from the present data, which are then synthesized below.***



## 4.6 Needs Assessment

For the participating organizations, the exploration stage mostly started with realizing that necessary shifts were required in service delivery due to rapid changes in the community and in clients' needs. These changes resulted from external circumstances such as the arrival of the Yazidi refugees, who had and were continuing to experience extreme levels of trauma and violence and their impacts; the toxic street drug overdose crisis; and an increased level of poverty and homelessness in the city. There were also growing internal needs, such as the need to improve skills and knowledge within the organization about trauma and violence and attend to vicarious trauma and staff well-being.

The established structure of the participating organizations could not respond, for various reasons, to these needs, and sometimes outdated policies and procedures acted as a barrier for implementing change. Difficulty in communication with staff, lack of sufficient time and time-use flexibility, and funding issues were among these barriers. These internal and external pressures, in various combinations, led many of the organizations to search for innovations that could facilitate change. Advocacy for change in some organizations was a bottom-up approach initiated by direct service staff, and in others it was a top-down approach encouraged by the executive directors.

### 4.6.1 Learning about Possible Interventions

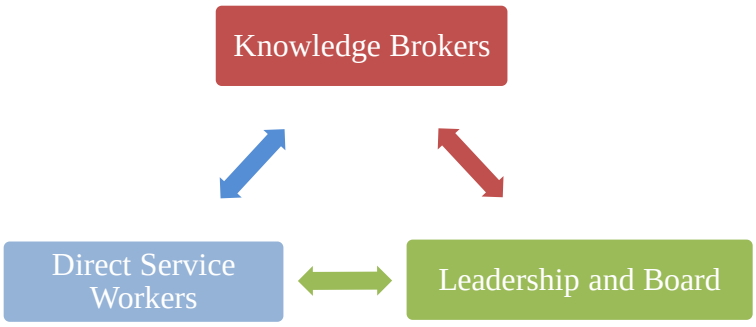
Two factors played essential roles in learning about TVIC: 1) informal relationships and/or formal partnerships with other organizations in the city; and 2) the collective decision made by the London community to become a trauma and violence informed community, facilitated by CRHESI (a community-university partnership) and key local champions such as the GTV Incubator and especially Sophia. Many organizations had longstanding partnerships with other organizations in the community that were pioneers in implementation of trauma-informed approaches, such as the mental health agency. Through these interactions, the organizations interested in TVIC implementation learned about TVIC and its impact on an organization, accessed valuable knowledge about the implementation process and eventually had the opportunity to be mentored and coached. In addition, the CRHESI meeting that specifically focused on promoting TVIC in London provided a chance for many of these organizations to

come together and sparked new interest in the implementation of TVIC. Our presence in the meeting as researchers from Western University also increased the credibility of TVIC as an evidence-based intervention.

Many of the individuals who became champions of the implementation of TVIC participated in this meeting and acted as knowledge brokers in their organizations. Knowledge brokers (KB) are individuals who are often aware of required changes in an organization and search for evidence-based interventions that could bring the desired outcomes to the organization (Dobbins et al., 2009). The KBs in this study – both those from organizations and from the GTV Incubator (including overlap in these – i.e., champions often came from or became members of the Incubator for exactly this work) usually initiated partnerships with other organizations with expertise and prior knowledge in the implementation of TVIC. Initial first steps of the implementation, such as meetings, planning and training sessions, were usually taken by these individuals. These champions usually worked as coordinators and capacity-builders in the organization; therefore, they had access to their Board, leadership and direct service workers and were able to create valuable links in the system (figure 4). When KBs had robust interorganizational relationships, they could advocate for the TVIC implementation and increase readiness.

**Figure 5**

***Displaying the Role of KBs in the Implementation Process***



### 4.6.2 Organizational Readiness

Creating readiness for change in individuals and organizations (discussed in chapter 2) is an essential step in the exploration stage (Fixsen et al., 2013).

The level of readiness at the point of interviews conducted in this study varied among the six participating organizations. One was not ready to start the implementation process immediately, as their processes and infrastructure were overwhelmed by other demanding tasks such as reorganizing the configurations of the departments and starting other new initiatives. Therefore, they were not prepared to take up another intervention (lack of general capacity). There was also a lack of connections with other organizations in the community and insufficient knowledge and skill needed for implementation (innovation-specific capacity) in another organization, that prevented further exploration.

Four other organizations had a higher level of readiness and were moving to different stages of implementation. In the next section, I will discuss the motivational factors that increased these organizations' readiness and made TVIC a good fit.

#### 4.6.2.1 TVIC as a Good Fit

Perception of an intervention as a good fit often increases the change-readiness of an organization, and multiple factors could contribute to this (Fixsen et al.,2005; Greenlagh et al., 2004). Here I discuss some of these factors in relation to TVIC implementation.

#### 4.6.2.2 Relative Advantage

Among participating organizations, TVIC was mainly regarded as an effective tool for management and a new framework for implementing change. As an evidence-based intervention, TVIC enabled the organization to implement necessary cultural and structural changes. When an intervention has a clear advantage, such as effectiveness or cost-effectiveness, it is more likely to be adopted. TVIC also provided a shared reality and common understanding across different levels in organizations that facilitated communication – i.e., new language for direct service staff to share concerns about care practices (e.g., re-traumatizing practices as "structural violence").

#### 4.6.2.3 Compatibility

When organizations find an intervention compatible with their norms and values, they are more likely to adopt it. TVIC's main principles and values were compatible with many of the organizations that participated in the study. They were interested in developing policies and procedures based on understanding trauma and violence and creating an emotionally and physically safe environment for clients and staff. Furthermore, TVIC provided training opportunities for staff to learn about vicarious trauma and its impact on their health and well-being.

In addition, TVIC emphasizes fostering trust, collaboration and connection between providers and clients, resembling the main principles of client-centred care already familiar to many organizations and providers. Other programs such as anti-oppression workshops and Indigenous cultural safety training also shared similar norms and values with TVIC. These similarities enabled organizations to link TVIC to their prior knowledge and facilitated learning.

#### 4.6.2.4 Observability

The arrival of the Yazidi refugees with their extreme levels of trauma was a motivational factor for implementing TVIC across at least three of the participating organizations (settlement service, interoperation agency, community health centre). Therefore, TVIC's focus on understanding trauma and violence was a clear and observable benefit for these organizations. If the benefits of an intervention are observable, and "quick wins" can be had, organizations are more likely to adopt the intervention. Creating a safe environment that was mindful of the health impacts of trauma and violence based on the principle of TVIC could support staff and build their confidence and capacity to provide more effective care. In addition, partnerships with other organizations in the community that implemented TVIC offered excellent examples, and role models, of the impact of TVIC.

#### 4.6.2.5 Reinvention

TVIC is highly tailorable to the needs of organizations. This is a desirable attribute for organizations because they are more likely to adopt an intervention when it is adaptable to their context. During the exploration stage, the organizations learned that the training and

implementation of TVIC could be tailored to their priorities and needs enabling them to add and eliminate what they required. For instance, the interpretation and translation agency was interested in changing the title of TVIC to "trauma- and violence-informed interpretation," adding specific tools and skills necessary for interpreters. The police service had difficulty connecting to the concept of care, as they don't see themselves as providing "care" per se; therefore, trauma- and violence-informed care became "trauma- and violence informed-principles." These organizations were able to take advantage of the flexibility of TVIC and modify it to what was most appropriate for their context, while still committing to the main principles of TVIC.

Following this exploration stage, three of the six organizations decided to implement TVIC. They were selected as cases for this study, and I will discuss the findings of the implementation process in these organizations in the next chapter.

# Chapter 5

# 5 Findings Part B

In this chapter, I will discuss the findings of phase two of the study, where I explored the TVIC implementation process in three organizations: a settlement agency, a police service, and a translation and interpretation agency. Each organization was in a different implementation stage when I started my data collection and moved through one or more subsequent stages as the implementation progressed. As discussed in previous chapters, the AIFs propose five interconnected frameworks that together represent the implementation process. Interactions between a usable intervention, effective implementation methods, and enabling contexts indicate the success of an implementation (Fixsen et al., 2010). In the previous chapter, I discussed TVIC as a usable intervention, the first implementation stage of exploration, and activities involved in this stage in participating organizations. Three of these organizations moved forward with the implementation of TVIC and engaged in the subsequent implementation stages, including installation, initial implementation, and full implementation. These stages are not linear, and an organization may return to the previous stages (Fixsen et al., 2005).

The **Installation stage** begins with creating and acquiring needed resources to move the implementation of necessary changes further along and incorporate the interventions' principles into service delivery. Purveyors and coaches work with the implementation team to establish essential competency and organizational drivers to foster the implementation (Fixsen et al., 2005. NIRN, 2021). The **Implementation team** encompasses the *Who* part of the implementation and consists of individuals who have the required knowledge and skills to ensure the sustainability and fidelity of the intervention. They select a usable intervention and address the structural changes required for supporting the new intervention. However, incorporating new interventions into the pre-established routines of an organization is not an easy task. Existing service delivery approaches, even if problematic, still feel convenient, and organizations may encounter resistance and push-back when implementing change. Therefore, evaluation and repurposing of established programs could facilitate the implementation and reduce interference with the new intervention (Bertram et al., 2015). The **Implementation drivers** are also formed in this stage and include the *How* of the implementation and three necessary factors for a successful

implementation: 1) staff competency drivers: providing staff support to use the new intervention; 2) organization divers: ensuring that the structural supports such as program, policies, and procedures for the desired implementation outcomes are available; and 3) leadership drivers: emphasizing current and future leaders' abilities to apply appropriate strategies when facing technical versus adaptive challenges. Ensuring the establishment of these implementation drivers is essential for fidelity and sustainability of implementation (Duda & Wilson., 2015).

**Improvement cycles** are also part of the *How* of the implementation process for initiating and managing change. An improvement cycle begins with goal identification and using the Plan-Do-Study-Act method, to achieve the desired outcomes. The implementation team applies the available information to *Plan* how they intend to achieve their goals. Then they set their plan in motion and enter the *Do* part. The impact of manifesting the plan is monitored in the *Study* phase. The implementation team gathers data and information to evaluate the impact of their actions. Finally, they act according to the data provided in the *Study* phase, and either continue with or modify, their actions. The cycle could be repeated if necessary (Duda & Willison., 2015).

In **Initial implementation**, practicing the new intervention begins, and its principles are integrated into the service delivery. However, the excitement of new ways of service delivery could be challenged by resistance to shifting the status quo and fear of change. Therefore, infrastructures placed in the previous stages play an essential role in providing structural and cultural support to overcome the resistance and move to full implementation. Support and encouragement from leadership particularly could have a positive impact in moving the implementation forward. Finally, **Full implementation** occurs when staff is comfortable enough with new service delivery and clients' satisfaction increases. Implementation drivers are fully established and supported. Ongoing and progressive evaluation becomes a routine in the organization to provide feedback for improvement(Bertram et al., 2015). Table 7 summarizes these key activities by stage.

**Table 7**

***AIFs Implementation Stages- Taken from Fixsen et al, 2005)***

| Installation | Initial Implementation | Full Implementation |
|---|---|---|
| • New service not yet delivered<br>• Develop implementation supports<br>• Make necessary structural and instrumental changes | • Service delivery initiated<br>• Data use to drive decision making and continuous improvement<br>• Rapid cycle problem solving | • Skillful implementation<br>• System and organizational changes institutionalized<br>• Measurable outcomes |

In the following sections, I explain the implementation process and the work undertaken in each organization, addressing the following two research questions:

1. What structural, cultural, and practical changes are required to implement TVIC, and what factors enable or impede uptake?
2. How does TVIC implementation impact organizations?

## 5.1 Overview of Case Sites

I interviewed individuals in various managerial roles in the three case organizations and discussed the TVIC implementation process in their unique context. I also participated in regular TVIC meetings in the settlement agency and the police service. The interpretation and translation agency had moved beyond the baseline training and was in the process of applying for extra funds to continue the implementation; therefore, the TVIC meetings were on hold. During these meetings, I collected field notes and recorded my reflective insights. The data gathered through these notes complements my analysis of the interviews in this chapter. Table 8 provides details of each site and the interviews conducted.

**Table 8**

***An overview of the participating agencies serviced as cases for this part of the study.*** [2]

| Type of Organization | Number of Staff | Number of interviews | Participant Pseudonym & Role |
|---|---|---|---|
| Settlement Agency:<br><br>Mission: facilities resettlement for newcomers and refugees, provides integration services and supports, and promotes intercultural awareness and understanding<br><br>Vision: A more welcoming community where newcomers can succeed<br><br>Organizational values: inclusion, compassion, empowerment, advocacy and | Over 100 | 7 | Kent, Executive Director (ED) – (2 interviews)<br><br>Sally, Capacity-building coordinator – 3 interviews)<br><br>Kia, Project and administrative coordinator – (1 interview)<br><br>Jain, Wellbeing counsellor - (1 interview) |

[2] Data from one of the participants in the settlement agency was excluded because they did not provide any relevant information.

| Type of Organization | Number of Staff | Number of interviews | Participant Pseudonym & Role |
|---|---|---|---|
| Police Service<br><br>Mission: to ensure the safety and wellbeing of the communities served.<br><br>Vision: to be respectful and responsive to the evolving needs of the community through a strategic and collaborative partnership.<br><br>Organizational Values: professionalism, excellence, integrity, inclusiveness, transparency, accountability, diversity and trust. | over 600 sworn members and 300 civilian staff | 4 | Bob, Superintendent of the corporate division-(1 interview)<br><br>Roy, Administrative Sergeant-(1 interview)<br><br>Sam, Administrative Sergeant of the Human Resource-(1 interview)<br><br>Karen, Former police officer and Purveyor (assisted the implementation team)- (1 interview) |
| Translation and Interpretation agency<br><br>Mission: provides translation and interpretation services to the community to reduce language barriers<br><br>Vision: assisting service providers, decision makers and clients to communicate accurately and confidentially with | 18 member staff and 60 interpreters | 2 | Anita, ED-(1 interview)<br><br>Linda, Agency's training coordinator (her role should not be confused with the TVIC trainer)- (2 interviews) |

| Type of Organization | Number of Staff | Number of interviews | Participant Pseudonym & Role |
|---|---|---|---|
| each other through qualified interpreters, translators and other language service professionals and services.<br><br>Other services include:<br>• interpreter training and certification<br>• Language testing and test development<br>• Voice talents and voice-over recording | | | |
| Gender Trauma and Violence Knowledge Incubator | | NA | Sophia, TVIC Coach and Purveyor |

In the **settlement agency**, I conducted interviews with the TVIC committee responsible for the implementation of TVIC and participated in their meetings from 2018 to 2019. At the onset of the implementation, I interviewed Sally, the organization's capacity-building coordinator. We had another conversation a year later, and the last interview took place online in April 2020. I interviewed Kent, the executive director (ED), twice at the onset of the implementation and then a year later. Two other committee members (Table 6) participated in one interview each after the TVIC baseline training. The settlement agency was in the stage of full implementation when I stopped my data collection. In the following section, I will discuss this agency in more detail compared to the other two organizations.

The second case in this study was a police service. I interviewed three members who were part of the TVIC implementation team and one purveyor (Table 6). These interviews took place approximately six months after the onset of implementation in March and April 2019. I also participated in meetings with the implementation team starting in Oct 2019, which continued beyond the original data collection period. Therefore, some of the insights I share in this chapter are informed by my continuous involvement in these meetings. At the time of writing, the organization had completed the installation stage, but the project has been paused while the implementation team and the partnering organizations consider starting the second implementation phase.

The interpretation and translation agency was the smallest organization among my cases, with an 18 member staff and 60 interpreters contracted as needed if there was an interpretation assignment in their language of expertise. The implementation process was slower, and the TVIC committee included only three members: the ED, the agency's training coordinator, and the TVIC trainer. I interviewed Linda, the agency's training coordinator, at the onset of the implementation in late 2018. I conducted the second interview with Linda and Anita, the agency's executive director, in March of 2020, right before the first COVID-19 pandemic lockdown (Table 6).

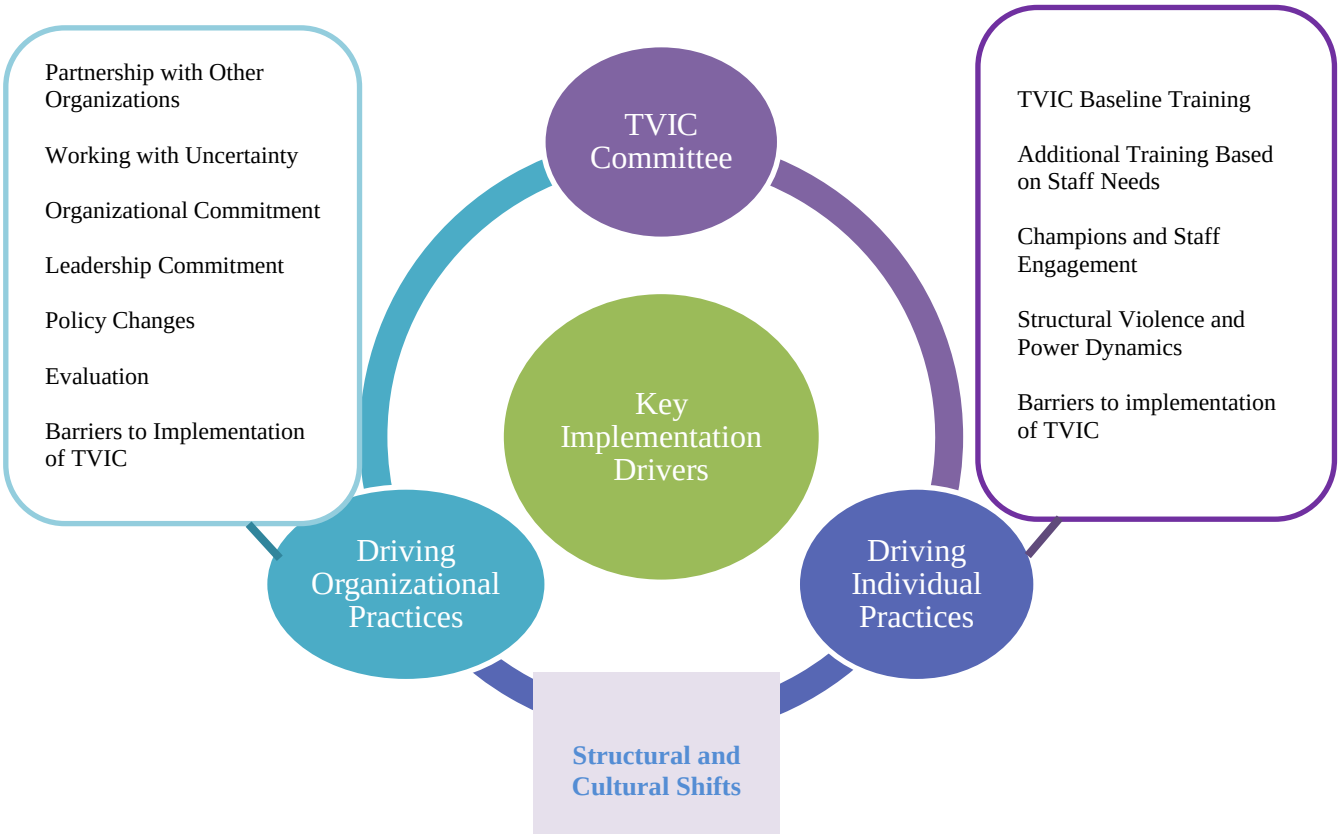
This organization completed the TVIC baseline training and was in the process of applying for extra funds to continue the implementation. I did not participate in any meetings or other TVIC-

related events in this organization. Although the ED invited me to become more involved with the implementation process during my second interview, pandemic disruptions, staff turnover, and a failed funding grant for the TVIC implementation meant an indefinite pause on implementation, effectively ending data collection for this case.

The participating organizations were all in different stages of implementation when I ended my data collection. The settlement agency was in full implementation; the police service was in the initial implementation, and the interpretation and translation agency was beginning the installation stage. Therefore, the volume of data I have from each organization differs. The settlement agency is the richest and most comprehensive case among the three, followed by the police service, and as noted above, much less was collected from the interpretation and translation agency. This discrepancy in the available data from each case is reflected in the analysis, though each case provides unique insights in terms of implementation processes. I start the following section with the formation of the TVIC committee in each organization and its contribution to the implementation process. Then I move to structural and cultural changes in each organization, both on the individual and organizational levels. In the final section, I apply the active implementation frameworks as a lens to understand the implementation process in these organizations and contextualize my findings.

**Figure 6**

***Key Implementation Drivers***




## 5.2 Key Implementational Drivers

### 5.2.1 TVIC Committees

The TVIC committees and implementation teams across cases were diverse in size, responsibility, and how they were constructed. Their primary purpose was to facilitate and support TVIC implementation. The initial implementation for **the settlement agency** started with forming a TVIC committee, including the executive director and the capacity-building coordinator. They invited managers and senior staff across the organization to be actively involved in the committee. Sally, the capacity building coordinator, said:

> When we started our committee, we had members from the whole agency. I think it was a great suggestion [from Sophie][3], and I'm happy that we learned that from them because if we didn't have members from throughout the agency, you sort of risk it being slanted in one direction and not actually filtering out throughout the agency.

The settlement agency is a large organization and includes multiple departments and sections. Sophie, the coach and purveyor, advised them to have representatives from all departments on the committee to ensure the involvement of the entire organization. Having a diverse committee enabled them to hear multiple perspectives and be aware of the specific needs of each department. Kia, the project and administrative coordinator, was enthusiastic about joining the implementation team and bringing TVIC to his department. Participation in the TVIC committee also enabled him to become a bridge between the staff in his department and the committee.

> I see my role as one of the committee members that whatever we discussed in the [TVIC] meetings, …, so I just take those issues to my department. This way, we would let everybody know about what we've been doing, and I take their feedback or any suggestions about any aspect of it [back to the TVIC committee] …. I do regular check-ins with them kind of because they are more front staff people. So, I tried to form a bridge between my department and the committee.

The participation of senior staff in these meetings created a point of connection and a feedback loop between the committee and other staff. The members of the TVIC committee were able to keep their department updated and connected to the initiatives brought forward by the TVIC committee. Also, having a member of their department on the TVIC committee created opportunities for staff to communicate their feedback and suggestions regarding the implemented changes.

[3] Sophie: the purveyor and coach from the local mental health agency, and the GTV Incubator who worked with all three organizations, in varying capacities, as a purveyor

In the **police service**, the TVIC committee was a subcommittee and part of a larger mental health and wellbeing committee initiated by staff and supported by leadership. Although the committee was established by the deputy chief, it was a bottom-up initiative from staff, and leadership involvement was limited to supportive roles. However, it should be noted that the culture and structure of police services are hierarchical, and staff regard their leaders as role models; therefore, the involvement of senior members was a significant implementation driver for the legitimization of the mental health and wellness, and consequently, the TVIC, committee. The mental health and wellness committee had members and representatives from across the organization to respect the diversity of their structure. Bob, the superintendent of the corporate division, explained the structure:

> The committee is made up of members from across the organization. It's a volunteer committee, and we wanted representation from the many different areas of the organization because of the different stressors and different impacts that policing and exposure to violence and trauma have on those different areas. We wanted to make sure that it was an equal mix of sworn and civilian members.

Even though the mental health and wellness committee was established before the implementation of TVIC, understanding the impacts of daily exposure to trauma and violence was a primary concern for the committee. They were also aware of the diversity of traumatic experiences across the organization. Ensuring staff participation from different areas of the organization provided a chance for everyone to be heard and contributed to equity. Three members of this committee formed the TVIC implementation team, joined by coaches and purveyors from partnered organizations. The coaching team included five members, four from Western University, and a former police officer, Karen, whose insight and feedback was invaluable to the implementation team because of her background and familiarity with police culture and structure. As a result, the TVIC committee/implementation team in this organization was similar to the settlement agency but significantly larger than the interpretation and translation agency and more involved in TVIC-specific decision making and guidance. While the sworn members-i.e., active service officers- were part of the mental health and wellbeing committee, they were not included on the TVIC committee. Their exclusion was not intentional

but an oversight that went unnoticed by the committee members. The exclusion of sworn members later surfaced as a problem, mainly when the committee planned the baseline training, discussed below.

The TVIC committee in the **interpretation and translation agency** was a small committee including the ED, the agency's training coordinator, and Sophie, the coach from the partnering mental health organization. The size of the organization and its structure played a role in forming the TVIC committee. The organization had 18 staff, including both part-time and full-time, and 60 interpreters. However, the interpreters rarely came to the organization and were only contracted if needed. Therefore, the interpreters were not aware of, or much involved in, the changes happing in the organization. Anita, the ED, hoped that developing peer-to-peer groups could enhance connections among interpreters and motivate them to become more involved. The TVIC committee was a key organizational driver of the implementation process in all the participating organizations, initiating or hoping to provoke structural and cultural change.

### 5.2.2 Structural and Cultural Change

Changes were more significant and pronounced in the settlement agency because they were further ahead in their implementation process. The police service and interpretation and translation agency experienced some subtle changes; however, they mainly elaborated on the types of changes they hoped to see in their organization. I discuss these actual and potential changes at individual practice and organizational levels. However, it should be noted that change on the individual and organizational levels is always very intertwined. It is often difficult to draw a clear line between where the individual levels changes end and the organizational level begins.

#### 5.2.2.1 Driving Individual Practices

##### 5.2.2.1.1 TVIC Baseline Training

TVIC baseline training – consistent with the first principle of TVIC (knowledge and understanding of trauma and violence) - was one of the first initiatives recommended by the TVIC committee in all three organizations. The baseline training had particular importance since it introduced TVIC to the staff and communicated the organization's intention to implement TVIC. In each organization, the TVIC committee designed and planned introductory training

sessions for staff with the guidance of the coaches and purveyors to modify the training to target their unique needs.

**Table 9**

*TVIC Training: Similarities and Differences Among Participating Organizations*

| **Participating Organizations** | **Length of the Training** | **Type of the Training** | **Trainer/s** | **Participants** | **Post-training Feedback** |
|---|---|---|---|---|---|
| Settlement Agency | Two days | In-person | Sophia/ another trainer from the mental health agency | All staff | Yes |
| Police Service | 12 weeks<br>26 sessions | Online | Sophia/ another member of GTV Incubator | All staff | Yes |
| Interpretation and Translation Agency | Two days | In-person | Sophia | All staff | Yes |

The **settlement agency** planned two full-day training sessions for the entire organization to establish a baseline understanding of TVIC principles. The committee intended to provide knowledge and tools for the staff to support their work with traumatized clients. The TVIC committee had several sessions with the coaches and purveyors from the partner mental health

agency to prepare appropriate content for the TVIC training for their staff. Sally, the capacity building coordinator of the settlement agency, said:

> So, we are a settlement agency. There are many cultural factors in a lot of work that we do, so we really needed to target and tailor the approach for us, which our coaches really worked hard through that with us.

Many concepts included in the TVIC baseline training were universal approaches regarding exposure to trauma and violence. However, the committee and the coaches ensured the settlement agency's context was recognized and included in the training. The goal, according to the trainers/purveyors, was to provide core content of TVIC, share their own lessons learned, and support the settlement agency in tailoring TVIC to their own needs and context. The training concepts included: newcomers' wellbeing, a basic understanding of complex trauma, vicarious trauma, and practical applications and tools. During the TVIC training Sophie invited the staff to participate in the sessions by providing examples from their daily jobs. They encouraged staff to apply the trauma and violence-informed care principles by reframing the examples and providing alternative approaches. The TVIC training created awareness and validated the wisdom and skills staff had developed over years of experience. Kia said:

> I remember talking to one of my colleagues and saying Oh my God, this has been interesting. I want to read more about it! It really helped me to re-evaluate things that we do and that there is so much room for improvement when it comes to trauma and violence to inform care about our clients, about our families, like I just thought like we could do better, and I thought that this would really help to create awareness around these issues.

In addition, being immigrants and refugees themselves, many of the staff could relate to the training personally and found an explanation for their trauma history. The training created motivation for some staff to be more actively involved in the TVIC implementation. Kia was very excited about the training and became a member of the TVIC committee to support the implementation work. By learning about trauma and TVIC principles, he created new ways to understand his clients and be more mindful of their circumstances and difficulties. TVIC also gave him hope and tangible tools to apply in his department to enhance service delivery:

> I believe that it's an important part of the work that we do especially because of the profile of the people that we work with. We provide service that it is very likely that we need those tools, or we need that information. [We need to know] what might be the triggers for people or how do you identify trauma. I really find that part important.

TVIC training also positioned the intervention as scientifically valid and evidence-based. It provided a reliable framework and validated their work. Sally, the capacity building coordinator, said:

> I think it is, you know, it's the work that I think we all do, and I think hopefully that was validating for some people that I think they do this, but they didn't know what it was called, a professional language.

Jain, the wellbeing counsellor also enjoyed the training and was excited to find a reliable tool. She said:

> I benefited from articulating some of the things maybe that I didn't know it was in TVIC like I just knew in my heart. I knew it in my gut. I knew it in my interactions, but now I can put it all in this nice little box. It's empowering and it's lovely.

The feedback from the staff was positive, and the training was well-received, encouraging the organization to be more committed to moving forward with the implementation of TVIC and making it happen. After completing the baseline training for the entire organization, the TVIC committee identified TVIC related priorities and developed an action plan to implement necessary changes. One of the priorities for the organization was building the capacity to train their part-time contractors, including language support staff, interpreters, life skill workers, and even volunteers. They also needed ongoing baseline training for new employees to learn about TVIC and incorporate its principles into their service delivery. Therefore, some of the committee members stepped up to deliver the baseline training for new employees and part-time employees, and due to their effort, the baseline training evolved. Learning from the first round of training the coaches and purveyors provided, they modified and redesigned the training further to map their organization's specific needs

The new topics were more directed at the acculturation process and the pre-- and - post-migration processes. A key learning for staff was that the resettlement process itself could be traumatic for some newcomers since they had to leave their homes and family behind in the country of origin.

For the **police service,** the implementation of TVIC was about creating resilience of staff. Bob, the superintendent, who was an active member of the TVIC committee, explained

> [A]s a police officer, you are going to be exposed to violence and traumatic events and hazards of the occupation, and a big piece of resiliency is being informed.

TVIC training was the vehicle for the committee to create awareness about the difficulty and hazards that police members often encounter in their day-to-day jobs. These encounters tend to be traumatic and violent and could often result in occupational stress and injuries. Therefore, the TVIC committee intended to unpack the symptoms and signs of these injuries and emphasize organizational support for the staff. Roy, the administrative sergeant and a member of the TVIC committee, reflected on how this awareness could help create certainty and stability:

> It's not necessarily the worker has that mindset initially, but because of the day in and day out grind of law enforcement or day-to-day tasks, people end up adopting certain outlooks or mindsets … to be able to address the membership as a whole for best practices and standards and expectations on, you know, if something does happen. This is what the organization is going to do and support and what we're going to do versus an unknown scenario type of thing.

Baseline TVIC training for the police service was integrated with other initiatives to change the narrative around mental health. The organization was interested in changing its culture and breaking down mental health stigma by communicating to its staff as Bob said, "it is not something that's wrong with you; it's something that's happened to you and had an effect on you. It's a health issue." This message was the basis of the training and the implementation, which aligned with TVIC principles. TVIC training was thought to provide a fresh perspective on stigmatization of mental health that had been normalized in the organization for a long time. Sam, the administrative sergeant of human resources, said:

> It just opens their minds to like maybe there was one time when I had a bad day and I could handle the situation differently; here you could be more self-aware by I think by having some training on the topic it's always good to revisit it.

Sam, who was at the end of his career and thinking about retiring, could see the training as a new frame of reference for the staff to reflect more deeply on the daily hazards of their occupation and take the signs and symptoms of stress more seriously. The committee and the coaches worked side-by-side to ensure these messages were communicated explicitly through the baseline training, and TVIC principles were contextualized in the provided materials. As a step toward achieving this goal, the team developed scenarios based on the reality of police work and hired professional actors to play these roles. TVIC principles informed the development of these scenarios while the scenarios' content was built on issues such as signs and symptoms of trauma (dissociation, anger, avoidance, suppression), and coping mechanisms such as substance abuse and infidelity. In addition, a baseline survey was developed "to measure the organization's temperature and familiarity with the TVIC principles," as Sophie, one of the coaches and purveyors said. The survey was sent to the entire organization prior to the baseline training, and the results were applied to inform its content further.

The baseline training was first presented to the leadership and the rest of the mental health and wellness committee. This session demonstrated to staff that leadership was supportive and engaged and provided an opportunity for the leadership and the committee to identify potential connections and tensions. Another significant achievement for the team was that the chief and other senior members agreed to record videos with personal messages to support the TVIC implementation and the expected outcomes.

The training sessions were initially planned for in-person delivery, but due to the restrictions of the COVID-19 pandemic, they moved online and took place over four months. The TVIC committee also developed a post-training survey to measure the learning outcomes of the training and conducted individual interviews to receive feedback from the staff.

The **interpretation and translation agency** was also interested in informing their staff and interpreters of the impact of exposure to trauma and violence to improve their health and

wellbeing, and consequently, service delivery. Therefore, they worked with Sophie, the coach and purveyor from the mental health agency, to modify and change the TVIC baseline training based on their organizational needs. The baseline training was first presented to the Board of the organization. Anita, the ED, said, "when working with Sophie, we realized that it had to be top-down and so we actually shifted, and we went to the Board first … we definitely made the Board guinea pigs". The TVIC committee decided that the training should be presented to the Board first to obtain their support and receive feedback. Anita, the ED, said:

> They [the Board] were very open, engaged a lot, and had many questions. They saw the value and were incredibly engaged with [Sophie] and wanted more. I think that was 100%. Everybody wanted more and definitely looked forward to hearing about what it would look like for staff and interpreters.

The reaction from the Board was encouraging. The TVIC committee incorporated the feedback into modifying the baseline training and proceeded with the plan to train on-site staff first. The training was well-received and engaged staff positively. Before going further with training interpreters, they conducted a focus group. Anita, the ED, said:

> We did more extensive training with staff but still only scratched the surface. We did two sessions, and then we started talking with interpreters through a focus group and then actually kind of had information/training sessions with active interpreters.

The TVIC committee approached the interpreters' training differently because the interpreters worked in a unique context and setting (as discussed in chapter 4). Therefore, the TVIC committee invited the interpreters to participate in the contextualization of TVIC based on their needs. The focus group provided critical insight and feedback for the TVIC committee to modify and reconstruct the TVIC training. Linda, the training coordinator, said "so, when they are in training, I talk to them and I give them different types of strategies that would apply to different types of personalities and situations and other things."

Other comments and reflections were shared, such as interest in having opportunities to connect with other interpreters. Since the interpreters did not come to the organization regularly, meeting

with other interpreters and connecting with them was a challenge. Linda, the training coordinator, said:

> Something came up about them wanting to have more opportunities to connect and support each other by sharing strategies to deal with tough situations. With Sophie, we decided to come up with some guidelines on how to provide support to one another to avoid additional re-traumatization of the person or additional concerns created and respecting confidentiality which of course for us is big. So we thought let's provide us with a little bit of structure so when they touch base with one another they can follow.

Based on the interpreters' requirements, the trainers emphasized the importance of debriefing. They provided applicable guidelines and strategies for debriefing without creating a challenging situation for their colleagues. They also encouraged the interpreters to exchange their phone numbers for staying in touch and facilitating connections.

#### 5.2.2.1.2 Additional Training Based on Staff Needs

TVIC principles informed every step of the implementation process; therefore, to emphasize collaboration and shared decision-making in the organization, the implementation teams were determined to incorporate staff feedback into their action plan. All three organizations provided a chance for the staff to give feedback on the baseline training and communicate which additional resources or training should be brought to the organization to assist staff in service delivery. Sally, the capacity building coordinator in **the settlement agency** said:

> I think overwhelmingly, the feedback was good. I think more people wanted continual resources, and that was very clear on the evaluation that they wanted continual wanted to sort of seeing it implemented, so they didn't want just it to be a staff training, but you know a lot of people said that this needs to move forward I think people could see really the value in it.

The baseline TVIC training was well-received because the staff were able to connect to the teaching provided, and they saw the value of learning new skills-facilitating service delivery. Staff were also familiar and aware of organizational tendencies for 'ticking the check box' of

doing something new, then moving on and never returning to it. Therefore, they communicated their concern and requested more related training. Based on the feedback provided after the baseline training, the committee implemented other training. The first subsequent session was focused on self-care in general, and mindfulness meditation, which was well-received by the staff. But more importantly, the organization invited the Canadian Centre for Victims of Torture to train them on debriefing. Sally, the capacity building coordinator, commented on the practical value of this training:

> We've been resettling our Yazidi clients that have had a lot of traumatic pre-migration experiences. So, a lot of our staff are really dealing with a lot of burnout [and] vicarious trauma aspects like that. So, they need some really specific support not just around general knowledge pieces but actually like practical tools and skills that they can learn.

The staff were able to connect to the baseline TVIC training and appreciate the benefits of learning about trauma and violence-informed care; however, they also needed continuous support to learn about practical tools to cope with the difficulties of working with the Yazidi refugees. Therefore, the debriefing training was a suitable option to meet this need.

The **police service** also developed a post-training survey to evaluate the baseline training. In addition, members were invited to participate in confidential interviews with trainers to provide direct feedback they might have hesitated to address in the survey or during group training sessions. The feedback from staff was overwhelmingly positive and the training well-received. . They were also interested in seeing that the implementation of TVIC was not limited to the baseline training and that follow-up steps would be taken by the organization to ensure structural and cultural shifts. For instance, the staff did not feel comfortable discussing their mental and physical struggles with their supervisors even though they believed supervisors were available. Part of this hesitation, particularly for the sworn members, was because of the negative stigma associated with the concept of " they will take my gun away." Gun removal could have significant implications for the officers, such as forced sick leave and being put on administrative responsibilities instead of patrol upon return. Sam, the administrative sergeant of the human resource, explained the police input:

> We were employed and were given force options by the chief, and you worry that well if something is exposed, then they take my gun away from me, right? So and then what kind of implication is there, you know, over that it could be a social or emotional on your own level you know so those could be barriers. Discipline can be a barrier like in terms of getting in trouble for something that's happened or even charged criminally if it is that bad so those are barriers for everybody you know. Even like we talked about in the meeting like just the scenario of you have domestic violence disclosed and now from one colleague to another. Now you have a legal authority to do something right; that's a conflict. That's a barrier. You still have that pride in your career. It would be like going up to a doctor who has been a doctor for 30 years, just take the scalpel out of his hand tell him he can't keep operating.

The culture of policing is unique because of the responsibility given to the members to "fight the bad guys." A "good" police officer does not let down their leaders and colleagues (i.e., shows no weakness). Therefore, the trust provided by the chief, and other leaders, should not be jeopardized under any circumstances, which weighs heavy on a member's shoulders. This culture prevents officers and other civilian members from opening up and talking about their mental and physical struggles. In addition, the suppressed anger and frustration sometimes get translated into domestic violence and, in some cases, homicide and suicide. In the policing system, reports of domestic violence from the organization members are dealt with as criminal acts because they have access to force. This approach further perpetuates the culture of "don't ask, don't tell" and the silence around these issues. The organization is aware of these problems and established a mental health and wellness committee, now a separate organizational branch. The reintegration program and efforts at becoming trauma and violence informed, were initial steps taken by the organization to respond to cultural barriers to help-seeking. The reintegration program, which originated in Edmonton aims to facilitate returning to work for officers who experienced PTSD due to the nature of their job. Further, the organization tried to encourage the Duty to Report culture by framing it as helping a colleague struggling with the impact of exposure to trauma and violence. Based on the feedback received after the baseline training, the police service has planned follow-up online training. Also, further training for supervisors on compassionate and trauma-informed approaches has been developed and prepared by Wounded Warriors, an

organization specializing in working with first responders. This training was scheduled to take place in Fall 2021 and with a follow-up in Winter 2022, but it has not started.

The **interpretation and translation** agency also received positive feedback from the staff and the interpreters; however, due to financial constraints, they were not able to provide further support for their staff and interpreters, such as additional complimentary training. The implementation team has applied to multiple resources to receive financial aid. At the time of writing this dissertation, the organization is still waiting.

Across sites, the implementation teams' commitment and enthusiasm for bringing TVIC to their organization was one of the essential drivers of TVIC implementation and required a separate section for an in-depth analysis. I will discuss this in the next section.

#### 5.2.2.1.3 Champions and Staff Engagement

In all organizations, champions were one of the main implementation drivers for making the implementation happen. In each organization, one or two individuals firmly believed that the implementation of TVIC could bring the long-awaited change and outcomes the organization needed. They invested much of their time and resources to ensure the implementation process unfolded successfully. In **the settlement agency**, Sally, the capacity-building coordinator, was one of these champions. Her unique role as the capacity builder also allowed her to be fully invested in TVIC implementation. She believed that TVIC could enhance the service delivery in the settlement agency:

> I think you have to really believe in it. You have to really believe in how it [TVIC] can sort of transform the agency in how it can massively benefit newcomers and the clients that we have.

Her enthusiasm for implementation, coupled with her job description, allowed her to focus on building organizational capacity for implementing TVIC. This was a unique situation for the agency and was also supported by the executive director (ED), Kent, who said:

> It's also important to have the internal capability. The [TVIC] training was developed by the HR manager and our capacity building specialist, then reviewed by the committee and

> so on. I would call it top-notch, so we had that internal capability. Then for me, it was just creating the space and providing the support.

The HR manager was another champion in the agency. Sally and the HR manager were both a part of the TVIC committee, and their teamwork facilitated the TVIC implementation. Kent was aware of his staff's skill, capability, and contributions to the implementation process; therefore, he felt comfortable giving them enough space and providing the necessary support and resources. Other staff in the TVIC committee also showed interest in TVIC implementation, finding TVIC, a critical initiative. Sally the capacity building coordinator said:

> it's not just me or Kent [the ED] who is spearheading this whole thing. It's other people, and you want other people to take it up, and I think that's been a nice part of the committee. Even starting the committee a year ago, there was also I think two or three other people that really brought it up and not just coming month to month and being interested in participating but really actively doing things really actively taking a leadership role, and they weren't initially involved in the initial process, so I think that's really nice to see that people are just sort of actively engaging.

Staff engagement grew over time. Other staff who were part of the TVIC committee also started to show interest and enthusiasm for the implementation. It was interesting to hear that participation in the TVIC committee after one year did not turn into a mundane task for the staff or another work hassle, among other numerous meetings. As time passed, the committee members showed more interest in being actively involved with the implementation process. Sally, the capacity building coordinator attributed part of the staff engagement to their position in the organization, allowing them to pursue new initiatives.

> I think it also relates very much to their roles, which always helps because it's hard to do things when you're sort of doing direct work and it doesn't tie as strongly to maybe your daily work in terms of sometimes the capacity building component because the individual component absolutely does. [Sic]

Although the alignment of TVIC with organizational values underpinned staff interest, when their role in the organization enabled them to contribute to something they found meaningful,

their interest increased. Sally also emphasized that it is important for the champions and leaders of the implementation to allow this readiness to emerge. She said:

> I think it's sometimes allowing also enough time for people to naturally take it on themselves, and not just saying ‘can you do this?’ You know, not just delegating, saying, well, ‘can you do this’ or ‘can I ask you to do this?’ It takes time for people to think to buy in, and it takes time for people to, like, naturally sort of feel empowered with it or interested in or engaged in it again; these things don't happen quickly.

Having the patience to let staff develop readiness encouraged a bottom-up approach toward the implementation. Even though Sally could assign different tasks to staff as the project manager, she was more interested in supporting her colleagues to engage with the implementation in their own time. Her approach encouraged someone like Jain, the wellbeing counsellor, who had been waiting for structural and cultural changes, to participate in the TVIC committee. Jain said:

> Like I said, it's long overdue. I'm thrilled that the executive at the top thinks it is important. Often as one of the only social workers in the organization, you're always pushing that. You're always pushing at staff meetings at team meetings. You are always saying, hey, did you think about this, and you feel a little bit like you're going uphill. So when the executive brought it forward, I thought, yes, and I wanted to be part of the team. I wanted to be part of the implementation of it because, yeah, I feel it's very important.

The TVIC implementation for Jain was a long-waited call to bring necessary changes to the organization; therefore, being part of the implementation was exciting and allowed her to act on her commitment. The leadership and staff engagement and support created a positive loop between the top-down and bottom-up approaches toward the TVIC implementation.

Bob, the superintendent of the police service’s corporate division, and Roy, the administrative sergeant, championed TVIC implementation. For Bob, breaking the stigma around mental health and creating resiliency were significant motivational factors. He said:

> Our officers are at risk for occupational stress injuries, [and] post-traumatic stress disorder, because of the violence and the trauma that they will be exposed to through

> their profession. We need to start to build some resiliency for those officers, sort of that ability to, you know, overcome those stressors and pressures.

Bob, as a senior officer, was aware of the difficulties associated with policing, and the inevitable impacts of daily exposure to trauma and violence. Therefore, he was very much invested in shifting the culture of policing and protecting his staff from injuries by advocating for TVIC. Resiliency meant, for Bob, being well informed, and TVIC was one strategy or way of thinking that could create this awareness in his staff. For Roy, the administrative sergeant, TVIC was a complementary training to what he was already championing in the organization, the reintegration program. He said:

> So it's been really rewarding compared to, I think, outside of anything I've ever done here professionally. It has been the most rewarding because you can take that individual who had their own cognitive type of distorted thoughts on what it [PTSD] is and what it's not and what they're capable of or not capable of but then to be able to say we're going to support this and we're going to help you come back and be the best that you can be.

Roy brought the same level of enthusiasm and commitment to the TVIC implementation. He said:

> I am really passionate about it. I think that I look at my own experiences with trauma here and definitely in my personal life as well, like, right through childhood up into adulthood and now in my own family and raising children and trying to break molds…With my own trauma experiences here and how I've gone about to get help and then recognizing gaps, I've had to find the answers on my own or realize that we can be doing more here. People are waiting to engage all right, but nobody is taking the lead on it.

Personal stories and struggles were among motivation factors for Roy and other people I talked to in all organizations. By learning about TVIC, they started to make sense of their own experiences. TVIC validated them by conveying the message that trauma is common and the responses to it are normal, i.e., the message that "there is nothing wrong with you." They realized their struggles were inevitable results of what they experienced and what "happened" to them, both in their personal and professional lives. This personal reflection created a significant

drive to advocate for TVIC implementation. Roy identified gaps in support and hoped TVIC would enable the organization to make the changes necessary for the well-being of his colleagues.

In the policing culture, staff are not encouraged to provide feedback, and presented information usually is taken as orders to be followed and not questioned. Despite these cultural tendencies, the training was very well-received. Members were also able to relate to TVIC from their personal and professional experiences and shared their experiences in the training sessions. The implementation team hoped to invite interested members to be more involved in the implementation moving forward.

Like Roy, Linda was also motivated to assist her colleagues in **the interpretation and translation agency**. The interpreters sometimes would choose to talk to her about their struggles, and she was trying to find different ways to provide extra support for them. Many interpreters were battling their own trauma and vicarious trauma that the organization never addressed. TVIC provided opportunities in the organization to initiate the conversation about trauma and show the interpreters their trauma matters. She said:

> Well, it is the first time that their … their own lived experience … was recognized as a key component of that communication happening in the interpretation sessions. Before, it was always right to the side that you're an impartial party, you are confidential for the first time, we said to them we are not helping you by telling you that [you are impartial]. We have to recognize that who you are and your lived experience matters.

Agency procedures required interpreters to be impartial and only to interpret what they hear. Before integrating TVIC, the organization ignored, or at best chose not to see, the impact of trauma and vicarious trauma on their interpreters and staff. TVIC created trauma awareness in the organization and clarified that the impartiality expected from interpreters is impossible. Their own trauma histories could be activated (“triggered”) by the information shared in the interpretation sessions, making it difficult to carry on with their responsibilities. Anita, the ED of the organization, complemented what Linda said by explaining that the self-care strategies provided by other training before TVIC were not inclusive enough of the interpreter's reality and

acted more like a band-aid solution. Anita said, “we used to tell them you are professionals, burn a candle, and you will be fine!” TVIC moved the organization beyond the self-care approach and provided tools and strategies that interpreters could apply and were compatible with their realities. The organization was interested in continuing with the implementation as soon as they received financial support.

In addition to champions who created enthusiasm in the participating organizations, other factors facilitated and sometimes prevented the implementation of TVIC. In the next section, I discuss three major factors identified in data analysis.

#### 5.2.2.1.4 Structural Violence and Power Dynamics

Teaching staff explicitly about structural violence and introducing them to the concept created an interesting dynamic in all three organizations. TVIC emphasizes the intersectionality of different factors such as race, poverty, intergenerational and historical trauma (i.e., structural violence) that people experience as harmful in their daily lives. Consequently, staff became aware of structural violence in their own lives and workplaces. Simultaneously, it could be argued that the conversation about structural violence and emerging awareness among staff acted like an implementation driver that moved the organization beyond viewing TVIC as just another training. In the interviews and meetings, people, for example, discussed the problem of hierarchical power dynamics within organizations and how these frequently prevented staff from voicing their concerns.

In **the settlement agency**, creating a feedback loop between staff, managers, the TVIC committee, and leadership proved challenging. The managers and the executive director had an open-door policy for their staff. Still, the staff did not feel comfortable enough to share their concerns with their managers. The busy schedules of the managers also did not allow this policy to be effective. Therefore, giving authentic feedback and having an honest conversation about the difficulties associated with the TVIC implementation or other issues was sometimes challenging. The hesitancy from the staff was also evident on the TVIC training days. Staff participated more actively when the executive director was not present at the training session. Kia, the project and administrative coordinator, was also aware of this problem. He said:

> There isn't really a formal way of checking in with the staff, and it's connected to so many different things, right? Like about the job security and everybody has to make a living you know. So nobody wants to do anything that will affect that which is very understandable, but this becomes one of the barriers to change unless someone on the top decides to change things. If someone on the top doesn't know about the other people, what other people think how can they change for the better? Like it's, you know, this kind of the structure is one of the structural problems. But I think it is related to the well-being of the staff when we are talking about the well-being of the staff being part of the TVIC.

The fear of losing one's job prevented staff from being honest about their experiences with their managers, resulting in difficulty creating a positive feedback loop. Since structural changes often involved top-down processes initiated by the leadership, this lack of connection was problematic because the leaders might be unaware about staff challenges. The TVIC committee at the settlement agency encountered this problem. Sally, the capacity building coordinator talked about the difficulty of receiving honest feedback from members of the TVIC committee when managers and the ED were present. Sally said:

> I think sometimes that is challenging, having really open and honest conversations. I think we try our best like anyone would, but to really … cause you still you know at the end of the day maybe your manager is in the room, or you know if your manager is not, your ED is in the room who[m] you report to.

Even though the active presence of the leadership on the TVIC committee was a very supportive factor for the implementation overall, the power dynamics between staff and leaders were sometimes problematic and prevented the committee from receiving feedback.

The problem of having top-down structures was also evident in **the police service**. Karen, the former police officer and coach, argued that police members, particularly the older generation, have been trained to follow their leaders without questioning them.

> Questioning is not a valuable trait inside. On the outside, if you're a good questioner, you're rewarded, and you will be put on the homicide branch. But when you question the

> leadership? No one literally questions leadership because then everything's gonna fall apart, you know.

This reluctance to question leadership sometimes made it difficult to create a feedback loop to inform decisions in the organization. Sam said:

> You know is that always the tough part I mentioned before is maybe that that younger officer who's kind of uncertain of himself or herself and trying to fit in and you know there's strong older personalities or it could be a rank thing, the classical … The Sergeant you know they observe some behavior that is, you know, that puts an officer in a tough spot, you know, in a sense of rank and whatnot it's hard to speak up against a colleague

Even though the organization implemented an anonymous system for members to provide feedback, the staff criticized it because they felt their feedback was not heard. The hierarchical power structure also created hesitancy from members to provide honest and authentic feedback on surveys because they feared that their information could be traced back by the organization and could create problems for them. The feedback on the surveys and interviews were discussed in the TVIC meetings to inform the TVIC implementation. Being aware of these cultural barriers, Bob believed the TVIC implementation should be a bottom-up approach. He said:

> [S]o my recommendation would be it's got to be driven, sort of bottom-up driven, if you will, so this is not being seen as being pushed on this organization by the senior executive, by the Chiefs, by the superintendents, by the administration, is I think the way to do it right; that's where you will get the biggest bang for your buck as far as buy-in from the members in the organization [that] it's not something that's being put on them it is something that is being put out to them by a committee of their peers who are primarily interested in their well being

Bob, aware of the power dynamics and the hierarchical structure of his organization, viewed advocacy for the mental and physical health of the members as a bottom-up approach to ensure staff engagement and trust.

**The interpretation and translation agency** experienced the same issue. Anita, the ED, said, "We work very closely together five days a week, some even on Saturdays at the time so it might not be completely safe to share, right." Even though staff and interpreters provided positive feedback on post-training evaluation, a lack of engagement and the sharing of personal stories in the training sessions was evident for Anita. She attributed this silence to her presence in the session, creating a fear of sharing.

#### 5.2.2.1.5 Barriers to Implementation of TVIC

A) Time Pressure

Time pressure was a barrier in the implementation of TVIC across organizations. Attending to competing demands sometimes made it difficult for staff to apply newly learned skills in their daily routines. In **the settlement agency**, lack of sufficient time and having busy schedules were among the dominant factors creating obstacles for the staff to incorporate TVIC principles into their practice. The deadlines and pressure of working through busy schedules made it impossible to keep the TVIC at the forefront of their minds. Kia said:

> I think one of the areas that has the most conflict and contention when it comes to the implementation of TVIC is that we're kind of like under the pressure of getting the work done right. And so, people want to get the work done because you want to be doing your job timely and in a good way. And sometimes like TVIC related issues might delay your work or might affect your work in a different way like when it comes to making decisions.

When staff were under pressure to get their work done, it became challenging to re-evaluate a routine that they were used to and knew well. Applying a TVIC lens required more effort. Jain, the wellbeing counsellor, attributed this problem to a lack of explicit commitment from the organization to keep the implementation of TVIC as a priority. She was particularly critical of the implementation's speed. She did not feel the TVIC implementation was a priority in the organization, making it easier for staff to forget their training and slip back into their old routines when they were busy.

> We're a busy organization. TVIC is not a priority. We make it a priority, yeah you just get busy with your call and computers and everything else and you lose that. To stop and breathe you know these simple things, we do for a little while, and then we let go again. And I think if we could hang on to them a little bit more, we would see the more lasting impact. It's one thing to get training, and it's another thing that the organization lives and breathes it.

Jain was clear that implementing TVIC principles in service delivery was much more complicated than attending a baseline training, and full implementation required time and organizational commitment. But she also believed if the staff and the organization were clearer about how TVIC implementation could enhance their service delivery even in small ways, they were more likely to stay with it.

There is significant pressure on the police service to attend to many competing demands that could interfere with their commitment to TVIC implementation. Karen, the consultant, and a former police officer, said:

> There's always pressure on policing. There are staffing pressures. Things happen they have to respond to, and those kinds of things. And so like there's never just sort of like one focus you know, and they're able to just like jump in. And we're all in and this is our project, and it's like there's so many things that are always just tugging.

Time pressure was already a problem when the COVID-19 pandemic started. Now organizations had new, ill-defined and changing responsibilities specific to the pandemic. Roy said:

> There are people here with at home concerns with fragile members or for immune exposed family members or spouses, or kids or maybe those grandparents that they're taking care of that live in their residence right. So it's been I wouldn't say it's not a struggle. Definitely there are conversations we had with them to make sure that they know organizationally we're doing everything we can to put mechanisms in place so, you know, sanitizing and masks and gloves and eyewear. And we have people brought in specifically to wipe down doors and contact points on it all-day basis. They’re walking around wiping doors all the time with the cruiser disinfecting.

The pandemic also created new concerns for the frontline police officers who could not work remotely and had immune-compromised family members at home. However, the organization tried to support staff by implementing new measures and following the recommended restrictions. On the other hand, in the early months of the pandemic, the call volume decreased because of the lockdown, and the streets were less crowded. Traffic decreased, making it easier for officers to attend to calls. However, in their latest informal report discussed in one of the TVIC committee meetings, the number of calls in 2021 is thousands more compared to 2019, 2018, and 2017. The increase in call volume is not the only problem. The calls are now more likely to be related to violent incidents, increasing the probability of exposing the officer to more trauma and violence. The TVIC implementation has become more critical, and the organization is hopeful, that the staff are better equipped with the necessary skills.

B) Lack of Competence.

Feeling competent when new skills are learned could enhance the confidence of the service providers to apply TVIC in their job. Even the implementation champions found it difficult for them to understand TVIC principles in the beginning. Therefore, they had to work harder to lead the implementation process. In **the settlement agency** Sally, the capacity building coordinator said:

> I think I would have advocated for myself to have more training because it's something that just sort of happened, and my position is a position that would take on things like this which I'm really grateful for. And I'm really excited that I've been part of it, but I think if you have a leadership role, it's your job and responsibility to sort of educate yourself first.

The implementation of TVIC was exciting for Sally, and she was a champion in the organization during the implementation process. However, despite her background in social work, she still felt unprepared at times.

> I have a good background, being a social worker. But now looking back, I'm like I've learned so much, but I think it would have helped at the beginning to ground myself in what it is and then look at a little bit about how to be a key person in the process moving forward.

Providing enough resources and support for the champions to feel competent and prepared was a vital implementation driver. Linda, the training coordinator in **the interpretation and translation agency**, also felt that she needed further training. She said:

> I was asking about resources you know where we can learn more about it [TVIC]. I mean for me it would be important to understand it better. I have the exposure to those training with Sophia but by no means do I consider myself knowledgeable in that subject. I can sort of see, and realize the connections, but I would love to have more understanding to help interpret better and myself, of course; everybody benefits from that.

Even though being part of the implementation training and working closely with coaches and purveyors was helpful for Linda, she did not feel confident enough to assist the interpreters more fully. Extra resources and complementary training for the champions could have been beneficial for the implementation process. Karen, the former police officer in the implementation team in **the police service,** also comment on this:

> I would have liked a little bit more upfront, like, some basic information about what TVIC is, and sort of more specific, like, maybe expectations around that. Because the first few months, I was very much like looking for information that I had to uptake and find on my own. So, I think it would have been helpful to just … down as a team to kind of like bring us all onto the same baseline or something like that would have been helpful for me.

Initiating TVIC implementation and being involved in the process could be confusing and unclear, therefore providing more support in the form of training or ongoing consultations from the coaches and purveyors who were experts in the content of TVIC seemed necessary for the champions and other members of the implementation team. This lack of competence was mentioned by staff in **the settlement agency**. Many of the staff in the organizations did not have background training in mental health. Even though TVIC training distinguished between trauma-specific therapy and trauma- and violence-informed care, some staff still lacked confidence. Kia said:

> None of us is coming as -at least in my department- from a how can I say it like a mental health or mental wellbeing background, or training like that. So, I feel like the best we can do is to identify early on if there's anything like that and find the proper support for those people.

Kia was also curious about the application of TVIC as a settlement worker during the TVIC training. He asked the trainer about how he was supposed to provide care for highly traumatized clients when he had no skills in this area. The trainer tried to clarify that TVIC is not trauma-specific therapy, and the staff was not expected to provide treatment. But in my interview with him, which was conducted after the TVIC training, he seemed still uncomfortable with his lack of knowledge about mental health.

C) Staff Trauma History.

TVIC implementation and application sometimes encountered resistance. Anita, the ED, and Linda, **the interpretation and translation agency** training coordinator, called it "guardedness." Linda said:

> I do know the staff, and I was there for both sessions. My take on that was more precisely about the guardedness was more about being able to openly recognize that something still might be a trigger for me or that something could have been perceived as traumatic for me. It opens vulnerabilities. And staff are very good at doing their job and doing it really well and presenting a very strong front and TVIC presented a different side to them, right? Like now I am vulnerable. And don't tell me I'm vulnerable because I don't want to be vulnerable.

Anita added "they would say I've come this far I can handle this". During the training sessions, sometimes there was a lack of response and engagement from the interpreters. They were hesitant to talk about their personal histories and their trauma-related stories, which, while not an explicit expectation, was often used as a way to engage staff in the training sessions. Anita and Linda believed talking about trauma and its impact threatened the resiliency built over time by interpreters who were themselves immigrants and refugees. Most of the interpreters had been in Canada for many years. Discussing trauma felt like moving backward, digging into something

buried and forgotten. Jain, the wellbeing counsellor in the settlement agency, also witnessed this resistance. She also believed that resistance created by the TVIC implementation could have stemmed from the difficulty of encountering painful memories from the past because many of the staff in the settlement agency were immigrants and refugees with trauma history. She said:

> I guess a challenge would be that people are uncomfortable with their own trauma background… [they] felt that they might you know, fluff it off or like I don't know what the word is. But just it's too uncomfortable for them so that they wouldn't even go there. Yeah, it is challenging for people to be self-reflective to be aware. Self-awareness is a challenge causing a lot of people just keep themselves busy to keep themselves entertained.

Working with a TVIC lens could itself be triggering for them; therefore, incorporating TVIC principles into their practice seemed too overwhelming. Jain, the wellbeing counsellor, believed that many of her colleagues imagined the difficult days were behind them. They were able to get through them, and it was time for other people to "toughen up" and get through the difficulty of the resettlement. She said:

> I feel that there's that challenge of maybe especially coming from immigrants. Like a lot of them are like, "we did it, so just toughen up a little bit yeah suck it up, and you'll be fine. Right, don't coddle them too much, don't baby them too much, you know they have to be independent." I don't know how many times I've heard that you know they want to throw them in the water to become swimmers. I'm doing vast generalizations here because there's many lovely folks too, but there's a good chunk that I feel yeah lack empathy.

In **the police service**, the culture of toughness and showing strength is also present, and this could prevent staff from relating to TVIC because it could be seen as “being too soft.” [Sam] However, the organization aimed at changing this culture by informing its members of the impacts of trauma and violence. The police officers mainly take pride in *going out there and capturing the bad guys,* [Roy] therefore, opening up to vulnerabilities associated with exposure

to trauma and violence was new for them. At the time of writing this dissertation, the application of TVIC in the daily practices of the police service is yet to be studied.

#### 5.2.2.2 Driving Organizational Level

##### 5.2.2.2.1 Partnership with other Organizations

The implementation of TVIC is still in its infancy, and there are not many organizations that have experience with the implementation process. The local mental health agency in London, and Sophie as the TVIC coach and purveyor, were rare assets for the community. The GTV Incubator at Western University also provided more support for TVIC implementation. The partnership between participating organizations, the local mental health agency, and GTV Incubator members initiated the implementation process in several organizations in London. The collaboration among these organizations was a significant implementation driver. Sally, the capacity building coordinator in **the settlement agency** said:

> I didn't know what that [the implementation of TVIC] would look like on the agency level, typically. Honestly because I think there wasn't really a guidebook, so I think we learned a lot from [the mental health agency] and Sophie.

Another essential factor in this partnership was the openness and willingness of the partnering organizations to build implementation teams together. Previous relationships and collaboration, involvement in other related committees and initiatives, and serving similar populations of clients created a solid foundation for further cooperation on the implementation of TVIC. The coaches and purveyors shared their knowledge and expertise with the interested organizations and helped them plan the initial steps in the process. The mental health agency, with more than ten years of experience in T(V)IC implementation, was a pioneer in the community. Western University also continued to inform the agency about the latest research and improvement on the TVIC principles and implementation process, staying with them throughout implementation. Kent, the ED, the executive director, said:

> I was aware of the [mental health agency] journey so we were interested in working with them to do what they did. We started with finding partners to support us and the expertise came from Western University and the [mental health agency].

In the settlement agency, the leadership was aware of the outcomes of the implementation of TVIC in the mental health agency. The initial Centre for Research on Health Equity & Social Inclusion (CHRESI) meeting also facilitated the organization's partnership with Western University. Receiving assistance from these organizations increased the confidence of the leadership to initiate TVIC implementation and design the baseline training. Coaching by the partners continued after the baseline training due to mutual interest.

**The police service** was also aware of the implementation of TVIC in the mental health agency. Their recent collaboration with Western's Centre for Research & Education on Violence Against Women and Children (CREVAWC) and GTV Incubator members provided extra support and motivation for becoming trauma and violence informed as an organization. Bob, superintendent of the corporate division, said:

> We became aware of the activities of [the mental health agency] in regards to violence and trauma-informed practice. And that's where we learned a little bit about it and how it would be maybe a good fit for us. About the same time, the organization was approached by CREVAWC and offered to develop this training for us that we felt would fit our needs towards becoming a violence and trauma-informed organization.

The TVIC implementation was aligned with the organization's recent agenda and action plans and receiving support from local organizations facilitated initiation. **The interpretation and translation agency** also had a long-term partnership with the local mental health agency and Sophie. They became aware that Sophie was providing training on TVIC to interested organizations. Thus, they approached her, and their collaboration initiated the TVIC implementation. The partnership with the local organizations and accessibility of TVIC training to the organization were significant implementation drivers and facilitators. However, as the trainer, coach, and purveyor, Sophie has a significant role in creating motivation and connection with interested organizations. I will discuss this next.

*The Purveyor/Coach*. Sophie had been involved with the implementation of TVIC in a local mental health agency for more than ten years. She had also been an influential figure and an advocate for promoting TVIC. Local organizations and smaller programs in London and across the country have benefited from her leadership and commitment to these approaches. She is well-known in the community and a vital figure in bringing new and beneficial initiatives to London. She assisted the participating organizations with modifying TVIC baseline training and planning their implementations, all informed by practical strategies based on her experience. Sally, the capacity building coordinator in **the settlement agency,** said, "Sophie has helped to guide us through what's been done at the mental health agency, initial steps, and what would be involved in implementing TVIC."

In **the interpretation and translation agency,** knowing that the board members' reaction and feedback could inform the training for the interpreters, Sophie encouraged training the Board before the interpreters. Anita, the ED, said:

> Well, that was interesting because I think we were focused on the interpreter groups initially but then when working with Sophie, we realized that it had to be top-down, and so we actually shifted, and we went to the Board first.

The same strategy was applied when Sophie was working with the TVIC team at the police service. The training was first presented to the leadership, which provided invaluable feedback for the implementation team (discussed in more detail in the baseline training section). She was also very well equipped to train a large group of people. With the assistance of colleagues in all participating organizations, she trained the entire organization. In the police service, because of the pandemic and COVID restrictions, all the training sessions were moved to the online format and took place in five months on Zoom. Her remarkable ability to connect with people even on the screen impressed everyone, resulting in very positive feedback from participants in the interpretation and translation agency. Anita said:

> All [training sessions] facilitated by one woman she had the same impact on everyone, I think she covered all board, all staff, and she had 60 interpreters. So, she had almost 80

> people, and she had a similar impact on 80 people. The board members were also incredibly engaged with Sophie and wanted more.

Sophie's impact on the participants was important, and her ability to connect all the present participants was outstanding. There could often be resistance in staff toward being trained by an outsider. But she was able to overcome possible resistance and connect with them. Linda, the agency training coordinator, said:

> I thought it was phenomenal, she had the ability to connect with all interpreters, and they saw the benefit in that. I have to say that has not always been the case from external facilitators. When we invite somebody from somewhere else, there's a certain resistance like who are you to come and talk to me about this coming but that didn't happen with her.

Sophie's meaningful involvement and association with the TVIC principles created "Sophie moments" in the interpretation and translation agency. Linda, the training coordinator, in moments of uncertainty and dilemma would often ask herself, "what would Sophie do?" The ED, Anita, also said, "We call it the Sophie moment! Can I have a Sophie moment please? so we call it Sophie moment!" The "Sophie moment" was a code for reflecting on the problem at hand with a TVIC lens.

Sophie had the same impact in the settlement agency. Sally, the capacity-building coordinator, said during implementation that she often referred back to her conversations with Sophie. She said, "I remember Sophie always saying you know finding ways to get to keep it alive right and that's always like an ongoing piece that you always have to do and be mindful of." The impact of Sophie as a purveyor, coach, and, more importantly, an implementation driver was significant and evident in all three organizations.

Even though the partnerships between organizations and Sophie as a purveyor and coach were essential implementation drivers, a lack of commitment from the interested organizations could easily prevent full implementation. I will discuss this in the next section.

#### 5.2.2.2.2 Working with Uncertainty

The uncertain and nonlinear nature of TVIC implementation was challenging for the participating organizations. Even though the desired outcomes were relatively clear, the path to full implementation was unclear. Particularly at the onset of implementation, the absence of a road map with timeline indicators for each implementation stage made the road ahead more uncertain. Sally, the capacity building coordinator in the settlement agency, said:

> I think it's very hard to you know when you're at the beginning of it and trying to do this whole sort of change on different levels to sort of say you know in one year, we're going to be here in two years you're going to be here. I think when you have done non-profit work for a while, you get used to certain ways of being, knowing and approaching, and planning. My position is very planning and project-oriented. So, I'm very used to being very task-oriented with deadlines and milestones and things like that. I think you see things in a very linear way. You have a project. You have A, B, C, D and you sort of follow that path, whereas this [TVIC implementation] is different and it's much more diffused.

For Sally, who had significant experience in the non-profit sector, implementing change had been a task or a project to be accomplished in a certain way. She was used to working with projects that had a starting point and an endpoint with clear expectations. Still, through her work as the leader of implementation in her organization, she learned that structural and cultural transformations do not always happen in a linear way. She said:

> I think it's a little bit more complicated when you're actually trying to embed something in an agency. It's not just like I said, a linear process. If you're really trying to have like a cultural transformation, really trying to embed something, you're tackling things from, you know, 12 different angles, right? And you're trying to learn as you go. You're trying to adapt as you go, and you're trying to learn from things that worked or maybe didn't work.

The process of implementation was complex and contained unknown obstacles. For Sally, the implementation process became a learning process in which she worked with her team closely,

with an open mind, to examine what could work and what did not work. The support from her coaches and purveyors also assured her that the implementation of TVIC is complex. Self-compassion and patience are required to move through. She said:

> I remember they said that they've done this work for a really long time. While having self-compassion, saying, you know, we've been doing this for like 10 years, right? And we're still learning, we're still growing.

Sally resolved the frustration and difficulties associated with the implementation process by cultivating self-compassion and patience. She learned it would take time to become a trauma- and violence-informed organization, and the learning process never stops. It was the commitment from the team and the organization that kept the implementation process moving. Even though I did not hear explicitly about the uncertainty of implementation in the other two organizations, the organizational commitment was the reliable driver for all of them to work with the uncertainty of the implementation process.

#### 5.2.2.2.3 Organizational Commitment

The organizational and leadership commitment was a significant driver in the implementation of TVIC. A culture of acceptance and commitment was expected from the entire organization to maintain the fidelity and sustainability of the implementation. The settlement agency accepted a commitment to the long and, at times, uncertain process of TVIC implementation. Sally, the capacity building coordinator, said:

> It is a huge undertaking, and it's something that you really have to think and be deeply committed to doing but also deeply committed to doing it for the foreseeable future. It's not something that's going to happen in six months, something that really has to be like a really long-term vision. We can’t just sort of say this is happening, and people just change. It doesn't happen like that. It has to come from the bottom up. So, I think trying to find ways for people to connect these things but also find a way for people just to keep things alive to sort of, you know, as we go.

Sally also discussed the importance of having a bottom-up approach where the frontline workers were engaged and aware of the significance of TVIC implementation and its impact on service delivery. Staff commitment could be achieved if an explicit organizational commitment to TVIC was communicated to them. As another member of the TVIC committee, Kia was also aware of the long path implementation process ahead of the organization. He said:

> I guess it will take time like I'm not saying we are failing, but no one should understand it as “OK we had TVIC training now we are a TVIC organization”. That would be the danger.

All three TVIC committees were careful not to approach TVIC implementation as another box to be ticked on the checklist before moving on to the next agenda item. The organizations tried to keep TVIC alive to ensure sustainability and fidelity. The ticked check box approach also is not uncommon, and being . aware of this tendency in police services, Roy believed that TVIC should be kept at the forefront. He said:

> I think just the mindset that this isn't a done thing. This is like the new initiative that is really at the forefront, but it has to stay at the forefront. It can't be, you know, a spark, and then it just kind of goes back to the way it was. It is not one time and done thing. This has to be a total change. It has to be a different look at the day-to-day that we do, and it's gotta be out there. It's gotta be marketed so that it just becomes a norm versus oh that's yeah, that was three months ago, and I don't know why they're still doing that like is that still a thing it has to be up front all the time for people.

Implementation of TVIC for Roy required a significant emphasis on transforming the organization's culture and preventing TVIC from becoming another “thing” or training that they did, and now they can move on. TVIC principles had to be implemented in the day-to-day routine of the staff. In the police service keeping TVIC alive required resiliency. He said:

> It is the resiliency to keep pushing through and, you know, confronting people that maybe forgot about it or didn't see it as essential. And maybe individually they don't, but on the global organization, it does; it means a lot.

By emphasizing TVIC as a global culture, the participating organizations tried to move beyond the ticking another checkbox tendencies in their organizations. The settlement agency was motivated to advance the organizational changes beyond the TVIC baseline training by focusing on TVIC implementation. They created different strategies to keep the momentum going. The TVIC committee tried to take advantage of opportunities for communication and to stay connected to the staff. Sally, the capacity building coordinator, said:

> So, it's things that are very subtle but hopefully, there are things to keep people connected ... We have a monthly staff meeting you know; someone will say here's an update from this [TVIC] committee.

The TVIC committee ensured that in the monthly meeting with staff TVIC related activities were communicated, showing that the implementation was still an important initiative. Jain, the wellbeing counsellor, believed that after a year of implementation, the committee created staff awareness.

> Awareness is still the key. I mean, if you're aware of something, at least you could do something about it. We have been doing it [TVIC implementation] here for a year. What's changed in a year, well it has hugely changed our awareness. I think people are at least aware of the acronym now, and they know what that means and what we're striving towards.

Creating awareness was another strategy to demonstrate that the TVIC implementation was not limited to the baseline training, and the entire organization was experiencing cultural and structural changes. Small but continuous reminders were planned for this purpose. Jain said:

> I like regular reminders. Whether it's, you know, every Monday morning, remember we are a TVIC organization. Here's your tip for the week or something like those regular reminders at team meetings, staff meetings.

The TVIC committee also started a newsletter to communicate the TVIC initiative and changes brought to the organization by the committee. Jain said:

> So we've been mindful of, I think, putting in updates through that channel that goes to the staff once a week …, and that's how we sort of "advertised," , things like our debriefing training or self-meditation or guided meditation piece that we did. We put that through our weekly mailouts, so this is from the TVIC committee. We were planning this guided meditation or planning this debriefing training see your senior manager for details.

**The police service** was also trying to implement changes that could facilitate connection to TVIC for the members. They changed the trauma and violence informed care to trauma and violence informed practice to show their staff that TVIC is not about emphasizing "there is a problem with you," rather it is about changing how "we do things." Bob, the Superintendent of the corporate division, said:

> I think you know by calling it a practice you're getting away from you know, saying that there's something wrong with you, your bad behaviour needs to be reported it needs to be addressed, or you need to do something you need to be better at responding to victims of violence and trauma. If you call it a practice, then people understand it as this is something that I can actually practice that I can work on that will help me both as a person and as a police officer.

As a champion of TVIC implementation, Bob was very experienced and familiar with the culture of policing; therefore, he knew very well how to communicate the underlying messages of TVIC principles with his staff. Roy, the administrative sergeant, also believed that TVIC could create a culture of safety for staff. Implementation of TVIC could communicate that "you are supported you know as an individual." He added:

> To make those members aware that the organization is a safe place to be, to work, and to talk about anything that you may be encountering on a day-to-day basis or cumulatively with work and with home and to be able to feel comfortable going to a supervisor or a peer within the organization to express those concerns…it's taken seriously, and you know every issue is looked at from an unbiased opinion or scope to address that member's concerns.

In a culture of “show no weakness” and “don’t ask, don’t tell”, keeping TVIC alive was necessary. By maintaining momentum for change, TVIC could bring about fundamental shifts in the culture, and change the institutional narrative. Roy said, “momentum is key and keeping momentum going, and I think on a daily basis showing people that we're not going to move from the outset objectives, and we're going to keep pushing those to assist people.” He believes that an organizational commitment by the leadership to TVIC will sustain TVIC implementation.

#### 5.2.2.2.4 Leadership Commitment

Support and encouragement from the leadership was another implementation driver evident in all participating organizations. The executive director of the settlement agency, Kent, supported implementation from the outset. Providing care and support for the staff who worked closely with highly traumatized individuals was part of the organization’s strategic plan. He knew working with clients with high levels of trauma would impact his staff and organization; therefore, he was looking for an intervention to help his organization. As he said:

> It [working with Yazidi refugees] affects our people, it affects our work, and I was looking for something to strengthen our staff, and this [TVIC] is the best investment we could do to invest in our people by giving them the tools to have a TVIC lens in their work and to better support their clients and better support themselves, for self-care, so that's why this was so important for us.

TVIC enhanced their knowledge about trauma and violence and provided a tool that they could apply to work with the clients fulfilling Kent's vision for his organization. Despite his busy schedule, he was part of the TVIC committee, and his support for TVIC implementation was clear to his staff. Kia said:

> We're moving in the right direction, I think. And the management seems to take it very seriously too, which is good and now I think it's yeah it is somehow empowering the staff to deal with clients.

Kia believed the implementation of TVIC was necessary, and he was clear that the leadership of the agency fully supported this initiative. He was also aware that the leadership intended to

provide support and extra resources for the staff rather than adding another task to their workload. Sally, the capacity building coordinator also emphasized the importance of the support Kent gave the TVIC committee. She said:

> I think I was lucky enough to also, you know, being in an agency where they're like, no we're doing this, which is, I think a privilege and a luxury that you have someone that's top leadership saying we are doing this is so important for us to do because that's not going to always be the case.

The leadership commitment and support were evident in the organization encouraging the champions and other staff to move forward with the implementation.

**Police services** have a hierarchical culture, and leadership is always looked up to as an example of proper conduct, with senior staff being role models for the younger generation; therefore, support from leadership was a significant driver for the sustainability of TVIC. As a senior officer, Bob was very committed to his role on the TVIC committee, and despite being transferred to another division, he maintained his involvement. He emphasized the importance of sustainability of the implementation and providing staff support to practice TVIC. He said:

> We talk about sustainability and sustaining this. You know this practice is not something that once the training is done in the in-service training block, everyone just walks away forgets about it, right it's practice. It's almost like you said it's ongoing. It's going to be a continuous process, and we're going to continue giving you tools.

The commitment showed by Bob as a senior officer was evident in the TVIC meetings and other related initiatives. He was aware that becoming trauma and violence informed was an important task that required continuous attention. Karen also talked about how leadership could impact the implementation. She said, “that it really is in leadership and when leadership emulates certain things people naturally follow them.” She also emphasized the involvement of the leadership and how their buy-in could increase the fidelity and sustainability of the implementation process. Roy also highlighted the importance of top-down support from the leaders:

> I think it has to be championed from them I think it has to be, you know, fought for by a representative within the executive that brings that to, you know, every commander meeting, every interaction, every opportunity that they can have they're going to try and interject little seeds I guess again of growth in everybody that they talk to. And whether that's through the web or through one on one or they throw money at it. To keep, you know, ingesting from the executive down, that this is a priority and always will be right. Otherwise, it loses air pretty quickly [and] people go back to their old ways.

Roy pointed out essential ways that the leadership commitment could support the TVIC implementation. For instance, their involvement in multiple meetings and committees in the organization could provide the chance to mention TVIC implementation and validate it. Also, the financial support for implementation needed top-down assistance from the executive level.

Anita, the ED of the interpretation and translation agency, was also committed to implementing TVIC because working as an interpreter was impossible without understanding the trauma and violence involved in pre-and post-migration. She said:

> I'll be very honest. Looking at how our staff have worked and how we stand in the work ourselves brought to my attention that we have to recognize who we are, who we were before we came to Canada, who we are in Canada, and how do we stand in this work since it is uniquely linked to who we were before and those we really share space with.

As the executive director of the agency, Anita was directly involved with the implementation process. She was also the other member of the small TVIC committee of two individuals. Despite her busy schedule, she monitored and facilitated the TVIC implementation every step of the way, and when the organization encountered financial obstacles, she worked closely with Sophie, the external purveyor, to find solutions.

Across the three organizations, the implementation process included both bottom-up and top-down approaches. The leadership commitment and the staff and champions' engagement were' complementary drivers of implementation'. TVIC implementation was moving forward in all the organizations because of these mutual commitments. Further structural and policy changes also facilitated TVIC implementation, as discussed in the next section.

#### 5.2.2.2.5 Policy Changes

The analysis in this section is only based on my data from the settlement agency since the other two organizations were not at the stage in which policy changes usually take place. In **the settlement agency**, the first implementation phase focused primarily on staff development at the individual level. The organization and the committee acted vigorously to implement the action plan items and meet their staff needs. After providing support and training for the staff on the individual level, the committee realized that even though there was value in investing in the staff's wellbeing, structural and cultural barriers embedded in the organization prevented the staff from benefiting from newly developed skills. Sally, the capacity building coordinator, said:

> We keep on brushing up against the structural piece, so you know. It's hard sometimes to do, like, self-care training, but then our staff don't have time for breaks. It's like one of the best examples I can come up with from an operational perspective. So it's great that we're giving time for people to, you know, increase some skills or learn about self-care or things like that, but when you're running into I often think like scheduling problems or you know policy pieces things like that. Unless those things change, it's hard for our staff, I think, on the individual level to really make sustainable changes which you want the sustainable piece, not just sort of the individual level pieces.

They realized that staff could not benefit from individual-level training if the organizational infrastructure was not supportive. To make implementation *happen* required the organization to move beyond the baseline training and fully commit to the necessary structural and cultural changes. Kia said:

> [I]t's not just about the training, right? Like if you want to be a TVIC organization, I feel like, unfortunately, you can't just provide some training and then just say, oh now we're a TVIC organization, you know, so there needs to be something more.

The committee was aware of the importance of the structural and cultural changes, but they were also aware that change could mean something different in different departments. They started an operational audit designed to connect individual teams to determine their unique needs related to

necessary structural and cultural changes in their section. Sally, the capacity building coordinator said:

> There are different programs, so we can't just sort of having a blanket audit. We have to sort of be mindful that there's different sorts of subcultures and different needs and then trying to sort of empower teams to make some structural changes in the ways that empower them to actually make changes that will possibly affect, I think, both the staff but then also clients.

The committee invested time and resources in understanding each department's unique and specific culture because they believed a one-size-fits-all solution could not accurately resolve the structural issues in the organization. Sally, the capacity building coordinator said:

> Things like, look for clients, how many drop-ins they have? Do the staff have scheduled appointments? are they taking breaks? Are they working through lunches stuff, like that.

In identifying the specific needs of each team and the organization's subcultures, the committee also encouraged and invited each team to participate in creating the necessary changes. For instance, after the TVIC training, one of the departments decided to re-examine their routines and procedures by applying the TVIC lens. Sally remarked, “they reviewed some of their intake forms, so I think that's a good example of sort of the structural piece that they had in training.” The department reviewed their intake forms to ensure that the questions were not causing further harm and re-traumatization. Other departments also started to implement significant changes in their work environment. Kia, another member of the TVIC committee, questioned his department's cultural norms and preestablished routines. He said:

> You know, like, is there anything that we should change about the work culture or the work environment? Because maybe it's not only the clients who are stressing out. Maybe it is the working environment or the working conditions that are also affecting the staff.

Implementation of TVIC for Kia included providing informed care for the clients and staff. As a committee member, he became curious about how the stress involved in their jobs impacted their wellbeing and how open the management was to implement changes to increase staff wellbeing.

He learned about structural violence in the TVIC training and translated his learning into how his clients and staff could experience structural violence.

The organization also changed its hiring and onboarding policies to make TVIC baseline training mandatory for the new employees. Kent, the executive director, said:

> Like, if you want to help a person, you would have the CPR and first aid certification. Somebody was having, let's say, a heart attack. Well, this is somebody having a dissociation syndrome or this type of trauma-related refugee … flashbacks or anything. So, there should be some kind of a basic level where everybody, even the volunteers working with the organization, they should be trained or knowledgeable or should undergo an orientation … it is something that has to be at the core of competencies of someone who provides service to traumatized refugees.

The leadership of the organization was very aware of the necessity of TVIC training for the staff. Implementation of TVIC required the entire organization to adapt the TVIC principles and learn how to work with highly traumatized clients. Having a consistent understanding of the TVIC principles across the organization was an essential goal for the leadership; therefore, top-down support was available for the staff at all levels.

To further establish consistency in service delivery, the organization also examined the physical space of the organization to find discrepancies between the TVIC principles and their environment. Sally, the capacity building coordinator, said:

> Looking at things like environmentally speaking like when clients walk into the agency, what do they see? is it accessible? is it welcoming? So, sort of environmental pieces, operational pieces.

It was important for the organization to exhibit its commitment to TVIC principles from the first moment a client would enter the organization. Therefore, they scanned their existing environment and decided to improve it accordingly. For instance, they changed the reception desk's size and replaced it with a larger desk. The new desk provided more space for the receptionists and clients to speak privately. They also added toys and other items in the waiting

area to keep children occupied. Jain, the wellbeing counsellor, suggested adding posters and signs

> We talked about it, a poster saying *we are a TVIC organization* … just that statement you know and something provocative, something that would give the message, give you a little bit of a smile.

The implementation of TVIC also encouraged the organization to move their offices to bigger rooms to provide more space for the staff and clients to have more privacy.

> We're too cramped. Clients come in, and there's no confidentiality, you know like it's not welcoming like in that. You come in, and you have three key workers in a room and clients coming in and then small waiting area … we've done our best, but it's not really sort of ideal circumstances so the staff made a decision to move one of the offices and they put a huge amount of effort of really thinking their way through it, so we now have dedicated or will have their dedicated offices for clients.

The implementation of TVIC continued to be a significant part of the conversation in the organization. New initiatives and changes were brought forward by staff voluntarily to facilitate service delivery. The organization and the committee continued improving the structure and culture of the organization to become more compatible with the TVIC principles. Changing the offices' layout was another step toward becoming trauma and violence informed. As the implementation unfolded, more staff showed interest in being involved in the process and applying a TVIC lens became more a natural way of doing things in the organization.

#### 5.2.2.2.6 Evaluation

Evaluation of the TVIC implementation was an important factor for monitoring the process and creating a feedback loop. In the settlement agency, the TVIC committee evaluated the baseline training. Since reliable scales and measures to evaluate TVIC implementation were not available, the TVIC committee was uncertain how to proceed. Sally, the capacity building coordinator, said:

> I think I mean I think another challenge is the overall evaluation processes because I think you know we've put in some just some really basic evaluations about like the training and new staff debriefing training, and in our meetings, we can sort out the progress anecdotally, but it's I think it's challenging for agencies like to know what are the right measurements in order to actually evaluate how we're going to in a way that's like reliable and valid.

The implementation of TVIC, as constructed by those involved in this project, is relatively new. Without prior implementations to learn from, the committee was trying to find indicators that could be measured to evaluate the TVIC implementation. Kent, the ED, said:

> Maybe you know even like sick days from our staff, frontline staff, less burnout, less stress leaves, less turnover. Again, how could we know which part of it is or could be attributed to TVIC, which part is to other measures because that's difficult to measure?

Kent was trying to understand what outcomes should be measured as indicators of a successful TVIC implementation. Since a primary focus and motivation for Kent was his staff wellbeing, he was interested in determining whether there was a reduction in the stress level of staff and if there was how it could be related to TVIC implementation. Yet, it was challenging for the organization to connect between reducing stress levels and TVIC implementation since other structural changes not related to TVIC, such as changing the management team or decrease in the workload, could also contribute to stress reduction. The agency was also interested in measuring the overall impact of the TVIC implementation on the organization. Kent said:

> This is what I'm asking the committee I asked the last time we met and now is going to be again a topic on the agenda how do we measure our success? How do you measure the impact? How do we measure the impact on our work? And again, this is why it is good to continue to have a relationship with researchers who could help us measure that.

Kent and the TVIC committee were aware of the importance of the evaluation, but they lacked internal resources to do it. Once again, partnership with an external organization, especially Western University, became vital to proceeding with the evaluation. In my last interview with

Sally, she stressed that developing specific and tailored measures to evaluate the TVIC implementation was in progress.

**The police service** approached evaluation differently. With the help of the coaches and purveyors, they used a logic model to determine the desired outcomes compatible with TVIC principles, such as increasing staff knowledge of the impacts of trauma and violence or providing a physically and emotionally safe environment in the organization. A climate survey was developed applying informed by TVIC principles. The survey measured staff knowledge of trauma and violence, staff interactions with the leadership and supervisors, and the organizational services and support available to them. The survey was sent to the entire organization before starting the TVIC baseline training. Another survey was developed to evaluate the staff feedback on the TVIC training, complemented by individual interviews. The climate survey was also modified and sent post-training to detect any change due to the TVIC training. The survey results informed further necessary steps in implementing TVIC (discussed in previous sections).

The interpretation and translation agency also conducted focus groups with the interpreters before the baseline training to invite them to decide what should be included in the TVIC training based on their needs. The agency also measured the staff feedback after the TVIC baseline training.

#### 5.2.2.2.7 Barriers to TVIC Implementation

A) Lack of Resources, Staff Turnover

The organizational barriers to implementation have been presented in previous sections intertwined with other concepts I have discussed. This section will review organizational barriers that have not been discussed and were often common to all cases. All three participating organizations had limited financial resources for TVIC implementation. In **the settlement agency,** the implementation of TVIC was an internal initiative, and the agency did not receive any external funding. Kent, the ED, said:

> It is also based on the capacity of our organization. We don't have extra funding for this [TVIC implementation] is just an internal effort. We don't have you know outside resources to help support this.

Kent and his Board were committed to bringing TVIC to the settlement agency; therefore, they utilized their internal resources to support the TVIC implementation despite lacking new resources. TVIC implementation in **the police service** was also dependent on external funding to compensate the coaches and purveyors. After completing the first phase of the implementation, the project was put on hold for several months to apply for more funding. The coaches and purveyors were, at time of writing, applying for more funding to continue with the second phase of implementation. Implementation of TVIC in **the interpretation and translation** agency also suffered from a lack of financial support. After completing the baseline training, the organization was not able to continue with the process. Sophie and Anita were, at time of writing, applying for more funds to continue the implementation.

Another difficulty for the participating organizations was staff turnover. Linda, the interpretation and translation agency's training coordinator, left the organization shortly after the TVIC baseline training was completed. As a champion of TVIC implementation in a small TVIC committee, her absence significantly impacted progress, leaving Anita (the ED) as the only champion in the agency. The settlement agency also had to deal with staff turnover. Sally, the capacity building coordinator, said:

> There's always these sorts of, you know, funding issues, and like whatever would happen in a general organization, there's always these sort of things that do happen. So I think to some extent you were going to go back and forth a little just because you sort of reach up a place, and then what happens with the major part of that component is that the staff leaves or what happens if you have a new resettlement group coming in or you know so there's these sort of operational, organizational things that happen.

The operationalization of TVIC in the settlement agency was sometimes difficult because of staff turnover. The new staff needed the baseline training even though becoming a permanent employee was not guaranteed. In addition, their clients could change, and new refugees with

unique needs could arrive demanding shifts in service delivery. The arrival of the Yazidi cohort prompted the TVIC implementation; having a new wave of newcomers with different circumstances and needs was always a possibility.

Other external pressures, such as the COVID 19 pandemic, created obstacles for TVIC implementation. For instance, the settlement agency had to postpone the evaluation process when the lockdown started and shift their focus on ensuring the wellbeing of their staff and clients. New approaches to service delivery had to be implemented to accommodate clients, such as having online sessions with newly arrived refugees. Competing demands were also problematic for the police service. Working with new restrictions installed because of the pandemic, increased call volume when they were short-staffed even before the pandemic, and negative public perceptions of policing (e.g., during Black Lives Matter protests and calls to defund police), were a few of the issues that the police service needed to attend to, which, at times, pushed the TVIC implementation aside.

In the next section, I summarize the implementation processes in the participating organizations by applying the Active Implementation Frameworks, to map organizations' progression by AIF stages.

## 5.3 Synthesis of the Implementation Process in Participating Organizations

In my analysis, AIFs acted as a guide for interpretating what happened in each site. There were also other emerging implementation drivers beyond what the AIFs offered or explicitly emphasized.

As discussed in chapter 2, Active Implementation Frameworks use a formula to describe the contributing factors for successful implementation (usable intervention x effective implementation methods x enabling context= desired outcomes). Each factor in the formula includes specific components, and installation of these components enables the implementation process and contributes to achieving fidelity and sustainability (Duda, 2015). The first part of this formula describes the criteria for a usable intervention. In the next section, I apply these criteria to describe TVIC as a usable intervention.

### 5.3.1 Effective Methods (When, Who, and How)

The second factor in the AIFs formula refers to effective methods and strategies for implementation. Together, these methods build the necessary infrastructures for creating an enabling context for the intervention to be practiced as intended and include stages of implementation, implementation team, individual and organizational drivers, and improvement cycles (Bertram et al., 2015). In the following sections, I review the implementation process in the participating organizations to review if/how the structural and cultural changes that resulted from the implementation of TVIC are aligned with AIFs' effective implementation methods.

### 5.3.2 Implementation Stages

Implementation for intervention is a nonlinear process that often happens over 2-4 years. The implementation stages always overlap, and there are no clear boundaries for when one stage begins and the other ends; however, AIFs include certain activities in each stage to provide a map for organizations to estimate where they are in the implementation process. An organization could move to earlier stages during the implementation process due to internal factors such as turnover or external factors such as financial constraints (Bertram et al., 2015). The participating organizations in this study moved through stages of implementation that overlapped with AIFs. As I discussed at the beginning of this chapter, at the end of the data collection process, the settlement agency was in the full implementation stage, the police service was in the initial implementation stage, and the interpretation and translation agency was in the installation stage. Table 6 below displays how activities in each stage of the active implementation framework were mapped to strategies implemented in participating organizations.

**Table 10**

***TVIC Implementation Progress in Participating Organizations: Applying AIFs Implementation Stages***

| Stage | Activities | Actions Across Case Sites |
|---|---|---|
| Exploration | • Assess needs<br>• Examine interventions<br>• Examine implementation<br>• Assess fit | ✓ Building partnerships with other organizations to learn about TVIC<br>✓ Assessing TVIC as a good fit for the organization<br>✓ Planning the implementations with coaches and purveyors<br>✓ Assessing the organizational readiness<br>✓ Making the final decisions to proceed with TVIC implementation |
| Installation | • Acquire resources<br>• Prepare staff<br>• Prepare organization<br>• Prepare implementation drivers | ✓ A few implementation drivers were established<br>a. Champions for the implementation team were identified and invited to be part of the implementation team (staff selection)<br>b. Baseline training was planned, and dates were set (training)<br>c. Coaches and Purveyors codesigned the baseline training and developed an implementation plan (coaching)<br>✓ Organizational leaders announced the implementation of TVIC as a priority and emphasized their support |

| | | |
|---|---|---|
| Initial Implementation | • Service delivery initiated<br>• Implementation drivers<br>• Manage change<br>• Data systems<br>• Improved cycles | ✓ Trainers delivered the training both in-person and online<br>✓ The TVIC meetings began, and the implementation team met regularly with the coaches and purveyors to consult on the implementation process<br>✓ Extra training and resources were provided for the staff based on their feedback<br>✓ Leaders of the organization attended TVIC training and TVIC meetings |
| Full Implementation | • Monitor and manage implementation drivers<br>• Achieve fidelity and outcome benchmarks<br>• System and organizational changes institutionalized | ✓ Training became mandatory for all staff and new employees<br>✓ Auditing all the departments to assess TVIC implementation in practice and the outcomes<br>✓ Planning evaluation of the entire organization to determine fidelity and sustainability<br>✓ Creating TVIC newsletter to communicate with staff<br>✓ Making environmental changes in the organization to create safe environments |

### 5.3.3 Implementation Team

The implementation team is one of the key implementation frameworks in AIFs. In all three organizations, an implementation team/TVIC committee was established in the initial stage, then actively engaged with the implementation process. The team members monitor the implementation process, establish implementation drivers, and ensure necessary structural and cultural changes for successful implementation (INIR, 2021, Fixsen et al., 2005).

The implementation team varied in size across the three sites. In the settlement agency, the implementation team was large and included members from different departments in the organization. The diversity of the team ensured equity and inclusion of the unique needs of different departments. The ED of the organization was also part of the implementation team, providing extra support and legitimacy. The police service also had a large implementation team with representatives from multiple branches; however, the sworn members were not included in the initial implementation team and were invited to participate in the committee in later stages. The implementation team was small in the interpretation and translation agency and included two people from the organization (one who later left the organization) and Sophie, the coach and purveyor.

In all three organizations, leaders, EDs, senior staff, managers, and direct service providers were part of the implementation team. Their commitment created a unique dynamic, making the implementation process a top-down *and* bottom-up approach that facilitated TVIC implementation.

Purveyors, also described as “agents of change,” work with organizations to facilitate the implementation. Their previous experiences and accumulated knowledge can help organizations to be more confident during the implementation process. Purveyors can also assist the implementation teams in being aware of any emerging complications and potential solutions (Fixsen et al., 2009). Coaches and purveyors were part of the implementation teams in all participating organizations. They assisted the organizations throughout the TVIC implementation. Their collaboration with the implementation team ensured that TVIC implementation was tailored to each organization’s unique needs and context while aligned with

TVIC principles. Together with the implementation teams, they reinforced structural and cultural changes and monitored the process. The implementation teams all had regular meetings and discussions with a specific action plan to follow, with the tasks were distributed across members to decrease the workload and create reasonable expectations.

### 5.3.4 Implementation Drivers

The implementation drivers provide the necessary infrastructure for the implementation of TVIC, with AIFs indicating nine implementation drivers in three categories (see above). Below I will discuss structural and cultural shifts implemented in the participating organizations according to the AIFs implementation drivers.

#### 5.3.4.1 Competency Drivers

The competency drivers have four subcategories, including staff selection, coaching, training and fidelity assessment. The purpose of creating competency drivers is to support staff in building confidence and competence to use the new intervention (Duda, 2015).

Staff selection: AIFs suggest that staff selection should move beyond academic qualification or professional experience. Specific characteristics that cannot be provided through training could be considered in staff selection (Bertram et al., 2011). In all three organizations, the champions of TVIC were more familiar with the principles of TVIC and had professional experience in leading teams. In addition, they strongly believed in bringing positive and necessary changes to their organization by implementing TVIC. This personal interest created a unique commitment to overcome implementation barriers such as administrative changes. For example, in the police service, Bob and Roy continued working with the implementation team after moving to other roles within the organization. The police service also selected champions from a well-established and trustworthy mental health and wellbeing committee to implement the TVIC. Both senior and junior officers were part of the implementation team except for sworn members who joined the implementation team in later phases.

The settlement agency effectively utilized the capacity-building coordinator as a champion of TVIC implementation. Her unique position and job responsibilities allowed her to become fully

engaged with the implementation process. She invited staff from across the organization to engage with the implementation in different capacities, such as participating in the TVIC meetings, communicating TVIC related initiatives with other staff, and applying learned skills in service delivery. The interpretation and translation agency also assigned the agency's training coordinator the implementation. She was also very much interested in bringing positive changes to the organization to support interpreters. Joined by the ED, both members believed TVIC was an excellent option to overcome organizational challenges.

Training**:** The implementation teams in all organizations started the implementation process by planning and designing the TVIC baseline training for the entire organization, providing professional development for all staff to understand how to embed TVIC in their own practice and across organizational policies and protocols. The settlement agency and the police service also planned and delivered other related training that supported the practice of TVIC. Providing relevant training and extra support became part of an ongoing agenda in these two organizations to ensure fidelity and sustainability.

Coaching**:** In all three agencies, coaches and purveyors were hired to support staff practicing the newly learned skills in real-time. The coaches and purveyors ensured staff received adequate and efficient support throughout the implementation process. They participated in the meetings regularly and guided the implementation team on how to move with the implementation plan.

Fidelity assessment**:** The impact of TVIC in service delivery was not systematically evaluated in any of the organizations. Even though TVIC fidelity assessment tools have not been developed specific to this conceptualization and operationalization of TVIC, post-training feedback was collected from all the staff in all three organizations. The feedback informed the implementation team about the impact and quality of the training. The input also informed the implementation team what further support was required by staff.

#### 5.3.4.2 Leadership Drivers

Leadership support was one of the essential implementation facilitators. AIFs also emphasize the importance of support from leadership. Leadership as a driver also focuses on types of leadership strategies as technical (more adaptable for direct and uncertain situations) and adaptive

(uncertain and multidimensional circumstances) (Bertram et al., 2011). Both forms of leadership were present in the implementation of TVIC. In the settlement agency, Sally, the capacity-building coordinator and leader of the implementation team, responded well during challenges requiring a more traditional leadership approach. She worked well with coaches and purveyors to plan TVIC training, organize the TVIC implementation team and the action plan, and follow up with other team members. Despite being more comfortable with the leaner process and project-oriented approaches, Sally also learned how to work with the non-linearity of TVIC implementation and adapted to the complexity and uncertainty of the process. She managed disruption that arose from questioning the status quo and the power dynamics between the staff and managers. She allowed staff to have enough time to understand what becoming a trauma and violence-informed organization meant for them. Sally also encouraged a bottom-up approach for championing TVIC implementation by staff.

The culture of police services is more comfortable with clear and precise structures and chains-of-command. Therefore, tasks such as planning training sessions that required traditional leadership were well-performed. However, leadership commitment for TVIC implementation also allowed - adaptive approaches to emerge. Even though the organization was dealing with many competing demands, the TVIC implementation remained a priority for the leadership; the organization kept moving forward through uncertain and challenging times, particularly during the COVIC19 pandemic and anti-racism protests.

Leadership in the interpretation and translation agency was also very supportive of the TVIC implementation, but the organization did not reach further stages of implementation.

#### 5.3.4.3 Organization Drivers

Organization drivers focus on providing structural support to facilitate implementation and use new interventions as intended. This structural support includes decision-support data systems, facilitative administration and systems intervention (Bertram et al, 2015).

**Facilitative administration** provides organizational support to facilitate implementation, including developing new policies, procedures, and guidelines. The pre-existing structures are also adjusted to support new ways of service delivery (Bertram et al., 2015). The interpretation

and translation agency did not reach this stage, but the settlement agency and the police service created structural and cultural changes in their organizations to provide the necessary support for TVIC implementation. Since both organizations were committed to moving beyond delivering the TVIC baseline training, they were aware that incorporating TVIC into their practices could not be accomplished without implementing and managing change. Commitment to cultural changes proceeded and encouraged the structural changes in the two organizations. TVIC provided a new perspective on working with highly traumatized clients in the settlement agency, creating a culture of care by changing the language from *non-compliant client* to *clients with a history of trauma and violence*. Providing the TVIC training to all staff, including contractors and new employees, indicated the importance of embedding this perspective into the organization's culture. The importance of confidentiality, creating safe spaces, and collaboration with clients encouraged environmental changes such as building spacious offices and welcoming reception desks. The intake forms and other settlement routines such as housing processes also were modified by taking a TVIC perspective. The police service was also interested in changing the stigmatization of mental health and trauma. The implementation of TVIC led to creating a new branch focused on staff mental health and wellness, which was nested in the TVIC implementation. Learning about the impact of trauma and violence on individuals also improved staff interactions with community members.

The **decision-support data system** assists organizations in making informed decisions (Bertram et al, 2015). The settlement agency collected feedback post-TVIC training informing their decision for providing extra training. In the further stages of implementation, the team often considered anecdotal information, budgetary factors, and other organizational capacities to inform their decisions. The police service conducted pre and post TVIC training surveys involving the entire organization. The interpretation and settlement agency also collected feedback post-TVIC training.

The **systems interventions**, which are the third component of the organization driver, refer to strategies often used by leaders to facilitate implementation and create an enabling context. These interventions often include acquiring financial and organizational support from external sources to aid the implementation (Bertram et al., 2015). All three organizations had strong

partnerships with other local organizations. The commitment of these other agencies to do their part in making London a trauma and violence-informed community sparked collaboration between various organizations to move this initiative further. For instance, in partnership with the local Community Health Centre, the settlement agency established a new clinic for newcomers and refugees to provide primary care. The participating organizations also applied for external funds to support and secure financial resources for TVIC implementation.

#### 5.3.4.4 Improvement Cycles

Creating Plan-Do-Study-Act cycles is also an essential step for continuous improvement and problem-solving. These cycles are often completed in later stages of implementation (Bertram et el., 2015). Therefore, the settlement agency was the only agency that reached this stage. The agency created an operational audit to monitor how TVIC was practiced and provide appropriate coaching and guidance based on each department's unique needs. Creating the improvement cycles assisted the organization with usability testing, which determines ideal situations in which TVIC was practiced as intended.

Overall, the AIFs provided a useful guiding framework to understand and make visible the implementation activities, processes and outcomes undertaken by the three case organization

# Chapter 6

# 6 Discussion

This study explored the TVIC implementation process in health and social services. In the first phase, perceptions of TVIC and factors motivating TVIC implementation among interested organizations were explored. In the second phase, the TVIC implementation process was studied in three organizations providing social services. Examining, across time, the implementation stages in each organization shed light on understanding the structural and cultural shifts required for the sustainable implementation of TVIC in multiple contexts.

The results of phase one underscored motivational factors for the implementation of TVIC in participating organizations. Factors such as providing tailored care to the needs of clients, and the impact of vicarious trauma and burnout on staff encouraged the leaders of the organizations to seek new solutions to implement structural and cultural changes. The participating organizations viewed TVIC as a viable solution to implement the required changes because the principles of TVIC provided valuable knowledge on the impact of trauma and violence both on clients and service providers, and offered guidelines for implementing change at individual and organizational levels.

In the second phase, the participating organizations started the TVIC implementation by establishing a TVIC committee and providing baseline training for the leaders and staff. The feedback from the baseline training further encouraged organizations to bring complementary training and workshops to the organization for building extra support. Implementation of TVIC was championed by staff as a promising intervention to implement change. Essential implementation drivers facilitating the process were identified, including establishing a dedicated TVIC committee, organizational commitment, and leadership support throughout the implementation process, and engagement and partnership with local organizations and experienced coaches and purveyors. Barriers such as lack of resources, staff turnover, and the COVID 19 pandemic were also identified.

It should be noted that TVIC as a newly developed intervention has not been studied extensively. Research up until this point mainly examined TVIC as a component of the EQUIP Healthcare intervention (Browne et al., 2015; Varcoe et al., 2019). In fact, this is the first study looking into the implementation process of TVIC as a distinct intervention in social services. In addition, Active Implementation Frameworks (AIF) have been mostly applied in the educational setting to guide the implementation process (Fixsen et al, 20). This study took a novel approach by using AIFs in other complex contexts and mapping these frameworks with the TVIC implementation. Therefore, the synthesis of AIFs with findings in chapters 4 and 5 provided an implementation science approach to map each organization's activities and processes to illuminate further what it takes to become trauma- and violence-informed. Applying AIFs to study the implementation process of TVIC confirmed the strength of the frameworks and identified other contributing implementation drivers (intra-inter relationships in organizations discussed below). Furthermore, applying interpretive description (ID), a pragmatic methodology, the findings provide insight into how to implement TVIC, offering practical suggestions for organizations interested in implementing complex interventions such as TVIC in complex contexts such as health and social services.

In this last chapter, I discuss the broader picture of this study's results, including TVIC as a usable intervention and its interactions with the complex contexts on macro, meso and micro levels while expanding on AIFs, implications for the evaluation of TVIC implementation, suggestions for future research, study limitations, and conclusions, including recommendations for policy and practice.

## 6.1 TVIC as a usable intervention

AIFs propose specific criteria for the usability of interventions, including a clear description of the program; clear program components that define the program; operational definitions of program components; and practical fidelity assessment (Fixsen et al., 2013). The first framework of AIFs suggests an intervention should have clear values, philosophies, and principles. To achieve consistency and fidelity, a clear description of the essential features and their operational definitions should also be provided. Finally, a systematic assessment should be designed to evaluate the fidelity of the intervention (Fixsen et al., 2013). TVIC was first developed –

grounded in previous work on trauma theory and trauma-informed practice - as a key dimension of equity-oriented health care as defined in the EQUIP Healthcare intervention model (Browne et al., 2012; 2015), and has undergone continuous evolution, including the addition of new concepts and supporting tools and resources via EQUIP and the GTV Knowledge Incubator at Western University. These resources explain and provide support for operationalizing the principles of TVIC and clarify the underlying values and philosophies behind each principle (e.g., Wathen & Varcoe, 2019; EQUIPPING for Equity Modules, 2021). Furthermore, by applying multiple examples and cases, these TVIC resources illustrate the translation of these principles into service delivery, both at the individual and organizational levels. Recently, the TVIC Foundations online curriculum was developed by Western University and the University of British Columbia and funded by the Public Health Agency of Canada (Canas et el., forthcoming). These, and related, tools together allow TVIC to meet the three criteria of a usable intervention; however, an assessment tool has not been developed to evaluate the fidelity of TVIC uptake, application and success. The EQUIP model includes a self-assessment tool to aid organizations to assess, from the client perspective, service delivery based on equity-oriented care core values, with TVIC principles included in this assessment tool (EQUIP Rate Your Organization Tool, 2021). The tool is designed as a group activity that can facilitate discussion about equity-oriented care in organizations. The settlement agency used this tool at the onset of implementation to assess the organizational capacity for implementing TVIC.

TVIC meets 3 of 4 criteria of a usable intervention suggested by AIFs; however, it could also benefit from further improvements. For instance, in some organizations, service providers with minimal prior experience or training in mental health felt less competent to incorporate TVIC into their practices. The implementation champions also highlighted the need for more in-depth training on the theoretical concepts of TVIC and guidelines on planning and leading the implementation of TVIC, particularly at the onset of the implementation. Based on this feedback, more in-depth training of TVIC principles – such as the Foundations Curriculum cited above, which was not available when these organizations conducted their implementations - could be built into the baseline training. These newer versions could be tailored to the unique needs of staff in the organization. The need for fidelity assessment and more precise evaluation of TVIC effectiveness are other areas for improvement that I will discuss in later sections.

The results of exploring the TVIC interaction with complex contexts illuminated the importance of the content of TVIC. Research on related approaches, such as trauma informed care developed by Harris and Fallot (2001), and the Sanctuary Model developed by Sandra Bloom (1994) were more focused on the outcome of the implementation, such as the impact of the implementation on service delivery. Less attention has been given to the embedded contributing factors and the interactive components of TIC(P) as a complex intervention. Looking at TVIC as a complex intervention adds to current knowledge by outlining how the content of TVIC interacting with organizational context evolves and contributes to the implementation process.

Furthermore, even though AIFs describe the importance of intervention usability, the complexity of the intervention and its interaction with the context is less emphasized. Therefore, an ecological view of the implementation was taken to examine how TVIC interacts with complex contexts. This ecological perspective recognizes that the interaction between the intervention and the context creates "networks of person-time-place" and consequently "changes relationships, displaces existing activities and redistributes and transforms resources." (Hawe et al., 2009, p 267) TVIC interacts with the dynamic properties of the context, including 1) activity setting (e.g., meetings, events, assemblies); 2) the social networks that connect people and the setting; and 3) time. Therefore, the implementation of TVIC as a complex intervention is an event in the history of the context; it is implemented in and creates new "structures of interaction and new shared meanings" (Hawe et al., 2009, p 267). It was interesting to observe how the interaction between TVIC and the contexts created new understandings of TVIC principles among the people in participating organizations. Being guided by pragmatism and ID, I focused on emerging descriptions of TVIC that resulted in practical and applicable ideas. Marshall and colleagues (2005) argue that pragmatism could add a beneficial perspective to reproducing knowledge through social practices (social constructivism). Pragmatism could aid researchers while respecting the existence of multiple views of reality constructed through the interaction of an intervention with the context, focusing on what is useful depending on the research questions. For instance, the interpretation and translation agency contextualized TVIC by moving toward trauma and violence-informed *interpretation*. The police service also changed TVIC to trauma and violence informed *practice* as it was more familiar for their staff to "practice" new skills.

TVIC also interacts with the context of the implementation on macro, meso and micro levels. Even though at the onset of the study I was more focused on the interaction between TVIC and the complex context of the participating organizations, through data analysis, it became more apparent that the interaction between TVIC and the context began prior to the onset of implementation in any specific organization. This is not an unknown phenomenon in implementation research and expands on understanding the interaction between complex interventions and complex context. Pfadenhauer and colleagues (2017) argue that depending on the nature of the intervention, it could interact with the context on three levels, and activities in each level could enhance or reduce the impact of the implementation. These three levels are: "macro-level (refers to everything surrounding a community or organization),… meso level (refers to a community or organization) …[and] micro-level (refers to the level of direct action and delivery)" (p. 8). In the following section, I discuss how TVIC interacted with each level.

### 6.1.1 Partnership with Other Organizations and Experienced Coaches and Purveyors as Implementation Drivers

#### 6.1.1.1 The Macro level: London as a Complex Context

In 2017, Western researchers and community organizations launched an effort to make London, Ontario, a "TVIC Community." As previously described, the Centre for Research on Health Equity & Social Inclusion (CRHESI) convened a meeting and invited interested health and social service organizations to initiate a conversation about TVIC and its applicability to various community services. This collective effort from the community provided a unique opportunity for bringing interested organizations together and initiated collaboration among many of them. The timing of this event with the concurrent arrival of a group of highly traumatized Yazidi refugees from Northern Iraq further prompted interest in TVIC implementation in local organizations that served this population. Furthermore, the establishment of the GTV Incubator (described in Chapter 2) created extra support for TVIC implementation by connecting experienced coaches and purveyors who guided the implementation of TVIC, to both interested organizations and to expert researchers. Members of the interested organizations were also invited to participate in the GTV Incubator's meetings and activities. This was a critical step

because the involvement of community members often increases the relevance, effectiveness, and sustainability of the intervention (Pfadenhauer et al., 2017).

The established and robust relationships among organizations in the community, researchers, and coaches and purveyors acted as a vital implementation driver to facilitate TVIC implementation. Even though AIFs discuss the importance of the involvement of coaches and purveyors and receiving guidance from them, these relationships are not addressed as an implementation driver (Fixsen et al., 2005). The findings of this study, on the other hand, showed that more attention needs to be paid to the inter-relationships between interested organizations in the community. For instance, the familiarity and connection between interested organizations and the local mental health agency, the GTV Incubator, and Western University researchers boosted the implementation process. The trust required for the involved parties to successfully collaborate was already established when TVIC implementation began. This allowed the leaders to have a more hands-off (though still supportive) approach, permitting the champions to move the intervention forward. In addition, organizations such as the local mental health agency had years of experience with TVIC implementation, setting an excellent example for other organizations to envision where they were headed and what success looked like. This trust between partner organizations, particularly the coaches and purveyors, made it easier for the interested organizations to tolerate the uncertainty and non-linear nature of a complex implementation. Even though there were no explicit guidelines or blueprints for taking up TVIC, the coaches and purveyors were able to assist interested organizations, especially in assessing TVIC as a good fit. This was particularly important in the early stages of the implementation because the chance of terminating it in these stages is high (Fixsen et al., 2013). The coaches and purveyors were also already familiar with the context of the interested organizations; they facilitated the tailoring process of TVIC to the context. Long-term relationships between coaches and purveyors with organizational champions of the TVIC implementations eventually led, for example, to associating the name of a coach, ‘Sophia,’ with the reminders of TVIC principles in the interpretation and translation agency. These findings further emphasized relationships between organizations in the community and the presence of experienced coaches and purveyors who could facilitate the implementation process as implementation drivers.

These observations also provide further support for what has been referred to in implementation science as *intermediary organizations.* These organizations engage in multiple activities and functions to assist other organizations with the implementation process, and they play a vital role in improving it (Frank, 2010; Frank and Bory, 2017). Assistance from intermediary organizations in the community significantly impacted the implementation process, especially at early stages where the risk of stalling or failing was high. The impact of intermediary organizations in this study was also evident in the decision-making process of the organizations from Phase one that did not pursue the implementation of TVIC. A lack of financial resources was a significant barrier for these organizations, along with less connection with other organizations, which further added to these difficulties. The findings of this study additionally support engaging intermediary organizations, an important focus for policymakers and funding agencies when considering how best to support organizations implementing TVIC (Frank and Bory,2017).

### 6.1.2 Intra-Organizational Relationships as an Implementation Driver

#### 6.1.2.1 The Meso Level: Organizations as the Enabling Context

Research on the implementation of a complex intervention in complex contexts has demonstrated that when an intervention integrates with the context, it also changes the social structures and relationships in the organization (Hawe et al., 2009). Even though staff selection, providing training and coaching are parts of competency drivers, AIFs do not discuss these intra-organizational relationships in depth (Fixsen et al., 2009; Bertram et al, 2015). The results of this study suggest however, that principles of TVIC in interaction with the implementing organizations on the meso level changed and shifted the existing dynamics by transforming the structure and culture of the organization and redistributing key resources. Consequently, TVIC as an intervention in itself also evolved through the organizational implementation processes. These intra-organizational relationships and network connections in the organizations often acted as implementation drivers increasing the fidelity of the implementation.

As the first step, the TVIC training was tailored to the context with the implementation team modifying the baseline training provided by purveyors to meet the unique needs of their organization. Furthermore, the interaction between staff and coaches during the TVIC training

sparked new ideas for other training and workshops. TVIC implementation also created new relationships and enhanced teamwork and trust between different departments in the organization. For instance, staff representation from various departments across the organization allowed diverse voices to be heard and engaged. This encouraged bottom-up approaches and created frontline ownership (FLO) (Metzl and Hansen., 2013). FLO refers to inviting staff to be part of the implementation process by sharing their concerns, providing feedback, and being engaged in the process of decision making (Varcoe et al., 2019; Kaufman et al., 2017). For instance, initiatives and plans aligned with the TVIC principles, such as creating safe and inviting environments for clients/service users and staff, were put forward by staff independently. The implementation team supported these initiatives by approaching the process with patience and open-mindedness. They waited for the staff to express interest in volunteering and becoming engaged with the implementation process rather than "ordering" them to do so. The interaction between TVIC and the context created an atmosphere of awareness about the impact of trauma and violence. During meetings, the implementation team often emphasized that the implementation of TVIC must also be trauma and violence informed, meaning that staff members' potential personal trauma histories, their vicarious trauma, and the constraints and pressures of busy schedules needed to be considered during the implementation process. Integration of TVIC with the context also shifted the perception of implementation (Hawe et al., 2009). Being aware of staff concerns, the implementation team and leaders became more mindful of looking at the implementation as a process that takes time and patience rather than a project that should be accomplished in a specific time with a set endpoint.

TVIC also enabled organizations to bring previously siloed service areas/teams/units together and provided a container that held and connected these services. For instance, in the police service, the post-TVIC training survey showed that staff became more aware of supportive services in the organization. In addition, TVIC implementation in the police service resulted in the establishment of a new and independent branch for staff mental health and wellbeing.

### 6.1.3 Understanding Trauma and Structural Violence as an Implementation Driver

#### 6.1.3.1 The Micro-Level- Bringing TVIC into the Practice

At the individual level, the integration of TVIC mostly changed how staff perceived their clients and their history of trauma and violence. TVIC raised awareness about the impact of trauma and violence on individuals and reconstructed the notion of "non-compliant clients." TVIC explicitly emphasizes both interpersonal violence (e.g., child maltreatment, intimate partner violence) and structural violence (poverty, homelessness, racism, and other forms of discrimination, etc.) and trains service providers on recognizing the impact of the historical and ongoing violence on their clients' lives (Varcoe, forthcoming). This emphasis often created structural competency in the participating organizations, i.e.,

> The trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of several upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (Metzl and Hansen, 2013, p.5).

Staff in all organizations became more aware that the intersection of systemic issues and social determinants of health could further perpetuate their clients' struggles. This awareness created structural competency, allowing staff to better understand the frustration they may experience in being unable to help their clients; the anger and disappointment showed by their clients and the inadequacy of resources in the community often stem from structural and systemic issues. This explicit emphasis on structural violence became an implementation driver and led to structural and cultural changes in the participating organizations. This was a significant finding because other participating organizations in Phase 1, which had implemented trauma-informed training, often were not aware of the concept of structural violence and had difficulty articulating what structural violence meant and how it could be manifested.

Participating staff also modified routines and procedures that were harmful to their clients. For instance, in the settlement agency, one of the coordinators voiced his concern about a mandate issued by the Ministry of Immigration, Refugees and Citizenship, requiring his staff to ask their Yazidi clients to repeatedly retell their traumatic stories. He believed this would further traumatize his clients and create vicarious trauma for his staff, who are not generally trained in mental health counselling. The police officers also anecdotally reported that the TVIC implementation had changed their relationships with community members. They have become more aware of the impacts of trauma and violence on people they encounter daily and felt more encouraged to act compassionately. This could be a critical service improvement because empathic responses from police have important implications in the community. For instance, perceived empathy from police officers correlates with enhanced relationships between the officers and sexual assault survivors, who are less likely to develop severe PTSD and feel shame and more likely to take their case to court when they perceived police officers as empathic (Maddox et al.,2011). Thus, embedding TVIC in police services can be one way to redress a significant gap in how officers interact with the public.

TVIC also helped staff members make sense of their individual trauma history, changing the culture of "show no weakness and toughen up*"* to recognizing the inevitable consequences of exposure to trauma and violence on individuals. This realization encouraged awareness of the impacts of vicarious trauma and engagement in activities that helped them, such as debriefing and building peer group support. We know from a significant body of literature (Williams et al., 2020; Williamson, 2018) that vicarious trauma, especially as we emerge from the COVID-19 pandemic, is a key concern for workforce wellbeing and strategies such as TVIC to address these are an urgent priority.

TVIC implementation and training could also create disruptions and challenge existing power dynamics (Browne et al., 2018). Understanding the impact of structural violence encouraged staff to investigate the structure of their organizations and locate where they were subjected to structural violence. For instance, staff questioned management approaches that were ignorant of the pressure and difficulties experienced by staff. Managers' policies, such as having open doors, were not seen as helpful by staff since they felt openly voicing their concerns could risk their job.

The content and principles of TVIC in interaction with the context acted as another implementation driver for sustainable implementation. In organizations in the later stage of TVIC implementation, it became almost unnecessary to keep reminding staff of the principles of TVIC. They did not need to choose to be trauma and violence informed in their actions. It had become the way they did things. TVIC became a lens that staff applied in their daily activities. This reinforces the need for ongoing formal training, onboarding and informal supports for new staff, especially during times of staff turnover.

## 6.2 Evaluation

Evaluation of TVIC is another critical point worth discussing here. Even though measures for evaluating the implementation of T(V)IC have been developed, a scoping review conducted by Wathen and colleagues (2021) showed that these measures are very limited and generally assess knowledge and attitudes about trauma and violence at the individual level, and do not fully examine all aspects/principles of TVIC or associated concepts like implicit bias. Therefore, there is a gap in research regarding how to evaluate the implementation of TVIC and assess various aspects of "success." Since this study explored the implementation of TVIC in select organizations, the results could shed some light on future directions for developing appropriate measures and the evaluation of TVIC.

This study also applied a complex context thinking approach, allowing the results to reflect the interactions between TVIC as a complex intervention within complex contexts. This is important because adapting complexity system thinking while designing and exploring the impact of complex interventions leads to important enhancements on traditional forms of evaluation (Hawe, 2015a). In traditional views of evaluation is "something that is done to an intervention" from a distant point of view. In reality, the implementation of an intervention is messy and unpredictable, and plans can change due to internal and external factors (Stolk and Ling, 2020, p.132). Furthermore, evaluation in the traditional view often takes a deductive and reductionist point of view using designs such as randomized controlled trials (RCTs), evaluating implementation as an episodic assessment of efficacy and effectiveness that could generate generalizable conclusions, while generally controlling for the very messiness that actually drives "real-world" implementation success or failure. This approach misses the point that interventions

interact with their context, and evaluators need to understand that these interactions involve significant uncertainty (Ling, 2012).

Stolk and Ling (2020) suggest *embedded evaluation* as an approach to evaluate complex interventions that recognizes implementation as an ongoing process with no clear start and endpoint and that "the evaluation activities are an integral part of the delivery and monitoring of an intervention" (p.133). The framework instead suggests avoiding restricted criteria that prescribe one-size-fits-all approaches to evaluation. Overarching principles should be used, tailored toward the intervention purpose and the setting in which the intervention is implemented. Evaluation of complex interventions such as TVIC is not an easy task since the intervention interacts with the context in real-time in unpredictable ways. Embedded evaluation could be an appropriate approach to the evaluation of TVIC because it recognizes the interaction between complex interventions and complex settings and views evaluation as part of an ecosystem in which the intervention and the context evolve (Ling, 2012). Furthermore, the embedded approach suggests that the evaluators can be service providers who are part of the implementation team (Stolk and Ling, 2020), rather than neutral outsiders. This approach is aligned with what AIFs recommend for ongoing and continuous evaluation of the fidelity of the intervention during the implementation process. The implementation team needs to review and evaluate the implementation process by establishing fidelity assessment as an implementation driver (Fixsen et al., 2005).

In all participating organizations, evaluation was part of the TVIC implementation from the beginning and even pre-baseline training. During the installation of TVIC, the police service, for instance, conducted a climate survey to assess the knowledge and understanding of trauma and violence among members. This real-time embedded evaluation was an essential step to guide the implementation team to determine the level of readiness in their organization and design the TVIC training accordingly. In all three organizations, feedback was collected after the TVIC baseline training to get some insight into how the training was received by staff and what expectations they had moving forward. The survey results and feedback led the implementation teams to bring other training and workshops to the organization, providing staff with extra support.

In the late stages of implementation, uncertainty and nonlinearity of TVIC implementation was another factor that impacted the implementation process and challenged the implementation team. The embedded approach expects uncertainty to arise since the adoption of a complex intervention often unfolds in unpredictable ways as the intervention evolves in the context (Stolk and Ling, 2020). In one of the settlement agencies, which was further ahead in the implementation of TVIC, the implementation team worked with the uncertainty, conducting a blanket audit in the whole organization to understand the unique needs of each department and team within the organization. This approach to evaluation is referred to as collecting "contribution stories" that capture the narratives from the service providers describing how they engage in activities for delivering the intended outcomes of the intervention (Ling and Villalba 2009, p. 8). The feedback that was provided informed the implementation team about how the components of TVIC were applied to service delivery. For instance, self-care practices aimed at reducing burnout, even though welcomed by staff, were challenging to implement because of structural barriers such as lack of time. Including the contribution stories in the evaluation of TVIC implementation obligated the organization to change these structural barriers and encouraged staff to develop creative ideas to include more self-care-related activities in, for example, 'lunch and learn' staff meetings.

The embedded evaluation approach aims at improving and adapting the intervention and suggests ongoing and continuous evaluation by the implementation team as the intervention and context evolve together (Stolk and Ling, p. 132). As long as the intervention exists, the evaluation should be continued to improve key outcomes, enabling organizations to move between assessment and change. The embedded approach could be used in TVIC implementation to ensure fidelity assessment suggested by AIFs (NIRN, 2021). Future research should aim to develop measures for the implementation of TVIC that could be used in different stages of implementation (pre-training, post-training, climate survey) while staying flexible concerning the complex nature of the context of implementation.

## 6.3 Limitations

This study was limited by a few factors that will be discussed in this section. Multiple case studies are limited by the number of cases that could be selected (Yin, 2014). Therefore, the

findings of this study were also limited by the number of participating organizations. The purpose of this study was to understand the implementation process in organizations interested in TVIC implementation. Therefore, purposeful sampling was used to include only those organizations interested in TVIC implementation.

Even though two organizations providing health care services participated in this study, this was only in Phase 1, and the implementation process was not explored further. The three cases selected for Phase 2 all broadly provide social services, in which we include policing. Therefore, the contexts of the organization explored in this study were limited, restricting the generalizability of the findings.

In the first phase, the number of interviews was limited to one per organization in most cases. In the second phase, the interviews included EDs and champions of TVIC implementation. Therefore, the insights and perceptions of direct service workers were minimal. More interviews with direct service workers could enhance the findings and shed some light on their experiences with the implementation of TVIC.

Finally, being bound by time, I could not continue my involvement with participating organizations to explore the implementation process at later stages. Therefore, the findings of this study were limited to two/three years of my involvement with the participating organizations.

## 6.4 Future Direction

Future directions for research have been mentioned throughout, and here I briefly outline additional ideas that could direct future research.

Given the flexibility and adaptability of the four TVIC principles, TVIC has the potential to improve services across a broad range of contexts. Future studies should examine its uptake in different complex contexts. For example, while we know from emerging literature that student teachers improve their knowledge when taught TVIC in the classroom, how can TVIC be brought into actual classroom, schools and school boards to better support student learning and teacher wellness (Rodger et al., 2020). On the other hand, TIC has been shown to be interpreted

and implemented differently in acute psychiatric inpatient units (O'Dwyer et al., 2020), perhaps because these contexts are also explicitly trauma-specific, i.e., treatment, oriented. Examination of such differences, including underlying values and philosophies of practice, will be key to understanding how best to implement TVIC broadly. In terms of ongoing work in the types of settings examined in this study, it would be important to see how other police services, perhaps less disposed to change, and with more ambivalent leadership, approach TVIC. Comparing and contrasting the differences between services with purportedly similar structures and cultures could be very informative.

We also need to understand a broader range of staff experiences, from people in multiple and different roles, including their perception of TVIC, the impact of TVIC on the organization, and how to best to articulate and assess intended outcomes. This would also allow more in-depth assessment of cultural shifts, including structural competency.

A key aspect of the success of TVIC is whether clients perceive and experience their care differently, and whether this leads to improved outcomes of various types. While this was found when TVIC was examined as part of the EQUIP intervention (Ford-Gilboe et al., 2018), assessing what TVIC actually changes, on its own, is a crucial next step.

Further, comparing TVIC to existing evaluations of TIC/P, would be interesting – does the "V" do the work intended? TIC/P approaches discussed in Chapter two have been undergoing implementation for a longer period, with some having developed essential guidelines and roadmaps for implementation (Fallot, 2015, Sanctuary, 2021). TIC/P has also evolved and been taken up by multiple organizations (Trauma Informed Oregon, 2014; SAMHSA, 2021), a process just beginning for TVIC. Tools and recommendations have been created to assist TVIC implementation. For instance, an online curriculum including seven sections provides a comprehensive learning opportunity for individuals and organizations to increase their knowledge of TVIC and how to change their practices accordingly (Canas et al., forthcoming). A forthcoming handbook on implementation of TVIC includes multiple chapters on recommendations and suggestions for TVIC implementation (Caxaj et al., forthcoming; Javan et al., forthcoming; MacPherson et al., forthcoming MacPherson and Wathen, forthcoming; Varcoe et al.; forthcoming). A TVIC Action Kit has also been developed based on AIFs and the

emerging findings of the present study (Varcoe et al., forthcoming). However, more research is needed to create implementation maps, tools and evaluation measures to improve fidelity and sustainability of TVIC implementation. From the present research, we learned that AIFs can be tailored to TVIC implementation and applied as a map to guide the implementation process. Embedded evaluation could also be used to evaluate TVIC implementation and measure fidelity and sustainability.

Finally, there might be organizations that do not find TVIC a good fit for their service delivery. Further research could illuminate the reasons behind this and investigate potential barriers to change.

## 6.5 Conclusion

TVIC and its focus on the safety and wellbeing of service users and providers, while taking into account the structural and systemic forms of harm that people have and continue to experience, is emerging as an important way to reorient health and social services. However, there is a gap in research to understand how TVIC is implemented in different contexts and settings. Therefore, I became curious to observe the implementation of TVIC in real-time as organizations took it up. This study explored how organizations understand and perceive TVIC, what motivates them to take up TVIC, how they do it, and how TVIC impacts the complex context of service delivery and evolves through this interaction. During the implementation process, I paid attention to what structural and cultural shifts were necessary for the implementation while monitoring the facilitators and barriers of the implementation.

Given the prevalence of trauma (Van Ameringen, 2008) participating organizations were interested in enhancing service delivery to meet the needs of individuals exposed to trauma and violence. Organizations felt structural and cultural shifts were required to respond to these needs and provide appropriate care. An increase in the number of highly traumatized refugees in the community further motivated organizations to implement these necessary changes. The motivation for this change was not limited to providing support for clients, though. Staff, especially direct service providers, were also impacted by challenges arising from working with a high level of trauma and violence. In fact, in many organizations, it was difficult to draw a

clear line between what the priority was: service delivery improvements or staff vicarious trauma, since they are intertwined, and enhancement of service delivery seemed impossible without attending to staff needs.

TVIC was a good fit for many organizations to address these concerns. Leaders and champions inspired by the principles of TVIC engaged in the implementation process by applying a trauma and violence-informed lens and providing ongoing support for their staff. Increasing the knowledge and understanding of the impact of exposure to trauma and violence helped the staff understand how to provide care and receive support for their own wellbeing. Emphasis on structural violence led to the emergence of structural competency that encouraged frontline ownership in staff and motivated them to transform service delivery. This study also showed that implementation of TVIC needs patience and care, because integration of TVIC with a complex context creates uncertainty and can be unpredictable. Therefore, engagement with the staff and the organization through continual evaluation and fidelity assessment is necessary for sustainable implementation.

Applying AIFs as an implementation science framework to order and synthesize the findings was extremely useful. Even though none of the organizations followed the AIFs per se, many activities during the implementation process were aligned with these frameworks and followed the same path. The findings could also further enhance the AIFs by suggesting new implementation drivers. For instance, the intra- and inter-relationships of the organizations significantly impacted the implementation forward. Partnership and support received from other organizations in the community facilitated taking up TVIC, particularly in the early stage of implementation. The strong relationship between champions, leaders and coaches, and purveyors of the implementation enabled the organization to trust the process and move forward despite feeling uncertain. Also, these collaborations enabled the tailoring of TVIC to the complex contexts of each implementation. The interrelationships in the organizations were enhanced because of the creation of new networks and teams that were motivated to bring change to the service delivery and create structural and cultural shifts that reduced the experience of structural violence for both clients and staff.

## 6.6 Implications for Practice and Policy

Implementation of complex interventions such as TVIC is an unpredictable process and, at times, messy. Therefore, what motivates organizations to implement such interventions could play a critical role in committing to a lengthy implementation process and help them tolerate uncertainty. All participating organizations in this study were motivated to implement TVIC to enhance service delivery and also provide extra care and support for their staff. Vicarious trauma and staff trauma history are essential factors in service delivery, and if enough attention is not paid to providing care for staff, the fidelity of the intervention could be impacted. If enough capacity is not built into the organization, for example employee assistance plans, time use flexibility, etc., it becomes difficult for staff to incorporate TVIC into their practice.

Creating feedback loops is another important implementation driver because it keeps the conversation about TVIC alive and everyone accountable. These feedback loops also facilitate structural and cultural changes necessary to support the intervention's fidelity and sustainability. External support from intermediary organizations and coaches, and purveyors also played an essential role in TVIC implementation. Organizations interested in TVIC implementation can tremendously benefit from connecting to these organizations in their community. Financial support is also needed. Therefore, funding opportunities to support the initiation of TVIC both in the community and within interested organizations is necessary.

Finally, the content of TVIC has a significant impact on the implementation process. The explicit emphasis on structural violence acted as an important implementation driver. In addition, creating awareness about the underlying mechanisms of trauma, vicarious trauma, and its impact could change the culture of 'toughening up' or 'being heroic' among service providers, encouraging them to actively advocate for their wellbeing and develop compassion for their clients, and themselves. Therefore, coaches and purveyors should pay particular attention to delivering this important message while tailoring it to the culture of the context. This may require changing the language or mode of delivery of some content to enable staff to connect to the material presented.

I had the privilege to be part of the implementation of TVIC in three participating organizations. They generously allowed me to walk with them throughout this journey and shared their invaluable insight to inform this study. Together, we wrote book chapters and presented at conferences to share what we learned, hoping that the findings of this study could guide future research on the implementation of TVIC and, more generally, improve service delivery for people who suffer enough adversity in their everyday lives.

# References


Agnes, M. (Ed.). (2000). Webster's new world college dictionary (4th ed.). Foster City, CA: IDG Books Worldwide.

Averill, J. B. (2002). Matrix analysis as a complementary analytic strategy in qualitative inquiry. Qualitative health research, 12(6), 855-866.

Baker, G. R. (2011). The contribution of case study research to knowledge of how to improve

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. BMC psychology, 3(1), 1-12.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. The Qualitative Report, 13, 544–559.

Bebout, R. R. (2001). Trauma-informed approaches to housing. New directions for mental health services, 2001(89), 47-55.

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., ... & Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological medicine*, *46*(2), 327-343.

Bernard, H. R. (2002). Research methods in anthropology: Qualitative and quantitative approaches (3rd ed.). Walnut Creek, CA: Alta Mira Press.

Bertalanffy, L. (1974). General systems theory and psychiatry. In S. Ariete (Ed.), American handbook of psychiatry (2nd ed., Vol. 1; pp. 1095–1117). New York, NY: Basic Books.

Bertram, R. M., Blase, K. A., & Fixsen, D. L. (2015). Improving programs and outcomes: Implementation frameworks and organization change. Research on Social Work Practice, 25(4), 477-487.

Blanchard, C., Livet, M., Ward, C., Sorge, L., Sorensen, T. D., & McClurg, M. R. (2017). The active implementation frameworks: a roadmap for advancing implementation of comprehensive medication management in primary care. Research in Social and Administrative Pharmacy, 13(5), 922-929.

Bloom, S. L. (1994). *The Sanctuary Model: Developing Generic Inpatient Programs for the Treatment of Psychological Trauma* in Handbook of Post-Traumatic Therapy, A Practical Guide to Intervention, Treatment, and Research, Editors: M.B.Williams and J. F. Sommer, Jr. Greenwood Publishing, 1994. (pp. 474-491)

Bloom, S. L. (1997) *Creating Sanctuary: Toward the Evolution of Sane Societies.* New York: Routledge.

Bloom, S. L. (2010). Organizational stress and trauma-informed services. In A public health perspective of women's mental health (pp. 295-311). Springer, New York, NY.

Bloom, SL (2000*). Creating Sanctuary: Healing from systematic abuses of power*. Therapeutic Communities: The International Journal for Therapeutic and Supportive Organizations 21(2): 67-91.

Bringer, J. D., Johnston, L. H., & Brackenridge, C. H. (2004). Maximizing transparency in a doctoral thesis1: The complexities of writing about the use of QSR* NVIVO within a grounded theory study. *Qualitative research*, *4*(2), 247-265.

Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. Journal of Psychoactive Drugs, 45(5), 386-393.

Browne, A. J., Varcoe, C. M., Wong, S. T., Smye, V. L., Lavoie, J., Littlejohn, D., ... & Fridkin, A. (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations. International Journal for Equity in Health, 11(1), 59.

Browne, A. J., Varcoe, C., Ford-Gilboe, M., Nadine Wathen, C., Smye, V., Jackson, B. E., . . . Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health, 17(1), 154. doi:10.1186/s12939-018-0820-2

Browne, A.J., Varcoe, C (forthcoming) Creating a Context for Implementing TVIC in Health Care Settings In: Wathen, C.N., Varcoe, C.M. (Eds). *Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts*. University of Toronto Press.

Browne, A.J., Varcoe, C., Ford-Gilboe, M. et al. EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. Int J Equity Health 14, 152 (2015). https://doi.org/10.1186/s12939-015-0271-y

Browne, A.J., Varcoe, C., Ford-Gilboe, M., Wathen, C.N., Smye, V., Jackson, B.E., Wallace, B., Pauly, B., Herbert, C., Wong, S. Blanchet-Garneau, (2018). Disruption as opportunity: impacts of an organizational-level health equity intervention in primary care clinics. *International Journal for Equity in Health* .

Browne, A.J., Varcoe, C., Lavoie, J. *et al.* Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Serv Res* 16, 544 (2016).

Canas, E., Pradhan, S. & Wathen, C.N., (forthcoming) Development of a Core Trauma- & Violence-Informed Care e-Learning Curriculum. In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto

Caxaj, S., Sandu, J., Javan, T. (forthcoming). Thinking through Gaps and Support Needs: What Newcomer and Migrant Worker Interventions Teach us about Trauma & Violence Informed Care In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2008). Developing and evaluating complex interventions: the new Medical Research Council guidance. *Bmj*, *337*.

Deming, W. E. (1986). *Out of the crisis*. Cambridge, MA: MIT Press.

Denzin, N. (2012). Triangulation 2.0. *Journal of Mixed Methods Research*, *6*, 80-88.

Dobbins, M., Robeson, P., Ciliska, D., Hanna, S., Cameron, R., O'Mara, L., ... & Mercer, S. (2009). A description of a knowledge broker role implemented as part of a randomized controlled trial evaluating three knowledge translation strategies. *Implementation science*, *4*(1), 1-9.

Duda, M. A. (2015). *Make It Happen : Using Implementation Science with Wilson Programs Make " It " Happen Using Implementation Science with Wilson ® Programs Exploration*. *January*.

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science: Springer.

Elwyn, L. J., Esaki, N., & Smith, C. A. (2015). Safety at a girls secure juvenile justice facility. Therapeutic Communities: The International Journal of Therapeutic Communities.

EQUIPPING for Equity Modules (n.d.). Module 3: Trauma- and Violence-Informed Care. EQUIP Healthcare. Available: https://equiphealthcare.ca/equipping-for-equity-online-modules/

Esaki, N., Benamati, J., Yanosy, S., Middleton, J. S., Hopson, L. M., Hummer, V. L., & Bloom, S. L. (2013). The sanctuary model: Theoretical framework. Families in society, 94(2), 87-95.

Fallot, R. D., & Harris, M. (2015a). CCTIC Program Fidelity Scale Instruction Guide. ResearchGate

Fallot, R. D., & Harris, M. (2015b). Creating Cultures of Trauma-Informed Care (CCTIC): A Fidelity Scale. ResearchGate.

Fallot, R. D., & Harris, M. (2008). Trauma-informed approaches to systems of care. *Trauma Psychology Newsletter*, *3*(1), 6-7.

Fallot, R. D., & Harris, M. (2015c). Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol. ResearchGate.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine, 14(4), 245-258

Fixsen D, Blase K, Metz A, Van Dyke M. (2013) Statewide Implementation of Evidence-Based Programs. *Exceptional Children*. 79(3):213-230.

Fixsen, D. L., Blase, K. A., Duda, M. A., Naoom, S. F., & Van Dyke, M. (2010). Implementation of evidence-based treatments for children and adolescents: Research findings and their implications for the future. In J. R. Weisz & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 435–450). The Guilford Press.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2009). Core implementation components. Research on social work practice, 19(5), 531-540.

Fixsen, D. L., Blase, K. A., Naoom, S. F., Van Dyke, M., & Wallace, F. (2009). Implementation: The missing link between research and practice. NIRN implementation brief, 1, 218-227.

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation Research: A synthesis of the literature (FMHI #231). Tampa, FL: University of South Florida,Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

Ford, J. D., & Blaustein, M. E. (2013). Systemic self-regulation: A framework for trauma-informed services in residential juvenile justice programs. Journal of family violence, 28(7), 665-677.

Ford-Gilboe, M., Campbell, K., Heslop, L., (forthcoming). Trauma, Violence, Health and Well-Being In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Ford-Gilboe, M., Wathen, C. N., Varcoe, C., Herbert, C., Jackson, B. E., Lavoie, J. G., ... & Browne, A. J. (2018). How equity-oriented health care affects health: key mechanisms and implications for primary health care practice and policy. The Milbank Quarterly, 96(4), 635-671.

Ford-Gilboe, M., Wathen, C.N., Varcoe, C., Herbert, C., Jackson, B.E., Lavoie, J., Pauly, B., Perrin, N., Smye, V., Wallace, B., Wong, S. Browne, A.J. for the EQUIP Research Program.(accepted). How Equity-oriented health care impacts health: key mechanisms and implications for primary health care practice and policy. *Milbank Quarterly.*

Franks, R. P. (2010). Role of the intermediary organization in promoting and disseminating mental health best practices for children and youth: The Connecticut Center for Effective Practice. Emotional & Behavioral Disorders in Youth, 10(4), 87–93.

Franks, R. P., & Bory, C. T. (2015). Who Supports the Successful Implementation and Sustainability of Evidence-Based Practices? Defining and Understanding the Roles of Intermediary and Purveyor Organizations. New directions for child and adolescent development, 2015(149), 41–56.

Galtung, J. (1969). Violence, peace, and peace research. *Journal of peace research*, *6*(3), 167-191.

Greenhalgh, T., Robert, G., Macfarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovations in service organizations: Systematic review and recommendations. *Milbank Quarterly*, *82*(4), 581–629.

Greenhalgh, T., Stramer, K., Bratan, T., Byrne, E., Mohammad, Y., & Russell, J. (2008). Introduction of shared electronic records: multi-site case study using diffusion of innovation theory. Bmj, 337, a1786.

Greenwood-Lee, J., Hawe, P., Nettel-Aguirre, A., Shiell, A., & Marshall, D. A. (2016). Complex intervention modelling should capture the dynamics of adaptation. BMC medical research methodology, 16(1), 51.

Grol, R., & Grimshaw, J. (2003). From best evidence to best practice: effective implementation of change in patients' care. *The lancet*, *362*(9391), 1225-1230.

Gundacker C., Barry C., Laurent E., Sieracki R. A Scoping Review of Trauma-Informed Curricula for Primary Care Providers. Fam Med. 2021;53(10):843-856.

Harris, M. E., & Fallot, R. D. (2001b). Using trauma theory to design service systems. Jossey-Bass.

Harris, M., & Fallot, R. D. (2001a). Envisioning a trauma-informed service system: A vital paradigm shift. New Directions for Mental Health Services, 2001(89), 3–22. http://doi.org/10.1002/yd.23320018903

Hawe, P. (2015a). Lessons from complex interventions to improve health. Annual review of public health, 36, 307-323.

Hawe, P. (2015b). Minimal, negligible and negligent interventions. Social science & medicine (1982), 138, 265-268.

Hawe, P., Shiell, A., & Riley, T. (2004). Complex interventions: how “out of control” can a randomised controlled trial be?. Bmj, 328(7455), 1561-1563.

Hawe, P., Shiell, A., & Riley, T. (2009). Theorising interventions as events in systems. *American journal of community psychology*, *43*(3-4), 267-276.

Henry, J., et al., A Grassroots Prototype for Trauma-Informed Child Welfare System Change. Child Welfare, 2011. 90(6): p. 169-86.

Hermans, H. J. M. (1991). The person as co-investigator in selfresearch: Valuation theory. European Journal of Personality, 5(3), 217–234.

Holstein, J. A., & Gubrium, J. F. (2005). Interpretive practice. In N. K. Denzin & Y. S. Lincoln (Eds.), The Sage handbook of qualitative research (3rd ed., pp. 483-506). Thousand Oaks, CA: Sage.

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

Houghton, C., Murphy, K., Shaw, D., & Casey, D. (2015). Qualitative case study data analysis: An example from practice. Nurse researcher, 22(5).

Hummer, V.L., et al., Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change. Child Welfare, 2010. 89(2): p. 79-95.

Jack, S. M., Boyle, M., McKee, C., Ford-Gilboe, M., Wathen, C. N., Scribano, P., ... & MacMillan, H. L. (2019). Effect of addition of an intimate partner violence intervention to a nurse home visitation program on maternal quality of life: a randomized clinical trial. Jama, 321(16), 1576-1585.

Javan, T., Sandu, J., & Wathen, C.N. (forthcoming). How organizations take-up TVIC In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto

Press.

Kaufman, A. J., McCready, J., & Powis, J. (2017). Impact of a multifaceted antimicrobial stewardship program: a front-line ownership driven quality improvement project in a large urban emergency department. Canadian Journal of Emergency Medicine, 19(6), 441-449.

Khalil, H. (2016). Knowledge translation and implementation science: what is the difference?.

Kothari, A., & Wathen, C. N. (2013). A critical second look at integrated knowledge translation. *Health Policy*, *109*(2), 187-191.

Krieger, N., Kosheleva, A., Waterman, P. D., Chen, J. T., & Koenen, K. (2011). Racial discrimination, psychological distress, and self-rated health among US-born and foreign-born Black Americans. American journal of public health, 101(9), 1704-1713.

Kuhn, T. (1970). Reflections on my Critics. *Lakatos, I. and A. Musgrave*.

Lanius, R. A., Bluhm, R. L., & Frewen, P. A. (2011). How understanding the neurobiology of complex post-traumatic stress disorder can inform clinical practice: a social cognitive and affective neuroscience approach. Acta Psychiatrica Scandinavica, 124(5), 331-348.

Lanius, Ruth a, Vermetten, E, Pain, C. (2010). The Impact of Early Life Trauma on Health and Disease

Lavoie, J. G., Varcoe, C., Wathen, C. N., Ford-Gilboe, M., Browne, A. J., & EQUIP Research Team (2018). Sentinels of inequity: examining policy requirements for equity-oriented primary healthcare. BMC health services research, 18(1), 705.

Levine, Colleen Varcoe & Annette J. Browne (2021) “We went as a team closer to the truth”: impacts of interprofessional education on trauma- and violence- informed care for staff in primary care settings, Journal of Interprofessional Care, 35:1, 46-54,

Ling, T. (2012). Evaluating complex and unfolding interventions in real time. Evaluation, 18(1), 79–91.

Ling, T., & Villalba van Dijk, L. (2009). Performance Audit Handbook.

Macpherson, M., Macphail, S., Javan, T. (forthcoming). Becoming Trauma and Violence Informed in Policing In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Macpherson, M., Wathen, C.N. (forthcoming). Thinking Structurally: Using TVIC to Reimagine Service Systems In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Maddox, L., Lee, D. & Barker, C. Police Empathy and Victim PTSD as Potential Factors in Rape Case Attrition. J Police Crim Psych 26, 112–117 (2011).

Marshall, P. H., Kelder, J. C., & Perry, A. (2005). Social constructionism with a twist of pragmatism: A suitable cocktail for information systems research. In ACIS (p. EJ).

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. Journal of Occupational Behavior, 2(2), 99–113.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. Annual Review of Psychology, 52, 397–422.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3(1), 131–149.

McLaren, L., & Hawe, P. (2005). Ecological perspectives in health research. Journal of Epidemiology & Community Health, 59(1), 6-14.

Medical Research Council. A framework for the development and evaluation of RCTs for complex interventions to improve health. London: MRC, 2000

Metz, A., & Bartley, L. (2012). Active implementation frameworks for program success. Zero to three, 32(4), 11-18.

Metz, A., Bartley, L., Ball, H., Wilson, D., Naoom, S., & Redmond, P. (2015). Active implementation frameworks for successful service delivery: Catawba county child wellbeing project. Research on Social Work Practice, 25(4), 415-422.

Metz, A., Halle, T., Bartley, L., & Blasberg, A. (2013). The key components of successful implementation.

Metzl, J. M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. Social science & medicine, 103, 126-133.

Miles, M. B., Huberman, A. M., & Saldaäna, J. (2014). Qualitative data analysis: A methods sourcebook (Third edition.). SAGE Publications, Inc

Moore, G. F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., ... & Baird, J. (2015). Process evaluation of complex interventions: Medical Research Council guidance. *bmj*, *350*.

Morgan, D. (2014). Pragmatism as a paradigm for mixed methods research. In *Integrating qualitative and quantitative methods* (pp. 25-44). SAGE

Morgan, D. L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of mixed methods research*, *1*(1), 48-76.

Morgan, D. L. (2014). Pragmatism as a Paradigm for Social Research. *Qualitative Inquiry*, *20*(8), 1045–1053. https://doi.org/10.1177/1077800413513733

Morgan, D. L. (2020). Pragmatism as a Basis for Grounded Theory. The Qualitative Report, 25(1), 64-73.

National Implementation Science Network (2021) Active Implementation Practice and Science. Retrieved from : https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-Briefs-1-ActiveImplementationPracticeAndScience-10-05-2016.pdf

O'Dwyer, C., Tarzia, L., Fernbacher, S., & Hegarty, K. (2020). Health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings: A scoping review. Trauma, Violence, & Abuse, 1524838020903064.

Odom, S. L., Duda, M. A., Kucharczyk, S., Cox, A. W., & Stabel, A. (2014). Applying an implementation science framework for adoption of a comprehensive program for high school students with autism spectrum disorder. Remedial and Special Education, 35(2), 123-132.

Ogden, T., & Fixsen, D. L. (2014). Implementation science: A brief overview and a look ahead. Zeitschrift für Psychologie, 222(1), 4.

Oregon Health Authority, Addictions and Mental Health Division. (2014). Trauma Informed Services (AMH-060-1607).

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and policy in mental health and mental health services research, 42(5), 533-544.

Parlett, M., & Hamilton, D. (1976). Evaluation as illumination: A new approach to the study of innovative programmes. In G. Glass (Ed.), Evaluation studies review annual, I (pp. 140-157). Beverly Hills, CA: SAGE Publications.

Patton, M. Q. (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage

Pearlman, L. A., & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest

survivors. New York, NY: W.W. Norton.

Pfadenhauer, L. M., Gerhardus, A., Mozygemba, K., Lysdahl, K. B., Booth, A., Hofmann, B., ... & Rehfuess, E. (2017). Making sense of complexity in context and implementation: the Context and Implementation of Complex Interventions (CICI) framework. Implementation science, 12(1), 1-17.

Pollastri, A. R., Wang, L., Youn, S. J., Ablon, J. S., & Marques, L. (2020). The value of implementation frameworks: Using the active implementation frameworks to guide system-wide implementation of Collaborative Problem Solving. Journal of community psychology, 48(4), 1114-1131.

Ponic, P., Varcoe, C., & Smutylo, T. (2016). Victims of Crime Research Digest No 9. *Ottawa: Department of Justice, Government of Canada*.

Purkey, E., Davison, C., MacKenzie, M., Beckett, T., Korpal, D., Soucie, K., & Bartels, S. (2020). Experience of emergency department use among persons with a history of adverse childhood experiences. *BMC health services research*, *20*(1), 455.

quality of care. BMJ Quality & Safety, 20(Suppl 1), i30i35.doi:10.1136/bmjqs.2010.046490

Rate Your Organization (2021). EQUIP Healthcare. Available: https://equiphealthcare.ca/resources/toolkit/rate-your-organization/

Rodger, S., Bird, R., Hibbert, K., Johnson, A., Specht, J., Wathen, N. (2020). Preparing teachers to teach all students: Initial teacher education and trauma and violence informed care in the classroom. Psychology in the Schools, 57(2), 1798-1814.

Rodger, S., Hibbert, K., Sereda, M., Specht, J.(forthcoming). The Trauma- and Violence-Informed Classroom, K-12 In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press

Sanctuary Institute ( 2021). SANCTUARY MODEL. https://www.thesanctuaryinstitute.org/about-us/the-sanctuary-model/

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. New Directions for Evaluation, (114), 11–25. doi:10.1002/ev.223

Shiell, A., Hawe, P., & Gold, L. (2008). Complex interventions or complex systems? Implications for health economic evaluation. Bmj, 336(7656), 1281-1283.

Smye, V., Josewski, V., Gross, P., Efimoff, I., Patrick, L., Lambert, S. (forthcoming). Trauma- and Violence-Informed Mental Health Interventions: Our Work with Indigenous Men In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

St George, S. (2010). Applied interpretation: a review of interpretive description by Sally Thorne. The Qualitative Report, 15(6), 1624.

Stake, R. E. (1995). The art of case study research. Thousand Oaks, CA: SAGE Publications

Substance Abuse and Mental Health Services Administration. (2014).SAMHSA'S concept of trauma and guidance for a trauma-informed approach.SAMHSA.

Sukhera, J., Watling, C. J., & Gonzalez, C. M. (2020). Implicit Bias in Health Professions: From Recognition to Transformation. *Academic Medicine*, *January*, 717–723. https://doi.org/10.1097/ACM.0000000000003173

Thorne, S. (2008). Interpretive description (Vol. 2). Walnut Creek.

Thorne, S. (2016). *Interpretive description*. Routledge.

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International journal of qualitative methods*, *3*(1), 1-11.

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-traumatic stress disorder in Canada. *CNS Neuroscience and Therapeutics*, *14*(3), 171–181. https://doi.org/10.1111/j.1755-5949.2008.00049.x

Van der Kolk, B. A. (n.d.). The body keeps the score: brain, mind, and body in the healing of trauma.(446.p).

Vanderstraeten, R., & Biesta, G. (1998, January). Constructivism, educational research, and John Dewey. In The Paideia Archive: Twentieth World Congress of Philosophy (Vol. 2, pp. 34-39).

van Stolk, C., & Ling, T. (2020). Understanding the Practice of Embedded Evaluation: Opportunities and Challenges. Crossover of Audit and Evaluation Practices, 132-148.

Varcoe, Browne, A. J., & Cender, L. M. (2014). Promoting Social Justice and Equity by Practicing Nursing to Address Structural Inequities and Structural Violence. In Philosophies and Practices of Emancipatory Nursing (1st ed., pp. 266–284). Routledge.

Varcoe, C., Browne, A.J., Bungay, V., Perrin, N., Wilson, E., Wathen, N., Byres, D., & Price, R. (under review). Through an equity lens: Illuminating the relationships among social inequities, stigma and discrimination, and patient experiences of Emergency health care. International Journal of Health Services.

Varcoe, C., Bungay, V., Browne, A. J., Wilson, E., Wathen, C. N., Kolar, K., Perrin, N., Comber, S., Blanchet Garneau, A., Byres, D., Black, A. & Price, R. (2019). EQUIP Emergency: Study protocol for an organizational intervention to promote equity in health care. BMC Health Services Research, 19(1), 687. https://doi.org/10.1186/s12913-019-4494-2

Varcoe, C., Wathen, C.N., Sanchez, A.-M., & Courtice, S. Strategies, tools and resources for integrating TVIC across settings. In: Wathen, C.N., Varcoe, C.M. (Eds).

Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Wathen, C. N., MacGregor, J. C., & Beyrem, S. (2021). Impacts of trauma-and violence-informed care education: A mixed method follow-up evaluation with health & social service professionals. Public health nursing.

Wathen, C. N., Schmitt, B., & MacGregor, J. C. D. (2021). Measuring Trauma- (and Violence-) Informed Care: A Scoping Review. Trauma, Violence, & Abuse.

Wathen, C.N. & Varcoe, C. (2019). Trauma- & Violence-Informed Care: Prioritizing Safety for Survivors of Gender-Based violence. London, Canada.

Wathen, C.N. (2020). Identifying Intimate Partner Violence in Mental Health Settings: There's a Better Way than Screening. Psynopsis: Canada's Psychology Magazine. 42(2), 17-18. Canadian Psychological Association.

Wathen, C.N., Carswell, J. (forthcoming). Enhancing Public Understanding: Shifting Narratives on Trauma, Violence & Mental Health In: Wathen, C.N., Varcoe, C.M. (Eds). Implementing Trauma- and Violence-Informed Care: A Handbook for Diverse Service Contexts. University of Toronto Press.

Weatherbee, T. G., Dye, K. E., Bissonnette, A., & Mills, A. J. (2009). Valuation theory and organizational change: Towards a sociopsychological method of intervention. Journal of Change Management, 9(2), 195–213.

Williams, R.D., Brundage, J.A. & Williams, E.B. Moral Injury in Times of COVID-19. J Health Serv Psychol 46, 65–69 (2020).

Williamson V, Stevelink SAM, Greenberg N. Occupational moral injury and mental health: systematic review and meta-analysis. Br J Psychiatry 2018; 212:339–346.

Yanosy, S. M., Harrison, L. C., & Bloom, S. L. (2009). Sanctuary staff training manual for direct care staff. Yonkers, NY: The Sanctuary Institute at Andrus.

Yazan, B. (2015). Three Approaches to Case Study Methods in Education: Yin, Merriam, and Stake. *The Qualitative Report*, *20*(2), 134-152

Yin, R. K. (2002). Case study research: Design and methods. Thousand Oaks, CA: Sage.

Yin, R. K. (2009). Case study research: Design and methods (Vol. 5). sage.

Yin, R. K. (2014). Getting started: How to know whether and when to use the case study as a research method. Case study research: Design and methods, 5, 2-25.

Yin, R. K. (2016). Qualitative research from start to finish (ed.). New York: Guilford.

Yin, R. K. (2018). Case study research and applications: Design and methods.

# Appendices

**Appendix A**

**Text for Recruitment Email 1 sent by CRHESI to 25 organizations attending November 15, 2017 meeting**

**Dear xxx**

This email is in follow-up to the meeting you attended on November 15, 2017 at Innovation Works hosted by the Centre for Research on Health Equity and Social Inclusion (CRHESI), where we discussed the idea of making London a "Trauma- and Violence-Informed Care (TVIC) Community".

I am writing to invite you to consider participating in a study being conducted by Ph.D. Candidate Tanaz Javan. Tanaz is in Health Information Science Program at Western University, and is supervised by Dr. Nadine Wathen, with Drs. Marilyn Ford-Gilboe and Lorie Donelle. The research was briefly described at the meeting.

Attached is a one-page document summarizing the project. Tanaz would like to meet with you, for about 30 minutes, to discuss your initial and current thinking regarding uptake of TVIC in your organization. Please respond directly to Tanaz [redacted] if you are interested in participating, or would like additional information. You can also email Tanaz, or Nadine [redacted]) if you have any questions.

Thank you for your time and consideration.

Sincerely,

<CRHESI representative>

## Appendix B

## Project Summary

### Organizational Implementation of Trauma- and Violence-Informed Care: A Multiple Case Study Analysis

### Background & Rationale

Health and social inequities are increasing, especially for those already marginalized by systemic barriers, such as poverty, discrimination and racism. Many people, across the socio-economic spectrum, have experienced various forms of trauma and violence; for those facing structural barriers and marginalization, these exposures, and their consequences, are often worse, making it even more difficult to access health and social services. To address these challenges, there is a call to explicitly integrate equity-oriented care to address barriers and improve outcomes by addressing both individual and social/structural determinants of health. A core aspect of equity-oriented care is attention to trauma and violence, and their effects, and a commitment to minimizing harm by adopting what we call ***trauma- and violence-informed care*** (TVIC). TVIC, and its related concepts of contextually tailored, culturally safe care, and harm reduction, act both as "universal precautions" to reduce harm, and as an approach to tailoring care to improve the fit between people's needs and provided services.

### Study Overview

Very little is known about how to actually integrate TVIC into community-based services – this is an important research gap. A number of organizations in London, Ontario, have recently come together to discuss how to make our community trauma- and violence-informed. This means individual organizations are integrating common, but tailored, TVIC strategies into their services, so that clients experience this care across the system. This provides an important opportunity to evaluate the implementation and integration of TVIC into community-based health and social services. We are looking to partner with organizations that are in different stages of implementation of TVIC, including those already shifting their organizational culture

toward TVIC and those in the planning stages of TVIC uptake and implementation. This multiple case study will explore:

1. How organizations come to understand the concept of TVIC for their service context.
2. What structural, cultural and practical changes are required to implement TVIC, ands what factors enable or impede uptake.
3. How TVIC implementation impacts organizations.

**Proposed Approach**

This is a multistage, multiple case study design. In the first stage, we will approach organizations who participated in a meeting in November 2017, convened by the Centre for Research on Health Equity and Social Inclusion, on "Making London a TVIC Community". Interviews with those who attended the meeting will help us understand organizations' initial and subsequent interest and actions specific to TVIC. Three to five organizations from the initial sample will be selected based on their stage in the TVIC planning and implementation process: those who have initiated or are in the latter planning stages will be invited to participate as "cases" in the multiple case study. Data will be collected from interviews with key leaders and staff, document analysis, and observation of relevant meetings to understand TVIC planning and implementation.

The results of this study will inform the development of approaches to better integrate, and assess the uptake and impact of, TVIC into a range of health and social service settings.

**For additional information:**

Tanaz Javan, PhD Candidate: [redacted]
Dr. Nadine Wathen, Professor: [redacted]

**Appendix C**

**Reminder Email Script for Recruitment**

Subject Line: Invitation to participate in research- Reminder

An email was sent to you two weeks ago and we wanted to send you a quick reminder about the TVIC implementation study.

This study being conducted by Ph.D. Candidate Tanaz Javan. Tanaz is in Health Information Science Program at Western University, and is supervised by Dr. Nadine Wathen, with Drs. Marilyn Ford-Gilboe and Lorie Donelle. The research was briefly described at the meeting you attended on November 15, 2017 at Innovation Works.

Attached is a one-page document summarizing the project. Tanaz would like to meet with you, for about 30 minutes, to discuss your initial and current thinking regarding uptake of TVIC in your organization. If you would like more information on this study or would like to receive a letter of information about this study please contact the researchers at the contact information given below.

Tanaz Javan PhD (c)
Faculty of Information and Science
[redacted]
[redacted]

**Appendix D**

**Letter of information and consent form for interview (phase 1)**

**Letter of Information and Consent for Executive Directors and Staff**

**Organizational Implementation of Trauma- and Violence-Informed Care: A Case Study Analysis**

**Principle Investigator : Dr. Nadine Wathen.** [redacted]

**Doctoral Student: Tanaz Javan.** [redacted]

The proposed research will use a multiple case study design and partner with London community-based service organizations that are interested in implementing trauma and violence informed care. This includes organizations already implementation TVIC, and those in the first stages of considering TVIC adoption. The specific research questions are: 1. How organizations come to understand the concept of TVIC for their service context. 2. What structural, cultural and practical changes are required to implement TVIC, ands what factors enable or impede uptake. 3. How TVIC implementation impacts organizations.

**What will I have to do if I choose to take part?**

You will be interviewed once at the onset of the study. The interviews will take 20 to 30 minutes to complete. You will be asked questions about your experiences in your role at the organization,

and how the organization, and you personally, became aware of TVIC and any steps taken to implement TVIC .All interviews will take place in person at a location and time convenient for you.

**Are there any risks or discomforts?**

The risks of taking part in this study are minimal. Though unlikely, you may become upset or hesitant to answer some questions, and if this happens, you can refuse to answer specific questions or stop the interview at any time. You may withdraw from the study at any time prior to the completion of data analysis, and all data be destroyed. Any identifying information for data that is included in the study will be removed and data presented in de-identified, aggregate form.

**What are the benefits of taking part?**

The findings from this study may help you, and/or your organization, and possibly other organizations, become more aware of the process of implementing trauma- and violence-informed care, and barriers and facilitators that could impact this process.

**Do I have to take part?**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future employment. Your employer will not be told whether or not you have been asked to participate, or whether you accepted or declined participation.

**What happens to the information?**

The information you provide is confidential. Your answers will be written down by the interviewer and digitally recorded, with your permission. They may be discussed with you in a follow-up discussion to be sure we understood the information you provided. Your name and other identifying information will be kept separate from your answers to the study questions. Representatives of the University of Western Ontario Non-Medical Research Ethics Board may contact you or require access to your study related records to monitor the conduct of the research.

Your information will be stored in locked files (electronic and physical) in a secure office that only the research team can access. Neither your name nor identifying information will be used. The study results will be shared with all participating organizations at the end of the study, and posted in an accessible location.

**How are the costs of participating handled?**

You will not be compensated for your participation.

**Other information about this study**

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me [redacted] or [redacted]. You can also contact my supervisor, Dr. Wathen at [redacted]

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Director, Office of Human Research Ethics, The University of Western Ontario:

Phone: [redacted]

Email: [redacted]

This letter is for you to keep. If you prefer not to keep this letter, the interviewer will keep it on file for you at the study office.

In order to participate in the study, you will be asked to provide written consent (see next page).

**Consent Form**

**Project Title:** Organizational Implementation of Trauma- and Violence-Informed Care: A multiple Case Study Analysis

**Study Investigator's Name: Dr. Nadine Wathen.** [redacted]

**Additional Research Staff : Tanaz Javan .** [redacted]

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.
I agree to be audio -recorded.

☐ **YES** ☐ **NO**

I agree to note-taking by the researcher during the interview.

☐ **YES** ☐ **NO**

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

☐ **YES** ☐ **NO**

_____ _____

_____

Print Name of Participant Signature *Date (DD-MMM-YYYY)*

My signature means that I have explained the study to the participant named above. I have answered all questions.

_____ _____

_____

Print Name Signature *Date (DD-MMM-YYY*

Person Obtaining consent

## Appendix E

### Javan: Interview Guide 1

Interview Guide

Preamble:

I would like to gain an understanding of the implementation of TVIC from the perspective of those who are involved by initiating a conversation with interested organizations. This is a multiple case study exploring how organizations become interested in TVIC. This interview will take 15 to 30 minutes in which I will ask about your perception of TVIC and if you have any plans to implement TVIC in your organization.

I would like to audio-record today's conversation. I will analyze the transcribed and de-identified interview looking for themes and patterns. Responses are confidential. If you'd like me to stop or pause recording please say so.

Would you please read the letter of information and sign the consent form if you agree?

1) Please tell me about your organization - what are its main goals and mission??
2) How did the organization, and you personally, first become aware of TVIC? What sparked your (individual/organizational) interest in attending the November 2017 meeting at Innovation Works?

Probe: have you sought other sources of information about TVIC before or since that meeting? If so, please describe and tell me how useful they were.

Probe: what was your main take-away from that meeting?

3) How do you understand the concept / practice of TVIC? What are the features or aspects of TVIC that more resonate with you and your organization?
4) What was your individual/organizational thinking about TVIC going into the meeting? Has it changed since then?
5) Are you interested in implementing TVIC in your organization?
6) Have you/your organization taken any steps to implement TVIC (before that meeting, or since)?

If yes: please tell me about what you've done, and plan to do.

If no: do you plan to do anything, or is this on the "back-burner"? Why or why not?

7) Is there anyone else in your organizations that has been involved in thinking about TVIC implementation that I should speak with?
8) Is there anything else related to TVIC, or related issues in your organization, that you'd like to tell me about?

**Appendix F**

**Javan: Recruitment Email for phase 2**

Subject Line: TVIC Research Follow-Up: Invitation to participate (2)

Dear xxx

Thank you for agreeing to speak with me on <date of first interview> to discuss the implementation of trauma- and violence-informed care (TVIC) in your organization. I am writing in follow up to invite your organization to consider participating in the second phase of our study, being conducted as part of my Ph.D. in Health Information Science at Western University, under the supervision of Dr. Nadine Wathen, with Drs. Marilyn Ford-Gilboe and Lorie Donelle. I'd like to provide you with more information about this project and what your organization's involvement would entail if you decide to take part.

The attached Project Summary is a reminder of the purpose of the research. We believe that your organization would make an ideal "case" to study the process of TVIC implementation. I would be delighted to discuss what organizational participation would entail. Please let me know if you are interested or would like additional information.

Thank you for your time and consideration.

Sincerely,

Tanaz Javan Ph.D. (c)

[redacted]

[redacted]

**Appendix G**

**Letter of information and consent form for recruiting the organization for phase 2**

## Letter of Information & Consent: Organizations

## Organizational Implementation of Trauma- and Violence-Informed Care: A multiple Case Study Analysis

**Principle Investigator: Dr. Nadine Wathen.** [redacted]

**Doctoral Student: Tanaz Javan. Email:** [redacted]

The proposed research will use a multiple case study design to examine, in three to five London community-based service organizations, the implementation of trauma and violence informed care (TVIC). This includes organizations already implementing TVIC, and those in the first stages of considering TVIC adoption. The specific research questions are: 1. How do organizations come to understand the concept of TVIC for their service context? 2. What structural, cultural and practical changes are required to implement TVIC, and what factors enable or impede uptake? 3. How does TVIC implementation impact organizations?

We would like to invite <organization name> to take part in the study. The following information outlines what this means. Initially, your organization will be asked to designate a Study Liaison, who can orient the researcher to relevant aspects of TVIC implementation already enacted, or planned, including identifying documents to review, and meetings to observe. The Study Liaison may or may not be directly involved in data collection. If asked for an interview, they will have the same informed consent process and rights as all other potential participants.

We will request, at the onset of the study, confidential and anonymous interviews with consenting staff who may have relevant information and insights to share; follow-up interviews may also be requested. The interviews will take approximately 60 minutes to complete and will focus on the process of coming to understand and implement TVIC. We will request that interviews take place in a private location at a time and location convenient for the staff member. Service users will not be approached, observed, or otherwise included in any data collection activities.

We will also request access to relevant non-confidential documents, including policies and procedures, training materials, meeting minutes or other documentation relevant to TVIC uptake. In addition, with the Study Liaison, we will identify key staff meetings, training workshops, or other events that the researcher can attend to understand TVIC implementation. The researcher will also visually document (e.g., sketch, photograph) features of the physical space (e.g., reception set-up, signage, etc.) relevant to TVIC principles. No photos of individual staff, clients or others in the setting will be taken.

The risks of taking part in this study are minimal. Staff could become upset or hesitant to answer some questions, but can refuse to answer specific questions, or stop the interview at any time. Participants who take part in individual interviews may withdraw from the study at any time prior to the completion of data analysis, and their data all data will be destroyed. Any identifying information for those retained in the data set will be removed. Managers or others will not be told who is approached, or agrees/declines to participate in an interview.

All data will be presented in aggregate, non-identified form, and your organization will be given a case number (e.g., Site #2), with a brief description relevant to understanding your service context. Given the size of London and the often specialized nature of services provided, we

cannot guarantee that your organization's participation will remain anonymous, however we will not, without your permission, name your site in study materials.

The findings from this study may help your organization and other organizations in London and beyond become more aware of the process of implementing trauma- and violence-informed care and barriers and facilitators that could impact this process.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me. Tanaz Javan, [redacted] You can also contact my supervisor, Dr. Nadine Wathen at [redacted]

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Director, Office Research Ethics, The University of Western Ontario:

[redacted]

[redacted]

**Consent Form**

**Organizational Participation**

I, _____ (print name) give permission for our organization_____ (print name of your organization) to

participate in the study, "Organizational Implementation of Trauma- and Violence-Informed

Care: A multiple Case Study Analysis".

☐ I allow those staff who wish to participate (anonymously) to use work time for the interview, should they so choose .

☐ I consent to be contacted again if selected as a case organization

_____ _____

Authorized Representative of<Organization name>; Date

_____ _____

Witness Signature, Date

_____ _____

Principal Investigator's Signature, Date

**Appendix H**

**Javan: sample text for use by organizational leaders to inform staff about the research - (this could be in emails, bulletins, staff meetings, or otherwise, as deemed appropriate by the organization)**

Subject Line: Research on the implementation of trauma and violence informed care

To: Members of Staff

Our organization is participating in a study conducted by researchers from Western University. The research will be looking at different stages of implementing trauma and violence informed care (TVIC) in our organization. Tanaz Javan is a Ph.D. candidate in Health Information Science at Western University, under the supervision of Drs. Nadine Wathen (chief supervisor), Marilyn Ford-Gilboe and Lorie Donelle (thesis committee members). She will ask to interview staff, review relevant documents, and participate in meetings and workshops related to TVIC implementation. Please note that no data will be collected (either directly or through observations) from service users.

The attached Project Summary outlines the purpose of the research. Participation by individuals approached by the researcher is voluntary and confidential, and anyone approached may refuse. Participants who take part in interviews may withdraw from the study at any time prior to the completion of data analysis. Refusal or withdrawal will not affect current or future employment and who is approached, consents and refuses will not be shared with by the researcher with anyone.

If you are in a meeting or other group setting where the researcher is present, you may request that anything you say not be noted. Notes will be de-identified by the researcher. Each research activity will be preceded by an informed consent process.

Thank you for your attention, please let me know if you have any concerns.

(signed by ED or other organizational representative)

**Appendix I**

**Letter of information and consent for interview phase 2**

**Letter of Information for Executive Directors and Staff**

**Organizational Implementation of Trauma- and Violence-Informed Care: A Case Study Analysis**

**Principle Investigator : Dr. Nadine Wathen. Email:nwathe@uwo.ca**

**Doctoral Student: Tanaz Javan**[redacted]

We invite you to take part in a research study being conducted by researchers from the University of Western Ontario. The proposed research will use a multiple case study design with three to five London community organizations that are in different stages of implementing trauma and violence informed care (TVIC). This includes organizations already implementing TVIC, and those in the first stages of considering TVIC adoption. The specific research questions are: 1. How organizations come to understand the concept of TVIC for their service context.2. What structural, cultural and practical changes are required to implement TVIC, ands what factors enable or impede uptake.3. How TVIC implementation impacts organizations.

**What will I have to do if I choose to take part?**

You will be interviewed once at the onset of the study and fallowing interviews may also be requested. The interviews will take 60 minutes to complete. you will be asked questions about your experiences in your role at the organization, your perception of the main principles of TVIC, the challenges and successes you face in your day to day work to deliver TVIC, and the policies that affect service delivery.  All interviews will take place in person at a location and

time convenient for you. We will contact you in the way you prefer (i.e. by mail, e-mail, or telephone) to request a follow-up interview.

**Are there any risks or discomforts?**

The risks of taking part in this study are minimal. Though unlikely, you may become upset or hesitant to answer some questions, and if this happens you can refuse to answer specific questions or stop the interview at any time. You may withdraw from the study at any time prior to the completion of data analysis, and all data will be destroyed. Any identifying information for data that is included in this study will be removed and data presented in de-identified, aggregate form.

**What are the benefits of taking part?**

The findings from this study may help your and/or your organization and possibly other organizations to become more aware of the process of implementing trauma- and violence-informed care and barriers and facilitators that could impact this process.

**Do I have to take part?**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any

questions or withdraw from the study at any time with no effect on your future employment. Your employer will not be told whether or not you have been asked to participate, or whether you accepted or declined participation.

**What happens to the information ?**

The information you provide is confidential. Your answers will be written down by the

interviewer and digitally recorded, with your permission. They may be discussed with you in a follow-up discussion to be sure we understood the information you provided. Your name and other identifying

information will be kept separate from your answers to the study questions. Representatives of

the University of Western Ontario Non-Medical Research Ethics Board may contact you or

require access to your study related records to monitor the conduct of the research.

Your information will be stored in locked files (electronical and physical) in a secure office that only the research team can access. Neither your name nor identifying information will be used. The study results will be shared with all participating organizations at the end of the study and posted in an accessible location.

**How are the costs of participating handled?**

You will not be compensated for your participation.

**Other information about this study**

. If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me [redacted]. You can also contact my supervisor, Dr. Wathen at [redacted]

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Director, Office of Human  Research Ethics, The University of Western Ontario:

[redacted]

[redacted]

This letter is for you to keep. If it you prefer not to keep this letter, the interviewer will keep it on file for you at the study office.

In order to participate in the study you will be asked to provide written consent (see next page)

## Consent Form

**Project Title:** Organizational Implementation of Trauma- and Violence-Informed Care: A Multiple Case Study Analysis

**Study Investigator's Name: Dr. Nadine Wathen** [redacted]

**Additional Research Staff : Tanaz Javan.** [redacted]

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to be audio-recorded.

☐ **YES** ☐ **NO**

I agree to note-taking by the researcher during the interview.

☐ **YES** ☐ **NO**

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

☐ **YES** ☐ **NO**

I agree to being contacted for a follow-up interview, if required.

☐ **YES** ☐ **NO**

_____ _____ _____

Print Name of Participant Signature *Date (DD-MMM-YYYY)*

My signature means that I have explained the study to the participant named above. I have answered all questions.

_____ _____ _____

Print Name of Person Obitaining Signature *Date (DD-MMM-YYYY)*

**Appendix J**

**Javan: Reminder text for use by organization prior to a group meeting/event**

Subject Line: ongoing research in our organization on implementation of trauma and violence informed care

To: Members of Staff

This is a reminder that Tanaz Javan, a PhD student from Western University, is conducting research on TVIC implementation in our organization and will be attending the <name> meeting/workshop on <date>.

She will take field notes to document the themes of the conversation related to her research questions. No identifying information will be recorded, but direct quotes may be noted (unattributed) for future use.

Participation in the research is voluntary. During the meeting, you may request that your comments are not recorded in the researcher's notes. This will have no effect on your current or future employment.

The attached Project Summary describes the purpose of the research.

Thank you for your attention. Questions or concerns can be shared with me, and/or the researcher.

Sincerely,

<organizational lead>

**Appendix K**

**Letter of information and consent form for meetings and workshops**

**Letter of Information and Consent for Executive Directors and Staff**

**Organizational Implementation of Trauma- and Violence-Informed Care: A Case Study Analysis**

**Principle Investigator : Dr. Nadine Wathen.** [redacted]

**Doctoral Student: Tanaz Javan.** [redacted]

We invite you to take part in a research study being conducted by researchers from the University of Western Ontario. The proposed research will use a multiple case study design with three to five London community service organizations that are in different stages of implementing trauma and violence informed care (TVIC). This includes organizations already implementing TVIC, and those in the first stages of considering TVIC adoption. The specific research questions are: 1. How organizations come to understand the concept of TVIC for their service context. 2. What structural, cultural and practical changes are required to implement TVIC, and what factors enable or impede uptake. 3. How TVIC implementation impacts organizations.

**What will I have to do if I choose to take part?**

Notes will be taken during the upcoming meeting or workshop by the researcher. During the meeting, you may request that your comments are not recorded in the researcher's notes. No personal or identifying information will be collected.

**Are there any risks or discomforts?**

The risks of taking part in this study are minimal. You can refuse to answer specific questions or you may withdraw from the study at any time prior to the completion of data analysis, and all data will be destroyed. Any identifying information for data that is included in the study will be removed and data presented in de-identified, aggregate form.

**What are the benefits of taking part?**

The findings from this study may help you, and/or your organization, and possibly other organizations, become more aware of the process of implementing trauma- and violence-informed care, and barriers and facilitators that could impact this process.

**Do I have to take part?**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future employment. Your employer will not be told whether or not you have been asked to participate, or whether you accepted or declined participation.

**What happens to the information?**

The information you provide is confidential. They may be discussed with you in a follow-up discussion to be sure we understood the information you provided. Representatives of the University of Western Ontario Non-Medical Research Ethics Board may contact you or require access to your study related records to monitor the conduct of the research.

Your information will be stored in locked files (electronic and physical) in a secure office that only the research team can access. Neither your name nor identifying information will be used. The study results will be shared with all participating organizations at the end of the study, and posted in an accessible location.

**How are the costs of participating handled?**

You will not be compensated for your participation.

**Other information about this study**

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please contact me [redacted] or by e-mail at [redacted]. You can also contact my supervisor, Dr. Wathen at [redacted]

If you have any concerns about the conduct of this study or your rights as a research participant, please contact The Director, Office of Human Research Ethics, The University of Western Ontario:

[redacted]

[redacted]

This letter is for you to keep. If you prefer not to keep this letter, the interviewer will keep it on file for you at the study office.

In order to participate in the study, you will be asked to provide written consent (see next page).

## Consent Form

**Project Title:** Organizational Implementation of Trauma- and Violence-Informed Care: A Multiple Case Study Analysis

**Study Investigator's Name: Dr. Nadine Wathen.** [redacted]

**Additional Research Staff : Tanaz Javan. Email:** [redacted]

I have read the letter of information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to note-taking by the researcher during the meeting or workshop.

☐ **YES** ☐ **NO**

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research

☐ **YES** ☐ **NO**

_____ _____

_____

Print Name of Participant Signature *Date (DD-MMM-YYYY)*

My signature means that I have explained the study to the participant named above. I have answered all questions.

_____ _____

_____

Print Name of Signature *Date (DD-MMM-YYYY)*

Person Obtaining consen

## Appendix L

## Javan: Interview Guide 2

Interview Guide

Preamble:

I would like to gain an understanding of the implementation of TVIC from the perspective of those who are involved by initiating a conversation with interested organizations. This is a multiple case study exploring how organizations become interested in TVIC. This is a multi-stage study and in our second stage of this study, I would like to know what the implementation of TVIC entails for organizations that are actively planning or have initiated their implementation processes. This interview will take 45 to 60 minutes in which I will ask you about your organization's approach to implementing TVIC.

I would like to audio-record today's conversation. I will analyze the transcribed and de-identified interview looking for themes and patterns. Responses are confidential. If you'd like me to stop or pause recording please say so.

Would you please read the letter of information and sign the consent form if you agree?

1) How did your organization become interested in implementing TVIC?

Probes: What was the person, activity or information that triggered your organization's interest in implementing TVIC?

2) Tell me about how you are approaching TVIC implementation.

Probes: Has your organization generated an implementation plan? If so, who contributed to this? Would this plan be available for review by the research team?

3) Where are you in the implementation process?
4) What are the goals / objectives of implementing TVIC?
5) How has the implementation been communicated to staff (or how do you plan to do so?)?
6) Is there formal training? Informal sessions? Please describe.
7) Which stakeholders [and in what order] have been engaged in TVIC development / implementation?
8) What changes have you seen, or do you anticipate seeing, as TVIC is implemented?

Probes: please describe any positive or negative impacts of these changes (if any) on staff, clients and organization.

9) What kinds of things seem to be helping? Hindering? Please consider any factors or influences that you've discussed or anticipate, including attitudes, knowledge, practices, policies, internal and external partnerships, etc.
10) Were there things being done up to now that were related to TVIC but not called that?

Probes: What have you been doing as an organization that aligns with TVIC practices but you didn't have TVIC terms or language to label these practices / policies, etc.

11) For those who have started to implement: what impacts have you seen?
12) For those that haven't: what impacts do you anticipate?
13) Have there been any challenges, limits, or downsides of the TVIC implementation process?
14) Did you modify TVIC to tailor its components toward the needs of your organization? If so, how?
15) For those who have implemented: what would you do differently?
16) Are there specific examples of things you've done (practice changes, new procedures, changes to physical spaces, etc.) to become more trauma- and violence-informed?

Probes: Have you partnered with any organization so far? How is this experience for you?

17) Has specific attention been paid to recognizing [assessing] and addressing compassion fatigue or vicarious trauma among your staff? If so, how? If not, is this planned?

18) Are there any questions that you think I haven't asked and would like to talk about?

**Appendix M**

**Javan: Recruitment Email 2 for follow up interviews**

Subject Line: TVIC Research Follow-Up: Invitation to participate (2)

Dear xxx

Thank you for agreeing to speak with me on <date of first interview> to discuss the implementation of trauma- and violence-informed care (TVIC) in your organization. I am writing in follow up to invite you to consider participating in the second interview of our study. You will be asked further questions about the implementation of TVIC in your organizations. All interviews will take place in person at your organization in a private location.

Participation in this study is voluntary. You may refuse to participate, refuse to answer any

questions or withdraw from the study at any time with no effect on your future employment. Your employer will not be told whether or not you have been asked to participate, or whether you accepted or declined participation.

Thank you for your time and consideration.

Sincerely,

Tanaz Javan Ph.D. (c)

[redacted]

[redacted]

**Appendix N**

Field Note

| | |
|---|---|
| Subject | Briefly describe the subject of the file note |
| Author | T. Javan |
| Other participants and witnesses | Indicate (e.g., by role) other participants; no names or personal identifiers |
| Date/time the event took place | Date and time the conversation or event took place |
| Date/time note written | Date and time the file note was written |
| Describe the details of the conversation or event here. What was the setting? What happened? What was discussed? What was the decision, instruction or agreement? | |
| Summary | |

| | |
|---|---|
| Write a one paragraph summary or abstract of the day's events. | |
| Narrative<br><br>Write a detailed narrative of what you observed. Use (OC: _____.) for observer comments. | |
| Questions/Things to follow up with | |

## Appendix O

Ethics Approval from the Western University Health Science Research Ethics Board (HSREB)

Western Research

**Date:** 20 September 2018

**To:** Dr. Nadine Wathen

**Project ID:** 111905

**Study Title:** Organizational Implementation of Trauma- and Violence-Informed Care: A Multiple Case Study Analysis

**Application Type:** NMREB Initial Application

**Review Type:** Full Board

**Meeting Date:** 06/Jul/2018

**Date Approval Issued:** 20/Sep/2018

**REB Approval Expiry Date:** 20/Sep/2019

---

Dear Dr. Nadine Wathen

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

**Documents Approved:**

| Document Name | Document Type | Document Date | Document Version |
|---|---|---|---|
| Interview Guide 1 | Interview Guide | | |
| NMBREB 111905R2-Letter of Information for Individuals Phase -1-9-14-2018 | Written Consent/Assent | 14/Sep/2018 | 2 |
| NMREB 111905R1 - Interview Guide 2 -8-11-2018 | Interview Guide | | |
| NMREB 111905R1 - Phase 1 Recruitment Email from CRHESI-8-11-2018 | Recruitment Materials | 11/Aug/2018 | 1 |
| NMREB 111905R1 - Sample text for EDs Pre-Meetings -8-11-2018 | Recruitment Materials | 11/Aug/2018 | 1 |
| NMREB 111905R1- Indiv Recruitment Reminder for Phase 2-8-11-2018 | Recruitment Materials | 11/Aug/2018 | 1 |
| NMREB 111905R1- Org Recruitment for Phase 2-8-12-2018 | Recruitment Materials | 11/Aug/2018 | 1 |
| NMREB 111905R1-Recruitment Reminder for CRHESI-8-11-2018 | Recruitment Materials | 11/Aug/2018 | 1 |
| NMREB 111905R2- Email for follow up interviews-9-14-2018 | Recruitment Materials | 14/Sep/2018 | 2 |
| NMREB 111905R2 - observation guide--14-2018 | Interview Guide | 14/Sep/2018 | 1 |
| NMREB 111905R2 - Organizational LOI Phase 2 -9-14-2018 | Written Consent/Assent | 14/Sep/2018 | 2 |
| NMREB 111905R2 - Sample text for EDs to Inform Staff-9-1-2018 | Recruitment Materials | 14/Sep/2018 | 2 |
| NMREB 111905R2-Letter of Information and consent form for Meeting-Workshops-9-14-2018 | Written Consent/Assent | 14/Sep/2018 | 2 |
| NMREB 11905R2-Letter of Information for individuals Interview Phase 2-9-14-2018 | Written Consent/Assent | 14/Sep/2018 | 2 |

**Documents Acknowledged:**

| Document Name | Document Type | Document Date | Document Version |
|---|---|---|---|
| NMREB 111905R2 - supplementary tables -9-14-2018 | Supplementary Tables/Figures | 14/Sep/2018 | 1 |

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

***Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).***

# Curriculum Vitae

**Name:** Tanaz Javan

**Post-secondary Education and Degrees:**

Western University
London, Ontario, Canada
2015-2021 PhD

Western University
London, Ontario, Canada
2012-2014 MSc

Western University
London, Ontario, Canada
2008-2011 HBA.

University of Science and Culture
Tehran, Iran
2000-2004 BFA.

**Honours and Award:**

Dean's Honour List, King's University College, UWO
2010-2011

The Suzanne Loranger Grenke Mature Student Award, King's University College UWO
2009-2010

Dean's Honour List, King's University College, UWO
2008-2009

**Related Work Experience**

Teaching Assistant
The University of Western Ontario
2012-2014
2015-2019

Graduate Research Assistant
Western University
2012-2021

Teaching
Fanshawe College
2017-2021

**Publications:**

MacGregor, J. C. D., Naeemzadah, N., Oliver, C. L., Javan, T., MacQuarrie, B. J., Wathen, C. N. (2020).Women's experiences of the intersections of work and intimate partner violence: A review of qualitative research. *Trauma, Violence, & Abuse*. Online first: https://doi.org/10.1177/1524838020933861

Chow, T., Javan, T., Ros, T., & Frewen, P. (2017). EEG dynamics of mindfulness meditation versus alpha neurofeedback: a sham-controlled study. *Mindfulness*, 8(3), 572-584.