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Fostering a Trauma- and Violence-Informed Community: Developing Strategies to Inform Public Education

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

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Abstract

Trauma and violence are pervasive public health issues. Social and systemic barriers can intensify these experiences and negatively impact access to health and social services. A key element of equity-oriented healthcare, trauma- and violence-informed care (TVIC) promotes the emotional, physical, and cultural safety of service recipients. This thesis extends ongoing work to enhance organizational implementation of TVIC. In collaboration with the Canadian Mental Health Association (CMHA) Middlesex, semi-structured interviews and a document review were employed to investigate how to frame and share TVIC information with the public and individuals accessing services, and to illuminate what barriers and facilitators may impact this process. Findings suggest efforts to cultivate a TVI-community may be integrally linked to various social, systemic, and structural factors that perpetuate fear, shame, stigma, and prejudice. Leveraging existing organizational efforts, and creative and collaborative engagement strategies, could help re-construct the social and structural landscape that perpetuates the experience of trauma and violence.

Keywords

Trauma- and Violence-Informed Care, Mental Health, Mental Health Education, Public Education, Structural Violence, Implementation Science, Knowledge Mobilization

Summary for Lay Audience

Trauma and violence are common and harm many people. Social factors such as poverty and discrimination can make these experiences worse and make it harder for people to find and get help. It's important to support health and social services to reduce the poor health outcomes associated with these experiences. Trauma- and violence-informed care (TVIC) promotes the emotional, physical, and cultural safety of all people seeking care, and those providing it. While there are efforts to incorporate TVIC principles into organizational policies and practices, little has been done to translate this knowledge for the public. This is important because social norms and structures can perpetuate the trauma, violence, and inequities experienced by vulnerable and marginalized groups – this impacts individuals, communities and society.

In partnership with the Canadian Mental Health Association (CMHA) Middlesex, this research used interviews and a document review to explore how to integrate the principles and practices of TVIC into public and client education, and what barriers and facilitators might impact doing so. The findings suggest that efforts to create broader community awareness and action about TVIC may be linked to various factors that perpetuate fear, shame, stigma, and prejudice associated with trauma, violence, mental illness, and other health and social issues. These challenges exist at the individual, organizational, and societal level. In order to address these challenges, a creative and collaborative approach that builds on current organizational efforts to promote TVIC and extends beyond the mental health sector is required. For meaningful and lasting change to occur, education efforts must involve the general public, those seeking support and their loved ones, and other service agencies.

Acknowledgments

I would like to express my heart-felt appreciation to my supervisor Nadine Wathen and committee members Susan Macphail and Victoria Smye for their invaluable support and guidance on this journey. I am also thankful for the significant contribution of the Canadian Mental Health Association (CMHA) Middlesex, Yvonne Lammers, and the other staff who have acted as study liaisons, as well as the study participants. Without their support and willingness to collaborate, this research would not be possible. Further, I would like to thank my friend and colleague Tanya Benjamin for her support and advice throughout this endeavor. Lastly, I would like to express my deep gratitude to my partner, family, and other close friends for their continuous help and encouragement as I worked to complete this project.

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Chapter 1

1 Introduction

In this chapter I introduce the pervasiveness of trauma and violence and the profound impact that these experiences have on the health and wellbeing of individuals and communities. Based on this discussion, the purpose and significance of the present research is established. I also explore the lens through which I view the world and myself as a researcher, and how this lens shapes my approach to the investigation and interpretation of the findings.

1.1 Statement of Problem

The experience of trauma and violence is prevalent around the world; various World Health Organization (WHO) World Mental Health (WMH) surveys have indicated this (Kessler & Üstün, 2008; Benjet et al., 2016). For example, Benjet et al. (2016) found that 70% of the 68,894 adult respondents of the WMH survey from 24 countries reported exposure to a traumatic event, and 30.5% were exposed to four or more. These findings are significant because it has been well documented in the literature that traumatic experiences can have a profound and lasting effect on multiple domains of life, including psychological functioning and physical health (Barile et al., 2015; Cloitre et al., 2009; Straussner & Calnan, 2014; Shonkoff & Garner, 2012; van der Kolk, 2000). A study examining the vulnerability of countries to increased prevalence of post-traumatic stress disorder (PTSD), a mental disorder that is conditional on the experience of trauma (van der Kolk, 2000), found the highest prevalence rates of PTSD were found in Canada (Dückers et al., 2016). These results suggest that the significant and severe impact of trauma is felt within our own country.

Understanding the connection between trauma, violence, and mental health and wellbeing is essential if we are to ensure that healthcare services are safe and effective for everyone. For example, research suggests that there is a high prevalence of people with trauma histories who access treatment for mental health and addictions (Elliot et al., 2005) Further, understanding the role that inequity plays in an individual's health status

and their engagement with health services is important, especially in the context of violent and traumatic experiences. Equity in health, as defined by Braveman and Gruskin (2003), is “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different underlying social advantage/disadvantage[s]...” (p. 254). Therefore, health inequity exists for groups who are already socially disadvantaged, and these groups are further disadvantaged in regard to their wellbeing by the unfair distribution of resources and other factors that affect health (Braveman & Gruskin, 2003). Employing a focus on health equity enables us to acknowledge and challenge the influence of social, political, and economic contexts on healthcare and access to services, ensuring those who are at the greatest risk of poor health receive the care they need (Browne et al., 2015). This is important given the fact that social and systemic barriers such as poverty and discrimination can intensify the effects of violent and traumatic experiences and negatively impact a person’s ability to access health and social care (Browne et al., 2015).

Trauma- and violence-informed care (TVIC) is an approach to care that is embedded within the broader concept of Equity-Oriented Health Care (EOHC), a series of dimensions and strategies that can be used to promote health equity when working with marginalized populations in primary healthcare settings (Browne et al., 2015). TVIC is an approach underpinned by the recognition that individuals who experience social inequities and disadvantages often experience various and multiple forms of violence, both interpersonal and systemic. TVIC also highlights how the structural conditions of people’s lives place them at an increased risk for experiencing violence, and the ongoing traumatic effects of such experiences. It is therefore a universal approach to care that attempts to reduce the possible harms and (re-)traumatizing effects of seeking healthcare by creating a physically, emotionally, and culturally safe environment (Browne et al., 2015; Browne et al., 2018). Given the aforementioned global impact of trauma, the multiple forms of violence often experienced by those affected by social and systemic inequities, and the ongoing traumatic effects that can result, TVIC is a systems-level intervention that can help transform healthcare services and lead to safer and more equitable service provision.

There is evidence to suggest benefits and positive health outcomes associated with implementing EOHC, including TVIC, in primary healthcare settings (Ford-Gilboe et al., 2018). Arguments have been made for the need to integrate the principles of trauma-informed care¹ at the policy level to try and create trauma-informed social policy (Bowen & Murshid, 2016). Such efforts could help address the structural violence and inequities that are often experienced by vulnerable groups. Through the incorporation of trauma-informed principles such as safety, collaboration, and choice, into social policy, it is suggested that there could be considerable benefits to society, including the prevention and reduction of human suffering, as well as financial savings as a result of more positive health outcomes (Bowen & Murshid, 2016).

Further, a call has been made for a public health approach for trauma and traumatic stress prevention (Magruder et al., 2017). It is suggested that prevention at the individual, community, and societal levels can aid in: reducing the actual occurrence of trauma (primary prevention); early intervention to reduce the impact of traumatic stress (secondary prevention); and preventing the long-term disability that can result from trauma-related illnesses (tertiary prevention). This perspective highlights the role that public policies can play in shaping societal norms, and how a true public health approach may involve integration of mental health and trauma- and violence informed policies and practices beyond the primary healthcare (PHC) sector (Magruder et al., 2017).

Making communities equitable and safe, while emphasizing trust and support for people who have experienced trauma and violence, and its impacts, is a priority. This is especially true given that many children and adults who have experienced trauma remain untreated (Straussner & Calnan, 2014). It is crucial that we create a supportive environment that fosters hope, recovery, and acknowledges the significant effect that violent and traumatic experiences can have on individuals. Efforts are being made to reconstruct the systems that perpetuate and intensify the effects of trauma and violence,

¹ Trauma-informed-care (TIC) is a precursor concept that TVIC builds upon, and this term is still widely used in both the literature and practice domains. The difference between these two terms and approaches is discussed in Chapter 2, section 2.3.

such as embedding trauma- (and violence) informed approaches into PHC, public health, and social policy. However, by continuing to broaden the reach of TVIC and related approaches, trauma- (and violence) exposed individuals can be more efficiently and effectively reached (Magruder et al., 2016), reducing the impact of trauma on the individual and their community.

1.2 Purpose

This research examines, from an organizational perspective, how the principles and practices of TVIC can be integrated into the delivery and content of public education and/or psycho-education material. It extends the current body of knowledge by exploring how TVIC and EOHC information can be shared with the community, as well as potential benefits, challenges, and leverage points. A focus of this research is to gain critical insight into community needs and interests related to education about trauma and violence, and how these experiences impact mental health and wellbeing, service delivery and help seeking.

This investigation was conducted in collaboration with a community-based mental health organization, the Canadian Mental Health Association (CMHA) Middlesex. This partnership helped ensure that the research design and end-products were relevant to the needs of the organization and the community in which it operates. Our discussion and dialogue with the community about these issues opened up a space for knowledge sharing and exchange, which we hope will in turn strengthen the foundation for health equity at both the organizational and community level.

A qualitative approach, involving interviews with CMHA staff, as well as a non-confidential document review, allowed us to explore these issues in-depth and collect knowledge and information from a variety of internal sources. The findings of this research will contribute to the creation of a report, including recommendations for action that the agency can use to begin the process of integrating TVIC into public education and/or psycho education. Importantly, the report will be created in consultation with our community partners to ensure it captures the information and recommendations that will serve their needs best. Lastly, the Active Implementation Frameworks (AIFs) model

(Fixsen et al., 2005) was used to guide the investigation; in particular, the first stage of the Stages of Implementation framework called, the Exploration Stage. This framework and specific stage provided a way to think about implementation in a complex area, supporting more effective and sustainable change if this work is to progress.

1.3 Research Questions

In this research I examined the following questions:

1. How can the principles and practices of TVIC be integrated into public education material?
2. How can the principles and practices of TVIC be integrated into the delivery of psycho education for individuals who receive services, and/or their caregivers?
3. What barriers and facilitators (structural, cultural, and practical) exist that may impact the success of implementing this kind of educational programming and material for the community?

1.4 Significance of Study

This research is important for a number of reasons. First, ongoing research is being done to explore the development and delivery of equity-oriented care, TVIC, and related practices and principles in health settings (Ford-Gilboe et al., 2018), and beyond.² However, despite various efforts towards TVIC and trauma-informed care (TIC) implementation, little evidence exists to support its effectiveness, and to my knowledge, no research exists that informs how to provide TVIC content to the public. This suggests important gaps in the research and understanding of the benefits and uses of this information.

²Visit the “Our Work” page at the Gender Trauma & Violence Knowledge Incubator at Western website, <https://gtvincubator.uwo.ca/our-work/> for information about ongoing efforts related to the development, delivery and evaluation of training and education on Trauma- and Violence-Informed Care (TVIC).

Second, CMHA Middlesex has been a community leader in the field of intra-organizational implementation of TVIC. This research will support the organization to further integrate a TVIC approach into its recovery-oriented programs and services. The project is a critical first step in extending CMHA's leadership into externally focused efforts to support broader community awareness and action regarding trauma, violence, equity and cultural safety. Third, this study has the potential to achieve impact at both the organizational and community levels and strives to foster a community that promotes health equity and equity-oriented care, through a trauma and violence lens. Through the eventual creation of recommendations for action, with this research I have begun to explore how to translate TVIC knowledge into information that can inform the general public. This is significant because social norms and structures can perpetuate the trauma, violence, and inequities experienced by vulnerable and marginalized groups – and inequities affect individuals, communities and society. Ultimately, by initiating public education and discourse about TVIC, it is hoped that such efforts can help confront and reshape narratives surrounding trauma, violence, mental health, addictions, and other related health and social problems, and create a greater sense of compassion and understanding in people providing formal and informal supports to those in need. Further, these efforts can help inform the public, including people accessing services and their caregivers, about EOHC and equip people with the knowledge and information necessary to challenge inequitable healthcare practices and approaches.

1.5 Epistemological Orientation

While a thorough examination of the paradigmatic positioning of this research is outside the scope of my Master's thesis, it is important to consider the overall perspective and assumptions that I hold, as the lens through which I view the world undoubtedly impacts the way I approach my research and the interpretation of my findings. Therefore, this research is positioned within the social constructivist paradigm, and acknowledges the subjectivity of experience, and the varied and multiple meanings that exist when attempting to understand and interpret the world (Creswell, 2007). This view recognizes the complexity of experience, and the way individual realities may be shaped, or constructed, through social and historical processes. It also promotes the self-awareness

of the researcher, and understanding of how their own experiences influence their interpretation of the data they gather. This orientation fits my study well as it supports the consideration of numerous viewpoints and experiences in order to construct, in consultation with knowledge users, meaningful recommendations for community-level action. I would also like to note that a critical lens was used to view and interpret the data collected in this study. Critical research perspectives recognize inequities and the power and social structures that perpetuate oppression, and seek equity and justice (Cannella & Lincoln, 2011). This orientation is in alignment with the broader mission of equity-oriented healthcare and the principles and practices of TVIC. Through this research, I aim to critically understand how such information can be shared with the public.

Chapter 2

2 Literature Review

This study exists within the broad field of health information science, with a specific focus on the creation of knowledge-based processes and tools to help expand the organizational scope and practice of TVIC into the realm of public education. The methodology and objectives of this study are relevant to the literature pertaining to trauma, violence, and mental health, health literacy, and knowledge translation (KT) and implementation science. The literature review therefore investigates these concepts and how they support this study's efforts to foster a trauma- and-violence-informed community.

2.1 Trauma, Violence, and Mental Health

Traumatic events and experiences can significantly impair a person's psychological and physical functioning. Straussner and Calnan (2014) reviewed the literature investigating the impact of various kinds of trauma through the life cycle (childhood, adulthood, and late life), and the differences in traumatic events and reactions experienced by various groups. The authors note the difference between *objective* causes of trauma, such as the experience of a physical act of violence, and *subjective* causes of trauma, which relate to one's emotional perception of being hurt or "wounded." These differences, Straussner and Calnan (2014) state, result in a large variation in what individuals might find traumatizing, as personal reactions to events are based on many factors such as age, gender identity, trauma history, social supports, and cultural, religious, or spiritual beliefs.

Trauma can result from events such as natural (e.g., floods, wildfires) or human-caused (e.g., mass violence, car accident) disasters, as well as "complex traumas" that involve repeated instances of traumatic events like ongoing interpersonal violence or sexual abuse (Straussner & Calnan, 2014). Trauma can occur as a result of being bullied, living in poverty, or ongoing discrimination because of racial, religious, sexual, or gender identity, among others. Interpersonal forms of violence often intersect with structural

violence (e.g., poverty and racism), and can be ongoing and historical or inter-generational, which compound the negative effects of these experiences (Browne et al., 2015). Traumatic and violent experiences have a significant impact on a person's wellbeing. Evidence from numerous studies suggest the stress that results from experiences perceived as traumatic can lead to cognitive difficulties, sensory sensitivity, and negative coping strategies (Straussner & Calnan, 2014). While most people only experience these reactions for a short time, research has concluded that others may experience more severe and persistent trauma-related impacts including mood disorders (anxiety and depression), sleep disorders, substance use disorders, and PTSD (Straussner & Calnan, 2014). There is also emerging evidence to suggest biological impacts, including epigenetic modifications, may result from the experience of historical and intergenerational trauma (i.e., Conching & Thayer, 2019).

When considering the evidence of the nature of trauma and how it is experienced at various stages of the life cycle, it is clear that it is complex and varied; no group is immune, though some are at increased risk. For example, women most commonly experience intimate partner violence, which is strongly linked to PTSD (Devries et al., 2013; Ellsberg et al., 2015). Straussner and Calnan (2014) find that as wars and natural disasters increasingly force migration, their negative experiences are compounded by micro-traumas and structural violence that people may experience in refugee camps, and after migration, such as prejudice and discrimination, the grief of leaving behind their home, family, language, and familiar religious institutions. Straussner and Calnan (2014) highlight the experience of intergenerational or "historical" trauma – such as colonialism and related practices, including land expropriation and residential schools – suggesting that the impact of the original trauma experienced by a person or group can remain for decades, resulting in subsequent mental ill health.

Traumatic and violent events can therefore have a profound and lasting impact on the individual, their family, and the community. Interestingly, there is evidence to suggest that the level of emotional support one has after having an adverse childhood experience (ACE), such as childhood maltreatment, can impact potential physical and mental health consequences in the future (Barile et al., 2015). Relationships that are socially and

emotionally supportive may lead to more positive health outcomes for individuals who are trauma- and violence-exposed. It is necessary to examine the role a community can play in helping create a safe and inclusive space for those who have or are experiencing trauma and violence, and how the public's attitudes can affect the experiences of trauma survivors.

2.2 The Public's Perceptions of Trauma, Violence, and Mental Health

Given the fact that significant mental health issues can develop as a result of violent and traumatic experiences, it is important to consider how stigma or other public beliefs might interfere with a survivor's (mental health) help-seeking behaviour and how they frame their experiences. Stigma, as described by Goffman (1963), is a "mark" that signals to others that a person, for some reason, is not "whole or usual" and is rather "tainted" or "discounted." This devaluation of a person may result from anything that contributes to this "less than fully human" characterization, such as physical deformities, things that may be perceived as "blemishes of character" like mental illness, or social/cultural/religious identities that may not be valued or of the majority belief system (Goffman, 1963). This concept of stigma and the various routes through which it can manifest is important for understanding the impact that trauma and violence exposure can have on an individual, as many of the "blemishes" or "marks" described by Goffman can result from traumatic experiences, such as physical violence or sexual abuse. This is significant as public attitudes can play a role in perpetuating trauma and violence.

The results of a study by Mojtabai et al. (2011) that investigated barriers to initiating or continuing mental health treatment suggest that perceived need, and attitudinal/evaluative barriers (e.g., stigma, felt they could manage on their own) were reported as major barriers to treatment. Further, structural (e.g., transportation, finances) and attitudinal/evaluative barriers were reported more commonly among individuals with more severe conditions. These findings suggest that those experiencing more severe and persistent mental health issues, which are likely to include the effects of trauma and violence, may face significant attitudinal/evaluative barriers to getting treatment. These findings are extended by Clement et al. (2015) who conducted a systematic review of

quantitative and qualitative studies and found that stigma has a small to moderate, but clear effect, on mental health help-seeking behaviour. Their findings indicate that anti-stigma programs, services, and practitioners should focus on countering stereotypes, social judgement, and rejection of people with mental illness, among other strategies. This is echoed in research that suggests healthcare practitioners may hold stigmatizing attitudes and implicit biases towards people with mental illness, or who belong to minority, underserved, or other stigmatized populations, which can unintentionally negatively impact service provision (Sukhera et al., 2018; Sukhera et al., 2017; Sukhera & Watling, 2018). Implicit biases reflect beliefs, stereotypes, and associations that exist outside of a service provider's conscious awareness and may lead to compromised decision making (Sukhera & Watling, 2018). In turn, patients and their caregivers perceive practitioners' resultant behaviours as prejudicial and discriminatory, which leads to an "erosion of trust" between them (Sukhera & Watling, 2018, p. 35). This suggests that when those in need of mental health support engage with health services, the attitudes and actions of those providing care may cause harm. Therefore, addressing negative attributions and stereotypes that exist in healthcare settings is necessary to improve health outcomes.

While an individual's perception and experience of stigma could be attributed in part to the feelings of shame that are inherent in many mental illnesses (Clement et al., 2015), as well as the shame they may experience as a result of the trauma and violence they incurred (e.g., Stotz et al., 2015; Vizin et al., 2016), research has been done to explore the general public's attitudes about mental illness. For example, Schomerus et al. (2012) completed a systematic review and meta-analysis to determine whether the increase in knowledge about the biological correlates of mental disorders has translated into greater public understanding, increased readiness to seek help, and more tolerance for people with mental illness. The authors found two significant trends: there was a trend towards greater mental health literacy in relation to the biological determinants of mental illness, and greater acceptance of professional mental health support. However, there were no changes in social tolerance for those living with mental illness. Schomerus et al. (2012) acknowledge the significance of these findings for future anti-stigma campaigns and address the fact that the biological approach to understanding mental illness (e.g., mental

illness is an “illness like any other”) may be reductionist and does not adequately represent the various social determinants that impact the onset and course of mental disorders, like the impact of trauma and violence on mental wellness.

Flood and Pease (2009) explored the impact of community and individual attitudes about violence against women. They found three key domains in which attitudes impact violence against women: perpetration of violence; response to victimization; and community and institutional responses. They discuss the powerful effects of gender and culture, and how they intersect at multiple levels to reinforce the social relations and institutional structures that support pro-violence attitudes and behaviours. They conclude that changes in structural relations (e.g., media representations, criminal justice system) and social practices (gender and sexuality norms) must occur if violence is to be prevented. This reality suggests that attitude change is not enough, and that the structural and social arrangements that perpetuate violence, and the traumatic effects that can result, must be dismantled.

Institutional and social structures can lead to cumulative and/or intergenerational trauma due to continued oppression, discrimination, and stigmatization of vulnerable and marginalized groups. Research shows that positive reactions from others can reduce the negative impact of trauma, however between 25% and 75% of trauma-exposed individuals receive negative reactions from their social support system (Bonnan-White et al., 2018). If the social and structural systems do not provide the safety and compassion necessary to support recovery, and ultimately, the prevention of system-induced trauma and violence, then the negative impacts of such experiences will persist and compound.

In the 2019 report on the state of public health in Canada, the country’s Chief Public Health Officer confirmed that these, among many other concerns regarding stigma, continue to lead to adverse health outcomes for Canadians (Public Health Agency of Canada, 2019). It was suggested that over one and four Canadians have expressed experiencing at least one form of discrimination in their lifetime, including discrimination related to race, religion, ethnic origin, gender, or sexual orientation (Godley, 2018). Those experiencing stigma face reduced access to, and quality of, the resources and

services needed to maintain good health, increased risk of chronic stress and poor coping responses, and are at higher risk of assault and injury, especially those experiencing stigma related to mental health (Public Health Agency of Canada, 2019). The report also highlights the complexity of intersecting stigmas, and the reality that an individual often experiences multiple stigmas relating to their health status and social identity and that these impact many domains of their life, leading to increased health and social inequities (Link et al., 2018; Stangl et al., 2019; Turan et al., 2019). In order to combat the detrimental health effects of stigma and create an inclusive healthcare system, intervention and change must occur at the individual, interpersonal, institutional, and population level (Public Health Agency of Canada, 2019).

2.3 Creating a Trauma- and Violence-Informed Community

In recognition of the harm that services and institutions can perpetuate, one way that structural change is being brought about has been through the introduction of trauma- and violence-informed service delivery. Previously, trauma-informed approaches have been developed and implemented in service settings (Ponic et al., 2016). This form of service provision recognizes the impact of interpersonal violence and victimization on a person's life, behaviour, and development (Elliott et al., 2005). Utilizing trauma-informed approaches, service providers can recognize that peoples' past and ongoing experiences of violence may result in traumatic effects, and this can impact how systems respond to them (Ponic et al., 2016). Further, service providers can create a supportive space that acknowledges the possible emotional and behavioural effects of violence and traumatic experiences on an individual (Ponic et al., 2016).

To bring attention to the significant and broad impact of violence and its traumatic effect on people, there has been a call to integrate factors beyond the individual in how we think about understanding and responding to trauma and violence. This begins with changing the language from trauma-informed, to trauma- and violence-informed policy and practice (Ponic et al., 2016). The addition of the term "violence" is intended to highlight the relation between trauma and violence, and acknowledges that the challenges a person may experience are not only a result of their psychological state (Ponic et al., 2016).

Trauma- and violence-informed care (TVIC) is a more general approach that

acknowledges the numerous types of violence one may experience as a result of the structural inequities (unjust and avoidable differences in health and wellbeing experienced between and within groups) operating in and on people (Browne et al., 2015). TVIC focuses attention on how social and structural conditions of people's lives may increase their risk of experiencing violence, as well as impact their ability to access supports (Browne et al., 2015). This equity-oriented approach to service provision expands upon the principles of trauma-informed care, with the aim of reducing the possible harms or traumatizing experiences that could arise from receiving healthcare or other services.

The principles and practices of TVIC are rooted in the notion that an individual should not have to disclose their violence and trauma history in order to receive high quality care, and instead service providers should use "universal trauma precautions" (Elliott et al., 2005; Ponice et al., 2016). This means that services are delivered in a way that reduces harm and provides positive support for *everyone*; importantly, knowledge of a person's trauma history is not necessary using this universal approach (Raja et al., 2015). As outlined by Ponice et al. (2016) the principles of TVIC include: understanding trauma and interpersonal violence, and the impact these experiences have on people; the creation of an emotionally and physically safe environment for everyone: staff and people seeking services; the opportunity for choice, collaboration, and connection between staff and people receiving care; and the use of a strengths-based and capacity building approach to service provision that encourages coping and resilience.

Efforts have been made to integrate these forms of practice at the systems level. For example, the Research to Equip Primary Healthcare for Equity (EQUIP) intervention program (Browne, et al., 2015) has been working to address systems level change. The intervention "was designed to enhance the capacity of primary healthcare (PHC) organizations to be as responsive as possible to diverse needs of populations whose health is influenced by intersecting forms of structural inequities" (Brown et al., 2015, p. 3). This intervention also was crafted using the central tenets of complexity theory, whereby healthcare environments are viewed as complex adaptive systems with components that interact and influence one another (Hawe, 2015; Varcoe et al., 2019).

This allows for the consideration and analysis of multiple factors that shape the uptake of the EQUIP intervention (Browne et al., 2015). TVIC is one of the key dimensions of this intervention, along with creating services that are contextually tailored (fits with the needs of the local population), and culturally safe (addresses power relations, racism, and other forms of discrimination that reinforce health inequities). In order to transform the capacity of organizations to provide equity-oriented care and promote safe and trusting environments, the EQUIP intervention is focused on educating staff in the principles and practices of TVIC, cultural safety, and harm reduction (added as a key dimension as a result of findings from the primary care study), as well as working at the broader organizational level to shift structures, practices, and policies to reflect this orientation (Browne, et al., 2015; Browne et al., 2018). Research has shown that as an organization shifts towards EOHC practices, pre-existing tensions among staff can surface; however, these tensions can serve as opportunities to challenge the status quo of service provision and catalyze positive organizational change (Browne et al., 2018).

Ford-Gilboe et al. (2018) examined the impact of EQUIP's equity-oriented healthcare (EOHC) intervention on patient outcomes in primary care, finding that patients who received higher levels of EOHC were more likely to experience increased comfort and confidence in the healthcare they received, leading to increased feelings of efficacy related to preventing and managing their health. These improvements in confidence predicted better health outcomes, including reduced depressive and post-traumatic stress symptoms and chronic pain, and increased quality of life. These results lend support for the benefits of integrating EOHC, including TVIC principles and practices, in healthcare. The interventions described above are beyond simply attitude change and aim to re-shape the service structures that respond to trauma- and violence-exposed individuals.

Importantly, research has been conducted that assesses consumer perceptions of integrated services that address issues of trauma, mental health, and substance use (e.g., Clark et al., 2008). However, in the present research I seek to extend the benefits of TVIC and EOHC from organization-level settings into the community through examining how to share TVIC-related information with the public and individuals seeking care.

Therefore, the focus is on generating community awareness of equity-oriented healthcare practices, rather than evaluating people's perceptions of the care they receive.

2.4 Connecting Health Literacy and Trauma- and Violence-Informed Care

Health literacy can be defined as “the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health”; it also “includes the capacity to communicate, assert and enact [such] decisions” (World Health Organization, 2015). Communication skills, motivation, confidence, trust, and ability to access care have all been identified as factors that can impact health literacy (Greenhalgh, 2015). Importantly, low health literacy levels have been associated with things such as increased hospitalizations, greater use of emergency services, poor engagement in health services, less participation in prevention activities, poorer overall health status, and higher mortality rates (Berkman et al., 2011; Greenhalgh, 2015; World Health Organization, 2015).

Inequities in understanding and use of health services can be explained in part by differences in health literacy (Greenhalgh, 2015). This underscores the growing appreciation of the “interdependencies between health understanding, health attitudes and behaviours, social determinants of health...and the design and delivery of health services” (Greenhalgh, 2015, p. 1). Someone who has experienced, or is experiencing, interpersonal and/or structural violence, for example, may also face other social, economic, or cultural challenges (Browne et al., 2015). This may in turn impact their engagement with health information and services, their health choices, and ultimate health outcomes. From this perspective, sharing information at the community level about TVIC and EOHC may help strengthen the health literacy of vulnerable populations and those groups who may face difficulties with having their health literacy needs met. EOHC aims to reduce the effects of structural inequities, lessen the impact of racism, discrimination, and stigma on accessing and receiving care, and seeks to dismantle dominant approaches to care that do not consider the needs of those who are affected by health and social inequities (Browne et al., 2018).

As mentioned above, factors such as communication skills, confidence, trust, and ability to access care are associated with the health literacy construct. All of these factors could be influenced by an individual's experience of trauma and violence and affect their health information seeking behaviours and health literacy needs. Therefore, equipping people – along with organizations and communities – with knowledge about TVIC and EOHC principles and practices may help transform expectations about service delivery and quality care and support advocacy efforts for practice and policy-level changes.

Efforts to cultivate a trauma- and violence-informed community that extend beyond the level of service provision to include sharing knowledge with people accessing care, their caregivers, and the general population may help to combat the effects of health and social inequities on health literacy. As noted by Greenhalgh (2015), meeting certain subpopulations and at-risk groups' health literacy needs may require a system-wide response, as well as a reconceptualization of what "literacy" means. Much work has been done to develop and integrate TVIC and other EOHC principles and practices into service provision (Browne et al., 2015; Browne et al., 2018, Lavoie et al., 2018; Ford-Gilboe et al., 2018). This thesis research seeks to expand these efforts to include a community-wide response, and begin tackling the knowledge inequities that exist in the general public, including within vulnerable and marginalized populations. As previously mentioned, preliminary results of integrating EOHC practices (including TVIC) in clinical care settings have been linked to positive health outcomes (Ford-Gilboe et al., 2018); equipping the public with such knowledge can help build the foundation for better health outcomes for all.

2.5 Knowledge Translation and the Third Sector

While research may demonstrate positive outcomes associated with the use of evidence-based programs (EBPs), best practices, and related interventions, there is evidence to suggest that context matters, and the outcomes found in research trials are not always achieved in widespread implementation (Wandersman et al., 2016). This reality calls attention to the complexity of our world and the difficulties that may exist when attempting to translate research evidence into practice. This is important to consider when

examining third sector organizations (TSOs) and how they use and value research and other forms of knowledge.

The third sector is comprised of organizations that bridge the “gap” between private and public services (Wilson et al., 2012). These organizations are characterized in many ways, but are generally defined as organizations that: have a formal structure; are privately owned and independent from the government; are non-profit distributing and self-governing; and benefit from voluntary activities (Bach-Mortensen et al., 2018). TSOs are said to have a unique culture and setting (Hardwick et al., 2015; Kothari & Armstrong, 2011), which could impact their fidelity to EBPs and best practices, as well as the perceived usefulness of such programs and practices.

The literature regarding TSOs and the creation and integration of research and knowledge into practice suggests that third sector practitioners do not consistently use available evidence in their work, and when it is used, efforts aren’t always successful or sustained. Practitioners may struggle to integrate EBPs and practices into service delivery because they perceive a lack of adaptability to their local context, or they feel they do not have the capability or capacity due to lack of training or organizational support (Bach-Mortensen et al., 2018; D’Ippolito et al., 2015). In some instances, practitioners have demonstrated indifference towards, or rejection of, research and evidence-based practices that they feel do not reflect the values, experience and knowledge of themselves, their colleagues, and the individuals they serve (Hardwick et al., 2015).

TSOs tend to value holistic programs with broad impact (Worton et al., 2017), and often prefer to explore the development of existing programs by incorporating local knowledge instead of using external initiatives (Hardwick et al., 2015). Interestingly, it has been found that some practitioners consider a program to be evidence-based if it incorporates the use of any kind of data (e.g., needs assessments and program evaluations) during its life-course (Ramanadhan et al., 2012). These preferences and perceptions of “evidence” are in contrast to more “scientific” methods of data collection and analysis used to build an ‘evidence-base’ for a program.

To ensure the effective integration of knowledge and evidence into practice, third sector organizations and practitioners must be meaningfully engaged in a two-way exchange of information. For example, Ollerton and Dadich (2018) found that research use in third sector settings may be enhanced if researchers use a more “dialogic approach” involving actively engaging practitioners in discussion about research aims to incorporate their feedback and ensure the initiative is acceptable and meets their needs and the needs of those they serve (Ollerton & Dadich, 2018). These kinds of findings suggest the need for researchers, when attempting to develop and implement EBPs into service delivery, to account for the environments in which TSOs work, and their knowledge values and preferences.

Collaboration between researchers and service providers can be supported through integrated knowledge translation (IKT). IKT is a research orientation that emphasizes and values the role of knowledge users in the research and knowledge creation process. The focus of IKT is on building relationships between the academic researcher(s) and those who will use the information, such as practitioners, policy makers, and the public (Kothari, & Wathen, 2013; Kothari, & Wathen, 2017; Wathen, & MacMillan, 2015). IKT is an adaptable process and addresses the knowledge-to-action gap through the incorporation of knowledge users throughout the research process. As Kothari and Wathen (2013) note, this may involve the joint creation and revision of research questions, methodology, participation in data collection and tool development, interpreting the findings, and disseminating research results. It does not assume which information is important, and instead allows researchers to consider what “knowledge” is worth translating to potential knowledge users by enabling the co-creation and examination of research priorities and knowledge with them (Wathen & MacMillan, 2015). Despite coming with its own set of challenges, such as the fact that little evidence may be generated to actually support changes to policy and practice (Kothari & Wathen, 2013), IKT can help ensure research and research products are informed by the needs of practice and policy communities. Successful IKT can help researchers and research users jointly reflect upon the process of implementing an EBP or practice, which can ultimately support organizational learning and change (Kothari & Wathen, 2013).

The IKT approach and the aforementioned considerations of TSOs' knowledge use and preferences are relevant to this thesis in that it seeks to create, in collaboration with our research partner, recommendations for action at the community-level. Our partner, CMHA Middlesex, belongs to the third sector and as a result, may face many of the challenges, or have similar perceptions of including research evidence in practice as those mentioned above. Therefore, involving the research partner in the identification of research questions, study design, data analysis, and ultimate creation of recommendations for ways forward is essential to ensure that the study and its findings are relevant to the needs of the organization and the practice community in general (see Carswell et al., 2020 for a more detailed discussion of this topic).

2.6 Active Implementation Frameworks

Given the many challenges associated with translating research into practice, it is beneficial to examine what barriers and facilitators exist to implementing evidence and other forms of knowledge in real-world contexts. Implementation researchers acknowledge the influence context has on an intervention, and attempt to understand and work within such conditions (Peters et al., 2013). This form of inquiry is concerned with all aspects of implementation, including barriers and facilitators, processes, results, as well as how to successfully sustain and scale an intervention (Peters et al., 2013). According to Peters et al. (2013), "the intent [of implementation research] is to understand what, why, and how interventions work in "real world" settings and to test approaches to improve them" (p. 1). As noted by Bertram et al. (2015), the implementation of an intervention is a process, as opposed to a singular event, that requires thoughtful and calculated organizational changes over the course of 2-4 years.

One approach to examine and support the successful implementation of interventions in practice settings is called the Active Implementation Frameworks (AIFs). These frameworks stem from a synthesis of transdisciplinary research on the evaluation of implementation by Fixsen et al., (2005). The frameworks and best practices derived from this work have since continued to evolve (Metz et al., 2015), and are comprised of a series of strategies that can be used to facilitate positive outcomes and fidelity to the innovation being implemented. Bertram et al.'s (2015) refinements have resulted in three

frameworks that include: Intervention Components; Implementation Drivers; and Stages of Implementation. According to Bertram et al. (2015), the first framework, Intervention Components, involves defining who should be involved, and how, in the particular activities and phases of service delivery; selecting the theory bases to support these definitions; understanding how the identified elements and activities lead to positive outcomes for the target population; identifying the characteristics of the target population and ensuring that they align with the practice model that has been selected; and a rationale for why alternate models of practice do not fit.

The second framework, Implementation Drivers, is composed of three drivers, whose aim is to create the organizational environment needed to achieve the desired outcomes. These are: competency drivers, which consist of strategies that build practitioners' competence and confidence in a way that supports program fidelity; organizational drivers, which are activities that foster agency and system readiness through the shaping of administrative, funding, policy, and procedural structures, which in turn support the competency drivers; and lastly, leadership drivers, which involves selecting and applying the right strategies and expertise needed to ensure the other drivers are operating successfully.

The third framework, Stages of Implementation, involves four stages (see Figure 1). The first is the exploration stage, which enables an organization to engage in a preliminary assessment to examine its needs and the fit of the intervention to these needs. The installation stage is a preparatory phase that involves acquiring the necessary resources, preparing the organization, and the implementation drivers. The third stage, the initial implementation stage, consists of the critical examination and alteration of organizational efforts after the initial program implementation in order to more effectively implement the program model. The fourth stage, full implementation, is achieved when the majority of staff are providing the new or refined program model in a way that maintains the integrity of the original model. It is important to note that all of these stages involve considerations of sustainability, and as stated by Bertram, et al. (2015), these stages are not always experienced in a linear progression, as organizations may be required to revisit past stages in light of significant social, political, or economic changes.

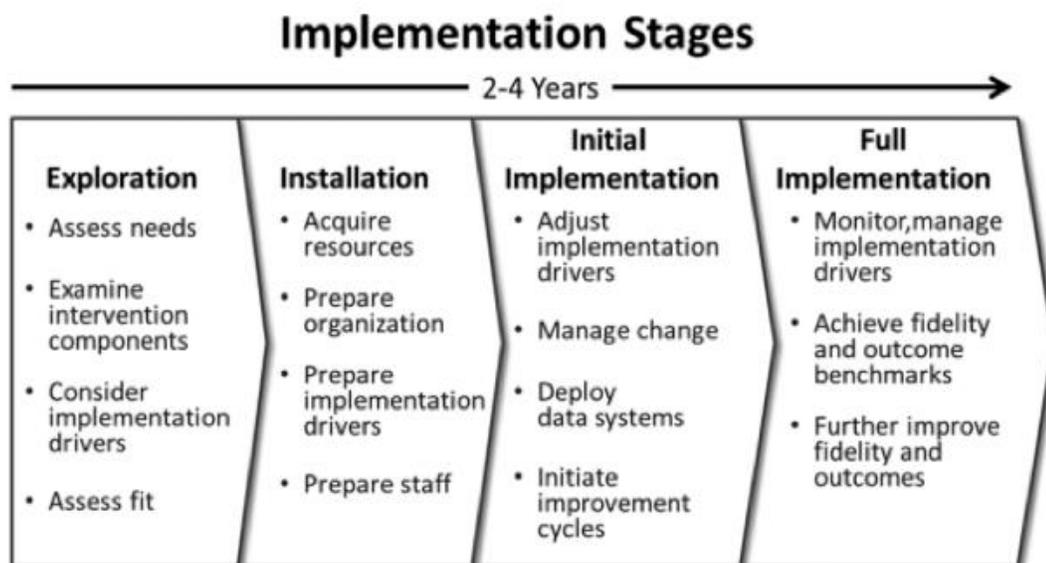


Figure 1: AIF Stages of Implementation; Bertram et al. (2015).

The goal of the AIFs is to give service providers and evaluators a model to follow that can help build and sustain organizational capability and capacity to effectively implement research-based and informed practices, and assess their impact. This thesis focuses on understanding how an organization can expand the scope of its TVIC efforts and begin implementing the principles and practices of TVIC into the delivery and content of its public-facing activities, including mental health promotion and psycho-education initiatives. Therefore, the AIFs, in particular the Stages of Implementation, can provide structure to understanding how this process unfolds, and assessing its initial impacts. Given the fact that this study will consist of a preliminary assessment of organizational readiness, needs, and potential direction, the exploration stage of the framework is the most relevant. This stage and how it was used in this inquiry will be discussed further in the subsequent chapter.

Chapter 3

3 Methodology

In this section I will review how I carried out this research, what sources of information I drew from, and how these efforts contributed to understanding the research questions and aims of this study. Study procedures and how the data was analyzed also is discussed, as well as the considerations that I made to maintain ethical research practices and ensure the integrity and trustworthiness of the data.

3.1 Study Design

To explore how to expand successful intra-organizational TVIC efforts into the community through public education and psycho-education, I utilized qualitative, semi-structured interviews with CMHA Middlesex staff and a non-confidential document review and analysis. In alignment with the principles and practices of IKT, these activities occurred in consultation and collaboration with CMHA Middlesex study liaisons. These liaisons assisted with study planning, design, and implementation, and provided organizational guidance and expertise. IKT is an adaptable process that allows researchers to consider what “knowledge” is worth translating to potential knowledge users by enabling the co-creation and examination of research priorities and knowledge with them (Wathen & MacMillan, 2015). Involving knowledge users in the research process allowed for the investigation to produce findings that are of interest and relevant to the needs of both the researchers and the community partner. The timeline of this study overlapped with the COVID-19 pandemic which resulted in an increase in organizational demands on our community partner. Study liaisons therefore were unable to support data analysis and the creation of recommendations for action. However, effort is being made to ensure that formal recommendations for action are created; details of these efforts will be discussed in the section, Summary and Recommendations for Future Research (Chapter 5).

3.2 Setting and Selection

CMHA Middlesex is a community-based mental health agency that provides recovery-oriented mental health services to individuals age 16 and older, as well as public education programming (CMHA, 2018). The organization employs over 300 staff and services clients at multiple sites throughout London, Middlesex County, Exeter and Goderich, Ontario. CMHA Middlesex has made significant progress in terms of reshaping internal policies and practices to promote safety and enhanced delivery of equity-oriented care for the individuals they serve (CRHESI, 2017). These changes have continued to evolve based on an emerging theoretical (Ponic et al., 2016) and empirical model of trauma- and violence-informed care (TVIC) (Browne et al., 2015; Browne et al., 2018, Lavoie et al., 2018; Ford-Gilboe et al., 2018) from the EQUIP Healthcare program (EQUIP Healthcare, n.d.), and in partnership with Western University researchers³. Therefore, given the advanced work CMHA Middlesex has done to become a trauma- and violence-informed agency, a next step is to examine how the organization can expand their TVIC efforts.

In addition to the leadership that CMHA Middlesex has demonstrated in the field of organizational implementation of TVIC, another factor that influenced the choice of setting is the relationship that I have with the agency. I have been employed as a Mental Health Worker at CMHA Middlesex for over five years and am presently on an educational leave of absence. I feel that the experience and existing relationships that I have as a result of my employment supported the success of the research. For example, I have previously built some rapport and trust with participants and the study liaisons. This is significant as research suggests that interactive relationship building using talk, trust, and time can help facilitate the adoption of KT-related initiatives (Wathen et al., 2011). I feel it is important to note however, that my professional role and experience influenced

³The agency has been working on the organizational implementation of trauma-informed approaches for over 10 years. Of note, the organization transitioned from “trauma-informed-care” (TIC) to the more structurally focused TVIC once they began working with researchers from EQUIP Healthcare and Western’s Gender, Trauma & Violence Knowledge Incubator, including members of the present thesis supervisory committee.

more than the setting selection and the ways in which I performed the research activities, and also impacted the investigation as a whole. The impact of my professional experience on this research, including the opportunities and challenges posed by my role, is discussed in Chapter 5.

3.3 Data Sources and Procedures

CMHA Middlesex was contacted by myself and my supervisor, Dr. Nadine Wathen, to inquire about its interest in partnering in this study. The study's project summary was shared with senior leadership and received approval. To represent organizational commitment to the research, study liaisons were assigned to support the project, and a letter was drafted, signed, and shared with the research team. An organizational letter of information and consent form was also signed (see Appendix A) to represent the agency's informed consent in the participation of this research, as required by Western's Research Ethics Board (REB – see Section 3.6, below).

My supervisor and I then met with CMHA's study liaisons to discuss objectives, research questions, and possible methods. These liaisons co-chair the agency's TVIC committee and are well informed about the organization's past and present TVIC efforts. Aligning with an IKT approach, meetings with the study liaisons, and a project schedule, helped ensure that from the onset of the study, the agency's needs and interests informed the investigation and supported time management, study expectations and responsibilities. Meetings with the study liaisons continued throughout the study, and involved progress updates, discussion about study needs (e.g., interviews and documents), reviewing findings, and planning knowledge mobilization strategies.

Multiple methods were used to more comprehensively answer the research questions (see Table 1). The study liaisons assisted with the recruitment of interview participants and the identification of relevant documents that could help the investigation. Details about these data sources will be discussed in the subsequent sections.

Research Question	Method	Data Source	Contribution to the Study
How can the principles and practices of TVIC be integrated into public education material?	<ul style="list-style-type: none"> • Interview transcripts • Agency documents 	<ul style="list-style-type: none"> • CMHA staff • Organizational material (meeting minutes; goals and action plans; internal program descriptions; strategic plan) 	<ul style="list-style-type: none"> • Understand themes re: <ul style="list-style-type: none"> ○ Staff understanding of TVIC principles and practices ○ Staff perceptions of expanding TVIC efforts ○ Community engagement strategy ○ Design/delivery of content and info • Organizational goals, interests, and initiatives related to TVIC • Illuminate process of implementation
How can the principles and practices of TVIC be integrated into the delivery of psycho education for individuals who receive services, and/or their caregivers?	<ul style="list-style-type: none"> • Interview transcripts • Agency documents 	<ul style="list-style-type: none"> • CMHA staff • Organizational material (as above) 	<ul style="list-style-type: none"> • Understand themes re: <ul style="list-style-type: none"> ○ Staff understanding of TVIC principles and practices ○ Staff communication (i.e., psycho education, standards of care, equity-oriented practices) with individuals and their caregivers • Illuminate resources • Illuminate process of implementation
What barriers and facilitators (structural, cultural, and practical) exist that may impact the success of implementing this kind of educational programming and material for the community?	<ul style="list-style-type: none"> • Interview transcripts • Agency documents 	<ul style="list-style-type: none"> • CMHA staff • Organizational material (as above) 	<ul style="list-style-type: none"> • Understand themes re: <ul style="list-style-type: none"> ○ Organizational goals related to TVIC ○ Current organizational TVIC-related initiatives ○ Challenges related to organizational TVIC-related initiatives ○ Internal/external setting, characteristics, and influence on the success of TVIC-related education

Table 1: Research Questions, Data Sources, and Contributions

3.3.1 Key Informant Interviews

3.3.1.1 Purpose

In the interview component of this study I explored staff roles and perspectives as they related to TVIC, public education and/or psycho education, and the perception of integrating TVIC into these areas. This allowed for an in-depth investigation of these issues and ensured that the information gathered was informed by the experience and expertise of staff. The interviews also allowed for feedback and evaluation, from a staff perspective, of the agency's past and current TVIC initiatives. The flexible nature of the semi-structured interview was beneficial as it created the opportunity for richer participant responses, allowing for comparisons across interviews, while also highlighting important individual perspectives or experiences that lay outside the structured questions (Berg, 2009). This permitted participants and me to explore other relevant issues that arose during the discussion and illuminated themes or important issues that were unknown to the research team.

3.3.1.2 Sampling & Recruitment

Inclusion criteria for these interviews were that participants were 18 years of age or over, able to speak, read and write in English, and work at CMHA. Recruitment involved all staff from the potential sampling pool of approximately 300 employees, regardless of employment status (e.g., part-time, full-time, or relief) or department. There was no exclusion criteria other than the reverse of the inclusion criteria listed above. It was hoped that staff from across the agency (e.g., direct service, leadership, administration), with varying degrees of familiarity with TVIC, would participate as this would help provide a diverse perspective. To recruit staff, I worked with the study liaisons to circulate agency wide announcements about the study (see Appendix B); the project summary was also included in the announcement. These announcements were circulated via bulletin boards in staff rooms or other accessible spaces, through agency wide emails, as well as a private online staff communication platform CMHA uses called, Workplace. Interested staff were directed to attend an information session to learn about the study and sign up to participate in a key-informant interview, or to contact me directly to inquire

about participation. CMHA study liaisons also reached out via email to the leadership of certain departments to extend an invitation to partake in order to promote a sample that was representative of the agency and its various programs.

3.3.1.3 Data Collection

A total of seventeen (n = 17) in-depth-semi-structured interviews of approximately 35-60 minutes in length were conducted. Interview participants represented various departments and staff levels within the agency, including: Community Programs, Peer Support, Crisis Services, Information and Brief Support, Transitional Case Management, and My Sister's Place, as well as participants from the agency's rural sites. Not all teams and departments are specified to ensure confidentiality. While participants were not explicitly asked about their historical education or professional background, some indicated a background in social work, psychology, and/or sociology. Importantly, not all roles at CMHA require an employee hold a registered health professional designation; employees may hold diverse educational and professional backgrounds related to mental health. Table 2 outlines further information about participants' roles at the agency. Participants reported varying degrees of knowledge of and familiarity with TVIC, the agency's efforts to integrate TVIC into service delivery. Importantly, not all participants indicated having completed the agency's internal TVIC staff training, with some expressing that they have been at the agency for a long time and have not had the opportunity to take it.

Participants also varied in terms of their knowledge of or experience delivering public education. When unable to speak to topics related to public education, participants spoke about psycho-education or the information they provide to individuals in-session, either one on one, or in a group setting. Participants varied in terms of what they spoke about, however all of their voices are represented in findings of this report.

All participants were provided with a letter of information and consent form that they were asked to read and sign before participating in an interview (see Appendix C). With permission from participants, the interviews were audio recorded.

Staff Role	Frequency (n=17)
Direct Service Staff	12
Direct Service Staff (Team Lead)	2
Administrative Staff	2
Department Manager	1
Current or previous involvement with the TVIG	6

Table 2: Description and Frequency of Participants' Roles

The recordings were complimented by notes that I took during the interviews to highlight certain themes or information that seemed novel or of particular relevance to the study. These notes were used during my reflective and analytic process to explore meaning and connections among the data. The guide used during the interviews (see Appendix D) was created with my supervisor and reviewed with the study liaisons. Feedback was given by the study liaisons to ensure the questions fully addressed agency needs and interests.

3.3.2 Document Review

3.3.2.1 Purpose

In order to gain insight into the agency's internal policies, practices, goal setting, and strategic direction in relation to TVIC and both public and psycho-education, I conducted a review of non-confidential agency documents. This review provided the opportunity to closely examine the agency's TVIC implementation and areas where opportunity may exist to build upon and/or strengthen such efforts. As with the interviews, the document review also supported the evaluation of the agency's past and current TVIC initiatives. This source of data helped contextualize the information gathered during the interviews, and was useful for understanding the social reality within the agency (Flick, 2014).

3.3.2.2 Document Selection

The study liaisons assisted in obtaining copies of the non-confidential documents, which were shared with myself electronically. The research team, including the study liaisons, determined together which documents were relevant to the investigation. Both internal and external documents were analyzed. Internal documents reflected information that was

created and shared with CMHA staff only, and external documents reflected information that was shared publicly or with other service providers. These documents were more recent and did not reflect the agency's complete document history pertaining to its TVIC-related efforts. The date range of the documents appears to be between 2015-2019, however not all material is dated. Table 3 describes the various documents and their relation to the investigation. Collectively, these documents reflect data that pertain to the individual level, organizational level, and engagement at the broader community level.

Document Type	Date	Frequency (n=16)	Relation to Investigation
Trauma- and Violence-Informed Group (TVIG) Meeting Minutes	Between 2018-2019	7	Internal document; Understand the needs and thought processes of the TVIG; Explore topics of discussion and how they relate to the perceived needs of the organization; Examine relevance and fit of TVIC-related public and psycho-education
TVIG Goals and Action Plan	Between 2018-2019	2	Internal document; Gain insight into the TVIG's priorities and goals for advancing the integration of TVIC into agency; Confirm past initiatives and actions; Explore relevance and fit of TVIC-related public and psycho-education
TVIC Training Material	2018; some dates not available	4	Internal/external documents; Gain insight into current TVIC-related training presentation material used within and outside of the agency
Participant Handbook	2016	1	External document; Examine and understand information provided directly to individuals accessing services; explore presence of TVIC-related information
Public Education Program Description	2018	1	Internal document; Examine and understand the agency's objective and rationale for public education; explore relevance and fit of TVIC-related public education
2015-2020 Strategic Plan	2015	1	External document; Gain insight into organizational needs and priorities; examine presence of TVIC-related goals and action planning; explore relevance and fit of TVIC-related public/psycho-education

Table 3: Document Type and its Relation to the Investigation

3.3.2.3 Data Collection

A total of sixteen ($n = 16$) documents were reviewed. During the review process, information was extracted systematically in order to explore and identify themes that were relevant to the research questions and data that emerged from the interviews. I created a form to capture information pertaining to the research questions (see Appendix E for a list of the categories), and used NVivo to link document data to the codes that were derived from the interview transcripts. Therefore, new and emerging themes were considered during the course of data extraction and were not limited to the original data collection form. Further, the AIF's Exploration Stage (Bertram et al., 2015) also was used as a lens to examine the documents; this framework will be discussed in greater detail in the subsequent section.

3.4 Data Analysis

Due to the large volume of data collected, I transcribed ten interviews and had seven transcribed by a professional transcription service. Importantly, the analysis process started during my transcription of interviews (and review of the professional transcripts), as I began to engage with the information gathered and started forming initial interpretations of possible themes. It was also initiated during other efforts I made to condense the data collected during the document review. Data condensation is part of the analytic process where information is selected, focused, simplified, abstracted, or transformed (Miles et al., 2014). In alignment with my paradigmatic values, it is important to recognize that a researcher's analytic lens influences how they perceive and interpret the data (Saldaña, 2016). This suggests that multiple realities can exist as people view the world differently (Saldaña, 2016), and fits well within the social constructivist paradigm, which recognizes the subjectivity of experience. Therefore, in the context of the present study, I am aware of my influence over the analytic process, and further, how my professional role at CMHA Middlesex and experience as a Mental Health Worker influenced data generation and analysis.

In order to identify relevant themes that could ultimately inform the creation of recommendations for action, content analysis involving coding was used to organize and

interpret the data collected from the key informant interviews and the document review. Categorizing and codifying the data helped divide, group, reorganize, and link concepts across the data collection methods in order to establish meaning and connections (Saldaña, 2016). As noted by Coffey and Atkinson (1996), coding is not the analytic process itself but instead provides a way to organize concepts. The codes therefore served as a way to support my analytic process, helping me establish connections between the data and my interpretation and thoughts about the data. For the majority of the coding process, I used the qualitative data analysis software, NVivo. This software enabled me to easily code my data (see Appendix F for code book) and compare and contrast findings across the transcripts and documents. The software also allowed me to create and store reflective and summative memos that I used during the analysis process to help refine my understanding and interpretation of the data. All memos were shared with my supervisor and committee.

I followed a continuous and iterative process (Miles et al., 2014), that involved pre-coding, first cycle and second cycle coding (Aurini et al., 2016). I started with more general codes inspired by the AIF Exploration stage and research questions, and continued to code in more detail, leading with participants' voices and perspectives to ensure that I was not missing important concepts that were not captured in the framework or research questions. I then began to group the codes by categories, continuing to add, eliminate, and refine codes and categories as needed. I used these categories to identify and interpret larger patterns and themes that related to the investigation's points of focus. I engaged in a preliminary analysis of ten transcripts, followed by a full analysis of the rest of the transcripts and documents. This enabled me to review my preliminary findings with my supervisor and committee, and adjust my analysis and interpretation accordingly. Figure 2 illustrates my analytic process:

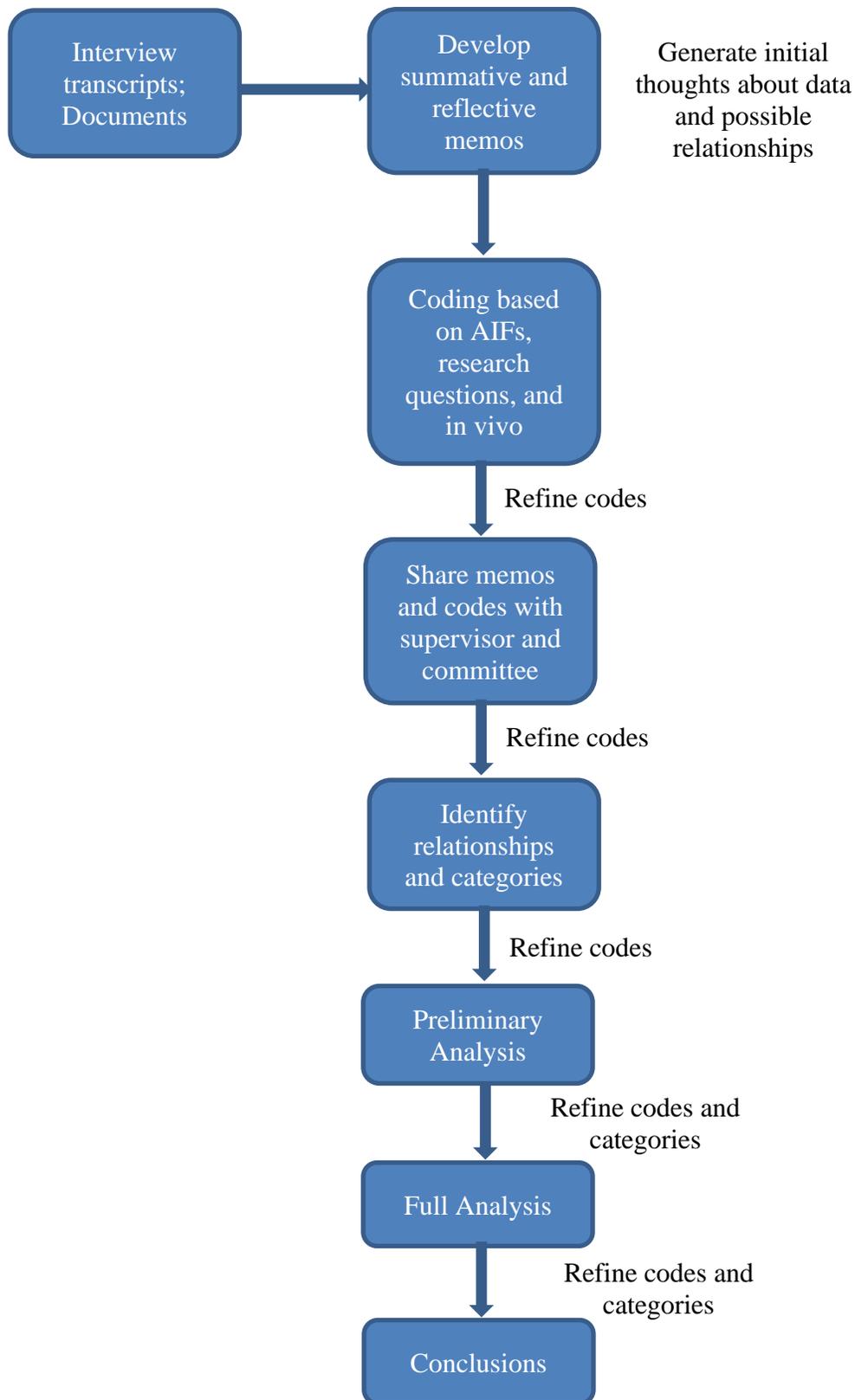


Figure 2: Analytic Process

As stated above, the AIF Exploration Stage (Fixsen et al., 2005) was used to guide the formation of codes and data analysis. As noted by Metz and Bartley (2012), the aim of this stage is to determine whether or not a program, model, approach, etc., meets the needs of the community, and if organizational implementation is possible. In this stage, it is important to consider the fit between the target population, available resources, and the program to be implemented (Bertram et al., 2015). Potential barriers to implementation as well as the organizational and systems changes required to support effective implementation of the program also need to be examined (Bertram et al., 2015). Therefore, the data collected during key informant interviews and the document review was examined through the lens of this framework in order to help organize and link data to understand the implementation of TVIC public and psycho-education and support the eventual creation of effective recommendations for action.

3.5 Data Trustworthiness

To ensure data trustworthiness, I continually engaged in discussion with my supervisory committee and research partners throughout the data collection and analysis process. Further, I employed (and will continue to employ) the use of member checking with CMHA study liaisons. Member checks consist of including participants, or in the case of the present research, the research partners, in reviewing the accuracy of descriptions, explanations, and interpretations of the data and study products (Miles et al., 2014). In the context of this thesis, this process involved reviewing the data and identified themes, and will include the review of the final study products (recommendations for action), with the liaisons in order to address issues of accuracy and relevance to organizational and study priorities. This activity will allow for the verification of the conclusions drawn from the study and create the opportunity to achieve “intersubjective consensus” (Miles et al., 2014).

I utilized reflexive practice and memo writing during the data generation and analysis process as it helped me engage in sense making, allowing myself to think critically about the information gathered, and how I influenced the inquiry process (Miles et al., 2014; Saldaña, 2016).

3.6 Ethical Considerations

This study was approved by Western University's Research Ethics Board (Project ID: 111905; see Appendix G). Therefore, the protocols and documents that were created for communication pertaining to study awareness and participant recruitment, requesting and receiving informed consent, and the confidentiality and anonymity in the gathering, reporting, and storing of data and results were reviewed and approved. As previously stated, consent was obtained for the recording of interviews, and participants were given the opportunity to request data be excluded from the study record. CMHA Middlesex was given the opportunity to review any documents that were examined in the study and redact any confidential information before releasing them to myself. CMHA staff were informed that their participation in the study had no effect on their future employment, and would not be disclosed to their employer. To ensure that participants did not feel undue pressure to partake in the study given my staff role, it was determined that I would not approach participants directly. Further, data obtained during the study was kept secure using a password-protected laptop, mobile device, and external hard drive, and any paper files were kept in a locked drawer. The data will continue to be stored in a protected and confidential manner, for a minimum of one year or as long as is necessary.

Chapter 4

4 Findings

The findings across the two data sets (interviews and organizational documents) converged around four main points of focus, each with their own themes. While the themes and data within these foci have been separated, the complexity of the topic means there was much overlap between and among themes, and across the interview and document data. This will be further explored in the Discussion. The figure below illustrates the themes and structure of the finding



Figure 3: Overview of Areas of Focus and Themes

4.1 Focus 1: Establishing the Community Context and Assessing Needs

Participants were asked about their perceptions regarding the integration of TVIC into community-focused education efforts, including the perceived value and needs associated with doing so. What emerged was the perception of the influence of the social world on norms and values, and how these factors shape community views and responses to trauma, violence, and mental health, ultimately perpetuating structural and systemic violence. This focus is divided into two overlapping themes: 1) the social context and 2) shifting the lens and the landscape.

4.1.1 The Social Context

Many participants spoke about the influence of the social environment on community members' and their own perceptions and experiences of trauma, violence, and mental health. Directly experiencing and/or being exposed to others' trauma and violence (including through media) is widespread, at both the individual and community levels. Given this, people may experience fear, which could manifest as defensiveness or denial that such problems exist. While explaining their perspective on the community's readiness to receive TVIC-related information and education, one participant stated, "people want to keep themselves safe, we want to wear our rose-coloured glasses, the world's a scary place as it is, and the fact that it's coming closer to home could cause some anxiety for people" (participant 15). In addition to self-preservation, people may even be desensitized to issues of trauma and violence given our constant exposure. These issues may speak to what one participant raised, "I think we live in worlds and systems that can be traumatizing" (participant 11). Therefore, it is important to consider not only how this reality could impact the community's reception of TVIC-related information and education, but how this reality affects groups who already experience marginalization, health and social inequities, and other injustices.

The sentiment that "the world's a scary place" is reflected in participants' accounts of the issues that they feel exist in their community: high rates of poverty, homelessness, addictions, and mental health issues. Points of tension included the negative perceptions of people actually experiencing these issues, and uncertainty in how to support them. Participants often spoke about stigma and how it influences the community's compassion and understanding, including the perception that peoples' struggles are their own fault, due to their bad choices, and that people should simply pick up and move on. The resulting lack of empathy is significant because these attitudes could translate into the actions, or lack thereof, that are taken at the community level to address these issues. For example,

I know just in London there is a lot of comments about the [encampments] and people who are living rough or who are not able to afford housing and things like

that. And I think there's this perception that it's choices and situations that these people have put themselves in (participant 2).

Another spoke about the controversy surrounding a temporary overdose prevention site and how a trauma- and violence-informed perspective could help reduce the blame that people tend to assign to people who use drugs,

The overdose prevention site, what a controversy that has been in our community. And if you are TVI, you realize why this is there, right, and you hear people go, 'oh well they deserve that', or automatically think that the jail system is where that person needs to be...it really disturbs me when I hear people talk like that person is nobody, that they deserve it, well wait a minute, back up here, you have to see the forest beyond the trees, there is always a story (participant 1).

Participants often highlighted the intersection of mental health and addictions with other social issues. Many called for the need to look at the broader context in order to understand the individual and their behaviour, e.g., "let's face it, mental health goes with everything. For someone who struggles with addiction usually has mental health [symptoms], someone who is struggling with trauma has mental health symptoms as well" (participant 3). However, despite participants' awareness and perception of this intersection, some felt that lack of community awareness is a problem:

I think there is a lot of people in our society that are really struggling, and we definitely need education. We need to help them, we need to help people who don't have any concept understand the concept of what is happening in our society and why, because those who aren't in social services, so many of them really just don't understand (participant 1).

Some participants linked this lack of awareness, insight, or acknowledgement of trauma and violence to factors such as gender and culture. For example, one participant spoke about the concept of masculinity and how it can be difficult to engage men in conversations about trauma and violence, "the men I find are a bit harder, just because of the old stigma of, 'I'm a man, and I just, I have to keep it in,' and also the comfort level

of saying ‘yes, something has happened to me’” (participant 15). These findings reflect the stereotype that men are not allowed to be vulnerable or reach out for help.

These environmental conditions can support the systems and structures that inflict and perpetuate trauma and violence. Participants shared stories about their personal experiences of trauma and violence, and of those they support. These experiences often reflected structural and systemic violence in healthcare, and lack of attention to the effects of trauma and violence, as well as vicarious trauma. Other stories illustrated the effects of “triggers” and how the surrounding environment can cause additional harm. One participant described the following story:

I just had a woman share her story recently who said she went in and out of the [healthcare] system for probably 30 years before anyone recognized that her extreme volatility or her depression or her self-harm or her inter-personal difficulties had anything to do with the fact that she was sexually abused as a child and later sexually assaulted in adulthood. So when she met me she said, ‘you were the first person who has asked, this is the first conversation’ (participant 11).

In the review of organizational documents, the presence and detrimental impact of the community’s misconceptions about mental health is discussed in the “rationale” of the Public Education program description. It outlines the impact of stigma on individuals and cites research that recognizes stigma exists in interpersonal relationships and in systems and structures, including in the lack of structural intervention (i.e., government laws). This document supports participants’ concerns regarding the existence of negative community perceptions and the perpetuation of systemic violence and discrimination. The description suggests community-focused education and enhancing the mental health literacy of communities can improve attitudes, encourage help-seeking behaviour, and result in better health outcomes for individuals.

4.1.2 Shifting the Lens and the Landscape

Regarding the community's TVIC-related education needs, participants continued to highlight the public's lack of awareness of the intersection of mental health with trauma, violence, and other social issues. Therefore, a shift is needed in how the general public, and other service providers, view these issues, leading to transformation at the individual, community, and systemic levels. One participant emphasized the need to acknowledge this intersection:

You know someone struggling with addiction did not sit in a Grade 5 classroom and that was their future aspiration to be addicted to drugs and homeless – it wasn't a thing that happened, a whole bunch of things happened long before that happened and 99% of the time there was some sort of traumatic events in which they experienced physical, psychological, emotional or financial abuse. And until we start seeing it that way, it's what comes first, the chicken or the egg? And we see the egg – we don't see all the stuff the chicken has to do to have the egg (participant 17).

Participants linked the community's unawareness to a lack of open discussion and understanding about TVIC and the various effects of exposure to traumatic and violent events. One stated, "we know about diabetes, we know about depression, we know about all kinds of things, but who knows about trauma? People in my family don't necessarily know about it, they don't know it's normal" (participant 12). Participants also said that other service providers are not generally aware of TVIC, which can negatively impact the quality of care people receive and the ability for service providers to work in alignment. As one participant said:

I think there is a definite need for public education, in all aspects, the community, agencies, families, and to realize trauma is not always abuse, that's not always what it is, there is a broad, broad definition of trauma and it comes in all shapes, sizes, and forms (participant 1).

This was echoed by another participant who felt that TVIC awareness and education can help provide the community with this insight,

Trauma...can be shown in many different ways, so like in general for people in the community it can be beneficial because it will give more insight into what might be going on. I think any kind of education can be empowering whether it be for individuals in general, they might actually relate to some of this, and specifically for work places because when you look at any kind of customer service or anything like that, we're looking at how individuals can be best supported or be served (participant 9).

Participants often connected the lack of community awareness about trauma, violence, and other issues, to negative outcomes in terms of individuals' health and relationships with themselves and others. It was suggested that learning about TVIC can aid in creating a relational shift and can help reduce the experience of stigma and prejudice. Participants felt community education can help individuals gain better insight into their challenges (mental health issues, addiction, etc.) by understanding their experiences and responses to their environment, helping to externalize these issues by illuminating the fact that these challenges are not the result of something innately wrong with them. The result is increased self-awareness and self-determination when seeking help. One participant illustrated this benefit: "it [TVIC education] can shift relational dynamics from misunderstanding, isolating, blaming, shaming that only adds to the distress, to a much more supportive connection that is a lot more conducive to healing" (participant 10).

Another participant said:

The individuals who have experienced their traumatic event, know that they have a community that will support them. So it's a two-way conversation – sharing the information with individuals who are going to work with someone who's experienced trauma or violence, but then at the same time a person who's experienced trauma or violence understands that the community is really trying to figure out how to work with them and be supportive. So it creates a different

dialogue between the two and it becomes more therapeutic for everybody involved (participant 17).

Participants also spoke about the need for TVIC-related education to help people maintain their own wellness when supporting others. People may disclose their experiences of trauma and violence in places where they feel most comfortable, and so there must be a basic understanding of the resources and supports available. Generating broader community awareness and support for trauma, violence, and mental health may also help reduce the gap between diagnosis and available treatment.

Some made mention of the power to bring about change through advocacy and awareness by creating insight and setting a standard for how people deserve to be treated; i.e., providing safe and equitable care and holding organizations and systems accountable for this. Participants felt that equipping individuals (or their loved ones) with knowledge about their rights can help them “protest” situations where they feel they are being “disenfranchised” or “disempowered” and restore feelings of choice and agency. For example,

Individuals would be better informed about what it’s [TVI-service delivery] supposed to look like and perhaps then it’s about holding service providers accountable to provide that support and that’s never a bad thing, right? That should be probably a part of what we do (participant 14).

Some felt community-focused TVIC education may create allyship in that people may be more understanding of the effects of trauma and violence, their own judgements or assumptions, and be driven to challenge the stigma or biases they hold or are a bystander to. Further, TVIC education between different organizations and service providers can help provide a rationale and greater understanding for TVI-service delivery, creating safer spaces and services. These approaches could transform organizations and systems more broadly, as well as individual interactions:

If we are all aware of it, and we are all aware of how to assist someone then that would eliminate their suffering. So we can help the other person, we live in

trauma constantly and suffering a little bit in that fear, if every time they come into an agency or go to let's say, anywhere, any public service, OW or ODSP, you know, there's someone or the individuals they interact with are aware, are trauma-informed, then it makes that individual's life a little more, less traumatic (participant 3).

The need for system transformation is also emphasized in the agency's 2015-2020 Strategic Plan. One aim is to "advance system change," ensuring that "mental health services and housing supports are offered when and where they are needed." This highlights the organization's awareness of the need to reshape the service landscape to provide more effective and responsive care. It also highlights the intersection of mental health with other issues and the need for a system that recognizes and supports this interconnection.

4.2 Focus 2: Establishing the Agency Context and Assessing Needs

This section reflects participants' perspectives and experiences related to the organization's implementation of TVIC and their perceptions in terms of the agency's needs related to advancing efforts to provide externally focused TVIC education. The findings converged around two main themes: 1) organizational culture and 2) strengthening staff knowledge and support.

4.2.1 Organizational Culture

Participants spoke about the agency's efforts to implement TVIC and how it has influenced organizational culture, including its structure, and service delivery. Many expressed limited knowledge about organizational efforts, however were generally aware that the agency provides TVI-services, that there is a staff-led trauma- and violence-informed group (TVIG), and TVIC-related training is provided for new staff. Some spoke about their awareness of a psycho-education group (Trauma Stabilization Group) for individuals that provides information and skills for coping with the effects of trauma, and the TVIG's desire to create TVIC-related materials for individuals accessing services.

A review of the TVIG's documents outlined that a "top priority" of the group is to "bring TVI information to the individuals [they] are supporting." Efforts also have been made to create a brochure and poster to help clients understand trauma (e.g., "hyper arousal"), and the Trauma Stabilization Group has been expanded to include more facilitators and participants. Other participants referenced their knowledge of the external training that the TVIG has delivered for other community organizations. The TVIG's documents and external training materials validated participants' perceptions that the external training provides other organizations (e.g., London Police Services) with information about what it means to be trauma- and violence-informed, and how the agency adopted TVIC.

Participants affiliated with the TVIG demonstrated more knowledge about the agency's TVIC-related efforts than those without such affiliation. There was a sentiment that there is still "a long way to go" but progress is being made, for example,

What I am seeing from when I first came until now...is that it [TVIC] is something that is being talked about...it's in the developing process. When I first came I wasn't aware of the trauma, right, and then I'm seeing a committee was formed and the [trauma skills] groups were formed, and now the group has been extended to males. So I am seeing it's still a work in progress definitely, but...the agency is making some kind of a headway (participant 3).

Some described a heavy workload and perceived silos between departments and sites as reason for their limited awareness of organizational TVIC, e.g.,

I have come to realize a little more that [our site] seems to be very separate, much like I'm sure that [the] Crisis Centre is...we have so much going on and we have such a high volume [of participants]...it's very difficult to be engaged in that information. I try to read the updates and the training that's offered and it's just very, very challenging (participant 17).

Despite the majority of participants feeling uncertain or disconnected from internal TVIC-related initiatives, there was a sense from some that TVIC has become embedded within the organization. One stated, "I think it's in the culture now...even for you know,

older staff like myself, it's part of how we view the job, it's part of how we view our role, the culture within the agency" (participant 6). When describing the influence of TVIC on their practice, participants often said they make an effort to normalize people's experiences, ensure people are well-informed, and feel like they have choice and agency, and focus on people's strength and resiliency. Participants' descriptions of how they provide services and support aligns with how the agency promotes its services to clients in the Participant Handbook, which emphasizes highlighting personal strengths, abilities, preferences, priorities, gaining insight into "one's condition," and the ability to independently manage health and wellbeing through skill development and connection to resources.

While many praised the organizational culture and efforts to promote TVIC, some points of tensions arose regarding certain policies and practices that participants felt could impact the success of providing external TVIC education. These largely revolve around leadership practices and staff support, staff differences in the understanding and practice of TVIC, and the need to "look at our own house first" before extending TVIC education into the community. Some participants felt that there is a lot of "talk" within the agency regarding TVIC, but that this talk is not necessarily translated into action. Leadership's support for staff education, wellbeing, and safety was questioned, as well as whether all staff understand and utilize a TVI-approach. As one participant said:

I think we throw that word around a lot, but I don't actually – I don't really know if I see any practicality. So we'll talk about, for example clients that access our services, who are high risk. And then we'll talk about ways that we can make it trauma-informed and safe for them to come in. I don't always see some of the – some of the messaging from management doesn't always feel safe for staff. It seems more so an attempt to be safe for clients (participant 13).

The intersection of TVIC and staff wellbeing was emphasized by another participant:

I do think there is a lot of staff that do take that [TVIC] approach and I feel like, it is a good environment where people aren't stigmatizing, but I do think sometimes things do come up where, it might be related to burn out on the job, compassion

fatigue, it's a high-stress trauma environment. I mean, and then you have people that may be struggling that keep coming back and staff might not know how to best support that person. So there are many factors that come into it. I think most people try to take a trauma-informed, even violence-informed approach, but I think it can be difficult if there [are] other factors that are effecting their ability to do the work (participant 8).

Some felt that staff are not getting enough TVIC training and education. While there may be an assumption that staff practice in a TVI-way, some feel staff are not necessarily supported to do so. One participant articulated their frustration, “I think they are letting us down...I think it should be quite different than what we have experienced. We’ve been calling ourselves trauma-based but we haven’t had enough training I think to really prop that word up” (participant 5).

Another called for the need to critically examine service delivery to determine if agency practices support TVIC:

In some of the anecdotal experiences I hear sometimes from a peer worker perspective around, maybe a person is not engaging in an area where they are, and maybe it could be because they’re not able to because of their trauma experience, don't feel safe, don't feel understood, maybe their outward behaviour... people might think, ‘well they’re not ready’ and that word is really hard to use because, how do we decide that for somebody just by external things we see, so I wonder about kind of drilling that, peeling that back a bit further to go, well maybe somebody’s not doing something because we don't have, what’s in place for those safety, trusting pieces to happen (participant 16).

While there is a general feeling that TVIC has become embedded, there are some concerns regarding the depth of knowledge and application of this approach. Upon review of the TVIG’s documents, the group has recognized the need for increased staff education about TVIC and self-care. These findings will be discussed in the next section. The organization’s strategic plan articulates the need to enhance its “capacity and ability

to respond to the diverse and growing needs of [the] community,” however there is no mention of enhancing staff training or skill building to achieve this.

4.2.2 Strengthening Staff Knowledge and Support

Participants spoke about the need to strengthen internal TVIC education and emphasized that the education and training of service providers is linked to the success of TVIC-related community education. Participants described many benefits to learning about and practicing TVIC and had a desire to learn more. The professional impact of TVIC on their work included participants’ increased awareness and sensitivity to the individual with whom they are working. This increased awareness was tied to language use (e.g., victim/survivor) and a shift in thinking (e.g., focusing on “what happened” to the individual instead of what is “wrong” with them). TVIC-related information also helps build therapeutic rapport and promotes a non-judgmental approach. As one participant noted,

In my role for example, if someone no-showed on me twice, I would just say no more appointments, just access walk ins because we have so many referrals coming in. But it [TVIC] kind of reminded me to be a little bit more patient and...inquire a little bit as to why are they no-showing. Maybe they don’t have the funds to get here, maybe they had something going on that morning. Maybe the mornings don’t work for them and I just never asked, right? So it...made me think, take a step back and be a bit more mindful (participant 13).

Some participants spoke about the personal impact of TVIC education, and how the information has helped in their interactions with other community members, their parenting, and how they nurture their own wellness. For example, a participant stated, “I know that speaking from personal experience, I had witnessed an opioid overdose downtown and I think without this trauma-informed understanding I wouldn’t necessarily have been able to process it kind of as well as I did” (participant 2).

Participants varied in terms of their TVIC training (internal or otherwise), however, the majority stressed the need for more frequent and greater depth of training. Some called

for training that provides practical skill development and case studies to help problem solve challenging situations. Others highlighted the desire for training that focuses on compassion fatigue, vicarious trauma, and self-care, sometimes referencing the need to safeguard themselves due to feelings of helplessness, exposure to traumatic incidents, or listening to peoples' stories of trauma and violence. This recognition of the impact of personal experiences is important. One participant stated,

We need to continue to connect as teams and talk about how this work impacts us. Once it impacts us then we are impacting clients. If we don't have the self-awareness to know, 'I need a half an hour break after that session', we are going to carry it forward and dump it on the next client and we might not even be aware of that (participant 12).

There is also a need to provide TVIC-related education across the agency and ensure everyone is "on the same page", including those who do not provide direct services, as well as students and volunteers. Some suggested integrating TVIC information into broader staff discussions to create opportunities for active participation and application of knowledge, for example, as a participant said,

I think leadership, down to team leads, definitely [should be] a part of all meetings because that's an easy way to get across to all teams and people...it can't be an update from the [TVIG] because that's just telling people stuff, but more like having it part of discussions (participant 16).

As stated above, the TVIG is aware of many of these issues and has taken some action to address them. Analysis of meeting minutes and goals and action plan documents found that the group has identified the need to address compassion fatigue, create more frequent internal training opportunities, and ensure broad coverage of staff training to include new staff, students and volunteers, as well as provide "refresher" training for existing staff. The minutes outline effort made to revise the internal training content to address some of these needs as well as to create a new presentation for staff focused solely on vicarious trauma. According to the most recent minutes obtained, efforts to increase the frequency and availability of training were still underway, however the goals and action plans

documents suggests the group has “completed” some work to enhance existing training processes for staff (e.g., initiate tracking system; ensure new staff are trained in TVIC). Additionally, one of the priorities in the agency’s strategic plan is to “enhance the individual experience,” in part through education, to ensure that people are supported to lead their own recovery journey. This priority underscores the significance of the goals and actions of the TVIG, and desire to provide clients with TVIC information, and participants’ call to strengthen the knowledge, skills, and presence of TVIC within the agency. However, some participants reported a general lack of access to training and education due to limited organizational funds, illuminating the tension between staff needs and the strategic goals and directions of the agency. For example, a number of participants indicated that part, or much of, their TVIC-related knowledge comes from sources external to the agency and involved their own effort to self-educate. This may also be reflected in the finding that not all participants reported having received the agency’s internal TVIC training and the emphasis on training *new* staff members. This highlights a potential gap in the TVIC training and education of more “veteran” staff.

4.3 Focus 3: Barriers to Successful TVIC-Related Public and Psycho-Education

In this focal area I explore participants’ perceptions of factors that could impede the successful integration of TVIC into public and psycho-education, divided into three sub-themes: 1) specialized knowledge and application; 2) internal capacity; and 3) social and structural factors, representing the interplay between individual, organizational, and community level factors.

4.3.1 Specialized Knowledge and Application

When asked about possible barriers and challenges to implementing TVIC public and psycho-education, some participants expressed a unique and opposing view that questioned whether TVIC was something that could, or should, be shared with the general public. They felt the nature and characteristics of TVIC information was something that was more useful to service providers and employers, and reflected more

of a sensibility and disposition rather than knowledge that is “professed.” As one participant said,

I don't think it's [TVIC] a topic that you would go around and say, ‘we’re going to do a session on such and such,’ I think it’s just more of our sensibility or disposition...we live in a world where a lot of things happen, a lot of people have a lot of different experiences from childhood to...stages of life, world events, you know the whole spectrum, so it’s just ensuring people are sensitive to other people...it’s more like a way to be (participant 16).

The need for clients to know about TVIC was also questioned; it was thought that it may be more important to receive TVI-services than to necessarily know about it. This speaks to the importance of creating a safe, respectful, and responsive environment. One participant said,

I think it's [TVIC] important to experience when you're coming in. It's like I as a service user or I as someone who lives around the corner, who is like, ‘what's this building, what are they doing there? Why are there always police there?’ I don't think it's important that I know that it's trauma- and violen[ce]-informed, but I think if I'm accessing the services, I just want it to meet me where I'm at in that particular moment (participant 13).

Further, the general public may not think about trauma the same way providers do, instead thinking about trauma in terms of physical injuries or not considering the broad spectrum and profound impact of traumatic or violent events on individuals. As one participant said: “this is language we’re familiar with because of our field, so if I talk about TVI[C] to a neighbour or a friend, it kind of falls...over their head, because people don't think about their lives in defined ways like that” (participant 16).

TVIC terminology and information may not be accessible, and the subject matter intimidating. For example, a participant explained:

When I started here to hear ‘Oh God, I have to have trauma training.’ I didn’t fully understand what that was and trauma- and violence-informed care sounds a

little bit nicer, but I think when people hear the word trauma it seems like it's going to be something that's maybe heavy (participant 2).

Thus regardless of experience, terminology may pose as a barrier to creating interest or willingness to engage in the material. These perspectives reflect possible barriers that relate to individual understanding and perceived usefulness of TVIC-related information. Importantly, the participants called attention to the need to understand how individuals (general community members, individuals accessing services, and service providers) interact with the information and what they feel is of value to know. The document review found no mention of efforts or desires to provide general community members with TVIC-related information. This may speak to an implicit perception that this information is more relevant to service providers and clients.

4.3.2 Internal Capacity

More common was the consideration of possible barriers and limitations that exist within the agency. Participants identified structural and practical factors related to organizational and staff capacity to implement TVIC-related public and psycho-education, with the majority perceiving funding to be a large barrier, e.g., “I mean the hot topic in mental health and when it comes to barriers is always budget. Where are the dollars going to come from to support that program and to train those individuals” (participant 4). Some participants spoke about how the limited availability of funds has impacted the TVIG's ability to create materials that could be used to share TVIC information with individuals served. The TVIG document review validated this finding. The meeting minutes outlined the group's desire for a budget to be able to create posters and brochures and enhance internal TVIC-training and education. The minutes indicated their budget proposal was accepted, however they were given one-quarter of their initial request.

Some participants spoke about staffing challenges, including availability and expertise required to create and facilitate externally-focused TVIC education. For example, a participant said;

When I talk about the capacity issue, sometimes it's not just about signing up and doing it just because people are so busy in their roles. So it's not an easy, 'well just take the time and devote to this' – I mean we need to do it but there's just so many demands that are placed on employees nowadays and communities are hurting, so you kind of just get going in your day-to-day (participant 14).

A participant on the TVIG spoke about the intersection of limited funding and staff capacity,

Part of the challenge has been, we have to do that [TVIG-related work] on top of our other responsibilities so this is where some of the resources that we need, they need to expand to actually be able to do the work that we are all wanting to do (participant 11).

This aligns with the emphasis that some placed on the role of leadership and the commitment needed from the organization in order to advance TVIC-related initiatives, including training and education.

Some spoke about the need to have facilitators who are well-versed in the subject matter and that not all staff may have the skillset, knowledge base, or comfort to deliver TVIC education to the community,

I feel a bit out of my element...you know I'm not an expert in that [TVIC] field...so I've got to be mindful of the fact that I don't want to sort of tread in waters that I'm just not capable of managing (participant 6).

This reflects a possible barrier in that there may be a limited number of people who feel able or qualified to create and deliver such education. It also highlights a possible unintended negative consequence of providing community TVIC education, that is if the facilitator does not feel "capable of managing" the discussion, those engaging with the information could be negatively impacted. Therefore, the safety (physical and psychological) of both the staff person delivering the information, as well as those who are receiving it may be compromised. The TVIG's meeting minutes acknowledged that there were a limited number of staff trained to deliver the current training programs,

however, according to both the minutes and “completed” goals and actions, the group has since increased the number of members who are able to do so.

There is also concern about the possibility of the agency setting an expectation among the community and then not being able to deliver the standard of care it promotes. One participant stated,

If you're spreading the word that this is the type of support you're providing and then you have someone who comes in on shift who's maybe not well trained, or for whatever reason with that client is biased and doesn't agree with the principles, and then you don't provide that support that you're broadcasting that you have, I think that's just a double standard. Do what you say you're going to do. And I can see that happening. We have some frequent users who access our services, who are very challenging to work with. I think staff can often feel super frustrated and in those moments, they don't always provide the most warm and welcoming care, let alone the most trauma- and violence-informed care (participant 13).

This potential barrier could be exacerbated by participants' accounts that not all staff at the agency have received TVIC training, showing the intersection between staff training and community education and the possible disconnect that could arise. However, the TVIG's plans and actions (as specified in their minutes and goals and action plans) to include training in onboarding for new staff, and give “refresher” training for current staff could reduce the possibility and impact of these events.

4.3.3 Social and Structural Factors

It was felt that some systemic and structural barriers could impact the success of implementation. Specifically, the nature and characteristics of the healthcare system, and social factors relating to accessibility and perceptions of shame and stigma. For instance, different service providers have different philosophies regarding service provision. Participants spoke about the challenges they have faced when trying to utilize or promote a TVI-approach when working with other agencies to support an individual. One

described this experience as feeling “very out of sync” with other health professionals. Many participants felt that TVIC is not something widely understood or practiced within health and social services, and other service providers must be educated if there is to be broader community awareness and action regarding TVIC. There are also many priorities within health and social services, and TVIC education will have to compete with these, “it’s [TVIC] going to be another thing to push through when in our world we already have so many other things we are trying to push through” (participant 12). This also applies to the general public, given the many competing priorities and demands for our attention in daily life.

One participant spoke about the impact of the biomedical model on sharing TVIC information:

Some people don't make the connection between how their past impacted them and they might just feel unwell or they might have been given a whole array of diagnoses... so it's about trying to have that conversation about recovery and moving on with their life and I think that is the kind of contrast of working in the mental health system is dealing with a very medical model, where it is treating symptoms...there is nothing necessarily wrong with the medical model but sometimes people get stuck on wanting to try to treat symptoms (participant 8).

This example speaks to the broader issue of how society understands and treats mental health related issues. The agency’s strategic goal of advancing system change speaks to this perceived need to reconceptualize our understanding of mental health and related challenges and how services are provided. Further, within the TVIG’s training materials, there is information about the need to move from pathologizing and stigmatizing language to “language that captures the essence of people's experiences.” This type of education underscores the need to extend our perspective about mental health and wellbeing beyond a biomedical model and consider the individual and their experiences together when supporting their wellbeing.

Some raised the issue of accessibility (social, physical, and economic) and the need to ensure that education opportunities are open to everyone in the community, not just those

who can pay. Education would have to be offered freely and flexibly with regard to time and location, “how do they get there if they don't have access to bussing or a car, because sometimes they are just putting food on the table or are not even doing well doing that because of rent and all that stuff” (participant 7). This also included potential digital and literacy barriers and calls attention to inequities that could exist when trying to access community-based education. Further, one participant called attention to the role social position and power can play when creating and disseminating information,

I think there might be the question of who would decide what information was shared, how it was shared, who gets to decide that. And who gets to actually be the final word in terms of describing what trauma looks like, and how best to support, because different people might believe different things, that might be tricky (participant 10).

Another participant spoke about how some of their clients have not felt deserving of support due to internalized stigma or shame, “labelling,” and the possibility that this feeling could also impact their engagement with education opportunities within the community,

It's another label and I feel like individuals, especially mental illness and addiction, homeless – I feel like they have enough labels. So if you say, ‘you’ve got PTSD [Post-Traumatic Stress Disorder],’ there’s another label to slap onto them, or ‘you’ve got complex trauma,’ so there’s another. ‘You’re a survivor of domestic abuse,’ there’s another label. So I feel like that’s kind of a negative impact as well (participant 17).

There was also the view that some community members may experience fear, defensiveness, or disagreement when it comes to learning about TVIC, and this could result in the disregard or challenging of the information, “the community then will – in some areas, will put their back up and just be like, ‘okay so now we have to accept another thing’ which is...something that I heard recently” (participant 17). This suggests that sharing TVIC information could unintentionally create more barriers and divisions between the community.

4.4 Focus 4: Facilitators of Successful TVIC-Related Public and Psycho-Education

In this section, I capture factors that can help advance efforts to provide externally-focused TVIC education. Facilitators include resources and supports that currently exist or may be required for successful community-based TVIC education, and considerations for the effective creation and dissemination of the information. This section reflects organizational and social/structural level influences and is divided into three sub-sections: 1) leveraging current organizational efforts and resources; 2) creative outreach strategies; and 3) collaborative approach.

4.4.1 Leveraging Current Organizational Efforts and Resources

Participants spoke about agency TVIC-related initiatives, practices, resources, and supports. Some felt the agency has made a lot of progress in terms of implementing TVIC, and has the potential to promote increased awareness of TVIC by leveraging existing programs, staff, and opportunities where information and exchange already occur. Regarding staff education, some participants expressed the benefit of making training mandatory for all; they suggested using staff meetings to engage people in an ongoing discussion about TVIC and problem solving work-related issues using the principles and practices, and using the existing online training infrastructure to create accessible and frequent training opportunities for staff. These ideas were also present in the TVIG documents and were the subject of goal setting and action planning.

Participants also spoke about integrating TVIC information into pre-existing programs, including groups and workshops offered by Public Education and Community Wellness Programs staff. The review of the Public Education program description confirmed that it offers “formal training opportunities and public workshops...to local agencies, businesses and all members of our community that are seeking to improve their knowledge.” The Community Wellness Program offers free “social, recreational and skill building opportunities” for the whole community (CMHA Middlesex, 2020). In the TVIG documents, there is evidence that the group has already collaborated with these departments for the purposes of TVIC-related training. Leveraging these aims and

existing interactions with the community, including individuals served, to incorporate TVIC information, may help address issues of capacity. Further, it was felt this is something that should and could be done in the delivery of current programs. In speaking to some, this may in fact already be occurring, albeit informally, during the creation and delivery of some community programs and in-session psycho-education sessions with individuals as well as their loved ones. Some staff spoke about their explicit and tacit use of their TVIC-related knowledge, and the ways in which they incorporate it into the delivery and content of information that they share with people, with an emphasis on creating choice, safety, and respect. As one participant said,

Depending on the topic, it [TVIC] always ends up in there...because we know it is all interconnected. But depending on what [program] it is that I am starting...yes this stuff impacts there is no doubt about it, some of it might be consciously some of it might be sub-consciously because I have been in the field along time (participant 1).

Additionally, another participant shared a tool they use in-session with clients to help illustrate the effects of trauma and give insight into how a person's physical and psychological symptoms may be connected to their traumatic (and violent) experiences. These and other findings suggest that most TVIC-related information sharing centers around understanding trauma and its effects on mental health.

The agency's narrative and how it promotes its services was identified by some participants as an important vehicle for spreading awareness and creating a community supportive of TVIC. One participant said,

I think that's the big thing, how do we want people to feel? We want people to feel safe, we want people to know that we're going to hold them in high regard, they're going to have a dignified experience, they're going to be treated non-judgmentally, that we're collaborative in our approach (participant 16).

A more tangible suggestion was made to examine communication materials, such as the Participant Handbook, and explore ways to enhance the incorporation of TVIC-related

information. The Handbook had no direct mention of TVIC but the principles and practices were often implicit, reaffirming participants' perceptions that TVIC has become embedded within the agency and its approach to service delivery. Some also spoke about the TVIG and utilizing the expertise and current efforts of its members to help cultivate greater internal awareness and practice of TVIC and to help advance TVIC-related public and psycho-education. This possibility aligns well with the various initiatives outlined in the TVIG documents (e.g., create staff newsletter items that promote awareness and the practical application of TVIC; create TVIC-related psycho-education materials; and strengthen internal and external training practices). Ultimately, there was a perception that there could be many opportunities to open up dialogue and learning about TVIC, for instance one participant stated:

We [CMHA Middlesex] could be on the cutting edge of that, there is no doubt about it. We have the resources to do that, we have a public educator, we have community wellness programs, we have the support system of the TCM, we could really have that wrap around service, where we are just getting it from every angle (participant 5).

4.4.2 Creative Outreach Strategies

Many participants spoke about the need to provide creative and engaging ways for the community to interact with and receive TVIC information to help break down barriers that could impact people's interest or ability to engage with the information, creating a greater sense of accessibility. Methods could include: using the agency's website to provide TVIC-related information and education, social media, videos, the incorporation of storytelling that involves the perspective of lived experience, and providing online courses and tutorials. Some felt that such methods could allow the community to access the information more freely, and also provide a gateway in for those who are resistant to learning about TVIC or view the topic negatively. Fostering creative ways for the community to think about trauma and violence and the effects of such experiences may help people better understand the topic and relate to the information. This approach may help address the perceived challenge that TVIC is not commonly thought about or understood by the public:

If you look at creative ways to bring it into the conversation it will kind of start to make sense. So, like media, the news, world events, and so on. You know, people might say at times, you know, ‘we live in precarious times,’ politically and you know, global warming and all these different things, so if we become really conscious about, sort of our external things around us, we can maybe think of more ways to support the impacts of trauma and violence around us (participant 16).

These findings suggest participants thought about the need for creativity and accessibility both in terms of practicality and access to information, as well as subject matter, ensuring what is provided is responsive to community needs:

The more creatively we do it...being aware of the barrier that jargon creates, being aware of a dry clinical approach, that creates a barrier. And just finding a real interesting way of reaching the public...I think whatever happens in the public...it has to be wrapped around, it has to include the professionals that are dealing with the public, it has to reach the public where they are as well...so we have to find creative ways to break down those barriers as well as the more classic ways of doing it (participant 5).

Creative thinking may also be required to help reconsider who is on the receiving end of disclosures of traumatic and violent experiences. As one participant noted, “one of the things where I'd like to see that [TVIC] education go is to people who are first contacts...professionals that are not necessarily seen as frontline” (participant 10).

Information sharing must also be done in a trauma- and violence-informed way. Participants called for the need to create a sense of ownership and choice, especially when providing TVIC-related psycho-education. This involves not making assumptions about people’s knowledge, asking if they want the information, providing space for people to process the information and ask questions, and providing the opportunity to disengage with the information if they wish:

Particularly in this program we have a lot of [people] who are being told what to do and when to do it, the majority of their days. So for me, giving them the power to get that information is far more important than trying to ram it down their throat (participant 17).

It is important for education to highlight strength and resiliency and avoid a “deficit-based perspective.” This framing may reduce the potential to perpetuate the shame and stigma associated with trauma, violence, and mental health.

Some felt that it was important for the content and delivery of the material to be relational and humanize the issue, building upon the need to enhance the accessibility of this topic by helping people connect to the information, for example, as one participant said,

Creating the context of humanizing, this is a human, this is a social concern, we are all part of the human race, so we are all impacted by it, that kind of thing helps to bring more of a unified way of relating to the information (participant 11).

This approach could contribute to breaking down some of the stigma and shame that people feel, and help illuminate the invisible struggle that many people experience. Human connection can enhance empathy, which in turn can create deeper understanding and respect for those living with the effects of trauma and violence. This idea of creating connectivity was also tied to service provider interactions, and the need to find ways to turn TVIC-related learning inwards. This shift in focus from the individual to the self can, as one participant said, help foster “a ‘we’ dynamic rather than an ‘us and them’ dynamic.” However, it was noted that creating opportunities for reciprocity can be challenging, especially if people are feeling guarded or defensive. No data in the document review spoke explicitly to these perspectives, however the TVIG training material did address many of these calls, suggesting that there may be a solid foundation from which to build upon.

4.4.3 Collaborative Approach

Overwhelmingly, participants felt that the development of externally-focused TVIC education must draw on expertise within the organization and outside of it. If these

efforts are to be successful and contribute to reducing stigma, engagement needs to extend beyond the mental health sector. Internal expertise may include: leadership, members of the TVIG, direct service staff, the communications department, peer support staff, and individuals who access services. A similar engagement strategy in the creation and revision of their training materials and information products has also been used by the TVIG as evidenced by their meeting minutes. In terms of external collaboration, participants identified the LGBT2SQ community, newcomer and refugee groups, Indigenous communities, and other groups who may be vulnerable to experiencing trauma and violence. One participant stated,

I think that it is important to hear the voices of our minority communities because they have lived it, they have been there and getting their insight [into] how do we spread the word to help educate others and heal ourselves as well (participant 1).

Participants emphasized engaging individuals with lived experience, and their loved ones, as it can help ensure content is relevant and contributes to promoting safety and equity within the community, such as noted in the following,

I think having a person with lived experience, that's in a good spot, that is able to now say, 'ya, I had some trauma, this is what I found helpful', or 'this is what I needed', or 'this is what I need to help me understand or to help me...', you know, 'I would like my doctor to know this', or 'the first responders to know this' (participant 15).

There was also a call to engage a diverse range of community services and organizations such as: women's and other shelter supports, children and family services, newcomer and refugee supports, academics, family health teams, emergency medical services, the hospital, local government, and the larger ministry of health. However, many acknowledged that needs can vary greatly among groups, and so target audiences must be defined and engaged with to determine useful content and methods of delivery.

Participants felt that collaboration should also be one of the by-products of community-focused TVIC education. It was felt that efforts to strengthen service provider relationships would benefit individuals seeking help, as well as other service providers,

There's a lot of things that other community agencies do that I have no idea about...so I mean when we think of it from that perspective, we are ground level caregivers and a lot of the times we don't even know what's at ground level to present as an option. So doing the exchanges of information is the best because it's communicating, it's not just telling, it's also listening (participant 17).

This suggests that fostering collaboration and exchange of ideas between service providers may build capacity to provide effective support to the community. Further, inter-agency collaboration could create a “groundswell” of support for the movement and enhance buy-in and motivation to adopt TVIC. This aligns well with the agency’s strategic direction of advancing system change, where through education and evidence-based practice, it sets a goal to “expand partnerships across sectors to facilitate access to a holistic range of services and supports.”

4.5 Synthesis of Findings

These findings highlight how individual perspectives and experiences influence, and are influenced by, the social and systemic structures in which the organization, the community, and society at large are embedded. They showcase the interconnectedness between these elements and the belief that in order to shift the lens through which trauma and violence is viewed and the social and structural landscape in which these experiences are perpetuated, the whole community must be engaged. Participants expressed the need for education efforts to include the general public, individuals accessing services, and service providers and organizations more broadly. The need to broaden the educational focus stemmed from participants’ view of the world as a “scary place” and the unfortunate reality that experiences of trauma and violence are widespread and have profound effects on individuals and communities. Participants highlighted the intersections between a number of health and social issues, and the need for a compassionate community response to nurture the health and wellbeing of those

impacted by trauma and violence. However, stigma, fear, and prejudice were seen as sources of tension within the community and as reasons why TVIC education would be beneficial, but also challenging. These tensions were reflected within individuals, service providers, and organizations more broadly, continuing to demonstrate the inter-linkages between the various levels of the community's ecosystem and the fact that all of us live and work in the world we have, which we in part create. The following figure illustrates this complexity by showing the interconnection between the themes of the investigation:

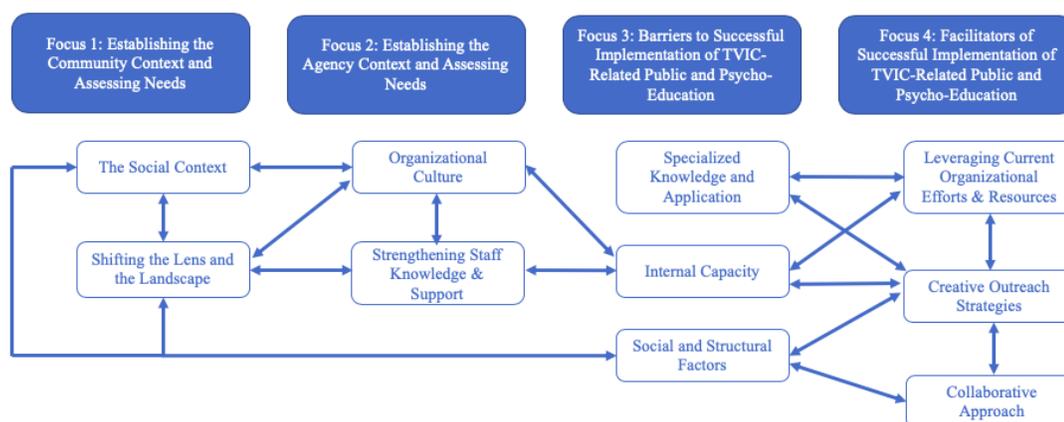


Figure 4: The Interconnection and Overlap Between Themes

Therefore, there were many suggestions and perspectives with regard to developing externally-focused TVIC education related to cultivating greater awareness and practice of TVIC. Using a creative approach to the delivery and content of the information can enhance the accessibility of the material and break through the barrier put up by more biomedical or intimidating conceptualizations. The connection between awareness and practice was highlighted in the recognition that providing the community and clients with knowledge about TVIC can shift people's expectation of care and enable them to hold service providers accountable if their – or their loved one's – right to safe and equitable care is not upheld. Also emphasized was building relationships and finding ways to humanize the issue in order to reduce the impact that shame, fear, discrimination, and ignorance could have on TVIC education efforts. Participants called for the need to engage a diverse group in the discussion and planning of this form of education to ensure the accuracy and relevancy of the information and build bridges between groups.

Using the AIF Exploration Stage as a guiding framework helped gain insight into the potential of organizational implementation of externally-focused TVIC education. The social context of the community and organization helps inform the understanding of community needs in relation to TVIC education. The exploration and assessment of needs also contributed to understanding the fit and feasibility of implementing TVIC education for the community. The possible barriers and facilitators presented in these findings further contributed to understanding the fit and feasibility of this initiative, while also highlighting the organizational and systemic change that is required to support implementation. Some findings supported the identification of intervention components, including certain elements and activities related to externally-focused TVIC education that can help create positive outcomes for those who will engage with the information, such as potential content and methods of delivery. Further, findings also contributed to understanding some of the implementation drivers needed to ensure successful implementation, e.g., support for staff training and wellbeing, support of leadership, a commitment to funding, and social and structural changes required to ensure system readiness and support.

Also represented in the findings is the complexity of organizational implementation and the non-linear flow between stages. This flexibility is acknowledged within the AIF framework and is highlighted in the findings that demonstrate current efforts, formal or informal, that are supportive of TVIC-related public and psycho-education. Given the agency has been a community leader in the implementation of TVIC, it seems natural that the findings reflect the existence of components that extend beyond the Exploration Stage, specifically, into the Installation Stage (see Figure 5). For example, findings in Foci 3 and 4 highlight the preparation of some implementation drivers (e.g., upping the number of TVIC trainers), and the acquisition of resources (e.g., collaboration with other programs; TVIG budget).

Focus 1 Themes and Findings	Focus 2 Themes and Findings	Focus 3 Themes and Findings	Focus 4 Themes and Findings
<ul style="list-style-type: none"> • <i>Exploration Stage</i> • Assesses needs of the community • Assesses fit of initiative • Preliminary identification of intervention components 	<ul style="list-style-type: none"> • <i>Exploration Stage</i> • Assesses needs of the organization • Assess fit of initiative • Considers implementation drivers • Preliminary identification of intervention components 	<ul style="list-style-type: none"> • <i>Exploration Stage</i> • Examines fit and feasibility of implementation • Considers possible challenges to implementation drivers • <i>Installation Stage</i> • Highlights (formal and informal) preparation of some implementation drivers and acquisition of resources 	<ul style="list-style-type: none"> • <i>Exploration Stage</i> • Examines fit and feasibility of implementation • Considers implementation drivers • Preliminary identification of intervention components • <i>Installation Stage</i> • Highlights (formal and informal) preparation of some implementation drivers and acquisition of resources

Figure 5: Alignment of Themes and Findings with the Stages of Implementation

Importantly, the findings outlined in Focus 4 produced data that fell outside of this framework. Other than the consideration of the resources needed and already acquired, there appears to be little to no acknowledgement or investigation of the larger social factors that could support the success of implementation. Instead, the framework seems to focus more on the structures, norms, and processes internal to the organization. The impact and usefulness of this framework will be discussed in the subsequent chapter.

Chapter 5

5 Discussion, Conclusions, and Implications

The purpose of this thesis was to address an important gap in the research on the benefits and uses of TVIC information for the general public, and individuals accessing services. While organizations and primary healthcare providers, including CMHA Middlesex, are actively adopting TVIC, little is known about the possible value, feasibility, and process of extending TVIC education efforts into the broader community. In this chapter, I will interpret and discuss the findings of this investigation in relation to the current literature and explore the limitations and future directions of this research.

5.1 Discussion

The main questions that framed this study were: 1) how can the principles and practices of TVIC be integrated into public education? 2) how can the principles and practices of TVIC be integrated into psycho-education? and 3) what barriers and facilitators (structural, cultural, and practical) exist that could impact the success of implementing this kind of education for the community? The findings are based on two data sources: semi-structured interviews and organizational documents. In-depth interviews with staff allowed for the exploration of their experiences in their role at the organization related to TVIC training and education and their perception of the organization's efforts in this area, the implementation of TVIC policies and practices, as well as their thoughts about the integration of TVIC into education efforts for the community and individuals served, including potential barriers, facilitators, and strategies for community engagement. The organizational documents enabled the cross-referencing of staff perceptions and experiences with the organization's more formalized priorities, goals, and training and education materials relevant to public education and TVIC-related practices. This review also allowed for a deeper understanding of where and how staff perspectives and experiences may intersect and diverge from the formal intentions, goals, and objectives of the organization.

Because the study used an integrated knowledge mobilization approach and was implementation-focused, engagement with CMHA study liaisons occurred throughout; this ensured the research process (and the eventual end-products) aligned with their needs and interests. While in the initial investigation I sought to explore the integration of TVIC principles and practices into the delivery and content of education for the general public and individuals accessing services, it became apparent that participants felt that TVIC education for both themselves as well as other agencies was an important factor in education efforts related to fostering a trauma- and violence-informed community. The findings reflect this need to consider the interconnectedness of service providers, the general community, and individuals accessing care, and the reality that these three cannot be separated when attempting to create broader community awareness and action regarding trauma, violence, equity, and cultural safety.

Importantly, I conducted this research in a way that upholds the principles and practices of TVIC. Given the sensitive and complex nature of this topic and the reality that individuals, regardless of their professional role, may have their own experiences of trauma and violence, it was important that I created a sense of safety and non-judgement, fostered opportunities for choice and collaboration, and involved a strengths-based and capacity building approach. The nature of the semi-structured interview enabled me to integrate these principles into my interactions with participants; for example, we could freely explore related topics that were of interest or significant to the participant. Further, the research partnership with CMHA and the effort we made to listen, collaborate, and engage in shared decision-making when and where possible, also reflects many of the core values of TVIC. We sought to understand the organization's needs and interests, and how these are situated in the broader context of the community, systems and structures that influence their work. Acknowledgement of this research approach is significant given the present study's investigation into how TVIC-related efforts can be extended beyond the organizational/service provider level. If we can begin to think about how TVIC principles and practices can be integrated into *all* facets of our communication and engagement with others, including the creation (and dissemination) of research, we may be better able to create and sustain the social and structural shift in how trauma and violence is viewed and responded to.

5.1.1 Research Questions 1 & 2: How can TVIC be Integrated into Public Education and Psycho-Education?

The social context appeared to be inextricably linked to participants' perceptions of the community (and organizational) landscape and how people perceive trauma, violence, and mental health. Understanding this overlap helps inform our understanding of the possible needs of the community in relation to TVIC education and the ways in which TVIC can be integrated into education efforts. The findings suggest that there is a general lack of awareness about trauma and violence, despite the prevalence and significant impact of such experiences. This perceived ignorance was attributed in part to the idea of the world as a "scary place" which could lead to defensiveness, desensitization, denial, and even intensification of such issues. As noted by Straussner and Calnan (2014) wars and natural disasters are increasingly contributing to forced migration and other experiences that can lead to exposure to trauma and violence. *Canada's Top Climate Change Risks* report (2019) outlines that the health and wellbeing of Canadians is being threatened by factors related to climate change. Further media exposure, as highlighted by some participants, may also contribute to increased fear or concern, leaving people in a hyper-vigilant state. This collective form of trauma is exemplified in the current COVID-19 pandemic where repeated media exposure and ongoing uncertainty have created massive psychological distress (Garfin et al., 2020). These examples reflect some of the realities of the present day and what may contribute to people's well-justified belief that the world is a "scary place." The negative impact of these events may be felt even more by those who are affected by social inequities as they are at an increased risk of experiencing trauma and violence (Browne et al., 2015), and are likely fighting against social systems and structures that deny, diminish, or ignore such experiences.

Participants linked the community's fear, misunderstanding, or lack of awareness of issues related to trauma and violence to experiences of shame, stigma and prejudice. Fear can lead to the stigmatization of people (Jackson-Best & Edwards, 2018), and it is well established that the experience of stigma leads to poor health outcomes (Public Health Agency of Canada, 2019; Turan et al., 2019). These effects are compounded by the fact that people often experience multiple stigmas (e.g., Link et al., 2018), highlighting the

complexity and interconnected nature of health and social statuses. The existence and detrimental impact of service providers' implicit biases (Sukhera et al., 2018; Sukhera et al., 2017) and the lack of social tolerance for those struggling with mental health concerns (Schomerus et al., 2012) underscores the finding that there is a lack of acknowledgement of the social and structural conditions that influence people's health. Participants' accounts and perceptions of these issues speak to the importance of community-focused TVIC education and how such efforts can be targeted to address social, structural, and systemic issues related to equity and justice.

The findings of this research show how the broader social context influences the community's response to the experiences and effects of trauma and violence. Findings support the use of TVIC education to build bridges between people and organizations and increase awareness about the numerous health and social issues related to trauma, violence, and mental health. This in turn can strengthen the emotional and social support for those who are struggling, two factors that play a vital role in people's healing and recovery (Barile et al., 2015). Integrating TVIC principles and practices into public and psycho-education may also help bring about social and structural change by encouraging resiliency and collective resistance. Thoits (2011) explains how public education about mental health can foster group protest that resists the stigma of mental illness and results in many benefits for people with lived experience such as legitimized anger, decreased individual risks, and the ability to exercise agency. This aligns with findings showing that community-focused TVIC education can support advocacy efforts and hold organizations accountable for providing safe and equitable services. TVIC psycho-education, specifically, may help normalize experiences and shift the blame away from the individual by illuminating the role of structural violence and social conditions that support acts of trauma and violence (Browne et al., 2015).

Due to the prevalence of trauma and violence, and the increasing complexity of community needs, results indicated that more emphasis needs to be placed on staff support and wellbeing. Supporting the safety and mental health of service providers is a key element of TVIC (EQUIP Health Care, 2018). Future education efforts would benefit from a deeper exploration of factors impacting service provider wellbeing, including

compassion fatigue, vicarious trauma, and personal experiences of trauma and violence. As noted in the analysis, supporting staff wellbeing can enhance TVIC service delivery, and is therefore a vital part of community education. These findings suggest that along with strengthening the knowledge and understanding about TVIC for the public and individuals served, there is a need to do so for service providers. Therefore, broader TVIC education should focus on strengthening the health literacy of the entire community. In doing so, it may provide a foundation to challenge the effects of health and social inequities on people's access to important health information and help dismantle the social and structural arrangements that negatively impact people's access to the information they need to improve their health. Further, implementing TVIC public and psycho-education could contribute to Greenhalgh's (2015) call for a system-wide response to enhance health literacy. Providing education to the general public, individuals accessing care, and service providers creates the wrap-around approach required to create sustained change.

The perception of the public's TVIC-related education needs reflected the importance of addressing the existing tensions related to the intersection of trauma, violence, mental health concerns and other social issues. The findings also highlighted tension within the agency in terms of the understanding and practice of TVIC and how this could impact the success of broader education efforts. The surfacing of these tensions and conflicts aligns with Browne et al.'s (2018) findings that the increased awareness raised by the EQUIP intervention (which includes TVIC) uncovered pre-existing tensions within the organization which helped catalyze change, but in some cases led to additional or reoccurring conflict. This is an important consideration for the present research in that it can aid in understanding the possible outcomes of implementing TVIC public and psycho-education. Findings suggest that tensions exist at the individual, organization, and systems levels, and while broader TVIC education can help challenge these tensions and social (and organizational) norms, it may also contribute to deeper divides between the community. While not all tensions and conflicts can be predicted, efforts to anticipate and frame such disruptions as necessary and positive may foster more successful implementation (Browne et al., 2018). While attitude change is positive, it is not enough to deconstruct the structures and systems that perpetuate violence (Flood and Pease,

2009). Therefore, it is important that TVIC public and psycho-education not only generates insight and awareness about health and social issues, but also equips people with the knowledge necessary to challenge the status quo and re-construct the social and structural norms that perpetuate and intensify the effects of trauma and violence.

While findings provided some guidance on how the agency could strengthen its TVIC-related efforts, the data also revealed many steps the agency already has taken to do so. Although there sometimes appeared to be a disconnect between organizational goals and strategic directions and staff needs and perceptions (e.g., desire to build organizational capacity to support increasingly diverse community needs but little support for staffs' professional education) the agency as a whole seems alert to the profound impact trauma and violence have on the community, individuals seeking help, and their staff. The findings emphasized the impact of external forces, such as the increasing complexity of community needs and limited funding, on the success of both internal and external TVIC education. The internal struggles and tensions that were highlighted in the data reaffirm the complex and adaptive nature of healthcare settings (Hawe, 2015). It is for this reason that the involvement of the organization in this research is crucial. Understanding the culture and needs of the organization, and how it is situated within the broader context of the community and surrounding systems can help explain how TVIC education can be provided for the public and service providers, and the value of doing so. The complexity of the findings also fits with the literature on knowledge translation within the third sector and the need for a two-way exchange of knowledge and information (Ollerton & Dadich, 2018). This approach enables the meaningful consideration of the environments in which TSOs work, as well as their knowledge values and preferences.

Understanding how the principles and practices of TVIC can be integrated in public and psycho-education is a complex process and requires a nuanced exploration of the various social, structural, and systemic conditions that enable the experience of trauma and violence to persist. The findings of this research provide a starting point for understanding the inter-linkages between the various levels of our individual and collective world and how these in turn may influence our education needs. An integrated, multi-tiered approach to education is required in order to transform our social and

structural systems. This mirrors the call made for a public health approach for trauma and traumatic stress prevention (Magruder et al., 2017). By integrating TVIC into education efforts beyond the PHC sector, the (re)occurrence of trauma and violence and the impacts of such experiences may be lessened.

5.1.2 Research Question 3: What Barriers and Facilitators Could Impact the Success of Implementation?

The exploration of factors that can impede or support the successful implementation of TVIC public and psycho-education is crucial to understanding how to navigate the social, structural, and systemic landscape that perpetuates trauma and violence. The connection between individual, organizational, and community-level factors was found in the analysis of the barriers and facilitators of implementation. One participant even asked whether the public would understand TVIC-related information or find it relevant. TVIC has been largely used as an intervention at the primary healthcare level (Browne et al., 2015; Browne et al., 2018, Lavoie et al., 2018; Ford-Gilboe et al., 2018), and as a result, has been targeted at healthcare workers and leaders. Therefore, there is a need to create accessibility for the broader public, both in terms of the ease of access to the information, and it being relatable and easy to understand. This perceived challenge reflects the fact that this information is currently isolated within professional domains and lends support for the call to create a public health approach to the reduction, intervention, and prevention of trauma (and violence) and traumatic stress (Magruder et al., 2017; Public Health Agency of Canada, 2016). However, it is important to be aware of participants' view that the public may regard the subject matter as "heavy" and not want to engage with the information. This perceived heaviness echoes the experience of the world as a scary place and may speak to peoples' desire to avoid difficult or unpleasant topics. Efforts to provide TVIC education at the community level could be met with resistance if the fears and reservations of the public are not recognized.

In order to address these fears and reservations, there is a need to design creative outreach strategies that seek to build relationships between people and organizations and humanize the issue. This approach could be one way to address the stigma and prejudice that people who are trauma- and violence-exposed face, shifting the focus from what is "wrong" with

the person to what “happened” to the person. This fits with the suggestion that countering stereotypes, social judgement, and rejection of people with mental illness should be a focus on anti-stigma programs and healthcare providers (Clement et al., 2015; Public Health Agency of Canada, 2019). Further, participants’ suggestions to include storytelling and the perspective of lived experience in education efforts may also help build compassion and empathy among the community. This approach can help individuals with lived experience of trauma and violence confront and challenge stereotypes and biases (Thoits, 2011) and complement education about TVIC principles and practices.

Additionally, contact interventions, including hearing first-hand accounts of personal experiences and testimonies from people with lived experience, have demonstrated utility in combating service provider stigma (e.g., Knaak et al., 2017), and are part of Canada’s Chief Public Health Officer’s recommended *Action Framework for Building an Inclusive Health System* (Public Health Agency of Canada, 2019). Social contact and personal testimony from people with lived experience was also recommended by the Mental Health Commission of Canada as part of the model for successful anti-stigma programming for practicing healthcare providers and trainees (Knaak & Patten, 2014). Developing creative content and delivery methods for TVIC education is essential to raising community consciousness and creating opportunities for people to understand the pervasive impact of trauma and violence, including experiences that they may identify with themselves.

However, the analysis also identified that there is a risk that community-based TVIC education could enable the perpetuation of stigma and shame by attributing additional “labels” to people who may already be stigmatized and ostracized. This “marking”, as Goffman (1963) suggests, devalues and discredits individuals, and reinforces the power imbalances and inequities within the community (Link et al., 2018). Thus, in alignment with participants’ perceptions, externally-focused TVIC education must be done in a TVI-way. Therefore, policies, practices, and materials that promote physical and emotional safety, trust, choice, collaboration, and emphasize individuals’ strength and resiliency should be a foundational requirement of any TVIC-related public and psycho-

education strategies and content. These principles are critical not only for the recipients of the information, but also for those who are providing the education. Creating educational environments that uphold universal precautions that ensure everyone, regardless of their role and experiences, is not (re)traumatized or harmed (Wathen & Varcoe, 2019) is especially important considering the pervasiveness and widespread impact of trauma and violence, and our inability to know who has been impacted and in what way.

These findings underscore the need to create and disseminate TVIC education in a collaborative way in order to reconstruct the cultural and institutional frameworks that contribute to an environment in which trauma and violence can exist. Some participants, for example, outlined the detrimental effects of the misalignment in values and practice between themselves and other service providers and the ways in which competing organizational priorities, community needs, limited funding, and the structure of the biomedical model could affect the success of broader TVIC education. These external influences and the apparent disconnect between the understanding and practice of TVIC in the community speaks to the need for an integrative approach to education. Engaging a diverse group of people and organizations that extend beyond the mental health sector can aid in transforming the community into a safer and more equitable place. By embedding trauma (and violence) informed approaches into a wide variety of systems (PHC, public health, social services, policing, education, etc.), we may be better able to reach and support trauma- and violence-exposed individuals (Magruder et al., 2016). Equipping everyone with the knowledge to respond compassionately and effectively to these and other intersecting experiences may help reduce the impact of trauma and violence on the individual and the community.

Importantly, the findings underscored various internal barriers and facilitators of the agency's ability to support the integration of TVIC into public and psycho-education. The identified barriers often reflected common factors that impact third sector organizations' ability to implement evidence-based programs (EBPs), such as limited training and organizational support, and the lack of human and financial resources needed to create and disseminate the information and education (Bach-Mortensen et al., 2018). In terms of

facilitators, strategies like the TVIG's efforts to increase the number of TVIC trainers and the frequency of training opportunities are promising. Further, nascent TVIC public and psycho-education efforts provide opportunities to explicitly incorporate this approach. These findings are in accordance with the literature on facilitators of EBP implementation and speak to the need to build flexibility into the initiative and allow staff to adapt it to their needs and preferences (Bach-Mortensen et al., 2018). Leveraging current efforts and staff expertise may help increase buy-in and the alignment of the initiative with the organization's mission and staff practices.

The barriers and facilitators of educating the general public, individuals who access services, as well as other service providers (within and outside of the health and social service sector) described in this analysis suggest that misunderstanding and lack of knowledge about TVIC may permeate many social, structural, and systemic facets of community life. Education efforts must therefore focus on addressing all levels of the community's ecosystem including individuals, organizations, and broader systems and community structures. These findings are echoed throughout this research and reinforce the need for a holistic and responsive approach to community-focused TVIC education. Efforts must challenge the social, cultural, and physical landscape that contributes to the perpetuation of trauma and violence and negatively impacts peoples', and communities', ability to heal.

5.2 Reflections on the Usefulness of the AIF Stages of Implementation

The Active Implementation Frameworks (AIF)' Stages of Implementation, specifically, the Exploration Stage, was used to understand the various factors that could impact the success of integrating TVIC into public and psycho-education. The objective of the exploration stage is to determine the fit and feasibility of the initiative through the consideration of community needs, available resources, potential barriers, and the organizational and systems changes required to support effective implementation (Bertram et al., 2015). This framework also identifies various implementation drivers that exist at the organizational level and create an environment that is conducive to successful

and sustained implementation: competency drivers; organizational drivers; and leadership drivers (Bertram et al., 2015).

Examining the data with these factors in mind proved helpful for organizing the data and providing structure; aiding in focusing the analysis and answering the research questions. While I strived to honour the voice of participants and ensure their views were accurately represented in the findings, the framework allowed me to understand how the various perspectives – and the organization’s documents – could be considered together to create a clear and cohesive narrative. It also enabled me to think about the findings in relation to the process of implementation and critically examine the steps the agency has taken, and needs to take, in order to promote the successful integration of TVIC into public and psycho-education.

Importantly, the AIFs were developed to help build service providers’ capacity to implement research-based programs and the fact that previous approaches to disseminating such work were insufficient (Metz et al., 2015). The AIFs therefore include consideration of a complex and integrated set of components and criteria to ensure successful and sustained implementation. The complexity and integrated approach built into the AIFs supported this investigation as TVIC is part of a complex intervention (Hawe, 2015; Varcoe et al., 2019), helping me understand the various components of the initiative and how individual, organization, and community-level factors interact to influence these components. The inherent complexity of the framework also allowed for a nuanced exploration of how the organization itself can support implementation and the ways in which it may already be doing so. While the nature of this investigation was exploratory, using the Stages of Implementation enabled me to consider the agency’s progress and the concrete steps it has taken to advance TVIC-service delivery and education both internally, and externally. This is in part due to the flexibility built into the AIFs and the recognition that while program implementation is staged, it is not a linear process (Metz et al., 2015).

While the AIFs’ Stages of Implementation proved valuable in a number of ways, the data did not always align fully with the components given the emphasis in the framework on

organizational implementation. The present investigation explored a wide breadth of factors that could impact the success of implementation, including various social and structural factors that lie outside of the organization. The framework allows space to consider community needs and the systemic changes required to support implementation, however I felt that it was limited in its consideration of what, and how, extra-organizational factors could impact implementation. These extra-organizational factors, such as social, political, and economic factors, are important as the findings of this investigation highlight the interconnection between individuals, organizations, and the overarching community and social structures and systems. Further, in this research I was exploring the *possibility* of implementation, using the framework as a lens rather than a “guide.” This approach to the investigation made strict adherence to the components of the framework challenging as data analysis was driven by interpreting the participant voice first and foremost.

5.3 Reflections on the Impact of my Positionality and Professional Role

Throughout the research process, I engaged in continual reflection on my understanding and interpretation of the data. This allowed me to explore my connection to the topic and how my professional role and paradigmatic positioning influenced the research. In my professional role at CMHA, I have extensive experience creating and delivering community programs. I also completed the agency’s TVIC training, and it had a profound and lasting impact on me, both professionally and personally. These experiences shaped my interest in this topic and how I viewed the potential of TVIC public and psycho-education. My acknowledgement and respect for multiple “truths” or social realities allowed me to look beyond the preconceptions I had about this topic and consider more fully the ways in which TVIC information could and should be shared with the broader community. For example, participant views that challenged this form of education provided valuable insight into the perceived usefulness and relevance of TVIC information for the community and enabled me to more critically consider how this information could be viewed and applied in a community context. Further, prior to the investigation, I had not reflected on the possible negative unintended consequences of

sharing TVIC information with the public and individuals accessing care. This was in part due to my positive view on the topic and strong belief in the value of sharing TVIC information with the community. Participants' views of such negative consequences opened my eyes further to the social and health inequities that exist in our community, and how these experiences can shape our interactions with other people, services, and information. This critical view of the data provided me with the opportunity to explore and understand how issues of power and (in)equity could impact the creation and delivery of TVIC public and psycho-education.

I strongly feel that my effort to reflect on the influence of my personal and professional experiences and beliefs, in conversation with my thesis supervisory committee, enabled me to more deeply and authentically explore this topic and uphold and amplify the participant voice. I strived to approach this investigation with humility and an open mind, and while there is no doubt that my views and experiences influenced the research process, I believe that my awareness of this reality contributed to a more honest, trustworthy, and critical thesis.

5.4 Limitations

Importantly, there are some limitations of this study. Given my role at CMHA, it was determined that for ethical reasons, I would not directly approach staff to request their participation in the study. While our CMHA study liaisons could reach out to department leaders more broadly to promote the study, the onus was on interested participants to come forward. This recruitment strategy may have affected participation in that only those who were interested in the study or were familiar with TVIC may have come forward. It also limited my ability to recruit participants from specific levels or departments within the agency, resulting in “missing” perspectives in the data set. First, there was no participation from staff at the senior leadership level (e.g., program director). Not having this perspective may limit the findings in terms of exploring the strategic direction of the agency and the challenges and facilitators of organizational implementation – and expansion – of TVIC from a leadership lens. This viewpoint may have also provided additional insights into the barriers and facilitators that could hinder or support the successful integration of TVIC into externally-focused education. While

participants provided many valuable insights, having a leadership perspective could have provided a more comprehensive picture of the agency's TVIC landscape and their position within the community. Relatedly, having a perspective from the human resources department (an opportunity lost due to COVID-19) could have provided additional information about TVIC-related policies and practices, including hiring and new staff orientations, and ongoing training efforts. Together, these perspectives could provide insight into how well TVIC has become "embedded" within the agency's culture.

Upon reflection, there may have also been additional internal, non-confidential documents that would have benefited the investigation, such as the trauma skills presentation that is used in-session with clients. Formal agency TVIC-related policy and practice documents were limited, and only a few documents were obtained that related directly to public and psycho-education. This resulted in a small document sample, which may have provided only surface-level insight.

Finally, this research was a preliminary investigation into how TVIC can be integrated into public and psycho-education, and as such included only staff and organizational perspectives. Future research, as further articulated below, should include more diverse participants, including people who access services and their support networks, general community members, other service providers, and representatives from academia and government.

5.5 Summary and Recommendations for Future Research

The findings of this research suggest that the complex interplay between individual, organizational, and broader community level factors shape our community's understanding and response to trauma, violence, mental health, and other intersecting challenges. Therefore, future education efforts must aim to create TVIC-related awareness and action at all of these levels in order to promote social change and system transformation, including among individuals accessing care and their loved ones, the general public, and service providers. Future research is needed to explore in depth the education needs of these different groups, as well as what these groups feel is important to include in TVIC public and psycho-education, with a focus on specific strategies to

share this kind of knowledge. Incorporating citizen engagement (CE) strategies in future research, such as those outlined in the Canadian Institutes of Health Research's (CIHR; 2012) Citizen Engagement Handbook, may be one way to actively and meaningfully involve various representatives from the community in developing TVIC public and psycho-education. Using this method of integrated knowledge translation can help foster an exchange between future research and the community, ensuring that the development and delivery of TVIC-related educational material is informed by community needs.

TVIC public and psycho-education may help challenge the fear, stigma, and prejudice surrounding trauma, violence, mental health and many other intersecting factors. Future research would benefit from exploring community attitudes towards TVIC and understanding how these attitudes could in turn impact education needs. A key finding of this research was the common perception of the world as a “scary place” which has resulted in people’s defensiveness, denial, and desensitization to a number of health and social issues and could negatively affect people’s reception of TVIC education. Research that further investigates this perception and how it influences community members’ attitudes towards trauma, violence, and mental health would be useful in ensuring the development of effective community-focused TVIC education. Additionally, there is a strong connection between TVIC public and psycho-education and service provider education and support. Future research that examines this relationship and how TVIC training can support staff wellbeing, reduce the impact of vicarious trauma and compassion fatigue, and strengthen TVIC-service delivery could enhance efforts to create a trauma- and violence-informed community.

Continued research on the organizational implementation of TVIC public and psycho-education is also beneficial to in order to ensure that future efforts are effective and sustained at the organizational level. To address one of the limitations of the present study, future research should incorporate leadership perspectives, including human resources. This will provide a more comprehensive picture of the organization’s TVIC-related efforts, providing insight into the policies, practices, and culture of the agency, and where opportunities exist to strengthen and extend its TVIC-related work.

Collaboration is essential in ensuring the success of TVIC public and psycho-education. Research that explores the barriers and facilitators of TVIC-related inter-organizational collaboration may increase our understanding of how to create a safe and equitable healthcare system. Exploring where opportunities exist to strengthen partnerships and comparing and contrasting various organizational policies and practices may help identify points of convergence (and divergence) and aid in fostering greater alignment among service providers. More research in this area is important to advance systems-level change.

Given our inability to co-produce formal recommendations for action and knowledge mobilization strategies within the time allotted to complete this thesis, collaboration with the study liaisons will continue in order to do so. In response to our partners' expressed needs and time constraints, these recommendations will be drafted by myself and Dr. Wathen, in consultation with the study liaisons. They will be based on the present findings and informed by what the liaisons feel is relevant and feasible for the organization. The goal is to create *actionable* recommendations and messages that can produce real and meaningful change at the organizational and community level.

The call for future research and action that supports the effective and sustained integration of TVIC into education efforts for the whole community is especially relevant and necessary, given the impact of the COVID-19 global pandemic. Our social, political, and economic realities have been disrupted, and what has been unearthed are the harmful, unjust, and inequitable systems and structures that have existed for so long and continue to negatively impact the health and wellbeing of marginalized, disadvantaged, and vulnerable communities. We are at a cross-roads as a community, country, and global society, with the opportunity to create something new, a different system and social structure that compassionately and equitably responds to the needs of everyone. Broader TVIC education and awareness may be one way to help transform public opinion and ultimately influence government policy to create the change that is needed to support the health and wellbeing of all. The global pandemic has revealed how fragile our society truly is, and future research and action regarding TVIC and other equity-oriented

initiatives is needed in order to enhance the capacity of our communities to confront and challenge the historical and ongoing inequities experienced by many.

5.6 Conclusions

This exploratory research suggests that efforts to cultivate a trauma- and violence-informed community are intimately linked to various social, systemic, and structural factors that perpetuate fear, shame, stigma, and prejudice. TVIC public and psycho-education may be one way to combat these injustices and promote safety, respect, compassion, and equity among community members, individuals accessing services, and service providers. Ultimately, externally-focused TVIC education may help create an inclusive community by shifting the lens through which trauma and violence is viewed and contribute to reshaping the social, cultural, and physical landscape that perpetuates such experiences.

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Appendices

Appendix A: Organizational Letter of Information and Consent Form

Letter of Information and Consent for Organization Fostering a Trauma- and Violence-Informed Community: Developing Strategies to Inform Public Education Content

Principal Investigator: Dr. Nadine Wathen [REDACTED]

Masters Student: Jessica Carswell [REDACTED]

The proposed research seeks to extend efforts made by the Canadian Mental Health Association (CMHA) Middlesex to adopt a trauma- and violence-informed care (TVIC) approach for service provision. This research will examine CMHA's priorities and current practices to understand how TVIC information can be translated for and shared with the general community. The specific research questions are: 1. How can the principles and practices of TVIC be integrated into the development and content of public education material? 2. What barriers and facilitators (structural, cultural, and practical) exist that may impact the success of implementing this kind of educational programming for the community?

We would like to confirm CMHA Middlesex's participation in the study, led by designated Study Liaisons <contact names>, co-Chairs of CMHA's Trauma and Violence Informed Group. The following information outlines what this means. The designated Study Liaisons will orient the researcher to relevant aspects of TVIC implementation, training, and education already enacted, or planned, including identifying documents to review, and meetings to observe. They 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 through regular staff communications (posters, newsletters, general staff emails), 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 explore how staff usually develop public education materials, how they would do/are doing so according to TVIC principles, and to what effect. Interviews will also explore staff perceptions of what barriers and facilitators exist that may impact the process of translating TVIC practices and principles into public education programming. Interviews will 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 training and education. In addition, with the Study Liaisons, we will identify key

staff meetings, training workshops, or other events that the researcher can attend to understand organizational TVIC training and education efforts.

The risks of taking part in this study are minimal. Staff could be 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 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.

It is important to note that we envision this research to be collaborative and conducted in partnership with CMHA Middlesex. Therefore, the research questions, priorities, and methods outlined in this letter of information are subject to change, based upon your organization's needs and preferences.

The findings from this study may help your organization, and possibly other organizations, become aware of how to successfully translate the principles and practices of trauma- and violence-informed care into public education programs, and what barriers and facilitators exist 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 Jessica Carswell at [REDACTED] or by e-mail [REDACTED], 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 of Human Research Ethics, The University of Western Ontario [REDACTED].

Consent Form

Organizational Participation

I, _____ (print name) give permission for our organization _____ (print name of your organization) to participate in the study, “Fostering a Trauma- and Violence-Informed Community: Developing Strategies to Inform Public Education Content”.

 Authorized Representative of
 Canadian Mental Health Association Middlesex

 Date (DD-MMM-YYYY)

 Witness Signature Date

 Date (DD-MMM-YYYY)

 Principal Investigator’s Signature

 Date (DD-MMM-YYYY)

Appendix B: Sample Email Text for Study Announcement

Carswell: sample text for use by organizational leaders to inform staff about the research - (this could be in posters, general staff emails, newsletters/bulletins, staff meetings, or otherwise, as deemed appropriate by the organization – it will not be used directly by leadership to individual staff)

Subject Line: Research on creating trauma- and violence-informed care- related public education programming

To: Members of Staff

Our organization is working collaboratively on a study with researchers from Western University. The research examines how to effectively translate the principles and practices of trauma- and violence-informed care (TVIC) into the delivery and content of public education programming in our organization. Jessica Carswell is a Master's candidate in Health Information Science at Western University, under the supervision of Dr. Nadine Wathen (chief supervisor). She will ask to interview staff, review relevant documents, and participate in meetings and workshops related to our agency's TVIC training and education. 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. Jessica will hold two information sessions on date/hour and date/hour. If you are interested in participating in the study or you would like to obtain more information about the study, please feel free to attend those sessions.

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 for those who are approached, the researcher will not share consents and refusals 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 C: Letter of Information and Consent Form for Individuals

Letter of Information and Consent for Executive Directors and Staff Fostering a Trauma- and Violence-Informed Community: Developing Strategies to Inform Public Education Content

Principal Investigator: Dr. Nadine Wathen [REDACTED]

Masters Student: Jessica Carswell [REDACTED]

The proposed research seeks to extend efforts made by the Canadian Mental Health Association (CMHA) Middlesex to adopt a trauma- and violence-informed care (TVIC) approach for service provision. This research will therefore examine CMHA's priorities and current practices to understand how TVIC information can be translated into a useful format for the general community. The specific research questions are: 1. How can the principles and practices of TVIC be integrated into public education material? 2. What barriers and facilitators (structural, cultural, and practical) exist that may impact the success of implementing this kind of educational programming and material for the community?

What will I have to do if I choose to take part?

You will be interviewed once at the onset of the study and follow-up interviews may also be requested. Interviews will take about 60 minutes to complete. You will be asked questions about your experiences in your role at the organization related to TVIC training and education and your perception of the organization's efforts in this area, the implementation of TVIC policies and practices, who you feel needs to be consulted in the planning and creation of TVIC public education content, and what barriers and facilitators you feel may exist that could impact organizational efforts to integrate TVIC materials into the delivery and content of public education programming. 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 be 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 your organization, and possibly other organizations, become aware of how to successfully translate the principles and practices of trauma- and violence-informed care into public education programs, and what barriers and facilitators exist 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. However, if you chose to participate in this study during your scheduled working hours, and you are in need of program coverage, you will need to notify your manager of your participation to ensure that the necessary program coverage is arranged.

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 Jessica Carswell at [REDACTED] or by e-mail [REDACTED], or 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 of Human Research Ethics, The University of Western Ontario: [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: “Fostering a Trauma- and Violence-Informed Community: Developing Strategies to Inform Public Education Content”

Study Investigator’s Name: Dr. Nadine Wathen [REDACTED]

Additional Research Staff: Jessica Carswell [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 Obtaining Consent Signature Date (DD-MMM-YYYY)

Appendix D: Interview Guide

Carswell: Interview Guide – CMHA Staff

Interview Guide

Preamble:

Thank you for meeting with me today. I would like to gain an understanding of how to translate trauma- and violence-informed care (TVIC) principles and practices into information that can inform the community through public education programming. I have a letter of information that I ask you please read, and then if you agree to participate, please sign the consent form.

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 would like me to stop or pause recording please say so.

1. What is your role here at CMHA?
2. Tell me about the public education program at CMHA; how does your work intersect with the public education program?
 - Probe: Have you supported the creation of any public education or related materials?
 - Probe: Have you supported the delivery of any public education trainings, workshops, in-session psycho-education, or related initiatives?
3. What do you know about TVIC?
 - Probe: Have you done anything related to TVIC?
 - Probe: Have you done any TVIC-related training and education efforts internally? Externally? Self-education or anything else?
 - If yes: Can you tell me about it; what has the impact been on you?
 - Probe: Do you that this information is valuable? If yes, why?
4. What is being done at CMHA regarding TVIC?
 - Probe: What has the organization and leadership done?
 - Probe: What are staff doing? Have you seen any changes in your work or that of others? Please describe.
5. Do you know of anything being done to incorporate TVIC into CMHA's public education programming, or other related initiatives, such as in-session psycho-education?
 - If yes: Can you please explain what is being done and how?

If no: Should TVIC be included in public education? Do you have any ideas as to what that might look like?

Probe: How would that happen? Are there certain policies and / or practices that you think should be reviewed / revised in order to assist this process?

6. What do you think about integrating TVIC into the area of public education?

Probe: Are there any perceived benefits to this? Do you perceive any negative consequences as a result of these efforts?

Probe: Is there anything that could help this process? Hinder it?

Probe: Are there other program areas that you feel might benefit from this approach?

7. If you were going to create this type of public education programming who do you think needs to be consulted? How would you do it?

Probe: Are there certain groups of people, communities, or organizations that you think should be engaged in the design of content?

Probe: Are there certain formats that you think may be useful for communicating such information with the public? Specific features or aspects of TVIC that should be included? Structure of workshops/programming?

8. Is there anything else related to TVIC, training, staff education, public education, or other issues that you would like to tell me about, or something that I haven't asked that you feel is important to discuss?

Wrap up:

Thank you for participating in this interview. If you have any thoughts or are doing any work in this area, please contact me. Do I have your permission to follow up with you in 6-8 weeks to see if anything has changed, and if so how would you like me to contact you? Thank you.

Appendix E: List of Categories on the Document Review Data Extraction Form

Document Review – Data Extraction Categories
Document type
Document title
Page number
Integration of TVIC in organization
Specific organizational TVIC initiatives
TVIC staff education and training (internal)
TVIC staff education and training (external)
TVIC in psychoeducation
Barriers to TVIC implementation
Facilitators of TVIC implementation
Development of public education
Challenges in public education
Success of public education

Appendix F: Code Book

Code Name	Description
Agency Efforts to Support TVIC	past and present actions CMHA is taking to support TVIC-related efforts, internally and/or externally.
Administration and Leadership Support	thoughts and examples that reflect the support that administrative and leadership staff provide to direct service staff; may include challenges to providing support.
Agency Tensions	participant perceptions, experiences, and examples of tensions that exist within the agency related to TVIC.
Areas for Improvement	ideas for how CMHA can improve their TVIC-related efforts, either internally within the agency or externally within the community.
need for action	reflects the perception that the agency needs more action in terms of implementing TVIC.
Available Resources	resources that could help support the integration of TVIC into public and/or psycho-education.
Partnerships	partnerships with community that have been formed by the TVIC committee in an effort to create and share TVIC-related training and education.
pre-existing TVIC training material	TVIC training and education material that has already been created by the TVIC committee.
TVIC Committee Members	the ability/responsibility for TVIC committee members to share information and train their own teams and departments on TVIC.
Wholistic Service Delivery	diverse program and service offerings can allow for TVIC-related education and information to be shared with individuals accessing services across the agency.
External TVIC Education and Training	efforts the agency has made to share TVIC education and training with other organizations in the community.
Internal Communication	challenges, opportunities, and/or current practices related to communication between staff within CMHA about TVIC-related information, education, and/or training.
Internal TVIC Training	structure, delivery, etc. of the internal TVIC training that is delivered to staff.
Internal TVIC-Related Programs	programs within the agency that promote TVIC-related principles and practices among individuals accessing services.

Code Name	Description
Strengthening Staff TVIC Training and Knowledge	TVIC-related knowledge and training needs, as well as recommendations for how to strengthen CMHA staff training and knowledge.
TVIC Committee Initiatives	examples of initiatives that CMHA’s TVIC committee are doing or have done in the past.
Historical Goals of TVIC Committee	previous goals and desired outcomes of CMHA’s TVIC committee.
Agency Narrative	the “story” that CMHA wants to share with the community about mental health and wellbeing; how its programs and services are perceived by the community and the type of culture it supports.
Barriers to TVIC-Related Public Education	possible challenges that could impact the success of integrating and sharing TVIC-related information with the community.
Accessibility	factors that may negatively impact a person’s ability to engage with TVIC-related public and/or psycho-education materials, workshops, etc.
Biomedical Model	reflects challenges associated with the biomedical model and related culture in mental health and the desire to treat symptoms as opposed to understanding the individual and their history; less emphasis on the psychosocial factors that impact mental health and wellbeing.
Buzz Word	thoughts and examples pertaining to the term “TVIC” becoming a buzz word.
Competing Priorities	challenges to implementation and education related to competing organizational priorities, both for CMHA as well as external organizations.
Expertise	challenges related to finding the staff with the expertise to deliver the material to the community.
Fear and Defensiveness	people may be afraid or feel defensive when listening to or learning about TVIC-related information.
Financing	recognition that there are limited finances and this could impact the success of implementation.
Jargon	in vivo code - reflects the need for TVIC-related public education efforts to be free of jargon as it may be a barrier to creating and sharing accessible and useful information.
Out of Sync	in vivo code - reflects the perception that not all service

Code Name	Description
	providers in the community know about or use a TVI-approach and how this can impact the consistency of service delivery for individuals.
Participation	reflects the possibility that community members may not participate in public education sessions; may relate to interest or buy-in.
Perceived Social Exclusion	information sharing efforts could be negatively impacted by the possibility that some people may not feel welcome or that they are not accepted.
Policy Constraints	the possibility that the policies of other community organizations may make it difficult to deliver public education.
Power Dynamics	thoughts related to the need to be aware and critically examine what voices are heard and privileged when determining the creation and sharing of TVIC-relating training and education.
Resistance	the possibility that the community may be resistant to learning about or be critical of TVIC-related information.
Specialized Knowledge	the perception that TVIC-related information may be hard to share with the community because it is knowledge that is related to the helping field and not something that is well-known or understood outside of the profession.
Staff Buy-In	in vivo code - reflects the need to get staff support for the initiative or else implementation may not be initiated or sustained.
Work Load	in vivo code - recognition that staff have their own workload and there are limits to what additional tasks they can take on.
Benefits of Psycho-Education	the value individuals can get from participating in programs and receiving information and education about topics related to mental health and wellness.
Externalizing the Problem	the ability for psycho-education and related information to help externalize mental health challenges and help individuals see that there is not something that is innately wrong with them.
Gateway	the ability for psycho-education and related programs to act as a gateway or entry point to receiving mental health

Code Name	Description
Maintaining Recovery	support. psycho-education groups can help an individual maintain their recovery through education, structure, socialization, etc.
Benefits of Public Education Programming	transformations in beliefs, actions, relationships. etc., that public education programs and workshops can contribute to.
Building Stronger Relationships	benefits of public education that relate to creating stronger relationships between people by fostering compassion and understanding.
Encouraging Helping Behaviour	providing public education about mental health and related issues can lead to people being more willing to help or support others.
Improving Attitudes	public education about mental health and related issues can help people develop a better understanding of the impacts of such challenges and lead to improved attitudes towards those who are struggling.
Improving Mental Health Literacy	public education can help increase people's understanding about mental health.
Community Needs	reflects the needs of the community in terms of programming, education, and support for understanding and addressing issues related to mental health, addictions, and other social and health related challenges and inequities.
Community Crises	statements, descriptions, etc. that reflect various crises that are occurring in the city related to mental health, addictions, poverty, and other related issues.
Community Tensions	examples of tension in the community regarding mental health, addictions, and other related issues.
It's Their Choice	perceptions in the community that individuals who are struggling with addictions, homelessness, etc. choose such lifestyles, or put themselves in situations that lead to such challenges.
Life is Hard	in vivo code - the perception held by some community members that life is hard and people should be able to move on from their emotional, mental, physical hardships; stigmatizes mental health.
Police Interaction	the recognition that interactions between police and individuals who are struggling in the community are

Code Name	Description
	becoming more frequent and intense.
Stigma	negative perceptions of mental illness and related challenges held by the community.
Strained Relationships	strained relationships amongst community members and small businesses and individuals in the community that are struggling with mental health, addictions, and other related challenges.
Community Service Agencies	perceived TVIC-related education needs for other community service agencies.
A Way of Being	education and information that supports health care providers to integrate TVIC into their approach.
Building Awareness	the reality that community organizations may not be aware of the concept of TVIC and therefore may not know or think to request the training for their staff.
Fostering Autonomy and Resilience	the need for TVIC education and information for healthcare providers in order to create healthcare environments that support people's autonomy and foster resiliency.
Top Down	the need to share TVIC-related education and information with the leadership of an organization, business, etc. in order to create and sustain a paradigm shift.
TVI-Service Delivery	the need for education and information that promotes TVI-service delivery in the community.
Vicarious Trauma	the need for service providers to be given education and information about vicarious trauma.
Work in Alignment	the need to share TVIC-related education and information with agencies, businesses, healthcare organizations, etc., in order to promote effective and consistent service provision.
Cultural Mosaic	in vivo code - reference to diversity in the community in terms of culture and the need to be aware of the experiences of trauma and violence that exist within minority communities.
Education Needs	information that may be useful for the community to help foster greater compassion and understanding for mental illness and related challenges.
Changing Language	the need for education and information about the power of language.

Code Name	Description
Family and Loved Ones	education and information that is perceived to be beneficial for family members and loved ones who are supporting someone who has experienced trauma and violence.
Inclusive	the perception that TVIC-related education, training and support needs to be available to and inclusive of everyone in the community, not just service providers.
Increase Understanding	the need to provide education to the community in order to increase people's understanding about the pervasiveness of trauma and violence and the impact on those who have, or continue to be, trauma and violence-exposed.
Individual Experience vs Event	the need for education and information about the diversity of experience and individual responses to events.
Knowledge of Community Supports	the need for education and information about services and supports in the community that can help people who have experienced trauma and violence.
People's Rights	the need for education and information about people's rights when they are receiving care.
Practical Skills	the need to provide community members with practical skills and take aways they can apply in their life.
Recognize Signs of Trauma and Violence	the need for education about the signs and symptoms of trauma and violence in order to better support people who may be experiencing distress as a result.
Seniors	reflects the perception that seniors need to be included in TVIC-related education efforts.
Shift Lens	need for education about the impact of trauma in order to reduce stigma and shift how community members view those with mental health, addictions, or related challenges.
Shifting Blame	the need for education and information about the impact of trauma and violence in order to externalize the problem and show that there is not something inherently wrong with the person who has experienced trauma and violence.
What is TVIC	the need for education and information about TVIC in order for people to better understand what it is and how to incorporate it into their practice/life.

Code Name	Description
Youth	the need for education and information regarding youth mental health and wellness and the effects of trauma and violence.
It's Important When You Need It	reflects ideas related to the reality that someone may not feel TVIC information is relevant to them until they have encountered someone who is struggling or have experienced a traumatic event themselves.
Responses to Trauma and Violence	stories that reflect individual experiences and responses to trauma and violence and how it impacts their engagement within the community and with healthcare and other services.
Rural Community Needs	perceived needs related to mental illness and related challenges, specific to rural communities surrounding London and Middlesex area.
The World's a Scary Place	in vivo code - reflects the perception that there is a lot of negative and traumatic/violent events happening in the world that people are aware of; contributes to people feeling afraid, desensitized, etc.
Workplaces	ideas about how and why TVIC-related education and information can benefit workplaces.
Facilitators of TVIC-Related Public Education	factors that can support the integrating of TVIC principles and practices into education for the public and/or individuals accessing services.
Agency Narrative	the usefulness of the agency narrative to convey spread awareness of TVIC.
Agency Resources	existing programs, services, staff, etc. that can be leveraged in order to provide TVIC related information and education to the public as well as individuals served.
Integration of Information	the benefit of integrating TVIC information into other presentations, topics, or sources of information.
Interesting Marketing Tools	in vivo code - reflects the need to create and use interesting and appealing marketing tool to reach and engage the public.
Reach the Public Where They Are	in vivo code - the recognition that TVIC-related education efforts must meet people where they are as community members may face various barriers to engaging with the information, such as work schedules, buy-in etc. Related to emotional, environmental, occupational needs, etc.

Code Name	Description
Social Responsibility	perception that many businesses in the city have a social responsibility mission and this could be leveraged to share TVIC-related information and training.
Staff Autonomy	the perception that staff have enough autonomy and flexibility in their role to be able to independently incorporate TVIC-related information and education into their work.
The Public is Really Thirsty for It	in vivo code - reflects the perception and examples of the public expressing desire to learn about TVIC.
Wrap Around Service	in vivo code - reflects the need to have a “wrap around” approach in the delivery of TVIC-related information, education and services; inclusion of the public as well as staff, other service providers, and integrated into all programs and service delivery.
Gender and TVIC	reference to how gender (male and/or female) can influence the perception and understanding of the impact and experience of trauma and violence.
General Service Delivery	descriptions, examples, etc. of the various programs and services that CMHA staff perform.
Goals of Public Education Programming	various outcomes that the public education program hopes for.
I Don't Think You're Ready Yet	in vivo code - comments pertaining to an individual's readiness to participate in programs and services.
Ideas for Integrating TVIC Into Public Education	participant's thoughts on how TVIC principles and practices, or related information can be integrated into public education programs and workshops, either implicitly or explicitly.
Challenges	perceptions about the challenges of sharing TVIC-related information with the community; includes ideas about relevancy and the potential negative consequences of trying to do so.
A Way to Be	in vivo code - the perception that TVIC-related information is not something that can necessarily be shared with the public, it is more of a way to be, a sensibility or disposition.
Diverse Communities	challenges related to the fact that there could be difficulties pulling together the needs and opinions of diverse communities while trying to create TVIC-related education for the community.

Code Name	Description
Negative Consequences	possible negative consequences or challenges that should be considered when exploring how to integrate TVIC into public and/or psycho-education.
Collaboration	reflects the feeling that CMHA needs to work in collaboration with other community agencies to strengthen efforts to integrate TVIC into all aspects of service delivery.
Audience	ideas about what audiences in the community would benefit from TVIC-related education.
Community Engagement Strategy	groups, communities, organizations, etc. who should be consulted and/or involved in the process of exploring how to integrate TVIC into public and/or psycho-education.
Broader Community	suggestions for what communities/populations need to be engaged in discussion about and planning of TVIC-related education for the public and individuals accessing services.
Expertise of Lived Experience	examples of how and why individuals who have lived experience with mental illness and other related challenges can add value to the process of understanding how to effectively integrate TVIC into public and/or psycho-education.
Internal Engagement	suggestions for who at the agency needs to be engaged in the discussion about and planning of TVIC-related education for the public and individuals accessing services.
Organizations and Service Providers	suggestions about the various organizations and service providers that should be engaged in the discussion about and planning of TVIC-related education for the public and individuals accessing services.
Go Beyond Mental Health	the perception that in order to create greater understanding in the community and reduce the impact of stigma, TVIC-related information and education must be shared with organizations outside of mental health.
Integrated System	reflects the need for a system that is integrated and reduces the number of times individuals have to recount their history or story of trauma and violence.
Stakeholder Engagement	reflects the need to meaningfully engage stakeholders to ensure ownership over the creation and implementation of TVIC-related public education materials.

Code Name	Description
Work in Alignment	in vivo code - reflects the desire to create an environment where all of the service providers within the community are aware of TVIC and approach their work in a similar way.
Communication Strategy	ideas for how to effectively communicate TVIC-related information with the community, including individuals accessing services at CMHA.
Creating Ownership	ideas about the need to create a sense of ownership among people to enhance interest and desire to learn more, as well as educate others.
Creative Approach	reflects the need to find creative ways to provide community-based TVIC education.
Depersonalization	ideas about sharing TVIC-related information and providing education in a way that is depersonalized and non-threatening so the individual can decide whether or not it applies to them.
Getting the Word Out There	in vivo code - relates to ideas about sharing TVIC information in accessible ways that promote the concept of TVIC and increases awareness.
Humanizing the Issue	relates to the perception that TVIC-related information and education must be presented in a unifying way.
Impact	suggestions related to highlighting the positive impact of implementing TVIC has made.
Incentives	suggestions related to creating incentives for people to attend TVIC-related information and education sessions.
Messaging	ideas related to thinking critically about what the main message is and how to share that with different audiences, while being sensitive to their needs.
Relevancy	the perception that TVIC-related information and education needs to be presented in a way that highlights its relevancy and connection to current research, best practices, etc. to help individuals understand and buy-in to the benefits of the approach.
Strengths-Based Perspective	reflects the need to provide TVIC-education and training from a strengths-based perspective in order to highlight people's abilities and resiliency.
Content	ideas about what content should be included in TVIC-related education.
Lived Experience	perceived need to incorporate perspectives from people

Code Name	Description
	with lived experience into the content, in addition to theoretical or professional perspectives.
Practical Skills and Knowledge	the perceived need to share practical information that people can use, for example, resources or quick, easy to understand information.
Self-care	the perceived need to teach people about the importance of self-care and how to practice it.
Trauma-Specific Information	the perceived need to share information related to trauma and how and why people might have a trauma-response.
Delivery	ideas about how to deliver TVIC-related education and information, as well as how to deliver education and information in at TVI way.
Choice	the need to provide people with choice and self-determination in the delivery of TVIC-related information and education; providing the opportunity for people to choose whether or not they engage with the information.
Common Thread	in vivo code - ideas relating to the need to intentionally integrate the principles and practices of TVIC into all program areas and education efforts of the agency.
Expertise	reflects the perception that those who are providing TVIC-related education and training to the community must have a strong knowledge base of TVIC.
Format	suggestions for the types of formats that would be useful for sharing TVIC-related education for the public and individuals served.
Global Perspective	in vivo code - suggestions related to the need to share TVIC related information using a global perspective; stemming from the idea of universal precautions.
Peers	suggestions to include peers and those who have lived experience of trauma and violence in the delivery of the material.
Psycho-Education	thoughts about how TVIC could be integrated into the delivery of in-session psycho-education.
Reciprocity	in vivo code - the need to create opportunities and deliver TVIC-related information and education in a way that supports reciprocity between all participants.
Safety	recognition for the need to build in safety measures to support individuals who are taking part in TVIC-related

Code Name	Description
	education.
Staff Education	ideas related to the future delivery of TVIC-related education and training for staff at CMHA.
Terminology	suggestions related to using the terminology of TVIC more frequently as a way to increase awareness about the concept.
Written Material	suggestions related to providing individuals with written material that they can read in order to learn about TVIC.
Impact and Evaluation	reflects thoughts about the need to capture the impact and evaluate learning and practice after the delivery of TVIC-related public education sessions.
Impact of TVIC on Personal Life	examples of how TVIC principles and practices have transformed the way the participant interacts with others in their personal life.
Impact of TVIC on Professional Practice	ways in which TVIC information has influenced and/or changed an individual's approach to their work.
Shift in Language	the acquisition of TVIC knowledge and information has resulted in the participant's shift in the language that they use when referring to and working with individuals.
Information Sharing	examples of the types of information and education that staff provide individuals who come in for support, including family members.
Internal Capacity for TVIC Public Education	reflects the needs and abilities of CMHA staff to be able to create and deliver TVIC-related public education.
Intersection of mental health	acknowledges the complexity of mental health and how it intersects with various other issues, for example, addictions, poverty, and other inequities
Leadership	identified need for strong leadership within the agency to initiate and sustain TVIC-related initiatives.
Organizational Culture	the culture and environment within the agency and how staff feel and interact with one another and the individuals they support.
Perceptions of Trauma and Violence	how others might view the experience of trauma and violence.
Personal and Professional Network	Individuals and connections that are known to CMHA staff; networks have or can assist in spreading awareness about mental health.
Personal Responsibility	participant indicating that they should or wish to assume

Code Name	Description
	responsibility for supporting the integrating of TVIC principles and practices into public education and/or psycho-education.
Policy and Practice Revisions	perceptions of what policies and practices need to be revised or created in order to help facilitate the integration of TVIC in public and/or psycho-education.
internal training	perceived need to strengthen internal training for staff.
re-examine policies and program requirements	relates to the perceived need to re-examine program requirements to ensure they are TVI.
creating mandates	ideas related to making TVIC-related policies and practices mandatory.
screening	perceptions of and experiences with the current TVIC-related screening tools used by the agency.
safety	relates to the need to create feelings of safety for everyone, including physical and emotional safety.
wellbeing for staff	relate to the need for policies and practices that support the wellbeing of staff.
Public Education	thoughts, examples, etc. related to the public education program, including content, delivery, audience, and requests.
Content of Public Education Programming	information that is being shared with people through CMHA's public education program.
Example of Public Education Workshop	a current or past program or workshop offered through the public education program.
Integration of TVIC into Public Education Workshops	ways in which TVIC principles and practices are currently being integrated into the delivery and content of public education programming.
Public Education Audience	groups, communities, organizations, etc. that have or are current recipients of programming and education through CMHA's public education program.
Public Education Requests	types of information requests that the public education program receives.
Inter-Organizational Public Education	public education workshop and program delivery for other organizations in the community.
Public Education Resources	different resources that are available to support the delivery of public education programming and workshops.

Code Name	Description
Structure of Public Education Programming	how CMHA's public education programs are current structured, for example, length of programs, style, delivery, etc.
Staff Wellness	recognized need to support staff health and wellness, especially when working with individuals who have experienced, or are presently experiencing, trauma and violence.
Debriefing	seeking support from other staff after experiencing a troubling or stressful interaction.
Helplessness	expressions of feeling helpless in their work with some individuals who have experiences of trauma and violence; may lead to avoidance in their work.
Personal Experiences of Trauma and Violence	reflects the reality that staff also experience trauma and violence in their own lives, as well as vicarious trauma as a result of their profession.
Safeguarding Myself	in vivo code - expressed desire for staff to protect themselves against vicarious trauma in their work; may lead to avoidance in their work.
Safety	reflects the need for creating feelings of safety for staff.
Self-Care	examples of how staff take care of their own mental, emotional, physical, spiritual health and wellness.
TVIC as a Right	statements that reflect the right to safe, equitable mental health care that individuals have.
TVIC in Psycho-Education	examples of how CMHA staff incorporate TVIC-related principles and practices into in-session or in-group information-sharing with individuals accessing services.
TVIC Information and Education for Individuals Accessing Services	internal practices to inform individuals accessing services about TVIC and the agency's approach to service delivery.
TVIC Service Delivery	descriptions of TVIC service delivery and how CMHA staff are utilizing TVIC-related practices and principles in their work with individuals accessing services.
Connection Between Peer Support and TVIC	examples of how the principles and practices of peer support are related to the principles and practices of TVIC.
Staff Concerns	thoughts, ideas, examples, etc. of practices, policies, other things that staff feel are not indicative or contra-indicated to the practice of TVIC.

Code Name	Description
Staff Support	practices, examples, thoughts, etc. pertaining to TVIC-related practices that support staff.
TVIC-Related Knowledge	participant expression of TVIC-related knowledge.
Behaviour	reflects a recognition of how an individual's behaviour may be associated with the trauma and violence that they have experienced.
Choice	reflects knowledge related to the fact that individuals have the right to make choices and lead their recovery journey.
Context	reflects the need to understand an individual's history and how their experience with trauma and violence can affect how they interact with the environment around them.
Coping	TVIC-related knowledge that reflects how certain behaviours have been developed as a way to cope or survive.
Cultural Safety	reflects a knowledge and understanding of the need to create a safe environment and to be aware of other cultures and cultural practices and how perceptions, biases, etc. can influence care.
Flexibility	recognition of the need to be flexible in their approach to service delivery and awareness of how the experience of trauma and violence may impact how an individual interacts with services and service providers.
Importance of the V	perceptions of how the incorporation of violence (or the "v") into trauma-informed care adds value.
Individual Experience	reflects the idea that individuals experience trauma and violence differently.
Integrated Care	reflects the benefit of providing services and supports in an integrated way that addresses the whole person and all of their needs, i.e., mind, body, spirit.
Language	reflects the understanding that language is important in TVI-approaches.
Non-judgmental Approach	reflects knowledge around utilizing a non-judgmental approach when working with people.
Physical Violence	descriptions that focus on defining the "v" in relation to physical violence and physical safety.
Recovery	understanding recovery as a "squiggly line" rather than

Code Name	Description
	something that is linear or transformational.
Resiliency	recognition that individuals how have experienced trauma and violence are resilient and have strengths that need to be acknowledged.
Safety	reflects knowledge about creating safety for individuals who are accessing services.
Self-Care	TVIC-related knowledge about the importance of self-care when providing care and support for individuals.
Staff Reflection	reflects knowledge about the need for staff reflection on their service provision in order to uphold TVIC related practices.
Strengths-Based Approach	the importance of recognizing the strengths and skills that people have rather than focusing on their illness or things they struggle to do.
Trust	reflects knowledge related to the need to cultivate trust between service providers and individuals accessing support.
TVI-Management	thoughts, examples, etc. that reflect knowledge and practice related to TVI-management.
Universal Precautions	knowledge, statements, examples, etc. that reflect the need to treat everybody as though they are trauma and violence exposed.
Vicarious Trauma	understanding the impact of other people's trauma stories on care-givers/service providers, and the need to exercise self-care.
TVIC-Related Training and Education	TVIC-related training and education that the participant has completed, and that has contributed to their knowledge and understanding of TVIC principles and practices.
External TVIC-Related Training and Education	TVIC-related training and education that the participant has taken outside of internal CMHA TVIC training, as well as experiential knowledge or knowledge acquired through their work.
Internal TVIC-Related Training and Education	TVIC-related education and training CMHA provides its staff.
Feedback	comments pertaining to feedback received from staff about their experience, perceptions, etc. of the internal TVIC training.

Code Name	Description
Onus on Staff	reflects the notion that staff learning, related to TVIC and other conceptions and practices, are the responsibility of the individual staff person
Trusting Staff	reflects the agency's trust in staff to incorporate TVIC into their approach and work with individuals accessing services.
Value of TVIC-Related Information	examples of how the community as well as individuals accessing services can benefit from TVIC.
Advocacy	TVIC-related information can assist individuals to understand the level of care and respect they deserve.
Closing the Treatment Gap	reflects the perceived value of sharing TVIC-related information with the community in terms of reaching individuals and their supports who do not access CMHA services for whatever reason.
Confidence	the perception that TVIC-related knowledge and information can help individuals, staff or others, build confidence in their ability to provide support for people.
Context	reflects the notion that TVIC-related knowledge and information can help provide context for why an individual is struggling; externalizing the problem rather than something that is innately wrong with the person.
Debriefing	the value of TVIC-related information in supporting staff's understanding and practice of debriefing after traumatic incidents.
Destigmatizing	reflects the ability for TVIC-related knowledge and information to help reduce the stigmatization of people living with mental health and other challenges.
Disclose Where You Are Comfortable	reflects the value of sharing TVIC information with the community as it may help people disclose to people and in places where they are comfortable as more people may be better able to understand and support individuals who have been trauma and violence exposed.
Employee Support	value of TVIC-related information from an employment/HR perspective.
Prevalence	the value of TVIC-related knowledge and information is related to the prevalence of traumatic and violent experiences.
Relationship Building	sharing TVIC-related information with the community can help strengthen relationships among community

Code Name	Description
	members.
Safety	TVIC-related information and practices creates a safe environment for people.
Self-Awareness	Understanding TVIC-related information can help promote self-awareness and aid in recovery.
Self-Determination	individuals who are informed about TVIC may be better equipped to manage future responses to trauma and violence.
Skill-Building	reflects the ability of TVIC-related information to help build and/or enhance knowledge and skills that can help people understand trauma and violence and its effect on themselves or others.
Support	the value of TVIC-related knowledge and information is connected to the ability to be able to provide help and guidance to those in need.
System Transformation	the value of TVIC-related information to help examine systems/institutions and the need to create change at the systems level rather than the individual level.
Understanding	TVIC-related education can promote understanding of trauma and violence and its effects on people.
Wholistic Approach	reflects the value of looking at the individual in a wholistic sense, including the systems and environment surrounding them.

Appendix G: Research Ethics Approval Notice



Date: 1 February 2019

To: Dr. Nadine Wathen

Project ID: 111905

Study Title: Organizational Implementation of Trauma- and Violence-Informed Care: A Multiple Case Study Analysis
New sub-study title - Fostering a Trauma and Violence Informed Community: Developing Strategies to Inform Public Education

Application Type: NMREB Amendment Form

Review Type: Delegated

Full Board Reporting Date: March 1 2019

Date Approval Issued: 01/Feb/2019

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 amendment, as of the date noted above.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
CMHA Organizational Letter of Information and Consent Form_REVISED CLEAN	Written Consent/Assent	24/Jan/2019	2
Interview Guide - CMHA Staff	Interview Guide	18/Jan/2019	1
Letter of Information and Consent Form for CMHA Indivs_REVISED CLEAN	Written Consent/Assent	24/Jan/2019	2
Letter of Information and Consent Form for CMHA Meetings-Workshops	Written Consent/Assent	24/Jan/2019	2
Sample text for CMHA EDs to Inform Staff_REVISED CLEAN	Recruitment Materials	23/Jan/2019	2

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
CMHA Public Ed TVIC Project Summary	Other Materials	18/Jan/2019	1

REB members involved in the research project do not participate in the review, discussion or decision.

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:	Jessica Carswell
Post-secondary Education and Degrees:	<p>Western University London, Ontario, Canada 2009-2014 BA (Hons) – Honors Specialization in Media, Information Technoculture; Major in Criminology</p> <p>Western University London, Ontario, Canada 2014-2018 BA (Hons) – Honors Specialization in Psychology</p> <p>Western University London, Ontario, Canada 2018-2020 Master of Health Information Science</p>
Honours and Awards:	<p>Ontario Graduate Scholarship, Western University 2018-2019</p> <p>Joseph Armand Bombardier Canada Graduate Scholarship (SSHRC) - 2019-2020</p>
Academic Fellowships	Global MINDS Fellowship Program, Western University 2017-2018
Academic Mentorship Roles	<p>Global MINDS Fellows as Mentors, Western University April 2018-2019</p> <p>Global MINDS Community Initiative Representative –Graduate Seminar Course, GHS9014B: Global Mental Health System Innovation Western University, January 2019-April 2019</p> <p>Canadian Coalition for Global Health Research – Western University Chapter, November 2018-April 2019</p>
Related Work Experience	<p>Teaching Assistant, Faculty of Information Media Studies Western University 2018-2019</p> <p>Mental Health Worker Canadian Mental Health Association Middlesex, London On 2012-present (currently on educational leave of absence)</p>

Publications:

Carswell, J., Kothari, K., Peter, N. (2020). Reflections on effective services: The art of evidence-based programming. *Voluntary Sector Review*, 00(00) 1-12. doi: 10.1332/204080520X15893044346921

Carswell, J., Oudshoorn, A., Amatruda, C., Burkell, J., & Carr, B. (2018). Partnering to enhance mental health in libraries. *Voices: Topics in Canadian Librarianship*, 2(1), 21-23.

Carswell, J., & Frewen, P. (2017). Experiences of psychopathology distract from focused attention during mindfulness meditation: Assessment in relation to meditation breath attention scores in mental health help-seeking participants. *Mindfulness*, 8(4), 943-948. doi: 10.1007/s12671-016-0670-1

Refereed Presentations:

MacDougall, A., Sule, R., Carswell, J., Bird, R., Wathen, N., Janzen Le Ber, M., Branzei, O., Ruhara, R., Mutiso, V., Ndeti, D., Saxton, K., & Rodger, S. (2018, June). The Global MINDS (Mental Health INCubator for Disruptive Solutions) Fellowship Program: Transdisciplinary Students Addressing Complex Mental Health System Challenges Through Social Innovation. Oral presentation at London Joint Mental Health Research Day, London, Ontario, Canada.

Carswell, J., (2017, June). Experience of Meditation Practice in Help-seeking and Student Participants. Poster presented at Department of Psychiatry Academic Research Day, London, Ontario, Canada.

Non-Refereed Presentations:

Benjamin-Thomas, T.*, Carswell, J.*, & Chege, M. (2018, November). Working Towards Building Inclusive Communities Through the VisAbility Kenya Volunteer Network. Poster presented at Power & Global Health Day, London, Ontario, Canada.
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Benjamin-Thomas, T.*, Carswell, J.*, Chege, M., Jackson, B.*, & Ngina, L. (2017, November). VisAbility Kenya: Making the Invisible, Visible. Poster presented at Global Health and Marginalized Populations Day, London, Ontario, Canada.
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