DEFINING AND OPERATIONALIZING TRAUMA-INFORMED CARE

TRAUMA-INFORMED CARE WITHIN AND ACROSS SYSTEMS OF CARE

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Lay Abstract

The concept of trauma-informed care (TIC) has emerged in response to increased awareness regarding the prevalence and impact of trauma. A growing body of empirical literature has demonstrated the effectiveness of TIC within specific programs and services as well as at the organizational and system levels. What constitutes trauma, however, and how TIC can be defined and operationalized at various levels remains unclear. This thesis aims to address these gaps in the literature by: (1) developing a conceptual framework on TIC and a theoretical framework outlining the barriers and facilitators of TIC (2) examining how and under what conditions can TIC be utilized in mental health policy documents (3) exploring what are the political factors that can lead governments to decide against utilizing TIC.

Abstract

Trauma has been described as a pressing public health concern and research evidence demonstrates how unresolved trauma can lead to multiple comorbidities including chronic medical conditions such as cardiovascular disease. Furthermore, epidemiological evidence demonstrates the high prevalence of trauma histories amongst service users seeking care across a range of systems including child welfare, education, health, social services and the criminal justice system. In response, the concept of trauma-informed care (TIC) has emerged, but how TIC can be conceptually defined and utilized remains unclear in the scholarly literature.

This dissertation utilizes a variety of methodological approaches to explore how and under what conditions TIC can be utilized within and across systems of care to address the prevalence of trauma-affected individuals seeking care. First, a critical interpretive synthesis of the TIC literature provides an overview of how TIC can be defined and utilized through the development of a conceptual framework situating TIC within and across systems of care. A theoretical framework outlines important contextual factors, such as system arrangements as well as the political system, that can act as either barriers or facilitators to the operationalization of TIC. Second, a document analysis examines how and under what conditions TIC is utilized in adult mental health policy documents in Ontario, Canada. Finally, a case study explores what factors led to the exclusion of TIC from Ontario's first province-wide strategy on mental health and addictions. Collectively, these three studies add several substantive, methodological and theoretical contributions regarding a cohesive understanding of what is trauma, how TIC can be defined and operationalized and the role of TIC at various levels within and across systems of care. Mobilizing sustainable and effective TIC has been demonstrated to improve the overall health and well-being of both service users and services providers, leading to stronger systems of care and healthier communities and societies at large.

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List of Abbreviations

ACE	Adverse childhood experiences
CBT	Cognitive behavioural therapy
CIS	Critical interpretive synthesis
DSM	Diagnostic and Statistical Manual of Mental Health
ECHO	Echo: Improving Women's Health in Ontario
ED	Emergency department
FOI	Freedom of Information
HiREB	Hamilton Integrated Research Ethics Board
MAG	Ministerial advisory group
MH	Mental health
MSF	Multiple streams framework
MOHLTC	Ministry of Health and Long-term Care
NE LHIN	North East Local Health Integrated Network
PTSD	Post-traumatic stress disorder
TIC	Trauma-informed care

Declaration of academic achievement

This dissertation presents three original research studies (Chapters 2-4) as well as an introductory (Chapter 1) and conclusion chapter (Chapter 5). Each of the three original research studies are co-authored and I, Maria Bargeman, am the lead author on all five chapters. Details of the specific contributions for each study are outlined in the preface of the relevant chapter. I was responsible for conceptualizing the area of focus for the dissertation, and for its design, as well as for conducting all data collection, analysis and preparation of the written chapters. Two members of my supervisory committee – Dr. Julia Abelson and Dr. Gillian Mulvale – contributed to the design, analysis and synthesis of all three research studies as well as provided feedback on written drafts. Dr. Anne Niec provided feedback on written drafts of the first two research studies (Chapters 2-3) and contributed the design, analysis and synthesis of the third research study (Chapter 4) as well as feedback on written drafts of that chapter.

Chapter 1

Introduction

This doctoral dissertation is comprised of three original research studies exploring the role of trauma-informed care (TIC) within and across systems of care. This introductory chapter serves to orient the reader to the dissertation. The chapter begins with a contextual overview of the TIC literature by first outlining the conceptualization and emergence of TIC and by situating the thesis within the broader scientific literature on TIC as it currently exists. Second, the overarching aims of, and rationale for, the dissertation will be identified as well as the specific methodological approaches utilized in each of the three research studies. Third, the chapter will discuss anticipated substantive, methodological and theoretical contributions of the dissertation. Finally, the chapter will conclude by situating the researcher and first author as the main contributor to this work.

The conceptualization and emergence of trauma-informed care

To understand how and why the concept of TIC began to emerge in the scientific literature as a necessary component of systems of care, one must first understand how and why the concept of trauma, itself, has emerged within both scholarly research and service provision. The word trauma first emerged in the 17th century, originating from the Greek work *traumatikos*, which translates to 'wound'.[1] Trauma, in this context, referred to a physical wound or injury. It was not until the 19th century that the concept of a wound, or trauma, became associated with psychological experiences.[1-3]

Knowledge and awareness of psychological injuries significantly increased in the post-war eras after both World War I and World War II. Despite advances in understanding how war trauma impacted both soldiers[4, 5] and civilians[6, 7], particularly survivors of the Holocaust and the Hiroshima bombing, psychiatry continued its 'episodic amnesia' by overlooking the impact of trauma in the last quarter of the 20th century.[2, 8, 9] This is most notable in the lack of adequate psychiatric support for American soldiers returning from the Vietnam War.[8]

Diagnostic recognition of psychological trauma was not established until 1980 when post-traumatic stress disorder (PTSD) first appeared in the *Diagnostic and Statistical Manual of Mental Health* (DSM).[3, 8] Thus, clinical recognition of psychological trauma, with regards to its diagnostic criteria and treatment, is still relatively new. In the 1990s, Judith Herman's seminal work recognized that trauma is associated with not only biological or psychological factors but is also related to broader social and political factors.[9] This was followed in the late 90's by the landmark Adverse Childhood Experiences (ACE) study, which demonstrated significantly higher prevalence of childhood trauma than previously identified with higher incidence of multiple adult onset chronic comorbidities positively correlated to higher rates of ACEs.[10] By the late 1990s and early 2000s, a variety of professionals began to recognize and speak out about the importance of the organizational context in the delivery of services to individuals who have experienced significant traumatic life events. The concept of trauma-informed care emerged from growing recognition that systems of care can be harmful, rather than helpful, when they fail to acknowledge trauma histories amongst service users.[11, 12] Additionally, when the concept of TIC first began to emerge in the literature, it recognized the importance of utilizing a trauma-informed lens not only with regards to specific care, but also in the design and delivery of health services more broadly.[12]

Around the same time, advancements in neuroscience greatly improved understanding regarding the neurobiology of trauma, specifically that psychological trauma can alter and disrupt structural and functional brain health,[13-19] with significant implications for childhood trauma and its impact on the developing brain.[20-22] Yet, despite robust evidence regarding the impacts of childhood trauma on the developing brain and the subsequent myriad physical and mental health consequences of untreated trauma, the DSM Version 5 rejected substantial efforts to include developmental trauma disorder as a distinct diagnostic category.[23-26] Although psychiatry has been historically hesitant to fully acknowledge trauma as it relates to psychiatric disorders, there has been much discussion in the scientific literature regarding incorporating trauma awareness into service design and delivery and a growing body of empirical literature regarding the effectiveness of TIC has begun to emerge.[27-41]

Situating the thesis within the broader TIC literature

While TIC first emerged in the scientific literature in the early 2000s, it is within the last five to ten years that the scientific body of literature related to TIC has begun to grow exponentially. Beginning with a high-level overview, TIC has begun to appear in the literature addressing a range of systems of care – specifically, child and youth services, community and social services, the education system, the health system and the justice system. Within child and youth services, TIC has been applied to adoption services, caregiver support, special needs trauma services, child protection and the child welfare system more broadly.[33, 42-48] Within community and social services, TIC has been discussed in relation to mental health and addictions services, trauma recovery programs, traumatic grief support groups, domestic violence programs, specific at-risk populations, community support services, emergency response and preparedness and the discussion of TIC more broadly in social policy development.[49-58] In education, TIC has been applied across the spectrum ranging from pre-primary education, through both primary and secondary education as well as post-secondary and higher education.[59-64] TIC has been outlined as relevant to curriculum development with discussions on how teachers can provide trauma-sensitive classrooms as well as how schools, holistically, can support student needs pertaining to trauma exposure.[65-68] There has been growing recognition regarding how trauma can disrupt student learning and academic performance, particularly in the early developmental years.[35, 69]

The largest repository of TIC literature, as it currently stands, lies within the health system. TIC has been discussed across the spectrum of the health system, from primary care to various specialty services.[70-74] TIC has also been discussed in relation to specific types of providers of services, such as general practitioners, speciality physicians, dentistry, nursing, social work and other members of the allied healthcare team.[30, 39, 75-79] TIC has also been discussed within the health system literature across the lifespan ranging from pre-natal care, neonatology, and pediatrics to geriatrics and dementia services.[1, 78, 80-87]

Within the justice system, the need for TIC has been highlighted in juvenile justice, adult court, and specific types of courts such as those dedicated to deal with

addictions and mental health cases.[39, 88-90] Additionally, TIC has been applied to various police services, the generalized court process, and in various types of incarceration settings.[37, 40, 91, 92] There has been discussion in the justice literature regarding the need for trauma services, specifically, and TIC more broadly within corrections facilities.[38, 93-95]

In addition to specific systems and services of care, the TIC literature discusses applicability to specific population groups and various consumers of services. This includes the homeless population, human trafficking victims, indigenous and aboriginal individuals, those with intellectual and developmental disabilities, veterans as well as refugees and immigrants as just a few examples.[52, 96-104] Furthermore, the TIC literature also includes discussions on the need for integration of TIC services across systems of care, including, but not limited to – child welfare, justice, education, health and social services.[39, 41, 50] Thus, as demonstrated above, while TIC is a relatively newly emerging phenomenon, it has been rapidly applied in a vast array of contexts across a myriad of services and systems of care.

Despite this newness, there has been some criticism of TIC in the scholarly literature. First, TIC has been criticised for a lack of conceptual clarity, specifically with questions raised regarding how TIC is different from good patient-centred care.[54, 55, 70] This criticism stems from some descriptions of TIC that emphasize facilitating patient choice and establishing a sense of emotional and psychological safety, which do not clearly delineate TIC from the broader tenets of traditional patient-centred care. Additionally, TIC's lack of conceptual clarity has created a sense of operational ambiguity in that service providers have identified it "means different things" to different providers.[41] Thus, the lack of consensus within the scholarly literature regarding how, precisely, to define TIC, which is further compounded by TIC's lack of conceptual clarity, has led to confusion regarding how to operationalize TIC. As the concept of TIC becomes more widely recognized, there is some criticism that it is being applied in an ad-hoc manner and without a clear definition and, thus, with no real way for meaningful evaluation of TIC outcomes.[105] In particular, concerns have been raised that various agencies and services are claiming to be either trauma-informed or providing TIC and yet what this means to these agencies and services is not clear.[106] Finally, there has been

growing awareness regarding the importance of recognizing the prevalence and impact of trauma amongst systems of care and despite the interplay between these systems, particularly child welfare, education, and health, they remain heavily siloed and lack uniformity in their approach to TIC.[50]

Overarching aims, rationale and approaches of the dissertation

The main objective of this thesis is to address gaps in current understanding regarding the role of TIC, particularly how TIC can be defined and utilized within and across systems of care. The following three specific aims will contribute to meeting the above-identified objective:

1. To develop a novel conceptual framework, via an exhaustive review of the TIC literature and use of qualitative data analysis, in which TIC is situated within and across systems of care with identifying variables that act as either barriers or facilitators in the operationalization of TIC (Chapter 2);
2. To critically examine how and under what conditions has TIC been conceptualized and utilized in adult mental health policy documents in Ontario, Canada (Chapter 3);
3. To explore why TIC was recommended for inclusion in Ontario's first province-wide mental health and addictions strategy, but was subsequently excluded from the strategy's development and implementation (Chapter 4).

With regards to the first aim outlined above, TIC, as a phenomenon, is still emerging and has been applied in a 'hodge-podge' manner to a wide variety of services across various systems of care. There has been some confusion within the research literature regarding whether or not TIC is a specific component of clinical service[42, 45, 94, 107] or if it is a set of governing principles applicable to organizations and systems of care[50, 68, 88, 108, 109] or if it is some combination of the two. Additionally, while TIC has been theoretically applied to a wide range of service settings, the specific ways in which TIC can be implemented and operationalized remain unclear.[110] Thus, there is need for a holistic review and analysis of the TIC literature across systems of care in order to better understand and clarify when, why and how TIC is applicable to service design and

delivery. The thesis addresses these gaps in understanding by utilizing a critical interpretive synthesis in which the TIC literature is comprehensively and exhaustively reviewed, with data extracted and analysed from a purposive sample of documents. Analysed data led to the development of a conceptual framework, which depicts how TIC can be defined, understood and operationalized.

With regards to the second aim outlined above, an increasingly frequent occurrence within the theoretical TIC literature is to discuss various issues in service delivery and conclude by recommending TIC policy as a way to address these issues.[70, 105] This is problematic as it is often not clear what is meant by TIC, or how it can be implemented, and this pattern raises concerns that TIC is becoming a less than robust policy solution in that it receives 'lip service' without meaningful operationalization.[106] One aspect of the criticism surrounding TIC is that it is the latest 'fad'.[41, 111] The thesis seeks to address this by conducting a rigorous document analysis of recent Ontario adult mental health policy documents in which TIC was recommended. This will allow for a comprehensive examination of how and under what conditions is TIC being used in policy discourse.

Finally, with regards to the third aim of the thesis, it has been noted with interest that TIC was strongly recommended during the consultation of Ontario's first mental health and addictions strategy, but it was excluded from both the development and implementation of the strategy.[112-117] This raises questions, and important opportunities for exploration, as to why TIC was recommended, but ultimately rejected. In the current literature, there is an incomplete understanding of the barriers and limitations of TIC within policy development. This study seeks to address this gap in understanding by utilizing an explanatory, holistic, single case study approach to explore why the Ontario provincial government considered, but ultimately omitted TIC in their 2011 mental health and addictions strategy.

The gaps identified above are addressed via three unique and original scientific studies aligned to the thesis's overarching objective and aims. A mix of methodological approaches is utilized in order to meet the aims of the thesis. First, a critical interpretive synthesis (CIS) is employed in Chapter 2 as this methodology is best suited to an

emerging body of literature in which the studied phenomenon may lack conceptual clarity.[118] Drawing on the structure of a systematic review, the resulting conceptual and theoretical frameworks are derived from qualitative analysis of the synthesized literature. Second, qualitative document analysis methodology is applied in Chapter 3 in order to hone in on how TIC is specifically utilized in policy documents.[119-121] Additionally, the conceptual framework developed in Chapter 2 will be tested throughout the document analysis of Chapter 3, which allows for rich insight into how policy documents define and operationalize TIC. Finally, an explanatory, holistic, single case study methodological approach is used in Chapter 4, which allows for a critical examination into why TIC was recommended, but ultimately rejected from Ontario's 2011 mental health and addictions policy.[122]

Anticipated contributions

This doctoral dissertation, as a whole, is anticipated to provide several substantive contributions. First, it is anticipated to significantly contribute to the current scholarly literature regarding how to better inform both system and service design from a trauma-informed perspective as well as provide critical policy insight regarding how and under what conditions TIC policy decisions are made. Specifically, the CIS employed in Chapter 2 will undertake a robust and comprehensive review of all TIC literature spanning multiple disciplines and systems of care. To our knowledge, this is the first review to conduct such a rigorous examination of the TIC literature across a variety of scientific disciplines. The CIS is also anticipated to provide rich and substantive insights regarding both the facilitators and barriers to TIC in systems of care, specifically child welfare, education, justice, health and social services. While the CIS will focus on these five specific systems of care, it is anticipated that the findings will be relevant, and provide helpful insight, to a variety of additional systems and services of care.

This dissertation is also anticipated to provide several methodological contributions. To our knowledge, the use of CIS methodology in Chapter 2, is the first of its kind to be applied to the TIC literature. Additionally, the CIS methodology will cast a wide net in that it will examine TIC from across multiple disciplines, sectors, and systems of care, which is anticipated to lead to unique insights. Additionally, use of document

analysis as will be employed in Chapter 3 is, to our knowledge, the first time this particular methodological approach has been applied to explore TIC decision-making. Chapter 4 is anticipated to provide important methodological contributions through novel combination of two distinct policy frameworks – a policy inaction framework,[123] which will be uniquely complemented by a framework outlining structural interests.[124] This will allow for in-depth analysis as to the various contributing factors that led to the Ontario government's rejection of TIC in its 2011 mental health and addictions strategy. This is also the first time, to our knowledge, that TIC has been explored with respect to government decision-making that resulted in a 'no-go' policy decision.

Finally, the intentional sequencing of the selected methodologies is also paramount. Use of a CIS in Chapter 2 is critical to establish a foundational understanding of the broader TIC literature. The output of the CIS – the conceptual framework – will then be used to inform the next two studies (Chapters 3-4). Selecting qualitative document analysis, as will be employed in Chapter 3, allows for the conceptual framework developed in the preceding chapter to be rigorously tested in combination with a prominent political science theory on agenda-setting within the policy process.[125] Finally, use of a case study in Chapter 4 builds on the findings of both Chapters 2-3 while allowing for robust data collection via multiple data sources, including key-informant interviews.

Several anticipated theoretical contributions can also be identified. First, the CIS in Chapter 2 is expected to produce a conceptual framework that outlines how TIC can be understood within and across systems of care. Second, use of document analysis in Chapter 3 to explore how and under what conditions is TIC utilized in policy documents, is anticipated to provide further insight as to how governments conceptualize and seek to utilize TIC in services and systems of care. Finally, the case study in Chapter 4 is expected to further currently limited understanding regarding what are the potential barriers and limitations within government that inhibit government support for TIC.

Situating the researcher

As the first author on this work, I am approaching this doctoral dissertation on TIC as a person uniquely situated within both a research institution, by way of my doctoral studies, and the clinical realm. In addition to my PhD studies, I am a registered

nurse with over a decade of experience in the emergency department (ED) and critical care. There are two primary reasons, via my clinical role, that draw me to this work. First, it is my experiences with the many patients who entered the ED seeking some type of care for their immensely painful emotional and psychological injuries only to encounter a system that struggles to acknowledge and aptly respond to types of pain that cannot be diagnosed via physical etiology. These patients were known as our 'frequent flyers' and it became apparent to me that while they were continually seeking help, very often in highly distressed states, we were consistently unable to address their needs in a meaningful way. Thus, the continued cyclical pattern of understandable inability to cope, a visit to the ED, a long wait to be seen and assessed, followed by the inevitable discharge back out to wherever 'home' was. Second, I have seen, time and again, the impacts of secondary trauma, burn-out and high rates of fatigue amongst my co-workers repeatedly exposed to various types of extreme trauma, both physical and psychological. It has become clear that the impacts of these repeated exposures can hold consequence for front-line staffers, both personally and professionally, and that if we are to improve our systems of care, we must also address how to better support our front-line staff.

In addition to outlining what draws me to this work, I would also like to situate myself within this work. The following chapters, excluding the final concluding chapter, have been co-authored by members of this dissertation's supervisory committee with the first author, myself, submitting the main contributions for each chapter as per the requirements of a sandwich dissertation. To provide clarity, the contributions of myself, as the student, versus those of the supervisory committee, have been outlined in the preface of each relevant chapter.

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Chapter 2

Preface

This chapter provides a synthesis on the conceptualization and operationalization of trauma-informed care across various settings. A review of the literature was completed in accordance with the methodology of a critical interpretive synthesis. A conceptual framework was developed in which trauma-informed care is situated within and across systems with identifying variables that either enable or hinder the operationalization of trauma-informed care. I was responsible for structuring the research question and study design, completing data collection and analysis and generating the conceptual framework. Dr. Kaelan Moat was the second reviewer in assessing the eligibility of 15% of the initial titles and abstracts and 15% of full-text documents. Dr. Julia Abelson and Dr. Gillian Mulvale contributed to the overall study design and methods, data synthesis and analysis as well as the construction of the conceptual framework and ongoing feedback to the chapter as it was drafted. Dr. Anne Niec provided feedback on full drafts of the paper including various iterations of the conceptual framework as it continued to be developed and refined as well as the full development of Table 1, Figure 2 and Figure 4.

Understanding the conceptualization and operationalization of trauma-informed care within and across systems: A critical interpretive synthesis

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Key words: trauma, trauma-informed care, child welfare, education, justice, health, social services

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Abstract

Introduction: Increased recognition of the epidemiology of trauma and its impact on individuals within and across human service delivery systems has contributed to the development of trauma-informed care (TIC). How TIC can be conceptualized and implemented, however, remains unclear. The objective of this study is to synthesize and analyze the TIC literature from child welfare, education, justice, health and social services and to generate a conceptual framework regarding TIC. Specifically, this study explores how TIC is defined and operationalized 'vertically' at the program, organizational and health system level and 'horizontally' across systems and what factors explain whether and how TIC is operationalized.

Methods: This study followed a critical interpretive synthesis methodology. Multiple databases (Campbell Collaboration, Econlit, Health Systems Evidence, Embase, ERIC, HealthSTAR, IPSA, JSTOR, Medline, PsychINFO, Social Sciences Abstracts, Sociological Abstracts and Web of Science) were searched as well as relevant grey literature and information-rich websites. A well-established coding tool was adapted to the TIC literature and used for data extraction

Results: Electronic database searches yielded 2,439 results of which 1,761 did not meet the inclusion criteria and were excluded. The remainder were reviewed in full for relevance and a purposive sample of 98 information-rich articles was generated. Conceptual clarity and definitional understanding of TIC is lacking in the literature, which has led to poor operationalization of TIC. Additionally, infrastructural and ideological barriers, such as lack of funding and service provider 'buy-in', have hindered TIC implementation. Significant factors affecting operationalization that cut across all systems were the impact of institutional policy legacies on the operationalization of TIC and the role of interest groups, particularly provider resistance towards TIC. The resulting conceptual framework defines trauma and depicts critical elements of vertical TIC, including the bi-directional relationship between the trauma-affected individual and the system, and horizontal TIC, which requires intersectoral collaboration, an established referral network and standardized TIC language.

Discussion: Successful operationalization of TIC both vertically, within systems, and horizontally, across systems, will require policies that address current gaps in systems arrangements, such as the lack of funding structures for TIC, and political factors, such as the role of policy legacies. The emergent conceptual framework acknowledges critical factors affecting operationalization, but requires further testing within and across systems.

Introduction

The seminal Adverse Child Experiences (ACE) study of the late 1990s was the first large-scale study to link adverse childhood experiences to later development of a multitude of risk factors associated with several leading causes of morbidity and death in adulthood [10]. Findings identified in the ACE study prompted further investigation into the impact of childhood trauma, which has led to increased awareness of the widespread prevalence of trauma experienced across the lifespan [126-128]. Epidemiological trauma trends become even more revealing when viewed within various human service delivery systems. Individuals with significant trauma histories are disproportionately represented in child welfare, the criminal and juvenile justice systems, mental health and addictions, and social services [45, 51, 88, 129].

Rising awareness of the prevalence of trauma over the last several years has coincided with recent advancements in neuroscience, particularly regarding the neurobiology of trauma. A growing body of research has shown how childhood trauma can disrupt normal neurocognitive development resulting in long-term negative outcomes in behavioural, physiological, cognitive and interpersonal functioning [19, 20, 130]. Responses to traumatic exposure can include anger, aggression, risky and self-destructive behaviours as well as engagement in criminal activity, particularly in the adolescent and young adult years [131, 132]. Understanding the link between trauma, neurocognitive function and behavioural outcomes holds significant implications for how various human service systems design service delivery. In addition to increased understanding of how trauma affects the brain, scientific discovery regarding neuroplasticity, specifically the brain's

ability to re-wire stress responses, and opportunity for post-traumatic growth also hold significant implications for service delivery, particularly with regards to trauma-informed care [133, 134].

The concept of trauma-informed care (TIC) emerged from increased awareness of the pervasiveness of trauma and growing understanding of how it can negatively impact structural and functional brain health. Various human service delivery systems such as child welfare, education, health, justice and social services, have begun to recognize that a significant proportion of service users have trauma histories [46, 65, 88, 96, 135, 136]. Additionally, the education system has started to respond to the implications of neuroscience regarding how trauma can impact student learning and academic performance [35, 66, 137]. An emerging body of empirical literature has shown promising evidence regarding the effectiveness of trauma-informed services in comparison to traditional services [28, 29, 32, 34, 35, 38, 40, 41, 52, 138, 139]. Various concerns regarding the conceptualization and operationalization of TIC, however, have also begun to surface [41]. The concept of TIC remains poorly defined within current literature and several contested definitions can be found regarding the understanding and application of TIC in diverse contexts. Some literature exists regarding the use of TIC in human service delivery systems, but consensus is lacking in both the definition and application of TIC within and across these systems. The purpose of this paper is to systematically review the literature on TIC within and across systems of care and to create a conceptual framework, informed by analytical findings of the review, that outlines how TIC can be defined and operationalized.

Methods

Design

This study design follows the methodological approach of a critical interpretive synthesis [118, 140, 141]. A critical interpretive synthesis (CIS) design was selected as it is most suitable for emerging literature that remains poorly conceptualized due to limited understanding and empirical research. In addition to elements of a traditional systematic review guided by an iteratively developed compass question, a CIS typically generates a conceptual framework resulting from qualitative analysis of synthesized evidence [118]. After a preliminary survey of existing literature on TIC, the following compass question was formulated: How is TIC defined and operationalized 'vertically' in the clinical setting, at the organizational level, and at the health system level and 'horizontally' across other systems of care including child welfare, education, the judicial system and social services, and what factors explain whether and how TIC is operationalized at these levels and in these systems?

Literature search and article selection

Drawing on traditional elements of a systematic review, a search-term strategy was formulated in consultation with an expert librarian to guide a structured, systematic literature search utilizing Boolean key phrases for both empirical and non-empirical

articles. The search-term strategy was initially piloted in select databases and revised several times in consultation with the librarian. The following health and non-health databases were systematically searched: Campbell Collaboration, Cochrane, Econlit, Embase, ERIC, HealthSTAR, Health Systems Evidence, IPSA, JSTOR, Medline, PsychINFO, Social Sciences Abstract, Sociological Abstracts, and Web of Science (Figure 1). The following iteratively developed line-item key-term searches were used for health databases: (1) "trauma informed" OR "trauma sensitive" OR "trauma expos*" OR "trauma specific" (2) "health practi*" OR "health prof*" OR clinician (3) "health polic*" OR "policymak*" (4) "health sys*" OR "health org*" OR healthcare with the subsequent line combinations: 1 and 2; 1 and 3; 1 and 4. Non-health databases utilized the following bounded search terms: "trauma informed" "trauma sensitive" "trauma resilienc*" "trauma specific" "trauma expos*" "trauma aware". Key search terms were slightly modified to ensure best fit for specific databases. In addition to the bibliographic databases, grey literature and reference lists of high-value articles were manually searched.

The searches were conducted between March and May of 2017 and abstracts were exported into an Excel spreadsheet and coded according to three categories: Include, Assess Further, and Exclude. Included documents addressed the topic of trauma-informed care at any of the three health system levels or when TIC was discussed in any of the four additional systems. Inclusion criteria also required documents to address the conceptualization and/or operationalization of TIC within the relevant systems. Documents were excluded if they primarily focused on treatment modality and efficacy studies or the development of clinical tools. The Included and Assess Further titles and

abstracts were then exported into a separate excel spreadsheet and the Assess Further articles reviewed again. After this second phase, a total of 316 documents were identified as eligible for inclusion based on title and abstract review. A third and final assessment phase consisted of creating an excel tracking sheet with the 316 documents separated into 6 different tabs: (1) child welfare (2) education (3) health (4) justice (5) social services (6) multiple. The first author carried out a full-text scan of each document and assessed according to the inclusion/exclusion criteria in order to generate a purposive sample of the most information-rich documents, which resulted in the selection of 98 documents. In order to ensure the inclusion and exclusion criteria were consistently applied and a reliable sample was generated, a second reviewer independently assessed a random generation of 15% of the initial titles and abstracts and then independently reviewed another random generation of 15% of the selected 98 full-text documents. Any discrepancies in coding were mutually discussed to reach consensus. Inter-rater reliability was assessed through a Kappa statistic, which was calculated to be 0.82 for the initial title and abstract review and 1.0 for the full-text review.

A master list of the selected documents was generated and entered into a central database in Excel in which each included document was catalogued with a unique identifying code and a brief article descriptor. This centralized database assisted with data extraction by providing a high-level overview of each system and contributed to the emerging conceptual framework. Throughout the article selection process and purposive sampling, the first author recorded emerging themes and concepts in a reflexive journal.

Data analysis and synthesis

A data extraction tool (see Appendix 1), derived from a pre-existing and well-established health and social system arrangements taxonomy, was generated and contextualized to the TIC literature in the data collection phase and used for data extraction [142, 143]. Health and social systems arrangements consist of three types of arrangements and three levels of implementation strategies. Regarding arrangements, the first type is governance, which describe various levels of decision-making authority and how consumers and stakeholders are involved in the decision-making process. Second, financial arrangements describe how various levels of the system are financed, how providers are remunerated, and whether/how consumers are financially incentivized. Third, delivery arrangements describe how care is designed to meet consumers' needs, who provides care, where it is provided and with what supports. Implementation strategies target consumers, providers and/or organizations [142, 144]. The taxonomy was also used to extract data about programs and service areas, trauma, TIC and study design. Data were additionally filtered and analyzed through the "3-I" framework, which outlines how policy development and choices are influenced by institutions, interests and ideas [145]. The "3-I" framework is a helpful analytical tool that allows for exploration of how variables within each of the three "I's" can either facilitate or hinder policy development and implementation [146]. The first of the 3 "I's" – institutions – can be defined as the informal and formal rules, norms and organization factors that constitute political behaviour. There are three components of institutions, the first of which is government structures, which refer to the specific political arrangements of individual countries as well as the mandate

and accountability mechanisms between the government and its agencies. Policy networks are the second component of institutions and they can shape policy development and choice by uniting government with actors outside the formal government process. Policy legacies are the final component of institutions and they both shape and limit policy development and choices based on previous policy decisions and the country's constitution. The second "I' is interests, which represents a range of actors who either benefit or bear the cost of policy decisions. Finally, ideas, or the third "I", refers to knowledge and beliefs about what is and values or opinions about what ought to be [146].

The data extraction tool was piloted during the final article selection phase with the format revised and finalized. The first author then systematically applied the extraction tool to each purposively sampled article by reviewing the article in full and coding it via the tool. Extracted data were then uploaded into NVivo12 and coded data was further analyzed utilizing constant comparison methodology, which provided greater elucidation into how TIC can be defined as well as what factors explain whether and how TIC is operationalized. A reflexive journal was maintained throughout this process and central themes emerging from the data were captured. Members of the research team were consulted at various stages throughout the data collection and analysis process to ensure methodological rigor and analytical comprehensiveness.

The output of a CIS, the conceptual framework depicted in Figure 3, was developed based on analytical findings from synthesized data regarding TIC, which were identified and further refined through an iterative analytical process. Ongoing observations recorded in the reflexive journal, which captured emerging themes and

categories, also contributed to the development of the framework. Through use of thematic analysis, the conceptual framework mapped out variables that are required to conceptualize and operationalize TIC. The three categories of outcomes – service user, service provider, and service user/provider – were created based on outcome themes identified in data analysis. Once data extraction was complete, the conceptual framework was reviewed for comprehensiveness, discussed with the research team and presented to a group of expert clinicians and researchers. The framework was then revised and finalized in accordance with feedback received.

Results

Search results and article selection

Comprehensive electronic database searches and grey literature/hand searches initially identified 2,467 documents (Figure 1). After duplicates were removed (*n*=678), 1,789 titles and abstracts were reviewed in accordance with inclusion/exclusion criteria and 316 documents were selected for full-text assessment. After full-text review, a purposive sample of 98 high-quality, information-rich documents was generated (Table 1, Figure 2).

Of the 98 included documents, almost three-quarters (*n*=73) were published after 2012, whereas 14% (*n*=14) were published between 2006 and 2012 and 11% (*n*=11) were published between 2000 and 2006. None of the included documents were published prior to 2000. Thirty-five documents were from the health system, seventeen from child welfare, seventeen from education, ten from justice, nine from social services and ten

from multiple systems. These five systems were selected after full-text review, as they had the most information-rich data. Several specific systems of care, such as the military, veterans' services and refugee-specific services were present in the original search results, but available data lacked both depth and comprehensiveness. Within health, 34% (*n*=12) were empirical studies. Child welfare had ten empirical studies (59%), seven were found in education (41%), four addressed justice (40%), four were found in social services (44%) and one empirical study was found in multiple systems (10%). In total, across all systems, sixty documents (61%) were theoretical papers and 38 documents were empirical studies. Included in the empirical studies were systematic reviews (*n*=3), other qualitative approaches (*n*=3), experimental - unspecified design (*n*=11), case studies (*n*=11), and mixed methods (*n*=10). Non-empirical papers consisted primarily of commentaries, editorials or theoretical applications of TIC.

Regarding the country setting, all documents in which the context was identifiable were generated from high-income countries with 84 documents from the United States, 8 from Australia, 3 from Canada, and 1 from the United Kingdom. Two documents did not identify the country setting. Documents specific to individual systems of care also touched on varied settings. Within health, TIC literature encompasses care across the lifespan and specialty services ranging from neonatology and pediatrics to diagnostic imagery, obstetrics and gynecology to geriatrics, as a few examples. TIC literature in health also focuses on specific professions, including nursing and allied health, primary care physicians, dentists and emergency room physicians. The education system currently focuses heavily on primary education, with some literature on secondary education and

only one article addressing tertiary education. Within justice, TIC literature has been applied to juvenile justice and family court, as well as specialized courts, such as mental health and addictions. Police services, various types of law enforcement, and corrections facilities are also included in the TIC justice literature. The social services TIC literature spans broad population groups and issues, including veterans, homelessness and marginal housing, domestic violence, intellectual disabilities, immigrants and refugees.

How TIC is defined and operationalized

Two themes emerged from the literature regarding how TIC is defined and operationalized (see Table 2, Appendices 2 and 3). The first theme centers around lack of both conceptual clarity and consensus regarding definitions. Trauma is defined in a myriad of ways, ranging from very narrow biomedical diagnostic criteria to broad definitions encompassing psychosocial, cultural and historical components (see Appendix 2). Lack of consensus in the literature regarding how trauma is defined and understood is directly linked to recurring critiques of TIC, specifically that it is conceptually weak, poorly understood and therefore difficult to operationalize in a meaningful way (see Appendix 3). The concept of trauma is complex and it still lacks cohesive understanding within the literature as seen in the variety of competing definitions outlined in Appendix 2. Thus, if the concept of trauma, itself, remains contested, it is not surprising that emerging solutions to address trauma (TIC), will also lack definitional consensus and clarity. Both trauma and TIC must be concretely defined with broad consensus before TIC can be successfully operationalized in a comprehensive manner. The literature

suggests that definitional understanding of trauma must include a holistic recognition of the impact of trauma in addition to diagnostic criteria. Regarding diagnostic criteria as relevant to trauma, the current DSM-5 provides diagnostic criteria for PTSD, which has been criticized within the literature as too narrow in focus [23, 25, 147]. This is important to note as it provides contextual relevance to the definitional and diagnostic understanding of trauma; however, in-depth discussion regarding diagnostic criteria for trauma is beyond the scope of this paper. Nonetheless, a comprehensive definition and understanding of TIC needs to recognize all aspects of trauma [88, 105, 108, 148, 149].

The second theme surrounds key barriers to the operationalization of TIC, which directly links to the first theme regarding lack of TIC definitional cohesion and clarity. Barriers to operationalization primarily fall into two categories – infrastructural barriers and ideological barriers. Infrastructural barriers include inadequate resources to support operationalization, such as insecure funding and lack of validated trauma screening tools, and system design barriers, such as lack of established referral networks and insufficient availability of trauma services [40, 80, 97, 150, 151]. Ideological barriers include provider resistance to TIC due to poor understanding of trauma, perceptions of TIC as 'weak' or 'ineffective', and lack of adequate training and education on what, precisely, is TIC and how to operationalize it both vertically and horizontally [32, 37, 69, 107, 152]. These barriers are explored in greater detail below.

Conceptual framework

Context of the framework

All components depicted in the framework (see Figure 3), excluding TIC outcomes, represent the foundational elements that comprise TIC. Conversely, Figure 4 outlines factors that affect the operationalization of TIC, specifically the barriers or facilitators that help or hinder whether or not TIC is successfully implemented, but these factors are not essential to the concept itself. The language of trauma-informed *care* is intentionally used in Figure 3 in relation to both health and non-health systems to capture the essence of human service delivery systems, which is to provide some type of care to members of society in need. The concept of care is not exclusive to clinical care and it is important to recognize that non-health systems also provide care through services that seek to enhance the general welfare and well-being of individual members of society or communities as a whole. For this reason, the phrase 'trauma-informed care' is used in the conceptual framework and throughout this paper. It is also important to note that while this study focuses exclusively on five systems, TIC is not limited to these systems.

Definitions of the framework

Several concepts outlined in the conceptual framework (see Figure 3) require definitional clarity. The following bolded definitions were derived from data analysis based on an extensive review of the literature. As depicted in Appendix 2, a wide variety of trauma definitions surfaced in the literature. Based on thematic analysis, two key components of trauma consistently emerged from the various definitions. First, there is the actual traumatic event, or series of events, meaning the definitions consistently

included some type of causal impetus, which was identified as a traumatic experience that could occur as either singular or repetitive in nature [65, 66, 153-156]. Second, the various definitions captured the negative *impact* of the traumatic event or events. This second component is a central distinguishing characteristic, as the literature describes that not all individuals who have been exposed to potentially traumatic events will go on to experience a negative impact resulting from that event or events [50, 80, 82, 157]. Regarding the negative impact, many trauma definitions focused on the clinical symptoms of trauma, such as the diagnostic criteria for PTSD, or symptomology related to the individual's emotional and psychological state [35, 45, 50, 68, 80]. Thus, concept of 'internal well-being', or the way in which the trauma-affected individual internally experiences the trauma and its impact, emerged as the first category. A second category of trauma symptoms, or trauma impact, moved beyond the individual's internal experience of trauma to include relational aspects, such as struggles with emotional attachment and the ability to establish and maintain positive relationships [35, 38, 91]. Thus, a second layer of trauma impact emerged and was categorized as 'inter-personal relationships'. And finally, some trauma definitions capture the wider impact of trauma on an individual, including negative impacts on education, occupation and income, which is categorized as 'societal functioning' [10, 38, 91, 154, 158]. As shown in Figure 3, the impact of trauma is conceptualized as a layered effect, moving from the internal, to the inter-personal and finally the societal. It is important to note, however, that traumatic responses are not always uniform in nature, and while all trauma-affected individuals will experience some degree of disruption to their internal well-being, not all trauma-affected individuals will experience

disruption, or the same degree of disruption, in the second or third layers. Thus, after reviewing the literature and following several iterations of data analysis, **trauma** is defined as when an event, or series of events, overwhelm an individual's capacity to psychologically self-regulate and can negatively affect the individual's internal well-being, inter-personal relationships and functioning in society. **Trauma-informed care** is defined as a bi-directional relationship between the trauma-affected individual (who can be a consumer or provider of services) and a provider of human services (who can also be affected by trauma) within a culture fostering mutual resilience supported by an integrated referral network which allows the bi-directional relationship to occur vertically, within one system of care, and/or horizontal across other systems of care if needed. **Vertical TIC** is defined as TIC that is operationalized at the following three levels within one specific system: program (or service), organization and system. The bi-directional arrows linking these three levels indicate that vertical TIC can start from a bottom-up approach (beginning with programs or services), a top-down approach (beginning with the system) or a combination of both bottom-up and top-down approaches. **Horizontal TIC** is defined as TIC operationalized across systems that are unified by an integrated referral network. The following systems of care included in this study were derived from the data - child welfare, education, health, justice and social services. When analyzing data regarding TIC outcomes, three categories emerged. These **three outcome categories** are defined as (1) service user outcomes, which include reduction in trauma symptoms, behavioural issues and service user crisis, and improved service user engagement and retention in programs/services (2) outcomes for both service

users and providers, which include improved overall mental health and well-being, mutual respect, and an enhanced sense of safety (3) service provider outcomes, which include reduction in service provider fatigue and burnout related to secondary trauma, reduction in service provider injuries, improved service provider morale, lower staff turnover and greater collaboration amongst service providers within and across systems.

Description of the framework

As depicted in Figure 3, TIC is oriented vertically and horizontally, with the point of intersection captured via an integrated referral system. The referral network, which links vertical TIC and horizontal TIC, allows non-health systems to rapidly refer service users to trauma-specific treatment or mental health services when needed. The integrated referral network is also relevant for the health system, as different health specialities and service areas will need timely access to a trauma-specific referral system if they identify a positive trauma screen and additional support and care are required. The trauma-affected individual is situated centrally within the figure, as the purpose of all human service delivery systems is to improve the quality of life for the serviced population. The three concentric circles emerging from the trauma-affected individual reflect that trauma has a three-dimensional impact on the affected individual. First, there is the internal experience of trauma, which includes psychological distress and emotional dysregulation due to life becoming uncontrollably unsafe. Second, the individual's interpersonal relationships can be affected as trauma often leads to a profound sense of disconnect. Finally, the individual's role in and relation to broader society can be altered due to trauma sequelae

and behavioural adaptations. It is important to note that trauma can affect one, two or all three of these domains. Encompassing all aspects of TIC and the individual is a culture of resilience. It is important that individuals affected by trauma are not treated simply as victims, but that their treatment or service milieu is infused with a focus on resilience, by identifying strengths, building skills and facilitating choice. Likewise, a culture of resilience is essential for programs/services, organizations and systems rather than a culture of control with rigid inputs and outcomes. As depicted in the figure, there are fundamental components to each level of vertical TIC (see Table 2). Horizonal TIC consists of intersectoral collaboration across systems, which includes mutually established and clearly defined roles for involved service providers and the creation of a common trauma language to ensure that service providers across systems are on the same page and can efficiently communicate. Finally, on the right of the figure are the outcomes of TIC, which are divided into three categories. The circle labelled days, weeks, months and years, which encompasses outcomes, reflects that both service users and providers fall along a continuum acknowledging that a variety of complex variables contribute to individual recovery, which looks different from person to person. Outcome measurements are not time-limited as the healing trajectory is often not linear and can involve processing complex layers of issues over a prolonged period of time.

What factors explain whether and how TIC is operationalized

The results regarding whether and how TIC is operationalized are organized into two categories – political system factors and system arrangements (see Figure 4).

Political system factors

Two main categories emerged when exploring whether or not TIC is operationalized – political system factors can act as either facilitators or barriers. There are two primary facilitators that help operationalize TIC. The first facilitator is the federal state government structure, which falls under institutions. The second facilitator is ideas, specifically the epidemiology of trauma and advances in neuroscience. Three main barriers to TIC in the political system were also identified – the impact of policy legacies within institutions, the power of provider resistance in interest groups and the lack of TIC empirical evidence and conceptual clarity under ideas (see Figure 4). These facilitators and barriers will be discussed in greater detail below.

When looking at how political system factors influence the operationalization of TIC, three main themes emerged (see Table 3). First, institutional policy legacies were identified across all systems as a significant barrier to TIC (see Table 2 and Table 3). In child welfare, the legacy of standard operating procedures, which include child removal from the home and heavy reliance on use of foster homes are a deterrent to change, despite wide recognition that both procedures can be significantly traumatic for the child, particularly the instability of foster home placements [33, 46, 159, 160]. In education, the legacy of educational policy and pedagogy, particularly as it defines the scope of a teacher's role in the classroom, has created resistance to TIC amongst some educators [34, 36]. In justice, the legacy of punitive justice and traditional courthouse and corrections facilities

procedures has challenged TIC, particularly as some judicial staff have identified TIC as 'soft' and excusing bad behaviour [37, 90, 91]. The health system has a strong legacy of pathologizing symptoms and providing care based on diagnostic criteria. Lack of trauma awareness and understanding amongst health providers has been linked to the dismissal of trauma symptoms and narrow diagnostic criteria regarding trauma has limited perceived medical validity of trauma symptomology [30, 79, 107, 136]. Finally, the legacy of social services as siloed programs present a challenge to TIC [96, 97, 102, 152]. As one example, service providers in a housing program felt the inclusion of TIC was beyond their scope [97]. Addressing the impacts of policy legacies across systems of care as they relate to the operationalization of TIC will be critical moving forward.

As noted above, an identified facilitator of TIC under institutions is the government structure of federal states, which allows for easier facilitation of TIC due to the partial self-governance structure of states or provinces. This is particularly evident in the United States, where several states have already begun implementing regional and state-wide TIC initiatives [35, 151, 159]. This can also be seen in Canada, where certain provinces have developed regional or provincial TIC initiatives [154, 161, 162].

The second theme within political system factors is the role of interest groups in the operationalization of TIC. Service provider resistance to TIC surfaced repeatedly as a common theme across all systems [36, 37, 75, 97, 102, 107, 155, 160, 163]. Service providers represent a powerful interest group and their perception that TIC will create direct and diffuse costs for providers has resulted in significant resistance. The various reasons service providers are resistant to TIC include lack of time, paucity of resources, inadequate training,

provider concerns that trauma screening will cause distress in the service user, fear of not being equipped to deal with trauma disclosure, resistance to provider exposure to trauma, concerns about vicarious trauma, provider perceptions that TIC is ineffective and beyond the scope of practice, and insufficient financial infrastructure to ensure provider remuneration for services provided [36, 41, 84, 85, 90, 97, 102, 106, 107, 155, 163].

The final theme regarding political system factors is that of ideas, which includes both knowledge and beliefs about what is TIC, as well as values and mass opinion about what ought it to be. Established knowledge regarding the epidemiology of trauma as a facilitator for TIC was a common theme across all systems, with widespread recognition that trauma is pervasive and impacts all human service delivery systems [32, 35, 44]. Additionally, the literature suggests that advancements in neuroscience have also helped facilitate TIC by dispelling the pathology of trauma symptoms as 'bad behaviour' thus, making TIC more tenable to providers [35, 94, 136, 149]. There are two barriers under 'ideas' that hinder the operationalization of TIC. The first involves a paucity of empirical research regarding the effectiveness of TIC, which has just started to emerge within the last few years. Second, as discussed above, the lack of conceptual clarity and definitional consensus regarding both trauma and TIC can negatively influence the acceptance of ideas about TIC. In particular, moving to a TIC model, in any system of care, may challenge deeply held beliefs about how to help service users and the etiology of the symptoms/behaviours they are displaying. A range of competing definitions are used to describe both trauma and TIC and this diversity of definitions reflects a gap in the current literature regarding firmly established knowledge and beliefs about what trauma is and

how scientific knowledge regarding TIC can address trauma. In the absence of widespread agreement on what is TIC, the current status of TIC literature primarily consists of value-statements regarding what TIC ought to be [70, 105, 164]. This lack of definitional consensus and clarity was particularly prevalent in child welfare, education and mental health, with concerns raised regarding both the under-diagnosis and mis-diagnosis of trauma in children within child welfare and education, and in individuals suffering from mental illness and addictions at all ages within the mental health system, as there is considerable symptom overlap with other common diagnoses and disorders [45, 136, 150].

System arrangements

Systems arrangements also affect whether or not TIC is operationalized in two main ways – as either facilitators or barriers (see Figure 4). The use of service user participation to inform policy decision-making under governance and improved accessibility to trauma-specific treatment as well as multi-disciplinary teams under delivery arrangements both act as facilitators for TIC [69, 152, 165]. The lack of comprehensive financial arrangements, including inadequate insurance coverage for TIC, lack of physician TIC billing codes and non-sustainable funding as well as siloed system structure without coordinated care under delivery arrangements both act as barriers to TIC [35, 56, 136, 166]. These facilitators and barriers are discussed in greater detail below.

Several themes emerged regarding how health and social systems arrangements affect the operationalization of TIC (see Table 4). First, within governance arrangements, both policy authority and organizational authority were identified as central to TIC [32, 88, 152]. Regarding policy authority, successful operationalization of TIC requires clear policies and procedures at the program, organization, system and inter-sectoral level. Lack of consistent policies and procedures across all levels has been demonstrated to significantly impede meaningful operationalization of TIC [58, 83, 108, 110]. Regarding organizational authority, management approaches, particularly ongoing and visible support from top leadership, is noted to be essential [42, 56, 84, 155]. The second theme relates to financial arrangements. Lack of financial infrastructure supporting TIC has hindered operationalization, both within health and across other systems, as insurance plans rarely provide coverage for trauma services, which decreases accessibility to trauma services for individuals with constrained financial resources, and physicians often lack billing codes for TIC, which limits their ability to provide TIC services [46, 166]. These current financial limitations are also likely compounding the human resource shortage in trauma services as many providers have to pay out-of-pocket for TIC training and face the realities of struggling to arrange adequate compensation once they are equipped to provide TIC [46, 56]. Additionally, sustainable funding at the organization, system and inter-sectoral levels has yet to be widely established [40, 44, 167]. Within delivery arrangements, several significant factors were identified. Adequate provider training is a major component of operationalization and must include both awareness of trauma and understanding regarding its impact, as well as appropriate responses to individuals with trauma histories

[54, 66, 85]. In addition to training, provider support has been identified as critical to TIC [32, 82, 152, 155]. Service providers can also be affected by trauma, both in terms of personal trauma histories and repetitive professional exposure to trauma, particularly in child welfare and justice. Vicarious trauma, burn-out and compassion fatigue have been identified by service providers as significant barriers to TIC and adequate support to mitigate and address these issues is needed [42, 44, 88, 92, 166]. Also under delivery arrangements is the use of multi-disciplinary or inter-sectoral teams. This theme was most prominent in child welfare, education and justice, but surfaced in health and social services [36, 40, 41, 69, 70, 107, 163, 164]. It included the integration of a healthcare provider specializing in trauma into non-health systems, as well as the need for rapid referral systems that provide timely access to trauma services [45, 71, 77, 107, 152]. Across all systems, providers demonstrated resistance to trauma screening with the absence of a clear protocol for how to respond to positive screens and with the recognition that there is a lack of readily available treatment and resources [105, 168, 169].

Discussion

Principal findings

The concept of TIC has yet to achieve widespread consensus in the literature regarding definitional understanding. Furthermore, TIC remains difficult to operationalize consistently and in a comprehensive manner, in part, because the concept of trauma, which TIC seeks to address, lacks an established and accepted definition and is neither

consistently recognized or understood within systems of care. It is important to acknowledge, however, that TIC is a newly emerging phenomenon and the majority of empirical studies have been published within the last few years. Additionally, published TIC literature is disproportionately theoretical and of the 98 included articles for this study, only 38 were empirical research papers. It is not surprising, given the complexity of trauma and the newness of empirical research on TIC, that the scientific literature is still working towards establishing consensus regarding what is TIC and how best to operationalize it. TIC has demonstrated viability as an effective intervention to improve outcomes for both service users and service providers. Additionally, empirical studies indicate TIC holds potential for significant improvement in service delivery as well as positive impact on health and social outcomes, both vertically and horizontally. The fundamental components of conceptual definition and understanding, however, need to reach widespread consensus within and across systems in order to achieve meaningful operationalization. Additionally, both the infrastructural barriers (inadequate training resources, inaccessible trauma services, and lack of sustainable funding models) and ideological barriers (policy legacies and provider resistance) need to be acknowledged and addressed in order to facilitate TIC operationalization.

The conceptual framework presented in this paper positions TIC both vertically, within systems, and horizontally, across systems. Vertical TIC compromises five elements – the trauma-affected individual, programs (or services), organizations, systems, and a culture of resilience that encompasses all four preceding elements. The bi-directional interaction between the trauma-affected individual and vertical TIC produces

three categories of outcomes – service users, service providers, and a combination of the two. It is important for providers and systems to acknowledge that TIC outcomes should not be measured as a 'success' or 'failure' as outcomes will fall along a continuum based upon the trauma-affected individual's unique composition of complex variables that directly impact what their specific recovery will look like. Additionally, recovery cannot be limited to a specific period of time and the results of TIC may continue to unfold over many years.

Strengths and limitations of the study

There are three major strengths to this study and one limitation. First, the methodology of a CIS is most suited to an emerging concept, which lacks comprehensive understanding in the literature. Given that TIC is a newly emerging phenomenon with limited empirical research, the use of a CIS is a methodological strength in that it best fits with the challenges of TIC, particularly the lack of conceptual clarity and widely-agreed upon definition. Additionally, use of a CIS allowed for broad data collection, including empirical research, theoretical papers and information-rich grey literature, which was important given the scope of data required across systems, some of which were just beginning to evolve in the TIC discourse. Second, the research team held considerable clinical experience and understanding of the cross-sectoral issues of trauma and TIC. Additionally, the research team also held extensive experience in political system analysis and health and social systems arrangements, which allowed for rigorous data analysis and the development of several iterations of the conceptual framework to ensure rich

conceptual insight. Third, to our knowledge, this is the first study to examine trauma and TIC both vertically within health and horizontally across child welfare, education, justice and social services. The inclusion of data across various aspects of the health system, as well as other systems, allowed for comprehensive data collection and analysis, which resulted in the generation of a conceptual framework that provides foundational insight into definitional understanding and operationalization of TIC.

The emerging nature of TIC posed a limitation to the study as various labels and descriptors were found in the literature regarding TIC. Generated search terms were intentionally extensive in attempts to capture as much data on TIC as possible, but it should be noted that data may be missing given that TIC, at times, is discussed in the literature without express use of common descriptors or labels. In attempts to mitigate this, the first author maintained a documented list of various conceptual definitions related to TIC in the pilot phase of the search strategy, which was used to inform the finalized list of search terms. Additionally, the first author collaborated with an expert librarian on several occasions to test and revise the search terms and strategies in attempts to allay risk of missing data. It remains possible, however, that not all relevant data was included, particularly in light of the wide-ranging descriptors of TIC and lack of definitional consensus within and across systems in the literature.

Implications for policy and practice

As outlined above, TIC requires clear and coordinated policies both vertically, within systems, and horizontally across systems. These policies will need to address

political system factors, such as the role of interest groups, and system arrangements, such as the mechanisms of intersectoral collaboration, adequate financial infrastructure, and accessible resources for positive trauma screens. Specifically, clear policies need to be established outlining the roles and responsibilities of service providers and how TIC can be practiced at the program and service level as well as what TIC means at the organizational and system level. Additionally, there is some recognition in the literature that service-user input should be included in the development of TIC policies, but there has been no acknowledgement regarding how to address the inherent power imbalances that exist between service user and service provider and between service user and system that allow for service user input to be easily discarded. This is important to address as TIC policy development and implementation continues to evolve. Finally, TIC implications for practice across systems will need to consider the bounds of various service providers' scope of practice and how to utilize multidisciplinary teams to address this concern.

Regarding implications for practice, there are two important considerations. First, in order to successfully implement TIC in practice, particularly at the program and service level, it is imperative that issues stemming from provider resistance to TIC, namely lack of time, resources and support for providers, are addressed. Emerging empirical studies have shown that providers are receptive to TIC when they first fully understand what trauma is and how TIC can address trauma and, secondly, when they are adequately provided with the tools, resources and support to successfully implement TIC. Regarding the second consideration for practice, it is important to note that positive outcomes have

already been achieved resulting from changes to practice at the grass-roots level across systems. For example, despite the policy legacies of pedagogy within the education system, several American primary and secondary schools have been able to implement TIC, which has produced significant benefit to both staff and students [35, 63, 67]. Similarly positive results have been achieved in the health system, specifically in mental health services, and in child welfare and the criminal justice system. These studies demonstrate that despite the power of policy legacies, strong leadership and provider buy-in within programs and organizations can create positive change [37, 58, 79, 88, 91, 108, 151, 159, 170].

Implications for future research

As noted above, TIC is an emerging and inchoate concept and a paucity of empirical research exists on how TIC can be operationalized. Several gaps in the literature have been identified and need to be further explored. Specifically, virtually no empirical research has been generated regarding the financial infrastructure needed to support TIC. Viable financial arrangements are essential to addressing a number of current barriers to TIC, including provider training and support as well as mechanisms for rapid referral systems. The financial aspects of all of these issues need to be studied in greater detail. Additionally, much of the current research is siloed into specific systems, despite the repetitive call for inter-sectoral collaboration, and this needs to be examined further [41, 44, 105]. Intersectoral collaboration will require a multifaceted approach with buy-in within and across systems [36, 61, 90]. Greater understanding is required regarding how to facilitate this. Furthermore, TIC represents an intricate response to a complex issue and

requires collective problem-solving and the rigorous testing of postulated solutions to address system barriers, particularly institutional policy legacies. Finally, the proposed conceptual framework requires further validation both within and across systems as the field of TIC continues to evolve.

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Figure 1 – Literature search results and study flow

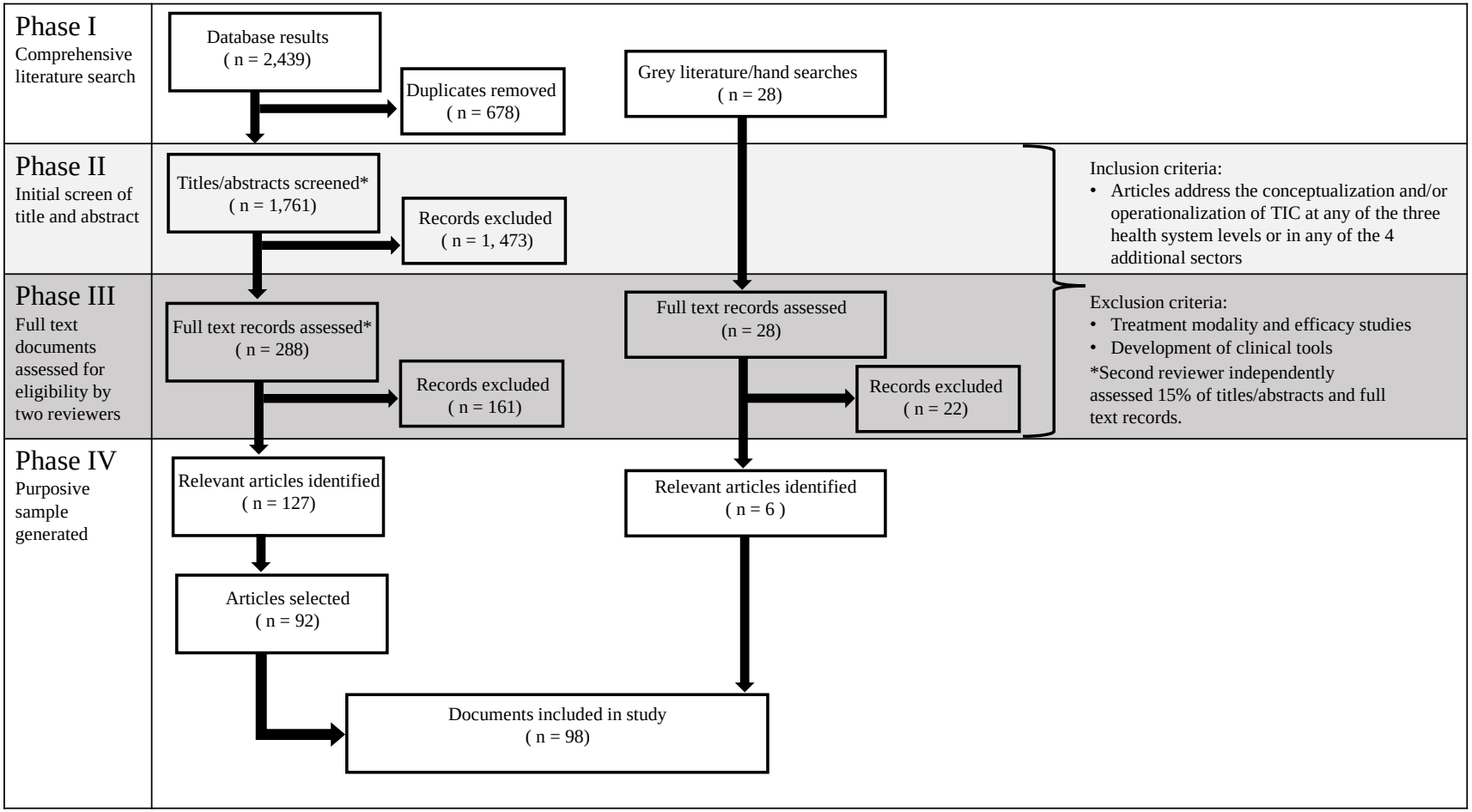

Figure 2 - Characteristics of studies in included systems of care

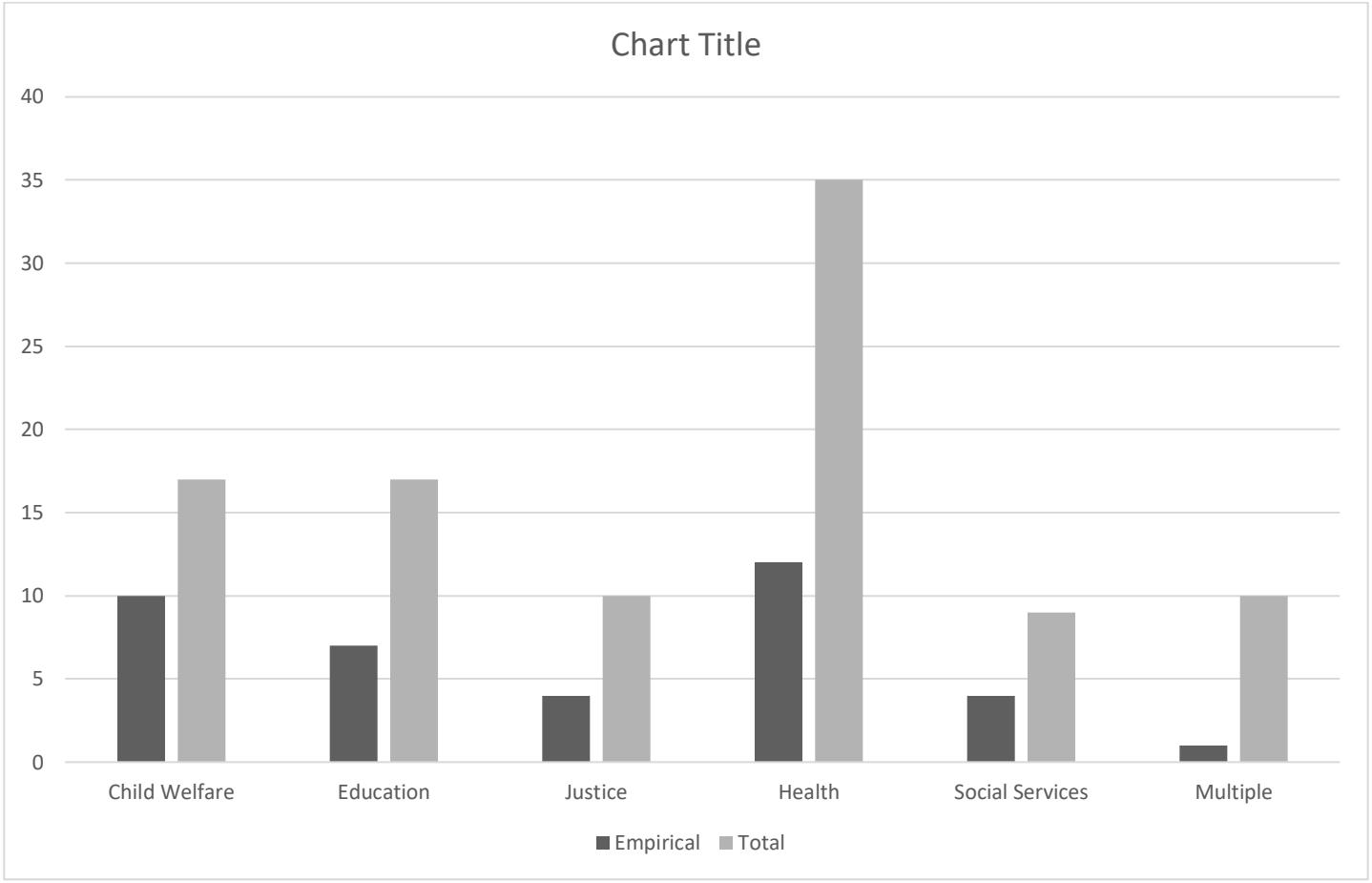

Figure 3 - Conceptual framework: How trauma and trauma-informed care are defined and operationalized

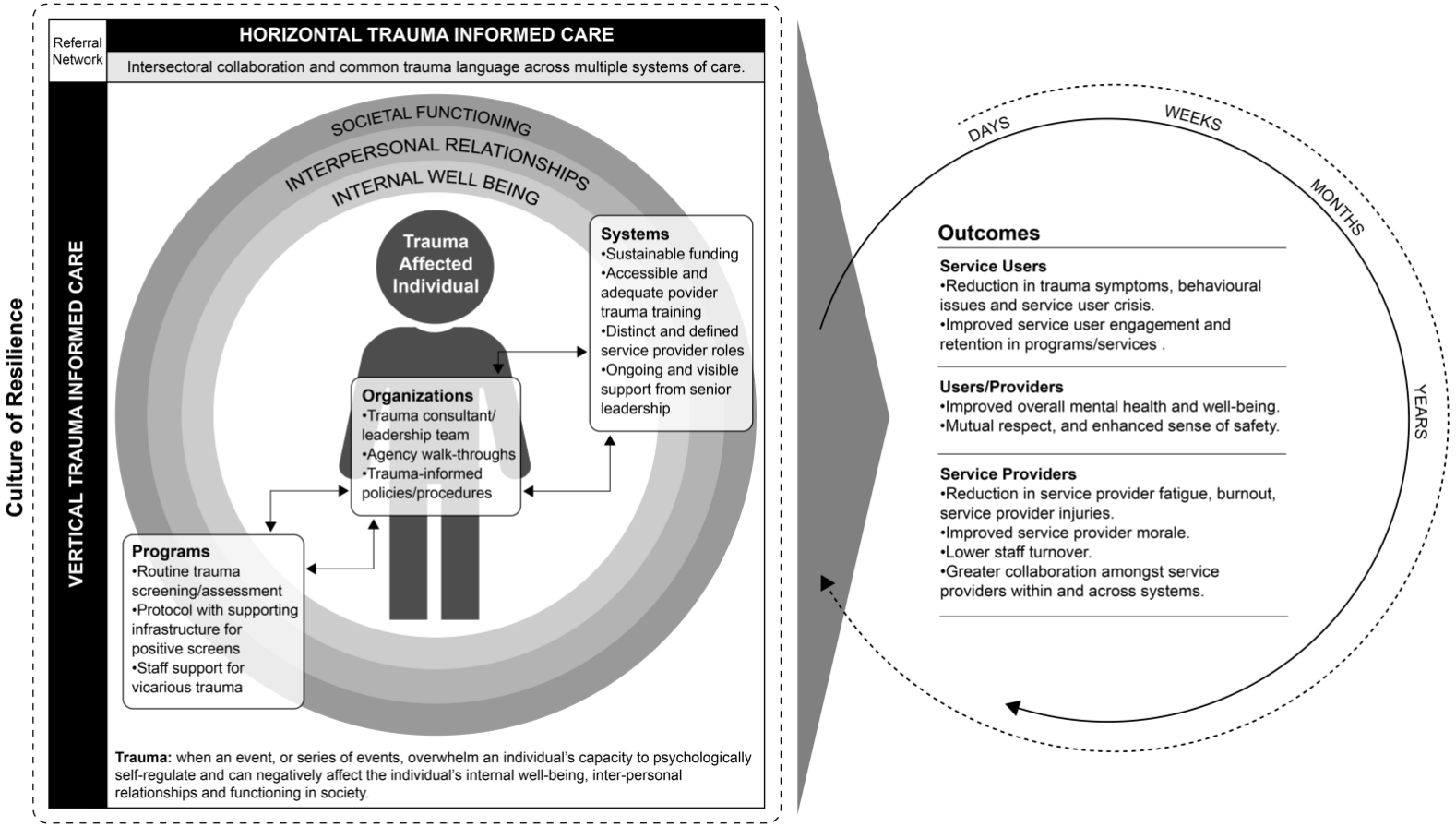

Figure 4 - Factors that affect the operationalization of trauma-informed care

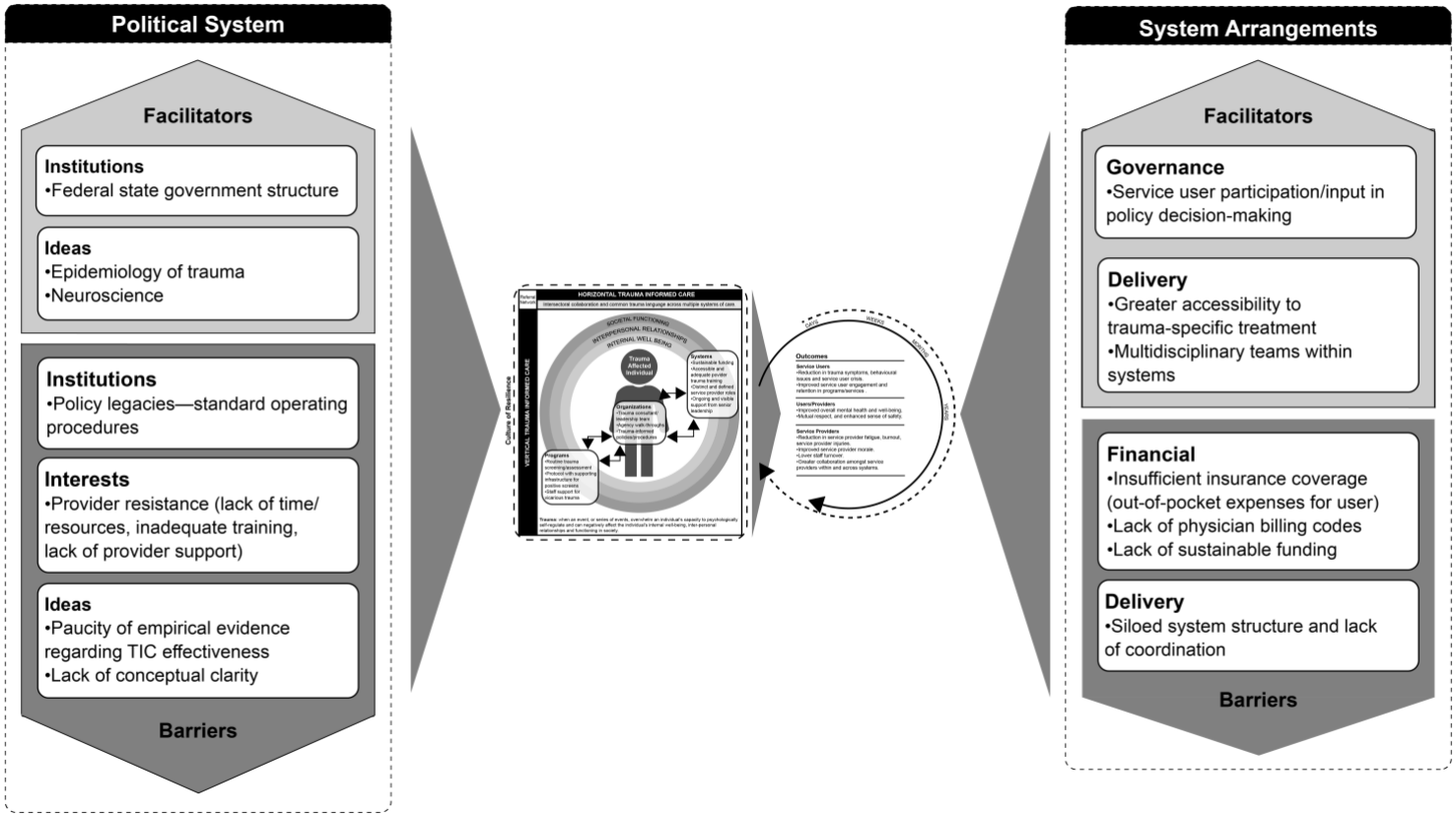

Table 1 - Characteristics of included studies

		Number of included studies
Country	USA	84
	Australia	8
	Canada	3
	United Kingdom	1
	Unknown	2
Year of publication	After 2012	73
	2007-2012	14
	2000-2006	11
	Before 2000	0
Review articles		3
Empirical studies	Qualitative case studies	11
	Quantitative studies	11
	Mixed methods	10
	Other qualitative approach	3
	Total: empirical	38
Non-empirical studies	Theoretical	45
	Commentary	14
	Editorial	1
	Total: non-empirical	60

Table 2 - How trauma-informed care is operationalized vertically within systems of care and horizontally across systems of care

Operationalization of trauma-informed care			Sources
At various levels within and across systems	Barriers	Facilitators	
Program and services • Universal trauma precautions – treating everyone as though they have a trauma history (e.g. In health, allowing patient to collect vaginal swabs; in social services, providing service users with as much choice as possible) • Universal context-adapted trauma assessment on trauma exposure and resilience skills	• Uneven commitment from front-line staff to change in practice (TIC perceived by some providers as latest hot topic) • Ambiguity of TIC – unclear to providers when TIC is actually being implemented (versus good care with a trauma lens	• Growing awareness among pockets of front-line service providers regarding need for TIC • Growing body of empirical research is beginning to demonstrate positive gains of TIC in service delivery	42, 45, 54, 60, 61, 65, 66, 69, 72, 85, 88-90, 96, 107, 108, 110, 152, 163-165, 169, 170
Organizational/systems level • Trauma education and training for all staff • Trauma-informed policies/procedures across all organizational levels • Incorporating consumer/stakeholder input into policy decisions regarding systems arrangements, including program/service delivery	• Service providers resistant to trauma awareness (screening) if system unable to respond appropriately to trauma by providing effective and accessible trauma services	• Emerging evidence demonstrates education/training can act as strong facilitator in TIC implementation • Use of trauma champion(s) and/or leadership team identified as central to operationalization	12, 32, 36, 38, 44, 55, 56, 61, 68, 88-92, 105-108, 151, 152, 160, 163-167, 169, 171-176 82-84, 136, 155, 170

• Visible senior management/executive support for TIC			
Inter-sectoral level • Recognized need to create common TIC language across all systems • Clearly identified roles/responsibilities across systems • Integrated funding across systems for TIC • Established referral networks with increased access to mental health providers specializing in evidence-based TIC	• Lack of vertical preparation within systems and horizontally across systems can limit infrastructure required for TIC as distinct approach to care (e.g. establishing referral networks to ensure trauma services readily available) • Financial infrastructure needed to support intersectoral collaboration (identify how sustainable funds can be generated and by whom) • Current lack of resources/services for positive trauma screens	• Increasingly widespread recognition of prevalence of trauma has demonstrated gap in current care across all systems • Service providers across systems recognize need for TIC and some awareness that TIC presents viable solution	36, 44, 45, 56, 61, 69, 83, 88, 90, 105, 107, 136, 152, 163, 164, 169
System-specific			
Child welfare • Universal trauma screening/assessment • Provider training on TIC including foster parents • Reduce placement instability • Close collaboration with trauma-informed mental health services (traumatized children being mis-diagnosed or under-diagnosed due to	• Institutional policy legacy: standard operating procedures (child removal/placement instability) • High staff turnover • Heavy caseloads	• Recognition of high trauma prevalence amongst children involved in child welfare services • Some regions/countries actively working on reducing re-traumatization of child welfare children, particularly harm caused by instability of out-of-home placements	32, 33, 42, 44-47, 105, 108, 151, 159, 160, 163, 177

symptomology overlap with other childhood disorders)			
Education • Incorporate TIC into educational curriculum (primary, secondary and tertiary) – students taught emotional regulation and resiliency • Create trauma-sensitive classrooms (with sensory stimulus activities to de-escalate triggered students and equip teachers to deal with vicarious trauma)	• Institutional policy legacy: traditional pedagogical approach • Some provider resistance that TIC is beyond scope of teachers	• Recognized link between trauma exposure and student academic difficulties • Increased acknowledgement that stability and structure of daily school routine is the ideal setting for creating trauma-informed education	34, 36, 59, 60, 62-64, 66-69, 150, 178
Health • Trauma screening becomes normalized, particularly in gatekeeper settings such as emergency departments and primary care • Trauma-informed approach, particularly for invasive procedures and necessity for exposure of body parts, which can be difficult and triggering for patients with trauma histories • Provider actions unique to health include full	• Institutional policy legacy: pathology of symptoms and limits of diagnostic criteria • Insufficient provider time • Lack of physician billing codes for TIC	• Growing body of scientific evidence correlating trauma exposure and negative health outcomes, particularly chronic disease (E.g. ACE studies etc.) • Empirical studies demonstrate effectiveness of TIC particularly in mental health/addictions services	1, 11, 12, 46, 56, 58, 70-73, 76-82, 84, 85, 110, 136, 152, 155, 164, 166, 168, 170, 171

explanation of appointment in advance, granting options for patient to sit or stand during exams, inquiring about patient preferences if possible, provider acknowledgement that exam/procedure may be upsetting with information provided regarding emotional regulation skills			
Justice • Judicial staff, particularly police, prosecutors and judges, trained to recognize and respond to trauma symptoms in victims, especially children/youth • Courts minimize triggers for trauma-affected individuals, particularly victims/witnesses being cross-examined • Prisons/corrections facilities aware of high trauma prevalence amongst offenders and respond appropriately	• Institutional policy legacy: punitive justice; traditional court-room proceedings - mechanisms of cross-examination and failure to acknowledge traumatic memory recall differs significantly from neutral memory recall; infrastructure of corrections facilities	• Acknowledgement of system barriers for victims of crime and potential for victim re-traumatization in justice system • Growing awareness of high prevalence of trauma amongst offenders and need to provide TIC in corrections services • Some justice systems setting precedence through incorporation of specialized mental health/addictions courts and integration of mental health/trauma services in corrections facilities	37, 38, 40, 88-92, 94, 95
Social services • Trauma-informed case management, which focuses on preventative measures (crisis interventions planned in coordination with service user) and moving past	• Institutional policy legacy: siloed services • TIC least developed conceptually in comparison to other systems – in current literature TIC is not clearly distinct from good care	• Increasing recognition of high trauma prevalence amongst social services populations including the homeless, veterans, refugees and immigrants, domestic violence and intellectual/developmental disability services	51-55, 96, 97, 102, 179, 180

symptom management/reduction to focus on skills-building and resiliency			

Table 3 - Political system factors that influence how trauma-informed care is operationalized

Political system factors	Relevant themes	Relationships with other factors	Key examples from literature		Sources
			Barriers	Facilitators	
Institutions	- Limited evidence on how TIC is affected by institutions	- Limited government support may reflect lack of substantial empirical evidence detailing effectiveness of TIC	- Cyclical nature of elected parties within government structures can be barrier to achieving sustainable, long-term government support, particularly as TIC very new and relatively untested concept - Policy legacies related to past decision-making in siloed structure of public bureaucracies creates significant challenge to implementing cross-sectoral approach to TIC	- The government structure of federal states can more easily facilitate uptake of TIC given the partial self-governing of states or provinces, such as the US in which certain states have already begun implementing TIC at the state level	35-37, 40, 90, 94, 151, 155, 160, 163, 181
Interests	- Professional organizations can act as either facilitator or barrier to TIC implementation depending on if	- Some interest groups are using empirical evidence (ideas) to demonstrate need for TIC within workplace or	- Some professional groups resistant to TIC's call for role expansion (e.g. teachers implementing trauma interventions in classroom)	- When relevant interest groups (e.g. professional organizations) "buy-in" to implementation of TIC and are adequately supported (management, personal support services to address vicarious trauma) they can act as a facilitator - Interest groups recognize service providers can benefit from TIC as evidence outlines prevalence of vicarious trauma amongst service providers across	36-38, 41, 42, 55, 66, 67, 70, 84, 85, 89-92, 94, 97, 102, 107, 108, 151, 155,

	support or resist TIC	service area, including evidence on prevalence of vicarious trauma amongst providers		systems and specific providers have begun advocating for workplace TIC to support staff	159, 160, 163, 170, 178
Ideas	*Knowledge and beliefs* - Rationale for TIC uses empirical evidence to demonstrate need (epidemiology of trauma) - Empirical studies in field of neuroscience suggest need for trauma-informed services - Routine screening for trauma exposure/impact identified as essential across systems *Values and mass opinions*	- Increased awareness of empirical evidence on trauma has generated interest group support for TIC - Lack of substantial empirical evidence on effectiveness of TIC likely contributing to limited government support (institutions)	- TIC lacks conceptual clarity (divergent values regarding what TIC 'ought to be' reflected in projection of implementation strategies)	- Research evidence suggests population need for TIC	32, 35, 44, 68, 105, 156, 167, 174 1, 30, 32, 37, 41, 51, 54, 55, 67, 76, 79, 88, 92, 107, 110, 155, 156, 170, 179

	- Perspective shift from pathologizing behaviour to recognizing role of trauma in behaviour				

Table 4 – System arrangements that influence how trauma-informed care is operationalized

System arrangement factors	Relevant themes	Relationships with other factors	Key examples from literature		Sources
			Barriers	Facilitators	
Governance arrangements	**Policy authority**				
	Centralization/decentralization of policy authority	Policy (and funding) support from relevant levels of policy authority identified as critical for sustainable implementation of TIC (C6)	Coordinating policy authority across systems may be challenging	Decentralization of policy authority can enable more efficient implementation of TIC, as seen in some states in the US	32, 35, 44, 56, 61, 83, 88, 89, 105, 107, 152, 169
	Organizational authority				
	Management approaches	Senior management "buy-in" for TIC identified as critical, particularly in relation to staff support; Management engagement with front-line staff seen as important for sustained commitment by staff to TIC	Front-line staff feel less supported in TIC and less motivated to embrace TIC implementation if regular management presence lacking	When administrators/executives provide strong leadership for TIC, increases feasibility and sustainability of implementation	32, 82, 84, 110, 136, 152, 160, 164, 170, 171, 173, 174
	Networks/multi-institutional arrangements Collaborative, intersectoral training argued to be more cost-effective and practical (establishing common language, clear roles/responsibilities amongst agencies)	Intersectoral collaboration, particularly close collaboration between mental health providers and relevant systems (justice, social services, education, child welfare)	Lack of common language Lack of timely referral process (to mental health services) Lack of integrated funding	Increased recognition within systems of need for trauma-informed, mental health services	36, 44, 50, 56, 83, 88, 89, 105, 107, 108, 152, 163, 169

	Continuity of care/collaboration across systems	identified as central element of TIC			
	Consumer & stakeholder				
	Consumer participation in policy and organizational decisions	Consumer participation at this level allows critical insight from service users to contribute to service delivery design	Service users invited to participate in decision-making might hesitate out of concern that involvement may impact their care	Increasing awareness across systems at the system level of importance in facilitating service user feedback to monitor system performance Can be personally meaningful and empowering for service users	42, 56, 88, 110, 152, 165, 169, 170
	Consumer participation in system monitoring	Participation of service users on advisory boards reviewing user feedback can provide important insight for providers into contextual factors regarding feedback	Inherent power dynamics can allow for easy dismissal of service user input	Increasing awareness across systems at the system level of importance in facilitating service user feedback to monitor system performance Can be personally meaningful and empowering for service users	88, 165, 169
	Consumer participation in service delivery	Appropriate use of peer support/mentorship in TIC is cost-effective and helps mitigate current shortage of service providers trained in TIC	Paucity of research examining use of peer support/mentorship in TIC	Use of peer support/mentorship in TIC can empower service users and minimize power imbalance between provider and consumer	42, 56, 90, 169

	Stakeholder participation in policy and organizational decisions or monitoring	Stakeholder participation in policy/organizational decisions regarding operationalization of TIC created better provider "buy-in" increasing effectiveness of provider delivery/implementation of TIC	Importance of stakeholder participation not widely recognized in literature	Participation via feedback in provider training provides built-in opportunity to incorporate stakeholder participation	42, 50, 166, 169
Financial arrangements	**Financing systems**				
	Private insurance in health has been the only system-level, revenue-raising mechanism identified in the literature	Financial arrangements are an integral component to sustainable TIC delivery arrangements and implementation strategies; without established TIC financial infrastructure for system financing, the delivery and implementation of TIC is weakened	Developing a financial system for TIC will be challenging given TIC operationalization remains inchoately understood More rigorous evaluation of TIC outcomes likely needed first to justify opportunity costs of TIC system-level financing	The financial cost to systems in not providing TIC has been identified in the literature Cost-sharing across systems can increase efficiency and reduce overlap (shared funding of combined staff training across systems when appropriate, such as justice and mental health/addictions)	41, 74, 85, 107, 164, 169
	Funding organizations				
	Prospective payment	Adequate prospective payment for TIC directly relates to feasibility of delivery arrangements and implementation strategies; lack of established financial arrangements currently	Anticipated implementation costs, such as staff training and development, consultation fees, costs related to creation of trauma tool kits etc., have not been		40, 106, 182 152, 183-185

		poses significant barrier to sustainability of TIC	widely incorporated into organizational funding mechanisms and lack of funding has been cited across systems as a barrier		
	Remunerating providers				
	Fee-for-service	Healthcare providers are much less likely to provide TIC if they are not able to be reimbursed for services provided	The lack of an established billing codes for TIC is a significant barrier, even when training and consultation is provided free of charge	Research indicates a growing awareness and willingness amongst providers for TIC if they are paid/reimbursed	46, 166
	Purchasing products & services				
	Scope & nature of insurance plans	Service providers across systems will likely not provide TIC if mechanisms lacking for remuneration of TIC services	Partial or absent insurance coverage for TIC and trauma-specific services has been identified as central barrier across the systems for both service users and providers		74, 107, 169, 186
	Restrictions in coverage/reimbursement rates for organizations, providers, & services		Only certain psychiatric diagnoses qualify for reimbursement and not all psychiatric services are eligible for full reimbursement		187, 188
	How care is designed to meet consumers' needs				

Delivery arrangements	Availability of care	Expanding availability of TIC requires stable funding infrastructure and sufficient workforce	Current lack of funding for staff training and TIC service delivery Providers reluctant to assess for trauma when low availability of and accessibility to trauma services and care	Increasing awareness within and across systems of need for TIC	32, 36, 37, 41, 44, 69, 72, 77, 80, 90, 92, 105, 106, 152, 159, 160, 163, 168, 169
	By whom care is provided				
	System – Need, demand & supply	Identified need for more MH professionals trained in evidence-based trauma-informed treatment; providers reluctant to complete universal trauma screening if they are unable to refer/provide adequate supports/treatment to respond to positive screens	Lack of established, secure financial arrangements for provider training and remuneration will continue to be barrier, despite increasing recognition for more professionals to be trained in TIC	TIC being incorporated into the curriculum of some university-level provider training programs	32, 41, 44, 89, 105, 106, 159, 160, 163, 169
	Skill mix – Role expansion or extension	Clear delineation of service provider roles within and across systems needs to be outlined in governance arrangements and incorporated into provider training	Some service providers outside health system concerned that providing TIC is beyond their scope of practice	Intersectoral collaboration, including a referral network to appropriate services for positive trauma screens, has been outlined in literature to support non-health service providers in TIC	61, 167

	Staff - Training	Sufficient workforce with appropriate training is essential to adequate service delivery	Empirical research identifies some providers are uncertain as to how TIC differs from "good care" due to current ambiguity of TIC conceptualization Evaluation tools to measure TIC outcomes remain poorly defined and tested, which limits feedback to staff regarding impact of TIC	Service providers cross-trained in TIC are better equipped to identify and handle the complex etiology of trauma Increased TIC awareness through staff training can enable providers to more readily identify trauma symptoms and facilitate referrals to necessary services	36, 42, 44, 50, 55, 56, 58, 61, 68, 83, 84, 88, 90, 91, 110, 136, 151, 152, 155, 165-167, 169, 170, 174, 176, 189
	Staff – Support	Recognition of prevalence of vicarious trauma amongst service providers holds implications for governance arrangements (policies, management approaches) and financial arrangements (providing medical benefits)	Denial or rejection of vicarious trauma acts as barrier to TIC (staff burnout, retention problems, resistance to TIC when staff not supported in dealing with vicarious trauma)	Acknowledgement of vicarious trauma is becoming more culturally acceptable in systems, such as justice, where traditionally it was seen as weak Need for adequate support services for providers dealing with vicarious trauma emerging as prominent theme in literature	42, 88, 92, 155, 160, 169, 176, 190
Implementation strategies	**Consumer-targeted**				
	Information or education provision	Intention of human service delivery systems often includes helping	Service users have identified insufficient provision of	Studies in neuroscience indicate the brain can recover from trauma	44, 56, 165

	Skills and competencies development	individuals in need through provision of information/education and skills	information/education on self-management of trauma symptomology due to lack of TIC or poorly trained staff	when the right tools and skill-set are provided Emerging empirical research suggests information/education and skills development can empower service users to better manage trauma symptoms	56, 165
	Culturally appropriate care	Recognizing unique needs across diverse population groups is a critical component of TIC and directly relevant to design of governance and delivery arrangements	Some service providers have indicated high-volume caseloads limit time needed to establish and provide for specific cultural needs	The principles of TIC provide a platform for culturally sensitive care by addressing power imbalance and attentiveness to unique needs	44, 54, 56, 152, 165
	Provider-targeted				
	Educational material	Directly relates to staff training and sufficient workforce for service delivery	Conceptualization and operationalization of TIC currently poorly defined and established	Growing body of empirical research on operationalization of TIC across different settings is providing important insight	38, 56, 61, 69, 83, 84, 94, 96, 108, 151, 165-167, 170, 171, 178
	Organization-targeted				
		Organizational policies/procedures incorporating TIC reflect serious commitment by senior leadership/management, which acts as impetus for increased staff	Lack of organization-targeted implementation strategies acts as barrier as it isolates front-line staff in bearing full responsibility for TIC	Organizational self-assessment tools (e.g. agency walk-throughs and various toolkits) for TIC Align policy and practice to principles of TIC	32, 38, 44, 58, 64, 68, 71, 82, 84, 88, 90, 92, 106, 108, 109, 136, 163-165, 167, 169-

		compliance in TIC implementation		Increased recognition of organizational role in re-traumatization of service users when TIC not provided	171, 174, 176, 189

Appendix 1 – Data Extraction Tool

Document title:

Document ID:

Type of document:

Empirical Research			
Quantitative Systematic review RCT Before/after study	Qualitative Case study Grounded theory Qualitative descriptive	Mixed Methods	Other Specify
Non-research			
Review (non-systematic)	Theory Discussion Policy Position paper	Commentary Editorial	Website

Trauma
Not defined
Individual trauma defined
SAMHSA definition
DSM definition
Toxic stress
Types of individual trauma
Sexual abuse
Violence
Psychological abuse
Neglect
Single incident external event
Car accident
Natural disaster
Terrorist attack
Developmental
Complex
Intergenerational/historical
Neurobiology of trauma
Neuroscience

Trauma-informed Care	
TIC	Less staff turnover
Not defined	Better staff morale
Trauma awareness	**Critiques of TIC**
Change perspective (what's wrong with you to what happened to you)	Lack of consensus on definition
	Lack of conceptual clarity
Recognize trauma epidemiology	Unclear how to operationalize concept
Recognize widespread, complex impact of trauma	TIC limited to awareness and good care
	Funding/financial constraints
Recognize trauma symptomology in	**Barriers to implementing TIC**
Patients	Insufficient clinical time
Families	Lack of training
Staff	Lack of managerial/organizational support
Others involved in system	**Rationale for TIC**
Understand potential paths of recovery	Not identified
Response – trauma knowledge integrated into all policies, procedures and practices	Epidemiology
	ACEs
Resist re-traumatization	Statistics
TIC embedded within good care	Individual well-being
SAMHSA 6 key principles	Trauma sequalae
Safety	Increased medical co-morbidities
Trustworthiness etc.	Behaviour maladaptions
Operationalizing TIC as distinct concept	Mental health/addictions
Staff training & education	Non-compliant health behaviour
Trauma screening	Misdiagnosis
Systematic tool	Incorrect treatment
Part of general history	Lack of improvement
Assess trauma impact	Societal implications
Trauma-specific services	Early intervention
Trauma-specific interventions	Decreased societal costs
Agency assessments	Lack of trauma awareness
Identified TIC model	Increased societal costs
SAMHSA	Increased healthcare utilization
Sanctuary	Poor school/academic performance
Results of implementing TIC	Juvenile justice interventions
Observable and measurable	Criminal justice system
Less violence	Decreased employment
Better client outcomes	Unstable housing
Decrease in symptoms	Increase in social services usage
Retention in programs/follow-up	**Necessary next steps**
Reduction/elimination of coercive interventions	Consensus on clear definition
	Conceptual clarity regarding operationalization
	Consistency across different systems

Program and Service Areas	

Health
▪ Services
  ▪ Primary care
  ▪ Mental health & addictions
  ▪ Co-occurring disorders
  ▪ Reducing use of restraints
  ▪ Intimate partner violence
  ▪ OB/GYN
  ▪ Pediatrics
  ▪ Pediatric ICU
  ▪ NICU
  ▪ Emergency
  ▪ Dentistry
  ▪ Geriatrics
  ▪ Dementia services
 	
▪ Provider of service
  ▪ GP
  ▪ Specialist MD
  ▪ Dentistry
  ▪ Nursing
  ▪ Social work
 	
Child and youth services
▪ Adoption services
▪ Caregiver support
▪ Special needs trauma services
▪ Child protection
▪ Child welfare
 	
Community and social services
▪ MH/addictions services
▪ Trauma recovery programs
▪ Traumatic grief
▪ Domestic violence programs
	Culture and gender
	▪ Gender equality
	▪ Gender specific
	  ▪ Male
	  ▪ Female
	▪ Cultural competence training
	
	Education
	▪ Pre-primary education
	▪ Primary education
	▪ Secondary education
	▪ Tertiary-higher education
	▪ Curriculum
	▪ Role of teacher
	▪ Student needs
	  o How trauma disrupts learning
	
	Housing
	▪ Homelessness
	▪ Access to housing
	▪ Temporary housing
	▪ Public/social housing
	
	Justice
	▪ Adult court system
	▪ Juvenile justice
	  ▪ Prevalence of trauma in justice-involved youth
	▪ Police interaction
	▪ Court process
	▪ Incarceration
	  ▪ Trauma needs in corrections facilities
	  ▪ Trauma services in corrections facilities
	
	Integration of services:
	▪ Health

▪ At-risk populations ▪ Community supports ▪ Community development ▪ Emergency response and preparedness ▪ TIC in social policy development	▪ Child and youth services ▪ Community and social services ▪ Culture and gender ▪ Education ▪ Housing ▪ Justice **Target of service:** ▪ Veterans ▪ Homeless ▪ Incarcerated ▪ Indigenous/aboriginal ▪ Human trafficking victims ▪ Intellectual and developmentally disabled ▪ Refugees

Governance Arrangements	Financial Arrangements	Delivery Arrangements	Implementation Strategies
Policy authority Centralization/decentralization of policy authority Accountability of the state sector's role in financing & delivery Stewardship of the non-state sector's role in financing & delivery Decision-making authority about who is covered and what can or must be provided to them **Organizational authority** Ownership Management approaches Accreditation Networks/multi-institutional arrangements **Professional authority** Training & licensure requirements Scope of practice Setting of practice Continuing competence Quality & safety Professional liability **Citizen & stakeholder involvement** Citizen participation in policy & organizational decisions Citizen participation in system monitoring Citizen participation in service delivery	**Financing Systems** Taxation Social insurance Community-based insurance Community loan funds Private insurance Social savings accounts (individually financed) User fees Donor contributions Fundraising **Funding organizations** Fee-for-service (funding) Capitation (funding) Global budget Case-mix funding Targeted payments/penalties (funding) **Remunerating providers** Fee-for-service (remuneration) Capitation (remuneration) Salary Episode-based payment Fundholding Targeted payments/penalties (remuneration)	**How services are designed to meet citizens' needs** Availability of services Timely access to services Culturally appropriate services Trauma-informed services Case management Package of services/service pathways Group services **By whom services are provided** System – need, demand & supply System – recruitment, retention & transitions System – performance management Workplace conditions – provider satisfaction Workplace conditions – health & safety Skill mix – role performance Skill mix – role expansion or extension Skill mix – task shifting/substitution Skill mix – multidisciplinary teams Skill mix – volunteers or caregivers Skill mix – communication & case discussion between distant professionals Staff – training Staff – support Staff – workload/workflow/intensity Staff – continuity of services Staff/self – shared decision-making Self-management **Where services are provided** Site of service delivery Physical structure, facilities & equipment	**Citizen-targeted strategy** Information or education provision Behaviour change support Skills & competencies development (Personal) support Communication & decision-making facilitation System participation **Provider-targeted strategy** Training, unspecified Educational material Educational meeting Educational outreach visit Local opinion leader Locus consensus process Peer review Audit & feedback Reminders & prompts Tailored intervention Citizen-mediated intervention Multi-faceted intervention **Organization-targeted Strategy** Staff – training/education Policies/procedures Organizational approach Universal trauma precautions Universal trauma screening Trauma-specific services **System-targeted strategy** Tiered approach Trauma informed Trauma responsive Trauma specific Trauma referral networks

Citizen complaints management Stakeholder participation in policy & organizational decisions (or monitoring)		Organizational scale Organizational structure Integration of services Continuity of services Outreach	

Appendix 2 - Various definitions conceptualizing trauma

Term	Definition	Sources
Trauma	Can involve a single experience or enduring repeated events that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved in that experience(s)	153
Individual trauma	Results from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."	34, 57, 61, 62, 71, 155, 169
Simple trauma/single incident trauma	An unexpected or overwhelming single incident or short-term event that is life-threatening or threatens bodily injury or serious harm	65, 66, 167, 176
Complex trauma	Describes both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure; these events are severe and pervasive, such as abuse or profound neglect	33, 35, 45, 65, 66, 95, 163, 169, 176, 178
Developmental trauma	On-going and repetitive trauma that occurs during a child's development years and disrupts the child's healthy attachment and development	155, 176
Type 1 Trauma vs. Complex/Type 2 trauma	Type 1 trauma = exposure to single, traumatizing event Type 2 trauma = multiple exposure to trauma over a pro-longed period of time	155, 156
Complex trauma history	A history of chronic interpersonal caregiver-related traumas consisting of at least two interpersonal trauma types (i.e. physical/sexual/emotional abuse, domestic violence, neglect)	191
Positive stress	Stressful experiences that promote and are necessary for healthy adaptation and development	45
Tolerable stress	Stressful experiences that children are able to manage with help by protective factors, such as an attuned parent	45
Traumatic stress	Can be defined by its unpredictability and the feelings of horror and helplessness it elicits	36
Toxic stress	Stress that is so emotionally costly that it can affect brain development and other aspects of a child's/individual's health; Excessive, frequent, or prolonged activation of physiological stress response systems in the absence of the protection afforded by stable relationships with adults	36, 45, 82
Extreme form of stress	Exposure to trauma that affects a child's brain development and can cause adverse reactions in all areas of life, including behaviour and learning	35
Acute stress disorder	Significant post-traumatic stress symptoms that emerge within one month of traumatic event	80

Post-traumatic stress symptoms	Re-experiencing the event or intrusive thoughts, avoidance of trauma reminders, hyperarousal, dissociation, and negative changes in mood or cognition	82
Psychological wound	Conceptualization of abnormal stress in the 19th century	192
Post-traumatic stress disorder	Post-traumatic stress symptoms that persist for greater than one month and result in impaired functionality	57, 74, 80
Potentially traumatic event	A potentially traumatic event is a powerful and distressing experience that is life threatening or poses a significant threat to a person's physical or psychological well-being. This event may have little impact on one individual while another individual exposed to the same event can go on to develop symptoms of post-traumatic stress.	50, 80, 82, 157
Secondary trauma/secondary traumatic stress	A trauma-related stress reaction and set of symptoms resulting from exposure to another individuals' traumatic experiences rather than from exposure directly to the traumatic event	60, 68, 160, 169
Vicarious trauma	Defined as "the taking in of the experiences, emotions, and reactions of trauma survivors"; often used interchangeably with secondary trauma	60, 160, 169
Social trauma	Traumatic experiences resulting from inequality, poverty, marginalization and racism	155
External trauma	Trauma resulting from an external, non-personal force (E.g. Natural disaster, accidents, poverty)	
Historical/ intergenerational trauma	Psychological and emotional consequences of traumatic experience are transmitted to subsequent generations through physiological, environmental and social pathways resulting in an intergenerational cycle of trauma response	155, 176
Traumatic grief	Childhood traumatic grief: follows death of someone important to the child when the child perceives the experience as traumatic. The death may have been sudden/unexpected or anticipated, trauma symptoms interfere with the child's ability to go through the typical process of bereavement.	193

Appendix 3 – Various definitions conceptualizing trauma-informed care

System	Term	Definition	Sources
General	Trauma informed	A program, organization or system that is trauma-informed (1) Realizes the widespread impact of trauma and understands potential paths for recovery (2) Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system (3) Responds by fully integrating knowledge about trauma into policies, procedures and practices (4) Seeks to actively resist re-traumatization	[194]
Child welfare	Trauma-informed care	A practice in which all involved within an agency/service system develop and maintain an awareness of the impact of traumatic experiences on children, caregivers and services providers, leading to the application of appropriate responses, training, practices and polices	[44]
	Trauma-informed care	An approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as aspects of organizational function; a core concept of TIC is universal precaution – presume every person in the treatment setting has likely been exposed to abuse, neglect, persistently overwhelming stress or other traumatic experience	[42]
	Trauma-informed care	A strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors and that creates opportunities for survivors to rebuild a sense of control and empowerment	[106]
	Trauma-informed child welfare system	One in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, and those who have contact with the system. Programs and organizations within the system infuse this knowledge, awareness and skills into their organizational cultures, policies and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.	[106]
Education	Trauma-informed schools	Create educational environments that are responsive to the needs of trauma-exposed youth through implementation of effective practices and systems-change strategies	[167]
	Trauma-sensitive school	One in which all students feel safe, welcomed and supported and where addressing trauma's impact on learning on a school-wide basis is at the center of its educational mission.	[181]
	Trauma-informed school	Realizes the prevalence of trauma in children; recognizes the physiological and relational impact of trauma on students and school personnel; responds by translating this knowledge into practice as part of school-wide supports; reduces re-traumatization by adopting practices that promote healing and growth rather than punishment and exclusion	[59]

	Trauma-informed education	Can be conceived as (1) deficit perspective – what deficiencies or developmental struggles does this student face? (2) strengths perspective – what positive strengths does this student have to build upon for future success?	65
Health	Trauma-informed primary	Good patient-centered care at its core.	71
	Trauma-informed care	An approach to working with participants that assumes the possibility of a trauma history in anyone who walks through the door	54
	Trauma-informed care	Recognizing and planning for detecting and treating the disorders that result after traumatic events	74
	Trauma-informed	Systems of care must be grounded in a thorough knowledge of the complex biopsychosocial implications of exposure to toxic stress, adversity and traumatic life experiences. Our philosophy is guided by a fundamental belief: “Hurt people hurt people”	164
	Trauma-informed care principles in in-patient mental health	Recognizing that violence and victimization play a central role in the lives of hospitalized consumers and a person’s symptoms are understood as attempts to cope within the context of one’s life experiences, history and culture	30
	Trauma-informed care	In contrast to trauma-specific treatments, which use direct counseling techniques and interventions to reduce trauma symptoms, TIC is more ambitious, aiming to transform entire systems of care by embedding an understanding of traumatic stress response in all aspects of service delivery and placing priority on the individual’s safety, choice and control. This philosophy aims to create a treatment culture of nonviolence, learning and collaboration in which a universal precautions approach is highlighted in all environmental and interpersonal interactions.	58
Justice	Trauma-informed care	It has as primary goals accurate identification of trauma and related symptoms, training all staff to be aware of the impact of trauma, minimizing re-traumatization, and a fundamental “do no harm” approach that is sensitive to how institutions may inadvertently re-enact traumatic dynamics	37
	Trauma-informed system of care	Engages young people and their families with histories of trauma by recognizing their trauma symptoms and appreciating the significance of trauma in their lives.	

	Trauma-informed approach to juvenile justice	Takes into account the traumatic experiences youth have endured when responding to their behavior, recognizing reduced culpability when trauma is an underlying cause of a child's offending and promoting resiliency for youth/families	[88]
Social Services	Trauma-informed care approach	Recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues	[51]
	Trauma-informed care	A philosophy of service delivery in response to awareness of organizations as a context for potential traumatization and/or re-traumatization of persons receiving services and those providing services	[102]
	Trauma-informed care	An organizational change process that is structured around the presumption that everyone in the agency (from clients through agency management) may have been directly or indirectly exposed to trauma within their lifetime	[55]
	Trauma-informed care	A perspective that acknowledges the pervasive influence and impact of trauma on an individual, their provider and the organization delivering case management and other supportive services. There is no singular definition of what constitutes TIC, but across descriptions there are three recurrent themes: (1) basic understanding of trauma (including behavioural responses to and symptoms of trauma, training, consultation and supervision in screening, assessment, and treatment), (2) creating an environment of physical and emotional safety for the trauma survivor and providers (i.e. ensuring privacy, confidentiality, respecting cultural differences, and awareness of trauma triggers), and (3) adopting a strengths-based approach to services (i.e. fostering skill-building, mastery, resiliency and rebuilding control through choice and empowerment)	[97]
	Trauma-informed care	A philosophy of service delivery that was developed in response to an increased awareness of the prevalence and impact of trauma throughout the life course; it represents an organizational commitment to a culture based upon principles of choice, collaboration, empowerment, safety and trustworthiness, which is sensitive to the needs of persons who have experience trauma; although TIC is not intended to treat trauma symptomology, it identifies traumatic experiences as central to one's identity and urges sensitivity toward the potential for pathology associated with prior trauma to manifest in a person's present circumstances; the adoption of TIC often requires a cultural shift for an organization; TIC acknowledges the likelihood of trauma in the lives of service recipients and service providers; TIC focuses on a standard of care that fosters the well-being of an individual with	[52]

		his/her interests and desires at the core of what and how support is given; within TIC, behaviours that appear maladaptive may be identified as attempts at self-regulation and coping with trauma sequalae.	
	Trauma-informed system	Issues of power are constantly explored and evaluated in an effort to help people who have seem themselves as victims begin to challenge that role in a safe setting. The trauma-informed model posits that with this new ability to challenge a passive "illness" role, people will become empowered to confront other areas of their lives in which they have felt powerless	[53]

Chapter 3

Preface

Building on the previous chapter, this study examines how trauma-informed care is utilized in adult mental health policy documents in Ontario, Canada. The Ontario Government Documents database was searched and relevant documents were selected as per study inclusion criteria. Extracted data were analysed in accordance with the conceptual framework developed in Chapter 2 as well as a prominent political science framework on agenda-setting.

I was responsible for developing the research question as well as the study design and I completed data collection and analysis. Dr. Julia Abelson and Dr. Gillian Mulvale contributed to the study design and methods as well as data collection and analysis. They also provided ongoing feedback on the chapter as it was drafted. Dr. Anne Niec provided feedback on full chapter drafts including commentary on the tables, figures and appendices.

Exploring the role of trauma-informed care in Ontario's adult mental health policies: A document analysis

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Key words: trauma, trauma informed care, mental health, document analysis, Ontario, Canada

Word count: 7, 978 (main text)

Abstract

Introduction

Recent developments in neuroscience and related epidemiology studies have led to increased awareness of both the prevalence and consequences of trauma. In response, the concept of trauma-informed care (TIC) has gained rising prominence due, in part, to emerging empirical evidence demonstrating the effectiveness of TIC, particularly in mental health and addictions services. This study seeks to answer whether, how and under what conditions has TIC been defined and utilized in adult mental health (MH) policy documents in Ontario through the utilization of a qualitative document analysis.

Methods

This study follows a document analysis methodological approach with data analysed according to thematic analysis. Data extraction and analysis regarding 'whether and how' were guided by a recently developed conceptual framework on TIC and 'under what conditions' was examined through application of Kingdon's Multiple Streams Framework. Extracted data were imported into NVivo software and coded according to the two frameworks listed above. Codes were then further analysed and organized into themes.

Results

Key-word searches in the Ontario Government Documents database yielded 38 results, of which six met the inclusion criteria. While five documents recommend TIC, only two define trauma and TIC. Although TIC has been repeatedly recommended as a policy solution to addressing service delivery problems in Ontario, it remains poorly defined and operationalized. TIC did emerge on the government's decision agenda between 2009 and 2010 and again in 2014-2015 due to activity within Kingdon's three streams, specifically through feedback from current programs and focusing events (problems stream), events within government including establishing select committees and the release of reports calling for TIC (politics stream) and the diffusion of ideas relating to how TIC can address current gaps in service delivery (policy stream).

Discussion

While TIC, as portrayed in the selected documents, acknowledges the impact of trauma and seeks to incorporate this into service delivery, it remains unclear how to do so. Thus, TIC is being utilized as a policy solution in addressing current service delivery gaps and needs, but has yet to be distinctly defined and remains poorly operationalized. In order for TIC to achieve meaningful operationalization, clear policies and procedures need to be established. Additionally, further empirical research regarding the current operationalization of TIC within Ontario is required to inform TIC policy development and implementation.

Introduction

The prevalence of trauma has been identified as a pressing public health concern [10, 19, 195, 196]. Specifically within Ontario Canada, while much work has been done to improve mental health (MH) and addictions services [113, 114, 197, 198], there is a current lack of understanding regarding how Ontario is working to address the needs of individuals affected by trauma who are utilizing services within the MH and addictions sector. As Ontario continues to invest in its MH system, it is important to understand whether and how trauma-informed policies are being included in the broader MH discourse across the province [51]. This is particularly relevant given that a growing body of literature has identified the high prevalence of trauma histories in individuals suffering from a wide range of mental illnesses, including depression, anxiety, substance abuse, eating disorders, personality disorders and psychosis [199-203]. Additionally, there is well-established evidence of high numbers of trauma histories amongst both psychiatric inpatient populations and those receiving outpatient services, which have been reported to exceed 50% and can be as high as 93% [129, 195, 204-217].

While the nexus of trauma and mental illness has been recognized for some time, there has been increasing awareness and understanding regarding the neurobiology of trauma within recent years. The latter half of the 20th century saw some recognition of the link between trauma, typically framed as physical or sexual abuse, and mental illness [195, 204-208, 210, 212-214, 217, 218]. Within the last 15 years, however, the recognition of trauma as an etiological factor in mental illness has become much more widespread mostly due to two factors. First, there has been an increase in epidemiological studies documenting the

prevalence of trauma at the provincial level in Ontario [126, 219] and at the national level across Canada [127] as well as internationally [200, 209, 210, 215, 216, 220, 221]. Second, recent advancements in neuroscience have provided greater elucidation regarding how trauma affects the brain [19, 20, 200, 222-224]. In particular, trauma has been shown to negatively affect brain development, disrupt neuroendocrinologic responses, and affect cognition and emotional regulation [225]. Both the prevalence of trauma and it's neurobiological impact hold significance for service design and delivery in the MH and addictions sector.

Given increased recognition that a significant portion of individuals accessing MH and addictions services have a trauma history, the concept of trauma-informed care (TIC) has recently evolved with rising prominence. Broadly defined, TIC entails the design of service delivery based upon an awareness and understanding of the pervasiveness of trauma and its impact on an individual's life and development [226, 227]. While the impact of trauma can be varied, depending on a myriad of contextual factors, there are several well-documented outcomes of unresolved trauma ranging from emotional dysregulation, behavioural difficulties and relational struggles to significant and ongoing medical conditions, including cardiovascular, auto-immune, musculoskeletal, digestive and respiratory diseases [131, 194, 228]. Thus, there has been growing awareness for improved access to trauma-specific services as well as the provision of TIC more generally [1, 11, 30, 58, 76, 79, 110, 136, 152, 170, 171, 229]. The call for TIC in MH has also been driven by wider acknowledgement that MH services can be the source of traumatic experiences, particularly given the frequent use of coercion and controlling principles, which include practices such as seclusion, physical restraints and forced medication [155, 230-233]. Empirical

research has demonstrated that traumatic experiences are a common occurrence in MH inpatient settings [234, 235].

In response to both the pervasiveness of trauma among MH service users and the acknowledgement of how services can further harm individuals receiving care, several empirical studies have explored the implementation of TIC in MH systems. Emerging evidence demonstrates that TIC can be effective in addressing issues related to mental illness and substance abuse when compared to traditional services [31, 236]. Specifically, implementation of TIC has shown reduction or elimination in the use of seclusion and restraints [27-29, 237-239], a decrease in the use of chemical restraints [29], a decrease in staff injuries [239], better treatment retention [138], improvement in the presenting problem(s) and coping skills [138, 139, 240-242], reduction in time to discharge [138, 240], and improved physical health outcomes [243]. The summarized literature includes a few high-quality systematic and literature reviews and several single studies, of which the majority are high quality and one determined to be questionable methodologically.

Over the last decade, Ontario has developed its first province-wide MH and addictions strategy [114], invested billions of dollars into MH and addictions services [244-250] and rolled out several initiatives [251-254], but it remains unclear whether and how the province has addressed the prevalence of trauma histories amongst MH and addictions service users. Given recent advancements in scientific understanding regarding the interplay between psychological trauma and overall physical and MH and well-being, Ontario's move towards an improved MH system provides an opportunity to examine what role TIC could, or should, play in the evolving MH policy discourse. This study

seeks to address the current knowledge gap on MH and addictions policy in Ontario as it relates to trauma by exploring whether, how and under what conditions has TIC, as a conceptualized idea, been described and utilized in adult MH policy documents in Ontario [120, 121, 255-257].

Design and methods

Study Design

Qualitative document analysis methodology was utilized to address our research objective, which is to explore whether and how mental health policy documents discuss the concept of TIC. Document analysis is a systematic research approach used to review, analyse and interpret data derived from various types of documents, including background papers, reports, policy documents, minutes of meetings and so on [119]. Thematic analysis techniques, which are commonly used within this methodology, were applied to the selected documents' contents [120, 121, 258].

Data collection

The Ontario Government Documents database [259] was searched between October and November 2017 for relevant MH policy documents. The following key words were used to search the database: "trauma inform*" OR "trauma-inform*" OR "trauma sensitive" OR "trauma expos*" OR "trauma specific". While the inclusion criteria outlined below limit included studies to a specific time period, no time restrictions were placed on publication dates in the database search to ensure the research team had adequate knowledge of relevant background Ontario MH policy documents. The initial

search yielded 38 results. One additional document was added -- *Open Minds Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy* (the Strategy) -- given its significance. The Strategy is in the government database, but it was not captured by the search strategy as it does not contain any of the key words. The Strategy was released in 2011 and as the first province-wide strategy, it provides a comprehensive approach to systematically transforming Ontario's mental health and addictions system so that "all Ontarians have timely access to an integrated system of coordinated and effective promotion, prevention, early intervention, and community support and treatment programs" p.4 [114]. The Strategy is a key mental health policy document that provides important contextual information regarding the broader mental health policy discourse in Ontario. Thus, the total initial yield consisted of 39 documents. All 39 documents were read by the primary investigator and a tracking sheet was used to capture each document's conceptual and information richness as related to the research question. A purposive sample of policy documents was generated by applying the following two inclusion criteria – (1) time-bound and (2) content-specific. Regarding time-bound criteria, selected documents had to have been published in the time frame leading up to and immediately following the publication of Ontario's 2011 comprehensive MH and addictions strategy. Two content-specific criteria were applied: (I) information-rich government documents that address trauma in policy areas related to adult MH in Ontario and that propose a set of options or strategies to address current gaps in Ontario's adult MH system; and (II) documents that outline the conceptualization and operationalization of TIC in Ontario related to adult health service delivery. Articles were excluded if they

focused on children and youth as this study is part of the first author's larger doctoral dissertation wherein child and youth mental health policy documents in Ontario are examined as part of a case study exploring the role of TIC in Ontario's mental health policy development and implementation specific to children and youth. At the outset of the research study, the primary researcher initiated a study journal to record methodological dilemmas, directions and decisions, and outline thought processes in order to document qualitative reflexivity [257].

After an initial review of all 39 documents, 14 were immediately excluded as they did not meet the first component (I) of content-specific inclusion criteria. The remaining 25 documents were reviewed a second time in greater detail and 19 documents were excluded because they did not meet the second component (II) of content-specific inclusion criteria (see Appendix 1). Thus, six documents were identified as eligible for study inclusion. The included six documents were imported into NVivo software to begin data extraction and initial coding. Data were extracted in two phases in order to address all components of the research question. In order to address whether and how TIC as a conceptualized idea has been described and utilized in emerging adult MH policy documents in Ontario, data were extracted using the TIC conceptual framework outlined below. Data related to 'under what conditions' was extracted using variables articulated within Kingdon's Multiple Streams Framework (MSF) as outlined in Appendix 2.

Data analysis

Data analysis occurred in two phases. The first phase addressed whether and how TIC as a conceptualized idea has been described and utilized. Analysis was guided by a

TIC conceptual framework derived from an extensive review and analysis of relevant literature across child welfare, education, health, justice and social services [260]. The framework outlines central components of TIC (see Figure 1) and defines TIC as a bi-directional relationship between the trauma-affected individual (who can be a consumer or provider of services) and a provider of human services (who can be also be affected by trauma) within a culture fostering mutual resilience and empowerment [260]. The framework consists of five key elements of TIC, which are trauma, vertical TIC, horizonal TIC, a culture of resilience and outcome categories. Trauma is defined as when an event, or series of events, overwhelm an individual's capacity to psychologically self-regulate and negatively affects some or all of the following - the individual's internal well-being, inter-personal relationships and function in society. Vertical TIC is operationalized at three levels (program/service, organization and system) within one specific system of care, whereas horizontal TIC is operationalized across systems, which are unified by an integrated referral network. A culture of resilience encompasses all aspects of TIC as well as the trauma-affected individual, as depicted in Figure 1. Within this culture, trauma-affected individuals are not treated solely as victims in that their treatment or service delivery includes an emphasis on resilience by facilitating choice, building skills and identifying strengths. Additionally, a culture of resilience includes developing resilience within service design and delivery as well as amongst service providers by ensuring proper procedures and supports are in place to address vicarious trauma. There are three outcome categories, which are defined as (1) service user outcomes, which can include a reduction in behavioural issues, service user crisis and

trauma symptoms as well improved service user engagement and retention in programs/services, (2) service provider outcomes, which can include reduction in burnout and service provider fatigue related to secondary trauma, reduction in service provider injuries, lower staff turnover, improved service provider morale and greater collaboration amongst service providers within and across systems, and (3) outcomes for both service users and providers, which can include an enhanced sense of safety and mutual respect as well as improved overall mental health and well-being [260]. Data derived from the selected documents was filtered through the framework to determine if TIC has been described and utilized, with the findings managed and organized in an excel spreadsheet. (see Figure 1)

In the second phase, the conditions under which TIC has been described and used will be explored through application of the MSF, which outlines the policy generating process of knowledge accumulation and perspectives amongst specialists and the development of policy proposals by these specialists [125]. This model depicts the various ways in which an item or subject either makes it onto the policy agenda or becomes stagnant. Within the agenda-setting process, there are three streams, or processes. In the problems stream, policy-maker attention to the problem of trauma can be driven by focusing events that garner widespread attention, indicators of a problem via statistical data, reports and academic studies, as a few examples, or feedback from the operation of current programs. The policies stream consists of three ways in which a TIC policy proposal, in response to the problem of trauma, can be generated. These three ways are the diffusion of ideas in a policy area, feedback from existing policies related to TIC, and

communication or persuasion regarding a specific policy solution. Diffusion of ideas was limited specifically to how TIC is being defined, understood and utilized to stay within the boundaries of the research question at hand. Lastly, the politics stream, which outlines political events that can influence whether or not TIC gains prominence on the agenda, includes swings in national mood, changes in the balance of organized forces, and events within government. Kingdon defines the governmental agenda as a list of subjects getting attention and the decision agenda is defined as subjects within the governmental agenda that are actively up for decision. The governmental agenda is influenced by developments in either the problems or politics stream, and by visible participants, such as politicians, interest group leaders or journalists. Hidden participants, such as academic experts or civil servants, can be engaged with policies. An item makes it onto the decision agenda when coupling of all three streams occurs [125]. A data extraction tool (see Appendix 2) was created based on the Multiple Streams Framework and contextualized to TIC through the application of a well-established coding taxonomy, which outlines various components of health system service design and delivery [142].

Results

Context of included documents

Considerable policy activity within the area of mental health occurred in Ontario between 2008 and 2011, which led to the development of a number of policy documents that touched on trauma and TIC to varying degrees. Two of the included documents – *Every Door is the Right Door Towards a 10-year Mental Health and Addictions Strategy*

A discussion paper [112] and *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy* [113] – were generated by a Ministerial Advisory Group (MAG) formed by the Minister of Health and Long-Term Care (MOHLTC) in 2008. The MAG consisted of "people with lived experience with mental illnesses and addictions, family members, service providers and researchers" (p.4) and its purpose was to provide recommendations to the MOHLTC regarding the development of Ontario's new 10-year MH and addictions strategy [112]. The third included document, titled *Submission to the Select Committee on Mental Health and Addictions*, was created in 2009 by Echo: Improving Women's Health in Ontario (Echo), which is an agency of the MOHLTC [261]. This document was developed in response to the Ontario government's establishment of a Select Committee on mental health and addictions in early 2009. The Select Committee was comprised of elected officials representing the three provincial political parties, and its mandate was to "consider and report its observations and recommendations concerning a comprehensive provincial mental health and addictions strategy" p.34 [197]. Echo consulted with more than 300 women and 40 front-line professionals from across the province to discuss issues related to mental health and addictions, which informed its submission to the Select Committee. While the Select Committee received a number of submissions, Echo's submission was the only document to meet the inclusion criteria of this study. The fourth included document, which is titled *Open Minds Health Minds Ontario's Comprehensive Mental Health and Addictions* Strategy, was released by the MOHLTC in 2011 [114]. The fifth document included in this study is titled *NE LHIN Aboriginal/First Nation and Metis Mental Health and Addictions*

Framework [262]. It was developed in 2011 by the North East Local Health Integrated Network (NE LHIN), which is a regional health authority responsible for administering public health services within a particular geographical area in Ontario. The sixth included document, titled *Select Committee on Sexual Violence and Harassment Final Report*, was released in 2015 by the Select Committee on Sexual Violence and Harassment, which was established in 2014 by the Ontario government and consisted of elected officials selected from across the three provincial political parties [263]. The Committee's mandate was to formulate recommendations to help prevent sexual violence and harassment and to improve Ontario's response to these issues in both the criminal justice and mental health systems [263].

Whether TIC has been described

While five out of the six included documents recommend TIC, only two documents specifically define trauma and TIC (see Appendix 1). Table 1 was created based on an initial pass of the data collected from the included documents. The documents were organized in a timeline, beginning with the oldest document and moving towards the most recent, to capture how TIC was conceptualized over time. The tick-marks represent how many times each document discussed the identified components of TIC. As outlined in Table 1, five documents describe TIC as an approach to care and provide rationale for the utilization of TIC. Three documents provide a broader conceptualization of TIC as it relates to the definition outlined in the TIC conceptual framework (see Table 2).

How TIC has been described and utilized

How TIC is described

There are two main ways in which TIC has been described in the included documents. First, the documents outline *what is* TIC, thereby defining TIC. Second, the documents describe *why* TIC matters by providing rationale for implementing TIC. These two themes are discussed in greater detail below.

Describing 'What is' TIC

The included documents were analysed for their description of TIC according to the five elements of the TIC conceptual framework, which are as follows (1) trauma (2) vertical TIC (3) horizontal TIC (4) culture of resilience (5) outcomes (see Table 2). Beginning with the first element, trauma, both MAG documents explicitly define trauma as 'physical and/or sexual abuse' [112, 113]. In the NE LHIN framework and the Select Committee's report on sexual violence and harassment, trauma is not explicitly defined but is more broadly conceptualized by recognizing how trauma affects an individual's internal well-being through the manifestation of post-traumatic stress symptoms, substance use and mental illness, and how trauma can significantly impact an individual's role in broader society [262, 263]. Regarding the second element, which is vertical TIC, all documents, except the Strategy, provide a contextual description of vertical TIC, which includes provider training on trauma and its impact, integrating provider trauma awareness into service delivery, use of culturally appropriate assessments and diagnostic tools, ensuring services are provided in a compassionate and culturally sensitive manner

and addressing vicarious trauma amongst service providers through adequate support [112, 113, 261-263]. The third element of TIC is horizontal TIC, which is again seen in all documents with the exception of the Strategy. Horizontal TIC is described as effective inter-sectoral collaboration, trauma awareness and education integrated into both health and non-health systems of care and strengthening the provision of community referrals and service coordination for individuals and families experiencing a crisis or trauma [112, 113, 261-263]. Regarding the fourth element of TIC, which is culture of resilience, descriptions can be found in all documents except for Echo's submission and the Strategy. Culture of resilience is described as utilizing a strengths-based approach to care that emphasizes problem-solving skills and coping skills, which empower service users to be more active partners in manging their own care, providing family-based life skills programs that build resilience and addressing vicarious trauma by ensuring service providers can access TIC themselves [112, 113, 262, 263]. The final element, which is outcomes of TIC, is described in both MAG reports and the Select Committee's report on sexual violence and harassment. None of these documents explicitly define TIC outcomes, but they relate the provision of TIC to reductions in symptoms of mental illness, improvements in educational measurements such as higher test scores and increased high school graduation rates, enhanced service collaboration between the criminal justice system and MH and addictions services, and reductions in individuals with MH and addictions challenges entering the justice system, as a few examples [112, 113, 263].

Describing 'Why' TIC Matters

Three common themes emerged from both the mental health and addictions sector and the criminal justice system in providing rationale for TIC. First, both sectors identify TIC as fundamental to achieving transformation within their respective systems. TIC has been identified by the NE LHIN as central to transforming Ontario's mental health and addictions system due, in part, to the cited high prevalence of trauma histories amongst individuals receiving mental health and addictions services [262]. Within the criminal justice system and the Ministry of the Attorney General, TIC has been given rising prominence as a promising approach to address systemic issues. The Select Committee on Sexual Violence and Harassment acknowledges that current judicial system arrangements can be harmful and re-traumatizing for survivors of violence with trauma histories [263]. Cited examples of this include the lack of trauma-sensitive approaches in court and system barriers, such as sexual assault victims required to travel long distances, often in police vehicles, in order to access the nearest hospital with forensic sexual assault evidence kits. The Committee recognizes how difficult it can be for individuals to disclose sexual violence and that these individuals require a trauma-informed response [263].

Second, both sectors identify the role of TIC in addressing the underlying root causes rather than focusing on symptomatic issues. A number of the policy documents identify addictions as a symptom of underlying trauma and recognize that individuals suffering from addictions require trauma-informed services to address the underlying trauma as part of addictions treatment [112, 113, 261, 262]. In its submission to the Select

Committee on Mental Health and Addictions, Echo cited a common theme arising from the various women who participated in its consultation process, which was the urgent need for trauma-informed services, particularly in addictions treatment [261]. In the justice sector, the Select Committee has also spoken of the high prevalence of a trauma history amongst perpetrators and that the system needs to address root causes of violence, stemming from trauma, in order to reduce the incidence of violence [263]. This, as well, requires implementing system-wide TIC.

Third, the role of TIC in addressing unmet needs has been identified by both sectors. The NE LHIN identifies TIC as a promising avenue for effective provision of mental health and addictions services to Indigenous people as the legacies of the residential school system and intergenerational trauma have been recognized as contributing to ongoing and unmet needs within this population group [262]. The NE LHIN also identified Indigenous individuals are at higher risk for addictions due to increased vulnerability resulting from historical trauma and the NE LHIN framework calls for greater access to TIC. In the justice sector, lack of support for service providers and judicial staff experiencing vicarious trauma has also been identified as a need, which can be addressed through TIC [263]. Furthermore, the Select Committee acknowledges that many social service professionals and healthcare providers are also dealing with their own trauma and require support in order to remain sensitive to the needs of trauma survivors accessing the system.

The health sector provided a fourth rationale for TIC. Three of the policy documents cited evidence that TIC has proven more effective than traditional treatment

for women in mental health and addictions services and TIC was provided at the same cost as traditional care [112, 113, 262]. The justice sector did not discuss potential economic concerns regarding financing the implementation of TIC.

How TIC has been utilized

Two themes regarding the utilization of TIC emerged from the health and justice sectors. First, both sectors have identified training as one mechanism to utilize TIC. In its submission to the Select Committee on Mental Health and Addictions, Echo has recommended that TIC be integrated into all mental health and addictions programs [261]. In order to achieve this, the submission recommends programs be developed that enable TIC mentors to train other healthcare providers. In the criminal justice system, the Select Committee on Sexual Violence and Harassment has developed an action plan, which promises to provide training for front-line workers across sectors, and specifically to provide TIC training for mental health and addictions professionals associated with the justice system [263]. Additionally, the Select Committee report stipulates that the Ontario government will facilitate training, education and the dissemination of best practices regarding TIC as they relate to survivors of sexual violence.

Second, both sectors identify expanded services as an element of utilizing TIC. In the health sector, Echo has recommended expanded use of identified exemplary programs, such as the True Self program in North Bay, which provides services to men and women who have experienced violence to assist in their healing and help them with employment and training [261]. The justice sector, as detailed in the Action Plan, has committed to providing TIC for front-line workers experiencing vicarious trauma. The

Select Committee also recommends expanding the use of trauma dogs to support young people providing court testimony, which is already happening in other provinces across the country.

Only one document, the *NE LHIN Aboriginal/First Nation and Metis Mental Health and Addictions Framework*, describes current utilization of TIC, which occurs primarily within the Nishnawbe Aski Nation [262]. The use of TIC in this context includes both training and expanded services. The Nishnawbe Aski Nations Crisis Team program provides various trauma services that address the impacts of intergenerational trauma. The Crisis Team program staff receive intervention and prevention training on various types of traumatic stress and severe trauma. Additionally, a trauma program was started in 2010 by the Native Child Welfare Agency within Nishnawbe Aski Nation, although details of the program were not provided. The NE LHIN cites its Aboriginal First Nations Metis Mental Health and Addiction Framework and Beyond Trauma as two examples of evidence-based programs that have integrated TIC and substance use treatment [262].

Under what conditions has TIC been described and utilized

As outlined in Table 3, during 2009-2010, events related to TIC appear in all three streams of the MSF framework, which has contributed to pushing TIC onto the government's decision agenda. While it is not common for an item to remain on the decision agenda for an extended period of time, in this case it was possible due to the government's prolonged attention to mental health issues during the run-up to the 2011 mental health and addictions strategy. First, in the problem stream, academic studies and

population surveys can draw attention to a problem that may require governmental attention. The MSF categorizes use of data in this way as indicators [125]. Three of the included policy documents used indicators to bring attention to the problem - lack of TIC. Echo indicated a gap in mental health and addictions services stemming from the recognition that violence, poverty, stigma and discrimination are often related to many women's struggles with mental health and addictions. Specific to the gap in trauma services within the mental health and addictions system, Echo found that, "Women across the province spoke about the need for trauma-informed services, especially for addictions treatment" p.4 [261]. Based on this identified gap, Echo recommended trauma-informed approaches be integrated into all mental health and addictions services and programs [261]. Additionally, both MAG reports cited a Canadian academic study to frame the problem of trauma and establish the need for TIC in the following way: "a significant proportion of people with mental illnesses, problematic substance use and harmful gambling – particularly women – have experienced trauma: physical and/or sexual abuse, and need a trauma-informed approach to help them heal and participate more fully in life" [112, 113]. Both reports indicate identified trauma-informed needs were not addressed by the service delivery model of the time and recommend TIC as an evidence-based, cost-effective way to strengthen MH and addictions services (see Table 1).

Second, activity also occurred in the policy stream during this time period, specifically through the use of communication and persuasion of TIC as a policy solution and also via diffusion of ideas regarding the use of TIC as an approach to care. Communication and persuasion of TIC as a policy solution occurs in the two MAG

reports, which highlight the viability of TIC as both an efficacious and cost-effective approach to care by citing an American study that found the following:

> "Women who receive integrated care that includes trauma-informed practice experience significantly more reductions in mental illness symptoms and in alcohol and drug use than women in traditional services – and the cost of service is the same" p.33 [112].

The way in which both MAG reports outline the above cited study is significant. Use of empirical data to highlight the effectiveness of TIC in this way – better clinical outcomes at no additional cost in comparison to traditional care – frames TIC as both credible and measurable, which are essential for TIC to be considered, politically.

Furthermore, the second MAG report identifies trauma as a risk factor for mental illness and positions TIC as a necessary component of mental health and addictions services by framing it as a way to provide "high quality, personalized, culturally competent care based on the recovery/wellness model of care" p. 32 [113]. Lastly, diffusion of ideas is also seen in the second MAG report, in which it recommends the development and implementation of standardized guidelines to support a recovery/wellness approach to care, which includes TIC. This captures an important consideration – TIC requires the development of standardized guidelines, which are necessary to inform the implementation of TIC in order to ensure evidence-informed, quality care is consistently provided across all settings [113].

Finally, in the politics stream, a number of events within government occurred. First, the MOHLTC took action by establishing the MAG, which was convened to

provide recommendations to government regarding the development of Ontario's first MH and addictions strategy. The MAG released its reports in 2009 and 2010 recommending TIC as an important component for Ontario's mental health and addictions strategy [112, 113]. Second, a Select Committee, consisting of elected officials, was established by the Legislative Assembly of Ontario in 2009 to address mental health and addictions care [197], which resulted in Echo's Submission to the Select Committee. The Select Committee released its final report in August 2010 and of particular note, it did not acknowledge trauma or discuss TIC in any capacity [197].

In 2011, TIC appears to move from the decision agenda on to the longer, less dynamic governmental agenda, which is a list of subjects the government is paying attention to. Neither trauma nor TIC are mentioned in the Strategy despite both MAG reports highlighting the pervasive problem of trauma and recommending TIC as a central tenet required to strengthen Ontario's MH and addictions system. It is important to note that the MAG was an advisory group whereas the Select Committee, which did not recommend TIC, consisted of elected officials. The Select Committee's report may have been more reflective of MH and addictions priorities within government.

The movement of TIC from the decision agenda to the governmental agenda in 2011 is seen by activity within the problem and policy streams (see Table 3). Within the problem stream, the *NE LHIN Aboriginal/Fire Nation and Metis Mental Health and Addictions Framework* uses two indicators to draw attention to the problem, first, by citing that up to 98% of residential school survivors, who had experienced trauma in the residential school system, may be afflicted with a mental health problem including post-

traumatic stress disorder and, second, that Indigenous children are over-represented in Children's Aid Society care, which is linked to parenting issues stemming from intergenerational trauma [262]. In the policy stream, communication and persuasion, diffusion of ideas, and feedback from the operation of current programs are captured. First, communication and persuasion is seen by the NE LHIN quoting the first MAG report to posit TIC as a critical element in mental health and addictions reform in Ontario: "In the Ontario discussion paper ―Every door is the right door - the importance of integrating evidence based, person directed approaches such as a trauma informed approach are identified as central to transforming the mental health and addictions system and to supporting new approaches to care and support" p. 40 [262]. Second, diffusion of ideas is highlighted by NE LHIN's recommendation that TIC "represent[s] a promising avenue in the effective provision of mental health and addictions care for Aboriginal people given the complexities introduced by experiences of residential school and historical trauma" p. 40 [262]. Third, regarding feedback from current programs, two programs within the NE LHIN – Seeking Safety and Beyond Trauma – were identified as facilitating trauma recovery and healing by providing an integrated approach to care for women with trauma and substance use issues [262].

TIC appears to re-emerge on the government's decision agenda between 2014 and 2015 as evidenced by activity within each of the three streams (see Table 3). Within the problem stream, several focusing events occurred during the fall of 2014, which involved a few high-profile cases of sexual harassment and violence eliciting a national response on social media that garnered global attention after two Canadian journalists launched the

twitter hashtag #BeenRapedNeverReported [263]. These focusing events led to a number of events within government, which falls under the politics stream. First, as a direct response to these focusing events, the Select Committee on Sexual Violence and Harassment was established in December of 2014. The following year, the Committee presented its final report, which resulted in changes to legislation, notably Bill 132 – Sexual Violence and Harassment Action Plan Act, which outlines the responsibilities of employers in relation to workplace harassment and sexual violence. Finally, within the policy stream, diffusion of ideas regarding availability of care highlighted policy options for addressing current gaps in the system [263]. Specifically, the Select Committee recognized that individuals often do not report sexual violence or harassment and suggests that the provision of TIC must be available to sexual assault survivors when they disclose their experience to the police or community service providers. Additionally, the Select Committee report recommends that "the Ontario government facilitate education, training, and the sharing of best practices relating to trauma-informed care for survivors of sexual violence" and that "the Ontario government, in cooperation with health and social service professionals, facilitate the provision of trauma-informed care for front-line workers who experience vicarious trauma" p. 9 [263].

It is important to note the context in which TIC re-emerges on the government agenda during this time. Trauma, as a policy problem, and TIC, as a policy solution, are framed primarily within the context of employment and the workplace, policing and the criminal justice system. Furthermore, in this context, trauma, as a *health* policy problem, is recognized only in relation to the psychological impacts on sexual assault survivors and

mental health challenges related to front-line workers who experience vicarious trauma within the context of their workplace within the criminal justice system. TIC, as a *health* policy solution, is limited to training health professionals regarding TIC as it relates to individuals who have experienced sexual violence or harassment and the treatment of vicarious trauma experienced by workers in the criminal justice system. Within this context, TIC has been successfully passed on to the government's decision agenda. Conversely, when trauma and TIC were previously framed within MH policy, they failed to make it onto the government's decision agenda.

Discussion

Principal findings

In addressing the question of whether TIC as a conceptualized idea has been described and utilized in emerging Ontario adult MH policy, two interesting findings emerge. The first is that in the initial survey of reviewed documents (see Appendix 1), all but one recommended TIC. The sole document that did not recommend TIC was Ontario's 2011 mental health and addictions strategy, which established the trajectory of MH and addictions care in Ontario over the next 10 years. Omission of TIC from the Strategy represents a missed opportunity for Ontario to implement TIC as part of standardized care across the province. Furthermore, while 24 of the initially surveyed documents recommend TIC, only two documents provide a specific definition for TIC. Thus, even when TIC is recommended as a policy solution, it remains poorly described. While this is noteworthy, it is unclear what is contributing to this trend in general lack of

definition in government policy documents, but one possible explanation is a lack of conceptual clarity within the TIC literature [260]. Second, it appears that TIC is being used in Ontario in a fragmented manner without coordination across regions to ensure consistent provision of quality TIC. Of the six included documents, only the NE LHIN describes current utilization of TIC, citing a few examples of TIC implemented within its region. Thus, while several Ontario government policy documents have clearly established both the problem of trauma and the need for TIC and despite the magnitude of work done to improve Ontario's MH system at the cost of millions of dollars over the last several years, there remains to be any standardized or coordinated approach to address trauma at the provincial level. This presents a policy puzzle requiring further exploration – why has trauma continued to be excluded from the Ontario MH policy agenda?

With regards to the question of when and how TIC is described in government policy documents, the primary finding regarding lack of comprehensiveness is consistent with well-documented issues of TIC as an emerging concept. Both descriptions of TIC in the included documents are comprised of two components – recognizing the impact of trauma and integrating this awareness into service delivery. These descriptions, however, do not provide a clear understanding of how trauma impacts individuals seeking care or how service delivery can be adapted to the unique needs of trauma survivors. The ambiguous conceptualization of TIC is a common theme throughout both the surveyed and included documents in this study. While TIC has been broadly recommended in various Ontario government policy documents, a clearly outlined description of what TIC means as a concept is substantially lacking. Current conceptualization centres around two

main components, the first of which limits TIC to a reflection of ethical values regarding approaches to care. Multiple descriptors of TIC consist of value-based statements, such as high-quality, personalized and culturally competent care and commitment to best practice, which fail to distinguish how TIC differentiates from current models of care. Furthermore, this lack of conceptual clarity presents significant challenges for service providers in knowing when and how to provide TIC. The second component conceptualizes TIC as service delivery which acknowledges and addresses underlying trauma related to mental health and addictions struggles. While this aspect clearly distinguishes TIC from the current delivery model, it features less heavily than the varied statements of TIC as an approach to care based on the recovery/wellness model as described above. The various descriptions of TIC, as a concept, have led to ambiguity regarding how, precisely, the concept can be defined, understood and operationalized. This could partly explain why TIC has failed to succeed on Ontario's MH policy agenda. Government officials will likely be hesitant to allocate funding for TIC if it is not clear how to effectively operationalize TIC. It remains unclear, however, why TIC has succeeded on Ontario's policy agenda specific to sexual violence and harassment as it relates to the workplace and the criminal justice system despite the above challenges with regards to lack of conceptual clarity.

Examination of the conditions under which TIC is described and utilized provides helpful insight into the context under which TIC was elevated to the decision agenda and when it remained on the governmental agenda. First, on the two occasions when TIC did reach the decision agenda, there were clear indicators of a problem, which resulted in

various select committees and a MAG being established by government. These are significant events within government, as an operational select committee or MAG guaranteed various policy options were being actively discussed and developed to address the outlined problem at hand, resulting in action across all three streams. Second, the context under which the Select Committees and MAG were carried out was different and this is notable as the outcome also differed. In 2009/2010 the government established both the MAG and the Select Committee on MH and Addictions. The MAG strongly recommended TIC whereas the Select Committee did not. It is important to recognize that the MAG included MH service providers and researchers who, by the very nature of their work, would likely have some degree of familiarity with the link between trauma and mental illness and the concept of TIC. Conversely, the Select Committee consisted of elected officials who likely had limited exposure to and understanding of trauma as it relates to MH service delivery. This possible lack of knowledge and awareness could explain why TIC was not included in the 2010 Select Committee's report. The context of the 2009/2010 Select Committee versus the 2014/2015 Select Committee is also noteworthy as the outcome of these committees, with respect to trauma and TIC, are markedly different. The Select Committee on MH and Addictions, which did not explicitly acknowledge trauma or discuss TIC, was established in 2009 and its final report was released in 2010 during the run-up to the 2011 provincial election. The purpose of the 2010 Select Committee was to focus exclusively on recommendations relevant to the development of Ontario's first province-wide MH and addictions strategy. Thus, it is somewhat surprising that within the context of MH and addictions, trauma was

overlooked and TIC was not discussed. It is possible that the Committee was aware of these issues, but given the complexities of trauma and the relative newness of TIC combined with limited empirical data on its effectiveness both topics were perceived as too politically risky so close to a provincial election. The Select Committee on Sexual Violence and Harassment, which recommended TIC as a policy solution, was established in 2014, five months after a majority government was elected. Its final report was released the following year. The 2014/2015 Select Committee focused on issues related to sexual violence and harassment in the workplace with relevance to policing and the criminal justice system. The contextual differences between the two Select Committees raise questions about the way in which trauma, as a policy problem, and TIC, as a policy solution, might be influenced by various political factors. Finally, when looking at the context of 2011, there was activity in both the problem and policy streams, but lack of supportive activity in the politics stream meant TIC did not advance to the decision agenda during this time. It is possible that the 2010 Select Committee's omission of TIC held more political weight than the recommendations of either ECHO or the MAG. Additionally, as mentioned above, the lack of clarity regarding how TIC can be operationalized may have been a significant political barrier.

Strengths and limitations of the study

Several strengths in this study have been identified. First, to our knowledge this is the first study to conduct a qualitative document analysis on adult mental health policy documents in Ontario using a TIC lens, which provides critical insight into how TIC is

being conceptualized and operationalized at the provincial level. Second, data analysis carried out in this study was guided by a recently developed conceptual framework of TIC informed by a comprehensive review of the TIC literature. Use of the conceptual framework allowed for rigorous analysis of TIC within the Ontario context as compared to synthesized research drawn from across the globe. Third, the study's novel methodology utilizing two distinct frameworks for analysis situated within a document analysis approach allowed for a multi-faceted handling of the data.

There are also some study limitations. First, by nature of document analysis, the study findings are based on limited data points derived from policy documents meaning that data is derived from the output of a document without any elucidation as to what factors led to the decisions made within the documents. Conducting interviews and focus groups to examine the process of producing these documents would allow for greater insight into how and why the selected documents recommend TIC without providing any further contextual information or definitions. Furthermore, applying the MSF to key-informant interviews would allow for greater exploration regarding why TIC did not feature in the 2011 province-wide MH and addictions strategy. Document analysis, alone, cannot provide sufficient elucidation to this particular policy question. A second limitation of the study relates to the inclusion criteria, which was limited to policy documents that provided rich insight into the concept of TIC. While a total 38 documents included a variation of the search term "trauma informed", only 5 provided more in-depth description regarding what is TIC and how it can be utilized. It is possible that the concept if TIC is more broadly present in policy documents not included in this study,

due to the search strategy and inclusion criteria, by virtue of discussing the concept without using the label, particularly given that TIC is just beginning to emerge as an established concept.

Implications for policy and practice

There are several implications of the study findings for policy and practice. First, a consistent and clearly defined conceptualization of what is TIC is essential to inform both policy and practice. Second, the utilization of TIC regarding when and how it will inform policy must be established. Third, the operationalization of TIC requires a clear delineation of roles for the involved sectors and service providers. As outlined above, current recommendations for the operationalization of TIC in Ontario include significant overlap between MH services and the criminal justice system. Collaborative coordination across relevant systems of care will be important for successful implementation of TIC. Finally, engaging with programs and services already incorporating TIC, such as those outlined by the NE LHIN, will be helpful in materializing the more widespread planned implementation of TIC across the province as discussed above.

Implications for future research

As alluded to above, this study reveals the need for more in-depth research on the definition and operationalization of TIC in policymaking within Ontario. In particular, it is important to understand why TIC featured heavily in the background policy documents

leading up to Ontario's 2011 mental health and addictions strategy and was subsequently omitted from the actual strategy. The use of key informant interviews would allow for greater insight into how and why TIC initially appeared as a critical concept for mental health and addictions and then was abandoned in the final strategy. Additionally, further research is needed to explore how policymakers are conceptualizing TIC when it is recommended in policy documents, but no definition has been provided. Furthermore, understanding how TIC as a recommended approach to care can be operationalized must be established in order for TIC to hold meaning as a policy solution. Additionally, a number of documents have recognized the link between trauma and mental illness and addictions, but the concept of trauma itself needs to be further refined in the literature. A comparative case study exploring the 2010 Select Committee on Mental Health and Addictions and the 2014 Select Committee on Sexual Violence and Harassment would provide helpful insight as to why trauma was recognized as a policy problem and TIC utilized as a policy solution in the context of the criminal justice system, but not within the MH system. Lastly, this study focused on policy documents in Ontario, which is noted to be less advanced in recognizing the role of TIC in comparison to some other Canadian provinces, namely British Columbia and Alberta. Thus, it is recommended that a similar study be replicated in other provinces and countries to explore the context of TIC within the broader policy discourse beyond Ontario.

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Figure 1 - Conceptual framework depicting how trauma is defined, trauma-informed care is operationalized and what are the outcomes of trauma-informed care

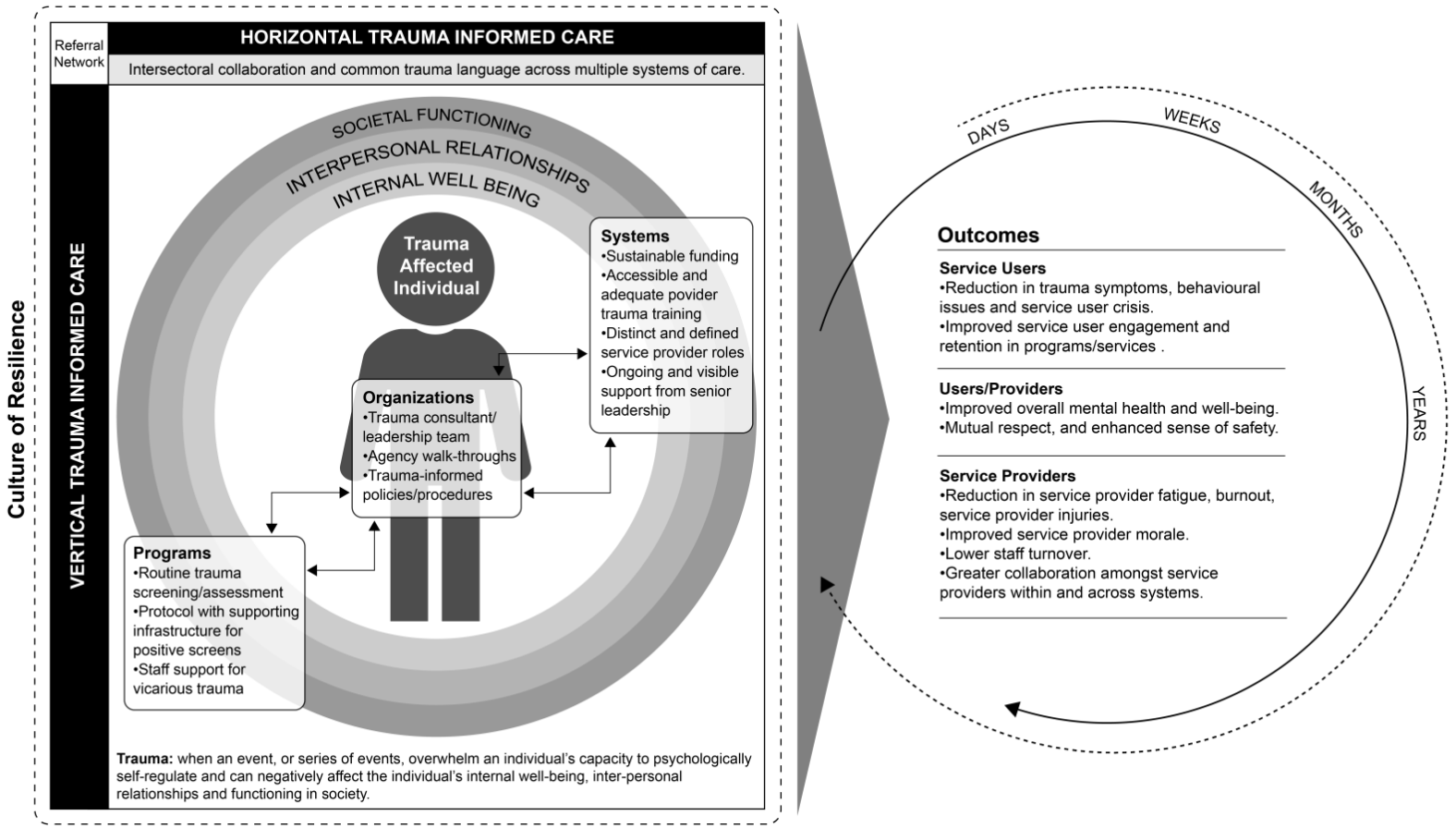

Table 1 - Timeline of how TIC as a conceptualized idea is described and utilized in Ontario

Theme	Key descriptors	Selected policy documents					
		Every Door [112] 2009	Echo, Submission to Select Committee, [261] 2009	Respect, Recovery, Resilience, [113] 2010	Open Minds [114] (2011)	North East LHIN [262] 2011	Select Committee Final Report [263] 2015
Describing TIC as an approach to care	**Health more generally**						
	• High quality, personalized, culturally competent care			✓✓			✓
	• Evidence-based	✓✓✓		✓		✓✓	
	• Person-directed	✓✓		✓		✓	✓
	• Commitment to best practice	✓					✓✓
	• Reflects system's principles	✓		✓			
	Mental health more generally						
	• Recovery/wellness model	✓		✓✓			
	Trauma-specific						
	• Includes trauma-specific services to address impact of trauma and facilitate recovery/healing	✓	✓	✓		✓✓	✓
	• Addresses gap in current mental health/addictions care that does not account for trauma	✓	✓✓	✓		✓	✓
Rationale for utilizing TIC	**System level**						
	• Central to transforming the mental health and addictions system					✓	
	• Cost-effective (cited studies that provided TIC at no additional cost)	✓		✓		✓	
	• Explicitly identified need for TIC	✓	✓✓✓	✓		✓	✓
	Service delivery level						
	• Delivery model accounts for impact of trauma and responds accordingly	✓	✓	✓		✓✓	✓

	• Trauma identified as risk factor for mental health and addictions problems	✔✔	✔✔	✔✔	✔	✔	
	• Cultural shift away from pathologizing behaviour toward empathetic exploration of underlying issues					✔	
	Individual service user level						
	• Reduces self-stigma and self-blame	✔				✔	
	• Reduces symptoms	✔		✔		✔	✔

Table 2 - How is TIC defined and utilized

Definitions		Selected policy documents					
		Every Door (2009)	Echo, Submission to Select Committee (2009)	Respect, Recovery, Resilience (2010)	Open Minds (2011)	NE LHIN (2011)	Select Committee Final Report (2015)
How TIC (which is comprised of 5 elements – trauma, vertical TIC, horizontal TIC, culture of resilience and outcomes) is defined and utilized	1. Trauma	-Physical and/or sexual abuse	Not defined.	-Physical and/or sexual abuse	Not defined.	Not explicitly defined but recognized in the following ways: **Internal** experiences of trauma manifest via post-traumatic stress disorder, substance use and mental illness. **Interpersonal** impact of trauma acknowledged as parenting issues (substance use). Trauma impact on the individual's broader **societal** role: recognized via historical trauma, which includes intergenerational effects of the Indian Residential School system and the over-representation of	**Vicarious** trauma recognized as resulting from service providers experiencing trauma after years of exposure to people in crisis. **Internal** experiences of trauma: Sexual violence can contribute to depression, anxiety, substance abuse and likelihood of further victimization. Trauma impact on the individual's broader **societal** role: individuals who have experienced discrimination because of race, sexuality, abilities or other factors (institutional trauma) may be distrustful of systems that sometimes treat them

						Indigenous children in Children's Aid Society, which is linked to parenting issues and substance abuse stemming from intergenerational trauma and abuse histories.	as though they are invisible.
	2. Vertical TIC	-TIC reflects a commitment to best practice -Trauma awareness integrated into all aspects of care	-Knowledge of a woman's exposure to violence helps determine the provision of service and care -Staff training on TIC and trauma via mentors who train healthcare providers to address and treat trauma	-TIC is a person-directed, recovery/wellness approach to care -Trauma awareness integrated into care -Develop TIC guidelines in all settings	Not defined.	-Takes into account knowledge of the impact of trauma and integrates this knowledge into all aspects of service delivery - Provider perceptions shift from pathologizing behaviour and asking "What is wrong with this person?" to "What happened to this person?" - Use of culturally appropriate assessments and diagnostic tools -Community Crises Teams receive training	- All members of court system receive training on trauma and the impact of sexual violence - Services are provided in a compassionate and culturally sensitive manner to create a safe environment for victims of sexual violence - Adequate trauma services for providers in recognition of prevalence of vicarious trauma

						regarding intervention/prevention of traumatic stress due to suicide, family violence and other types of severe trauma	
	3. Horizontal TIC	-Service providers able to effectively collaborate with people from other sectors -Service providers in non-health sectors (ie. education, child/youth, social services, housing, senior services and justice) are able to identify signs/symptoms of mental illness/addictions and appropriately refer individuals to the right services	-Trauma awareness and trauma-specific services integrated into all mental health and addictions programs and services	- In education, promote MH/well-being in classroom via teaching coping skills, stress management, and emotional literacy skills -Integrate health and other human services (including police/court systems) and improve transitions between services	Not defined.	-Community wellness workers provide 'referrals to/service coordination of counselling, legal and/or treatment services for individuals and families experiencing a crisis or trauma'	-Trauma awareness and education provided to intersectoral services relevant to criminal justice system, including the police, mental health and addictions professionals and social services - Societal collaborative response to address root causes of sexual violence
	4. Culture of resilience	-Empower service users to be active partners in managing their own care by offering range of approaching to care and facilitating service users' informed decision-making	Not defined.	-Service users shift from being patients to active partners in their care by utilizing their own strengths, wisdom and resilience to make informed decisions about care		-Family-based life skills program that increases resilience and reduces risk factors by building protective factors through improved family	-Provide TIC to service providers who have experienced vicarious trauma -Ensure service providers who have experienced vicarious trauma can remain sensitive and provide compassionate care

		-Utilize a strengths-based approach including problem-solving skills, social skills, coping style and community connection to build resilience				relationships and enhanced life skills for every family member -Use of culturally appropriate assessment tools that include resiliency and focus on strengths	for individuals who have experienced sexual violence
	5. Outcomes	TIC outcomes not explicitly defined, but recognized in the following: -Outcomes measured 'in terms of housing, education, employment and participation – not just reducing symptoms' -Women who received TIC experienced "significantly more reductions in mental illness symptoms and in alcohol and drug use than women in traditional services – and the cost of the service is the same"	Not defined.	TIC outcomes not explicitly defined, but recognized in the following: -Higher proportion of senior kindergarten students scoring high on Early Development Instrument -More youth graduating from high school and with better life skills -Fewer women will return to abusive relationships -Service users have a collaborative, individualized health and wellness plan used by all providers -Better collaboration	Not defined.	Not defined.	TIC outcomes not explicitly defined, but recognized in the following: - Improved conviction rates for crimes of sexual violence - Decreased incidence of sexual violence crimes

				between police/courts and hospital/community MH and addictions providers -Reduced police contact with persons with MH and addictions -Reduced number of youth, adults and seniors with MH and addictions entering the justice system -Increased access to MH and addictions services to persons pre-charged			

Table 3 - Under what conditions did TIC move on and off the government agenda

Year	Agenda	Events
2009-2010	Decision agenda	**Problem stream** *Indicators* • Echo's report identified many women across the province experience a lack of TIC in mental health and addictions services [261] • Both Ministerial Advisory Group (MAG) reports cite a Canadian study highlighting the 'significant proportion' of trauma histories amongst mental health and addictions service users [112, 113] **Policy stream** *Communication and persuasion* • Women who received traditional mental health services experienced a less significant reduction in mental illness symptoms and occurrence of drug and alcohol use when compared to a select group of women who received TIC as part of integrated mental health care at no additional cost [112, 113] • Trauma is a risk factor for mental illness and can be addressed via TIC, which provides high quality, personalized and culturally competent care based on the recovery/wellness model [112, 113] *Diffusion of ideas* • Strengthen mental health and addictions services by developing and implementing standards for a recovery/wellness approach to care, which includes TIC, in all settings [113] **Politics stream** *Events within government*

		• Government takes action to strengthen mental health and addictions services in Ontario [112]
		  ○ MAG established by Minister of Health and Long-term Care to help develop 10-year strategy for mental health and addictions services in Ontario releases its first report in 2009 [112]
		  ○ In 2009, the Ontario government establishes a Select Committee to help inform development of the 10-year mental health and addictions strategy
		• In 2010, the MAG submits its final report outlining strategy for improved mental health and addictions services in Ontario [113]
		• In 2010, Select Committee submits its final report outlining recommendations for improved mental health and addictions services in Ontario [197]

2011	Governmental agenda	**Problem stream** *Indicators* • The NE LHIN report indicates that up to 98% of residential school survivors may be afflicted with a mental health disorder [262] • Over-representation of Indigenous children in care of Children's Aid Society linked to parenting issues stemming from intergenerational trauma and traumatic legacies of residential schools [262] **Policy stream** *Communication and persuasion* • NE LHIN state the importance of integrating evidence-based, person-directed approaches to care, of which TIC is identified, as central to transforming the mental health and addictions system and supporting new approaches to care and support [262] *Diffusion of ideas* Delivery arrangements – By whom care is provided • Most clinicians lack education in historical trauma, residential school syndrome (a term used in reference to the negative impacts experienced by survivors of the residential school system) or how to work with Indigenous clients [262]

		• Nishnawbe Aski Nation Crisis Teams can choose types of training they feel necessary to provide intervention and prevention of traumatic stress due to suicide, family violence and other types of severe trauma [262] Availability of Care – New TIC Services • The Division of Child Psychiatry at the University of Toronto provides trauma-related follow-up consultation as required [262] • The Nishnawbe Aski Nation Crisis Teams provide a coordinated response to individuals experiencing trauma [262] Case Management • Addictions related to complex underlying symptoms of pervasive pain, unresolved grief, abuse history and other mental health issues [262] • Many individuals with mental health and addictions, particularly women, have complex trauma histories [262] • Complex intergenerational trauma results in broad range of needs [262] Culturally Appropriate Care • Historical trauma identified as presenting concern among Indigenous populations [262] Culturally appropriate assessment or diagnostic tools required to take into consideration cultural norms, historical and intergenerational trauma [262] *Feedback from Current Programs* • Seeking Safety and Beyond Trauma cited as two evidence-based programs that provide an integrated approach to care for women with trauma and substance use concerns [262]
2014/2015	Decision agenda	**Problem stream** *Focusing events* • Fall of 2014 – several high profile cases of sexual violence and harassments in Ontario [263] • Twitter hashtag #BeenRapedNeverReported launched by two Canadian journalists and garners international attention [263] **Politics stream** *Events within government* • Select Committee on Sexual Violence and Harassment is established [263]

		• Select Committee on Sexual Violence and Harassment presents its final report to the Legislative Assembly of Ontario (2015) resulting in the passing of new legislation [263] **Policy stream** *Diffusion of ideas* Availability of care – Current gaps • The Select Committee believes more needs to be done to address the emotional and psychological needs of sexual assault survivors during the court trial process [263] • The Select Committee learned that an employee suffering from a psychological injury as a result of workplace sexual harassment has compensation benefits restricted [263] • The Select Committee was informed that people living in certain geographical areas have to travel significant distances, sometimes in the back of a police car, to access a sexual assault or domestic violence clinic or a hospital equipped with sexual assault evidence kit services; the Committee acknowledged when individuals are in crisis, such a journey can be traumatic and acts as a barrier to accessing care [263]

Appendix 1 - Overview of whether TIC as a conceptualized idea has been described and utilized in Ontario adult policy documents

*Bolded text indicates policy documents included in study

Title	Year	Author	Trauma defined	TIC defined	TIC recommended	Information rich	Government sector	Type of document
Submission to the Select Committee on Mental Health and Addictions	**2009**	**Echo: Improving Women's Health in Ontario**	**N**	**Y**	**Y**	**Y**	**MOHLTC**	**Guidance Policy Paper**
Women's Views about the Ontario Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions Strategy Toronto Roundtable Results	2009	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Citizen/patient input
Women's Views about the Ontario Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions Strategy Sudbury-Francophone Roundtable Results	2009	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Citizen/patient input
Women's Views about the Ontario Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions Strategy Kitchener-Waterloo Roundtable Results	2009	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Citizen/patient input
Women's Views about the Ontario Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions Strategy Sudbury Roundtable Results	2009	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Citizen/patient input
Women's Views about the Ontario Ministry of Health and Long-Term Care's 10-year Mental Health and Addictions Strategy Ottawa-Francophone Roundtable Results	2009	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Citizen/patient input

Every Door is the Right Door Towards a 10-Year Mental Health and Addictions Strategy A discussion paper	**2009**	**Consultation paper written by Minister's Advisory Group**	**Y**	**N**	**Y**	**Y**	**MOHLTC**	**Government discussion paper**
Report from the Mental Health and Addictions Consumer Advisory Panels to the Toronto Central LHIN on Consumer/Survivor Perspectives and Families of Consumer/Survivors	2010	Toronto Central LHIN	N	N	Y	N	Ontario LHIN	Stakeholder position paper
Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy	**2010**	**Minister's Advisory Group**	**Y**	**N**	**Y**	**Y**	**MOHLTC**	**Government position paper**
Open Minds, Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy	**2011**	**Ministry of Health and Long-term Care**	**N**	**N**	**N**	**N**	**MOHLTC**	**Framework**
Toronto Central LIHN Stakeholder Equity Consultation Report	2011	Toronto Central LHIN	N	N	Y	N	Ontario LHIN	Stakeholder position paper
Supportive Housing for People with Problematic Substance Use 2010/11 – Phase 2 Call for Proposals	2011	Toronto Central LHIN	N	N	Y	N	Ontario LHIN	Program initiative
NE LHIN ABORIGINAL/FIRST NATION AND MÉTIS MENTAL HEALTH AND ADDICTIONS FRAMEWORK	**2011**	**North East LHIN**	**N**	**Y**	**Y**	**Y**	**Ontario LHIN**	**Stakeholder position paper**
The Ontario Women's Health Framework	2011	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Stakeholder position paper
The long-term effects of domestic violence: Recommendations for Policy Makers	2012	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Stakeholder position paper
The organization of perinatal mental health services in Ontario Recommendations for service, education and training, policy and research	2012	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Stakeholder position paper
The Way Forward: Stewardship for Prescription Narcotics in Ontario	2012	Report by Expert Working Group on Narcotic Addiction	N	Y	Y	N	MOHLTC	Stakeholder position paper

Adult Strategic Mental Health Plan for Erie St. Clair 2012-2016	2012	Erie St. Clair LHIN	N	N	Y	N	Ontario LHIN	Stakeholder position paper
Mental Health Strategy consultation paper	2013	Legal Aid Ontario	N	N	Y	N		Stakeholder position paper
Select Committee on Sexual Violence and Harassment – Final Report	**2015**	**Legislative Assembly of Ontario**	**N**	**N**	**Y**	**Y**	**Legislative Assembly**	**Government discussion paper**
It's Never Okay: An Action Plan to Stop Sexual Violence and Harassment	2015	Government of Ontario	N	N	Y	N	Government of Ontario	Government strategic plan
A place to call home Report of the expert advisory panel on homelessness	?2015	Expert Advisory Panel on Homelessness	N	N	Y	N	Ministry of Municipal Affairs & Housing	Stakeholder position paper
Methadone Treatment and Services Advisory Committee	2016	Methadone Treatment and Services Advisory Committee	N	N	Y	N	MOHLTC	Stakeholder position paper
Women and Alcohol Expert Panel Report: Alcohol Treatment Services for Ontario Women	N.D.	Echo: Improving Women's Health in Ontario	N	N	Y	N	MOHLTC	Stakeholder position paper
Central LHIN A Journey of Deliberate Steps 2013 / 14 Annual Report	N.D.	Central LHIN	N	N	Y	N	Ontario LHIN	Stakeholder position paper

Appendix 2 - Data extraction template

A) Initial classification and categorization of documents:
   1. Participants - who has issued the document
      i. Government
         1. LINH/Regional
         2. Provincial
         3. Federal (if applicable to Ontario context)
      ii. Interest groups
      iii. Are these participants:
         1. Visible (engaged with problems and politics)
         2. Hidden (engaged with policies)
   2. Does the document bring attention to the **problem** of addressing trauma through:
      a. Focusing events
      b. Change in an indicator
      c. Feedback about the program from the operation of current programs
   3. How is TIC being used as a concept in the generation of **policy** documents
      a. Diffusion of ideas on TIC
         i. Specifically how TIC is being defined, understood and operationalized using the following coded categories [142]:
            1. Governance arrangements
            2. Financial arrangements
            3. Delivery arrangements
               a. How services are designed to meet citizens' needs
               b. By whom services are provided
               c. Where services are provided
            4. Implementation strategies
               a. Citizen-targeted
               b. Provider-targeted
               c. Organization-targeted
               d. System-targeted
            5. Program and services areas
      b. How TIC frames feedback from the operation of existing policies
      c. Communication/persuasion regarding concept of TIC
   4. Does the document discuss/address relevant **political** events:
      a. Swings in national mood relevant to trauma
      b. Changes in the balance of organized forces
      c. Events within government

B) How likely is the concept of TIC within emerging policy documents to survive according to Kingdon's criteria:

1. **Problem stream** - Is the concept of TIC a clearly defined problem as established by the following criteria (a condition that meets the following problem definition criteria is more likely to elicit government action):
    - Compare current condition of trauma in Ontario with values concerning a more ideal state of affairs
    - Compare performance with the performance of other countries
    - Putting the subject of TIC in one category or another (framing the problem)

2. **Policies stream** – do the selected trauma-informed policy documents have the following conditions necessary to reach a state of serious consideration based on the following criteria:
    - Technically feasible
    - Fit within the dominant values and current national mood
    - Acceptable given anticipation of future constraints
        - E.g. Budget workability, political support/opposition

3. **Politics stream** – does the concept of TIC as depicted in these policy documents have the following characteristics (political agenda items more likely to arise to agenda prominence meet the following criteria):
    - Congruent with the national mood
    - Enjoy interest group support or lack organizational opposition
    - Fit orientations of current governing party or prevailing legislative coalition

Chapter 4

Preface

This chapter builds on knowledge gained through the two previous chapters. Specifically, this chapter addresses the gap identified in the previous chapter in our understanding of why trauma-informed care (TIC) was recommended in various Ontario policy documents, but was not included in Ontario's landmark 2011 mental health and addictions strategy. Thus, this study was conceived to explore how and why TIC was omitted from the 2011 strategy.

I designed the study under the guidance of my supervisory committee. I was responsible for all data collection and analysis, which took place between August 2018 and August 2020. My supervisory committee provided verbal and written feedback on iterative drafts of the study, which were integrated into the study as it evolved.

Exploring the role of trauma-informed care in the development and implementation of Ontario's 2011 mental health and addictions strategy: A case study

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Key words: trauma, trauma-informed care, Ontario, mental health, policy

Word count: 7, 121 (main text)

Abstract

Introduction: While the use of trauma-informed care (TIC) has been widely recommended in a number of Ontario government policy documents, it was omitted from Ontario's 2011 mental health and addictions strategy (the Strategy). This study examines why TIC was strongly recommended in the consultation leading up to the development of the Strategy, but excluded from both the Strategy itself, and its subsequent implementation.

Methods: This study followed Yin's explanatory, holistic, single case study design. Data were collected via semi-structured, key-informant interviews and publicly available government documents. A policy inaction framework in combination with a structural interests framework were used to inform data analysis, with data coded according to emerging themes as per the qualitative content analytical approach.

Results: Eighteen key-informant interviews were completed and eleven government documents were reviewed. Results from data analysis indicate TIC was excluded from the Strategy primarily due to government-driven ideological inaction in combination with network-driven inaction. Additionally, TIC was excluded as it contrasted with dominant government interests, which include not disrupting predominant use of the biomedical

model or challenging traditional psychiatric practice, which largely overlooks trauma and the need for TIC.

Discussion: This is the first study to explore why TIC was excluded from Ontario's 2011 mental health and addictions strategy. Furthermore, this study utilized a novel analytical approach by applying two theoretical frameworks to examine both how and why TIC was excluded. Use of the policy inaction framework in combination with a framework on structural interests allowed for nuanced understanding as to how both dominant interests and drivers of policy inaction contributed to Ontario's decision not to include TIC.

Introduction

Over the last decade, the concept of trauma-informed care (TIC) has been the focus of much research, both in the health sector and more broadly across a range of other sectors, such as child welfare, education and justice.[37, 41, 50, 82, 89, 107, 264, 265] The high prevalence of trauma was first noted in a seminal Adverse Childhood Experiences (ACE) study in the late 1990s, which demonstrated both the previously under-estimated burden of trauma and its many comorbidities, which include numerous chronic health conditions.[10, 131, 158] The ACE study findings spurred many neuroscience studies, which demonstrate the long-term, significant impact of trauma on the brain.[70, 149] More recently, researchers have enhanced our understanding of the neurobiology of trauma, which has contributed to a cultural shift away from pathologizing behaviour towards understanding why individuals suffering from trauma behave in certain ways and what can be done to support them.[109, 174] Moreover, service delivery systems are increasingly aware of how untreated trauma affects not only the individual's overall health and well-being, but also has broader implications for families, communities and systems of care.[44]

While a widely accepted definition for both trauma and TIC remain to be established, for the purposes of this study, trauma is defined as when an event, or series of events, overwhelm an individual's capacity to psychologically self-regulate and negatively affects some or all of the following - the individual's internal well-being, inter-personal relationships and function in society.[260] TIC is defined as a bi-directional relationship between the trauma-affected individual (who can be a consumer or provider of services) and a provider of human services (who can be also be affected by trauma)

within a culture fostering mutual resilience and empowerment.[260] TIC can be operationalized vertically, within one system of care, and horizontally, across multiple systems of care.[260]

Research evidence indicates that untreated trauma manifests in physical and psychological symptoms and can lead to significant health and social problems.[164] Additionally, trauma is now recognized as a risk factor for substance abuse, specifically, and mental health problems more broadly.[168, 170, 171, 226, 266] Despite ample evidence regarding both the clinical sequalae of trauma and the vast array of medical complications and comorbidities that can arise if trauma is left untreated, psychiatry has an episodic history of overlooking trauma as an etiological factor in psychiatric disorders and physical ailments.[2, 8] More recently, an attempt to include developmental trauma as a distinct diagnostic category in the *Diagnostic and Statistical Manual of Mental Health* Version 5 was rejected.[23, 25] This holds important implications as the lack of established and recognized diagnostic criteria for developmental trauma presents additional challenges for access to relevant and urgently needed treatment during the critical developmental years of childhood.[23-26] Even though psychiatry, as arguably the most powerful profession in mental health services, has not yet consistently acknowledged the role of trauma in mental illness, TIC has garnered increased attention as a key contributor to improving service delivery and patient outcomes in the mental health (MH) and addictions sector.[11, 155, 173, 237] Empirical evidence on the effectiveness of TIC is beginning to grow, particularly in MH and substance abuse programs when compared to traditional treatment.[136, 152, 166, 170, 266]

Despite growing awareness of the prevalence of trauma and the increased recognition of the need for TIC within the health system, there remains a lack of understanding regarding what are the political and policy barriers to implementing TIC in the MH system. Specifically, within Ontario, TIC has been recommended in a variety of MH policy documents, as identified by the research team in a previous study examining TIC as it relates to Ontario policy documents.[267] That study identified a gap in understanding why TIC has been broadly recommended in Ontario and yet was not included in Ontario's first, province-wide mental health and addictions strategy, released in 2011. The current study aims to fill this gap by exploring factors that influenced political decision-making regarding TIC and its role in the 2011 strategy. This study seeks to answer the following research question – why was TIC strongly recommended in the consultation phase leading up to the release of *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (the Strategy), but subsequently excluded from the development and implementation of the Strategy itself?

Context

Trauma affects a significant proportion of Canadians, as an estimated 55-90% of all people experience at least one traumatic event in their life.[268] A 1990/91 study surveying almost 10,000 Ontario residents concluded that a history of childhood maltreatment is common.[126] The study found that 21% of females and 31% of males surveyed had been physically abused as children and 13% of females and 4% of males had been sexually abused as children. A 2008 Canadian national survey found that 32%

of adult Canadians had experienced some type of child abuse, which included physical abuse, sexual abuse, neglect, emotional maltreatment, and exposure to intimate partner violence.[127, 269] Furthermore, the 2012 Canadian Community Health Survey: Mental Health indicates that 26% of Canadians have experienced child physical abuse, 10% have experienced child sexual abuse, and 8% have been exposed, as children, to intimate partner violence.[270]

With respect to the political and policy context of this issue, mental health and addictions has received increased and ongoing attention on the Ontario government's decision agenda. Three years after the Strategy was launched in 2011, the Ontario government appointed the Mental Health and Addictions Leadership Advisory Council, which was tasked with providing implementation guidance on the strategy, initially focusing on children and youth and later to include mental health issues for Ontarians of all ages. Since the Strategy was launched, core services for children and youth have been defined and are provided at the community level with specialized services available regionally.

Design and Methods

Study design

An explanatory policy analysis utilizing a case study approach was employed to examine Ontario's decision-making process in developing the Strategy and related policies[114, 117, 198]. Specifically, this study will apply Yin's explanatory, holistic, single case study design.[122] Yin states case study methodology is appropriate when a researcher

is seeking to understand complex social phenomenon and this approach allows the researcher to focus on a "case" while maintaining a comprehensive and real-world perspective.[122] Case studies are also relevant when the identified research question asks how or why questions regarding a contemporary set of events over which the researcher has minimal to no control. Additionally, a holistic, single case study design is also most appropriate for the research question at hand as the singular unit of analysis is government decision-making related to TIC at the provincial level in Ontario. That is to say, given the focus is a provincial-level government strategy, this research study is examining one level of decision-making – the provincial level – rather than analysing multiple levels of decision-making, which could include the organizational and municipal levels.

Establishing the Case and its Boundaries

A central feature of case study design is to explicitly define the case, or unit of analysis, and its boundaries. Within the confines of this study, the case is defined as the factors that explain government decision-making regarding the exclusion of TIC from the Strategy and subsequent reports resulting from the Strategy, as identified above. The case is bounded by context in that only data relating to the defined context of the policy process, as specified in the research question, will be included. The case will additionally be bound by time, as data will only be included from 2009 onwards, to reflect the inception of the Ministerial Advisory Group in 2009, which was part of the policy development and implementation process relevant to the Strategy.

Data Sources

Data were collected from multiple sources – a hallmark feature of case study design.[122] First, relevant documents, such as publicly available government policy documents, committee reports and technical reports related to the Strategy were identified and relevant data extracted. Second, semi-structured interviews were conducted with key informants. Finally, field notes were recorded throughout the data collection process and reflexive journaling was conducted.

Sampling, Recruitment and Data Collection

Relevant documents were identified using criterion sampling to ensure they complied with established boundaries of the case. Specifically, all included documents were required to address either government consultation work done leading up to the Strategy, the development of the Strategy, itself, or the implementation of the Strategy. Reference chaining, in which the references of a document are reviewed to identify potential new data sources, was also used to contribute to the generated sample of included documents, as policy documents often cite or refer to additional highly relevant documents, thus, drawing the researcher's attention to the potential of added data sources. Criterion sampling was also used to identify key informants. Specifically, key informants were included if they: (i) had been directly involved in the consultation phase (ii) worked directly on the development of the Strategy itself (iii) had been involved in the

implementation of the Strategy. Additionally, snow-balling sampling was used in that key informants were asked if there were additional data sources, including documents or individuals, they could recommend given relevance to the research question.

Prior to recruitment of key informants, ethical approval was received from the Hamilton Integrated Research Ethics Board (HiREB, protocol #5252). Relevant key informants were recruited via an emailed invitational letter (Appendix 1) along with an attached letter of information regarding the study and consent (Appendix 2). Potential participants were then contacted via a follow-up telephone call, if applicable (Appendix 3). Semi-structured interviews with key informants were conducted via telephone and facilitated through use of an iteratively developed interview guide (Appendix 4). Informed consent was obtained for all interviews, which were audio-recorded with participant permission. The audio-recordings were then transcribed verbatim and uploaded into NVivo. Included policy documents, field notes and reflexive journaling text were also uploaded into the NVivo database for analysis. Data collection and analysis occurred simultaneously.

Data specific to key informants was collected in two phases (see Table 1). The first phase of key informant interviews occurred between September and November of 2018, resulting in a total of nine completed interviews. Exhaustive efforts were made to identify and reach out to prospective key informants at this time, with over thirty research participant invitations sent out. Results of invited participation are as follows: Completed interview (n=9); invited, no response (n = 13), initially agreed, then no response despite follow-up by the first author (n=3); declined with explanation (n=7). Of those who

declined with explanation, the predominant provided rationale was that the invited participant could not speak to the role of TIC in the Strategy. One participant, however, declined to participate as the timing was 'too politically sensitive' given the provincial election of June 2018 resulted in a change in government and this individual's position in relation to the new government had not yet been confirmed. This is an important insight given that the research study was primarily targeting either former or current government officials, which provides some explanation of the challenges encountered with participant recruitment in this phase. Despite robust and comprehensive efforts in the first phase of data collection, data saturation had not yet been reached and further key informant interviews were required. A second phase of key informant interviews was carried out between April and June of 2020 and 100% of invited participants (n=9) were successfully recruited into the study. A Freedom of Information (FOI) request for access to internal documents and government data specific to the Strategy was also submitted in early May 2020 and the first author held a tele-conference with four government officials in late May 2020 regarding access to requested information. Despite this, and several follow-up emails, none of the requested information has been provided to date. In July 2020, the research team determined that sufficient data had been collected to move forward with the study based on the richness of collected data, the lack of new information emerging from completed data analysis and the likelihood that the research team would face ongoing delays in obtaining a response to the submitted FOI given the government's focus on the 2020 pandemic. Additionally, publicly available data, accessed by the research team, provided a comprehensive understanding of the events leading up to and occurring

throughout the Strategy's development and implementation (see Table 2). Furthermore, interviewed key informants were equally represented across the three phases of the Strategy (see Table 3), which provided a balanced overview of the Strategy's consultation, development and implementation phases by those involved at the time.

Yin's three principles of data collection were applied to the data collection phase of the study: i) use of multiple sources of evidence to achieve data triangulation; ii) the creation of a case study database housed within the NVivo12 software program, which was used to sort and categorize all collected data; and iii) maintaining a chain of evidence, which increases the reliability of the case study and allows for an external observer, typically the reader, to follow implementation of the research design and decision-making process.

Data Analysis

Data analysis occurred in two phases and was guided by two theoretical frameworks. The first framework, which draws on the field of policy sciences, specifically public policy and critical political science, outlines five typologies, or ways, in which government intentionally, or unintentionally, takes a position of policy inaction on a specific issue (See Figure 1).[123] Policy inaction is defined as:

> "an instance and/or pattern of non-intervention by individual policymakers, public organizations, governments or policy networks in relation to an issue within and potentially within their jurisdiction and where other plausible potential policy interventions did not take place."[123]

The first typology of inaction (Type I), also known as *calculated inaction*, occurs when inaction is intentional for strategic or tactical reasons. For example, decision makers may intentionally choose not to act on an issue because the timing is not advantageous or positive action may compromise other strategic goals. Type II, or *ideological inaction*, occurs when inaction is driven by ideological values or beliefs, such as government refraining from addressing societal issues deemed beyond its remit for intervention. It is important to note that ideology, within the context of this framework, is in reference to the ideological position of government as it relates to the overall role of the state and irrespective of political party affiliations. Ideological inaction, in this context, is not limited to the specific policy positions as pertinent to a particular political party, but rather is about government's perception, heavily influenced by past government decision-making, regarding what is considered appropriate versus inappropriate state interference or action. Type III, or *imposed inaction*, occurs when informal 'veto points' exist that will block action, such as bureaucratic or political stalemates or lack of consensus across decision-makers in a system that required unanimous support. Type IV, or *reluctant inaction*, occurs when there are no viable policy options or when necessary tools and resources, such as lack of funding or critical infrastructure, are not available. Type V, or *inadvertent inaction*, occurs due to political or institutional 'blind spots' or when a particular problem or issue is not considered because it has not generated enough visibility or urgency to be considered.[123]

There are four levels of policymaking in which the five typologies of inaction can occur.[123] First, there is *individual-driven* inaction. There are four primary drivers of

inaction at the individual level, the first of which is maintaining the status quo by paying attention to selective information and selectively interpreting or dismissing information that challenges the individual policymaker's understanding of the status. Second, individual policymakers can 'shift responsibility' for decision-making by passing the issue on to others. Third, past decisions can be reinforced by rationalizing why there is no need to reconsider them. Finally, individual policymakers can delay a decision by indefinitely prolonging the information-gathering state or engaging in continual deliberation without decision action, or by selecting to defer the decision itself. The second level of inaction is *public-driven*. Inaction can occur at this level when issues that could or should be within the realm of what public organizations act upon remain on the periphery due to organizational 'blind spots' or when organizations view only what they wish to view, which results in relevant issues being filtered out and ignored. *Government-driven inaction* is the third level on which policy inaction can occur. Government is typically hesitant to assume the required risks or costs necessary to address 'non-core' issues or affect the less 'essential' constituents, resulting in inaction on these issues due to ideological values. Additionally, governments are reluctant to acknowledge and address issues that highlight systemic problems that government has failed to adequately address, such as poverty, violence and discrimination. The last level of policy inaction occurs within networks, or *network-driven inaction*. The policy process increasingly involves crossing traditionally delineated boundaries to include various institutional stakeholders, cross-sectoral interests and differing jurisdictions. Coordinating positive collaboration within these complex networks is contingent upon the coalescing of multiple factors that

facilitate mutual trust and momentum. When this does not happen, networking and interagency collaboration can disintegrate due to poor communication and a lack of trust, resulting in network-driven inaction.[123]

The framework on policy inaction provided a structured and comprehensive analytical approach to addressing the research question, namely why the government took a position of policy inaction on TIC by excluding it from the Strategy, despite strong recommendation in the consultation phase for its inclusion. After completing a preliminary analysis of the data using the policy inaction framework, the researchers recognized some important aspects of the data were not captured. Specifically, captured data that spoke to whether and how the influence of various interest groups may have contributed to the exclusion of TIC was not addressed. This led to the use of Alford's model of structural interests to help inform a better understanding of the nuanced ways in which TIC was ultimately excluded from the Strategy.[124] Structural interests can be defined as interests that are either served, or not, based on how well they 'fit' the basic operating logic and principles of societal institutions.[124] There are three types of structural interests – dominant, challenging and repressed. Dominant structural interests are served by the existing structure of economic, political and social institutions.[124] Challenging structural interests emerge from the re-structuring of society.[124] Repressed structural interests do not align with current societal institutions, thereby guaranteeing they will not be served unless exceptional political willpower is mobilized.[124]

As outlined above, all collected data were managed in an NVivo database. Data analysis began by organizing data into the three phases of the Strategy - the consultation

phase, the development phase and the implementation phase. Data were then filtered through the five typologies and three drivers of the policy inaction framework.[123] Public-organization driven inaction was excluded as collected data was limited to the context of government decision-making. Data analysis, through the use of both theoretical frameworks, followed Yin's analytical technique of iterative explanation building in which patterns and themes emerging from the data are used to explain why something did, or this case did not, happen.[271] This technique was the primary analytical driver in that all data was analysed through the lens of explaining why TIC was strongly recommended in the consultation phase, but ultimately excluded from both the development and implementation of the Strategy. As highlighted above, data were collected from multiple sources, which is a strength of case study design. Use of data triangulation, via multiple data sources, strengthens the construct validity of the case study, with multiple sources of evidence providing alternative measurements of the studied phenomenon that can be considered alongside one another.[271]

Results

TIC at the consultation phase

Two parallel processes were at play during the consultation phase (see Table 2). First, there was the Ministerial Advisory Group (MAG), which consisted of service providers, researchers, individuals with lived experience and family members. The MAG was tasked with creating various recommendations for the Strategy. Second, the Select Committee on Mental Health and Addictions (Select Committee) was established and was

comprised of elected officials, specifically members of provincial parliament, who were similarly tasked with creating various recommendations as input into the development of the Strategy. The outcome of each process, with regards to TIC, was markedly different.

The MAG included a strong advocate for the recognition of trauma and the need for TIC within the Ontario mental health system. While this advocacy was ultimately unable to generate support for TIC from the Premier's office, TIC does feature as strongly recommended within both reports produced by the MAG. Conversely, the Select Committee entirely excludes both trauma and TIC in its final report. This is surprising given the Select Committee recognizes trauma within its interim report, even going so far as to say:

> "*Several witnesses stressed that unaddressed trauma is one of the most important causes of mental illness and addictions, particularly in the case of women, immigrants and refugees, and communities that are relatively deprived and suffer from high rates of violence*." (p.13).[272]

Despite the MAG's strong recommendations for TIC, all five typologies of policy inaction are present in this phase (see Table 4). With regards to Type I, both individual-driven and government-driven inaction are present as evidenced by the Premier's lack of interest in trauma and the exclusion of TIC in the Select Committee's final report. Type II, ideological inaction, is government-driven as TIC was perceived as beyond the remit of government decision-making. Imposed inaction, or Type III, is present in the Select Committee's exclusion of TIC in its final report. One of the political parties dissented to

the inclusion of TIC, which resulted in its omission as the final report required unanimous consent from all three political parties. Type IV, or reluctant inaction, is both government-driven and network-driven. The government is reluctant to take action on issues that do not have an easily winnable solution and TIC was viewed as lacking a cogent implementation strategy. Reluctant inaction was also driven by failure of the TIC network to mobilize a collaborative effort to provide government with the necessary research evidence to support TIC as a policy solution. Finally, Type V, or inadvertent inaction, is driven by individual policymakers who were both unaware of the prevalence of trauma and who did not see the relevance of TIC to mental health services.

Why TIC was excluded in the development phase

The first three typologies of inaction were at play in the development phase (see Table 5). First, government-driven calculated inaction is seen as TIC was considered by government to be an addictions issue, which was less of a priority in the Strategy. Second, government-driven ideological inaction resulted from government viewing TIC as a clinical issue, which conflicted with the government's position that it traditionally does not instruct service providers on how to provide care. Additionally, while government provided communities with funding for mental health services, in which TIC was seen as relevant, it was not involved in community decisions regarding what services should be funded. The third type of inaction in the development phase is imposed inaction, which occurred via the 2011 election. The Strategy was released in June 2011, just four months prior to the election. As one participant indicated, TIC was not on the political party

platform and it would have been very unusual to indicate a significant policy shift so close to an election. It is very possible that TIC was seen as too politically risky to include in the Strategy, given its close proximity to the election.

Why TIC was excluded in the implementation phase

The final two typologies of inaction are found in the implementation phase (see Table 6). Type IV, or reluctant inaction, occurred for two reasons. First, there were too many other competing priorities on the table for consideration while the Strategy was being implemented. Second, TIC was seen as a weak issue given that government lacked a comprehensive understanding of what is TIC and how it can be implemented. One participant explained why TIC was ultimately excluded by comparing it to cognitive behavioural therapy (CBT):

> *"I think CBT landed because there was evidence of effectiveness, there was evidence that 8 sessions would deal with this, 12 sessions would deal with that. It was easier to quantify and there still was a very significant gap. So again, on a comparative basis, with all the gaps happening, what was the one that was most available in terms of here's the evidence, we could prove it's cost-effective, it's actionable*." – Participant D5

Government-driven inadvertent inaction, or Type V, also occurs in the implementation phase. Several participants on Mental Health and Addictions Leadership Council, responsible for implementing the strategy, commented that TIC was not considered as

relevant or within the scope of their work as TIC was not viewed as a core mental health issue.

Key drivers of TIC policy inaction

Our data illustrate two key drivers of TIC policy inaction: government inaction and network-driven inaction. Across the three phases of the Strategy, *government* is the predominant driver of TIC policy inaction. There are several reasons for this. First, government ideology was a central driver of government inaction. When key-informant interviewees, who held roles as government decision-makers during the development of the Strategy, were specifically asked why TIC was excluded, a common thematic response was provided (see Table 4). In particular, interviewees indicated that with regards to TIC, the government does not decide for communities which services they should offer, nor does it dictate to clinicians what types of care they should provide. Second, the government was considering multiple priorities, which were simultaneously competing for recognition within both the Strategy, itself, and in the subsequent implementation of the Strategy. This led to a pragmatic default position in which the government dismissed or deprioritized TIC as there were too many other issues, perceived to be more credible, to consider. Third, as indicated by the policy inaction framework, governments are typically unwilling to address 'non-core' issues, which are issues that affect less 'essential' constituents. As outlined in Table 3 and Tables 5-6, our data indicate TIC was not viewed, by government, as a priority for the Strategy as it conceptualized TIC as mostly relevant to First Nations, refugees and other marginalized

population groups. Finally, governments are reluctant to acknowledge and address complex issues that highlight systemic issues. TIC was viewed within government as very complex and, likely, too politically risky, particularly given the Strategy was released in June 2011, just four months before the provincial election. This also contributed to government-driven inaction on TIC.

The second key driver of TIC policy inaction is *network-driven inaction*. Specifically, this was due to the failure of the TIC network to mobilize and collaborate in an effort to provide government with compelling empirical and research evidence highlighting both the prevalence of trauma across the general population and the role of TIC in providing better mental health services. As Participant D3 identified:

> "*When you compare advocacy organizations or groups, I don't think at the time there was a very organized advocacy momentum around TIC. I just don't think it existed.*"

It is very likely that a strong TIC network did not exist at the time, but this, on its own, is still a network failure in that TIC researchers, clinicians and service providers failed to cohesively unite in order to capitalize on the critical TIC policy opportunity represented in the development and implementation of the Strategy. Much of the government's rationale for rejecting TIC could have been addressed via empirical and research evidence, but the lack of a strong TIC champion and a mobilized TIC network resulted in a missed opportunity to present a compelling, evidence-based case for TIC.

Finally, while individual-driven inaction featured less prominently, there is one important aspect to recognize. Research participants indicated that during the consultation

phase, the Premier's office 'wasn't interested' in trauma or TIC. While this is an example of individual-driven inaction, it is important to recognize that the Premier's office represents arguably the most powerful individual in the policy process and lack of support by the Premier's office may have flagged TIC as a no-go issue for broader government.

TIC policy inaction as it relates to structural interests

Three major findings emerged when policy inaction regarding TIC was examined within the context of Alford's structural interests (see Table 7). First, government is typically more willing to consider issues that are readily quantifiable with cost-effective interventions and measurable outcomes in order to justify the use of government resources to address the issue. TIC was not aligned with this as, conversely, trauma was not seen as readily quantifiable and it lacked clear and implementable interventions. Thus, TIC did not 'fit' the government's operating principles and was dismissed. Second, across both the consultation and implementation phase, whenever TIC was recommended or advocated for, it was done by individuals representing indigenous populations, refugees, immigrants, persons with lived MH experience, ethnic minorities, and individuals struggling with poverty. When asked why one political party dissented to the inclusion of trauma in the Select Committee's final, Participant CS3 replied:

> *"The feeling was racism at play. It was mainly First Nations, poor people and refugees who had talked to us about the relationship between trauma and mental health and racism was at play. I don't know how else to say it although I'm not proud."*

Thus, those advocating for TIC were not part of powerful interest groups with a voice that government was inclined to consider and TIC was easily dismissed. Finally, psychiatry, which represents the most influential and dominant profession within the MH system, does not routinely provide training on either the prevalence or impact of trauma or how to address trauma within the context of TIC. Thus, trauma and the need for TIC are often overlooked or dismissed by psychiatry. With regard to TIC, Participant CS2 made the following comment:

> "*The golden rule of politics is that if people aren't talking about it, you don't have to do anything about it.*"

While some people were talking about TIC, its exclusion across all three phrases of the Strategy indicates that not all voices are equal with regards to political will and despite the various individuals raising the need for TIC at every phase of the Strategy, it was still omitted.

A comparison of how TIC relates to the interests of the government of the day provides important additional and nuanced insight as to why TIC was excluded from the Strategy. The traditional, and arguably still predominant, model of care within the MH system remains the biomedical model. In direct contrast to this, TIC is informed by a holistic biopsychosocial model and it is unlikely that government would be willing to significantly disrupt the MH system by introducing an alternate model of care. Additionally, as indicated by government, the priorities for care within the MH system are traditional mental illnesses, such as schizophrenia, bipolar disorder and acute psychosis; however, the role of trauma in these mental illnesses was not acknowledged or

addressed. Conversely, trauma remains on the fringes of the MH system as it is not routinely screened for or assessed and there were little to no trauma-specific services at the time of the Strategy. It is difficult to recognize or acknowledge a problem when the system does not screen or assess for it, thus, trauma has remained largely invisible. Furthermore, psychiatry, which is the predominant profession within the MH system, is not routinely trained in the prevalence of trauma or its impact. As indicated by Participant CM2, MH providers can, at times, overlook the scale or consequences of trauma and largely lack the necessary skills and training to adequately respond to trauma. Finally, as indicated above, across the three phases of the Strategy, advocates for TIC represented marginalized population groups, which further compounded the impact of psychiatry's dismissal of trauma and the need for TIC.

Discussion

Principal findings

The primary reason TIC failed to be included across all three phases of the Strategy was due to a crippling combination of government-driven ideological inaction and network-driven inaction. In particular, TIC was advocated for by representatives of marginalized population groups within the context of a MH system that holds deeply institutionalized structural interests, which maintain psychiatry and the biomedical model as dominant interests. Additionally, this was a very politically sensitive time during which government prioritized interventions that would yield quantifiable and clearly measurable outcomes. While a variety of policy inaction typologies are at play across the three phases

of the Strategy, government-driven inaction as it relates to ideology is the most compelling. It was clear that the government did not view trauma, or the need for TIC, as a pressing MH concern. The cumulative combination of the above-listed factors resulted in the exclusion of TIC from the Strategy.

The lack of an organized TIC network to effectively advocate for TIC as a critical component in Ontario's mental health system also contributed to TIC's exclusion from the Strategy. Additionally, this policy network failure represents a missed opportunity to challenge the government's perception of TIC in which it viewed TIC as limited to clinical decision-making and beyond the scope of government policy. It is important to note, however, that our findings were unable to conclude whether or not a strong TIC champion and a cohesive, mobilized TIC network would have been sufficient to overcome the government's rationale for rejecting TIC. In particular, our findings were unable to determine to what extent a unified and engaged policy network would have been able to successfully mitigate the systemic issues outlined above as related to how structural interests are likely to repress TIC as a viable policy option.

Additionally, it is important to note the government's rationale for rejecting TIC was very technical. As previously outlined above, one of the provided explanations for TIC's exclusion from the strategy was that government does not determine what community services should be provided. Around this time, however, the provincial government was actively participating in discussions regarding defining a basket of core services to be provided in the community. Thus, it is evident that government does, at times, engage in decision-making regarding the provision of community services. A

second stated reason for government's rejection of TIC is that government does not instruct clinicians on how to provide clinical care; however, it is important to acknowledge that government policy and the allocation of funding directly impacts how and under what conditions clinicians can provide care in practice. Thus, there is clear interplay between government decision-making and the provision of clinical care. It is possible that the more simplistic explanations provided regarding why government did not include TIC, as outlined above, allowed for the avoidance of acknowledging or discussing more deeply rooted, systemic issues that make TIC less attractive for government to act on as discussed above under structural interests.

Finally, use of Alford's structural interests framework allowed for critical analysis of the interplay between TIC and government interests. Three important findings emerged from this work. First, it is very likely that government was hesitant to disrupt the predominant model of care – the biomedical model, which does not account for trauma – employed within the MH system. Thus, the need for TIC has remained largely invisible when the system, itself, does not assess for or acknowledge either the prevalence or impact of trauma. Second, our findings indicate the dominant profession within the MH system – psychiatry – is not yet provided with the necessary training required to comprehensively assess for or understand the impact of trauma as it relates to mental illness. Third, advocates for TIC primarily represented marginalized population groups, which likely allowed for government to dismiss TIC as irrelevant to the broader population.

Strengths and limitations of the study

This study has several strengths. First, a significant strength of this study is the equal representation of key-informant participants across each of the three phases of the Strategy. This allowed for rich data collection and in-depth analysis as to why TIC was excluded at each phase of the Strategy. Moreover, the opportunity to interview key informants involved with the two parallel processes in the consultation phase – the MAG and the Select Committee – provided critical insight as to why one group, which was compromised of clinicians, researchers, and persons with lived experience, strongly advocated for TIC while the other, consisting of elected officials, did not. Second, this study builds on a previous study completed by the first author.[267] Insights gained from this previous work were used to inform participant interviews. Third, to our knowledge this study is the first to apply the policy inaction framework. This novel application allowed for rigorous analysis of the nuanced variables that contribute to policy decision-making. Additionally, use of the policy inaction framework particularly complements data analysis as the framework was developed from insights gleaned across the fields of public policy and critical political science. Finally, this is the first study, to our knowledge, to utilize the policy inaction framework in combination with Alford's framework of structural interests. This further allowed for both a comprehensive and robust analysis regarding the various types of policy inaction, as it relates to the exclusion of TIC from the strategy, how drivers of inaction contributed to this and how dominant interests at play influenced the decision to omit TIC.

There are a few limitations to this study. First, some challenges were encountered with regards to participant recruitment in the first phase of key-informant interviews as discussed earlier in the data collection section. It is possible that given the political sensitivity at the time, some relevant key-informant data was not captured due to lower participant recruitment in this phase. Additionally, the first author attempted to access senior government officials involved in the development of the Strategy, particularly the Ministers or assistant-deputy Ministers of the involved sectors. This proved to be exceptionally challenging and only one assistant-deputy Minister participated in the study. While it is likely that the explanations for why TIC was rejected are still valid, as identified by the included research participants, it would have been helpful to have greater access to senior decision-makers involved with the Strategy. A final limitation of the study is the elapsed time of about ten years between when the Strategy was developed and implemented and when key informants were interviewed. There is potential for inaccurate or incomplete memory recall on the part of key informants and this could lead to missing or misrepresented data. Regarding the potential for inaccurate memory recall, the use of case study methodology is a mitigating factor. Specifically, data was collected from multiple sources – key informant interviews, government policy documents, interim reports, and government files relevant to the Strategy – in a process known as data triangulation. No contradictory findings emerged. Regarding the potential for incomplete memory recall, this was addressed by providing all key informants with a comprehensive letter of information in advance of the scheduled interview, which outlined what the interviewees would be asked. This allowed interviewees to prepare for participation.

While many interviewees indicated they had reviewed their personal notes and files regarding the Strategy in order to prepare for the interview, it is still possible that relevant data has been unintentionally omitted due to potential challenges with memory recall.

Implications for policy and practice

The findings of this study have practical implications for the broader TIC policy network, particularly stakeholders in trauma policy such as clinicians and researchers. While government was aware of both the prevalence of trauma and the need for TIC throughout the three phases of the Strategy, failure of the TIC network to present a strong case for TIC by providing a succinct, yet compelling overview of the TIC literature, including the growing body of evidence regarding its effectiveness, resulted in a critical missed opportunity for TIC in Ontario. Thus, in order for TIC to be included in mental health policy moving forward, the TIC network will need to collaboratively put forth a concerted effort regarding impactful knowledge translation of TIC within government. Unified, collaborative effort by the TIC network is particularly important given the challenges outlined above regarding government dominant interests. Furthermore, given psychiatry's historical position of overlooking trauma, which was further evidenced in our findings, consideration must be given for how such a position may influence government. Specifically, government is not likely to endorse TIC if the most powerful professional group with the MH system does not fully acknowledge or support it. Finally, mobilization of a unified and collaborative TIC policy network will be

an important next step for TIC in Ontario in order to, at the very least, advance in raising awareness on and advocating for the importance of TIC for Ontario's MH system.

Implications for future research

There are several implications for future research. First, as this study was focused on government decision-making, we did not include any data related to public organizations, which is the second potential driver of policy inaction. Examining why government ultimately excluded TIC from the Strategy also meant there was limited data on network-driven inaction, as the inclusion criteria for the study limited data to government documents and key informants with roles specific to the Strategy. Thus, it will be important for future research to examine whether and how public organizations and the broader TIC network can interplay with government decision-making to influence the uptake of TIC government policy.

Second, while this study focused specifically on the government's decision not to include TIC in the Strategy, the findings highlight a need to further explore why the mental health system, and psychiatry in particular, receive little to no training in or acknowledgement of trauma despite empirical evidence documenting the high prevalence of trauma in a myriad of mental illnesses. Specifically, it is important to better understand psychiatry's current and historic position of overlooking trauma given the profession's predominant role as gatekeepers to the MH system in that psychiatrists, alone, can diagnose and prescribe treatment for mental illness. Although there may be pockets of recognition and support for the role of trauma emerging within psychiatry, particularly

with regard to developments in neuroscience, there is a paucity of discussion on TIC in psychiatric academic journals in comparison to the academic literature on mental health more broadly. This holds significant implications for the availability of, and accessibility to, trauma-informed services. Thus, further research is needed to examine how the assessment of and response to trauma, via TIC, might challenge dominant norms of the biomedical model, generally, and psychiatry, specifically.

Third, while Ontario ultimately chose to exclude TIC from its first province-wide MH and addictions strategy, TIC has been acknowledged and implemented in other Canadian provinces. [154, 161, 162] To gain a better understanding of the barriers of TIC in Ontario, specifically, it would be helpful to conduct a comparative case study examining how and why TIC has been implemented in other provinces yet remains largely unacknowledged in Ontario. There is also the possibility to do a comparative case study between Canadian provinces and American states as some states have also implemented state-wide TIC policy while others have not.[273-275]

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Table 1 - Flowchart of participant recruitment and key informant interviews

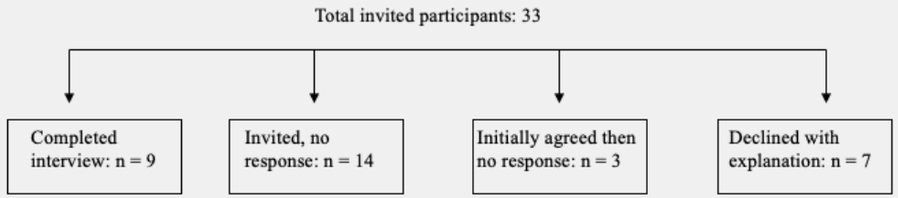
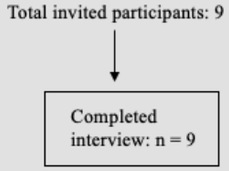
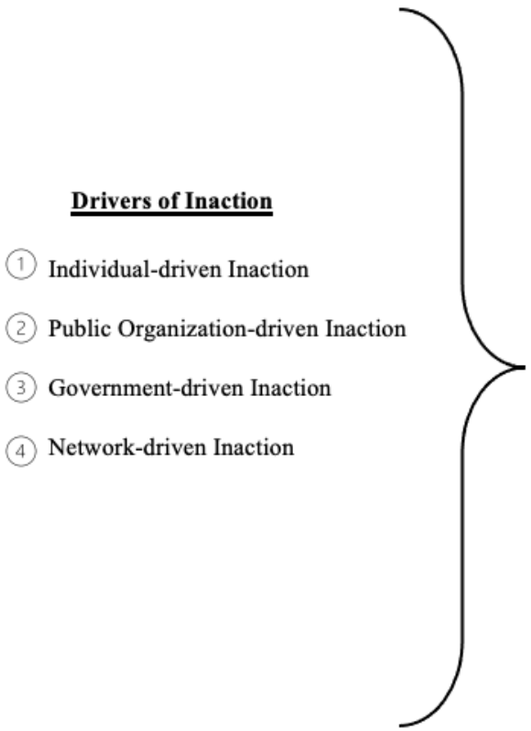
Phase I: September – November 2018	
Phase II: April – June 2020	

Figure 1 - Key drivers of inaction and five typologies of policy inaction[1]



Typology	Definition
1. Calculated Inaction	Issues that are intentionally neglected for strategic reasons – need more evidence, timing is off, choose inaction to protect other goals.
2. Ideological Inaction	Issues that are 'ideologically out of bounds' – views on the role of state/government may limit government scope for action
3. Imposed Inaction	Issues that likely will not gain enough support to be approved, thus, taking action is not feasible
4. Reluctant Inaction	Issues where action is not possible – inaction due to insufficient tools or resources to address the issue
5. Inadvertent Inaction	Issues are not visible to government due to institutional 'blind spots'

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Table 2 – Timeline of significant events related to the role of trauma-informed care in the development and implementation of Ontario's 2011 mental health and addictions strategy

Year	Event	Events specific to trauma and trauma-informed care
2007	Liberal majority government is re-elected under Premier Dalton McGuinty	
2008	Ontario government commits to strengthening mental health and addictions services. In October 2008, the Ministry of Health (MoH) forms Ministerial Advisory Group (MAG) consisting of people with lived experience, family members, researchers and service providers with a commitment to develop a mental health and addictions strategy.	
2009	On February 24, the Legislative Assembly of Ontario passes a motion to appoint a Select Committee on Mental Health and Addictions (SC) consisting of members of provincial parliament with representation across all three of Ontario's political parties. The Committee's purpose was to 'consider and report its observations and recommendations concerning a comprehensive provincial mental health and addictions strategy'.	
	July: The MAG releases its first report, *Every Door is the Right Door Towards a 10-Year Mental Health and Addictions Strategy*.	Trauma is recognized in this report as a predisposing factor of mental illness and trauma-informed care (TIC) is strongly recommended.
2010	March: The SC releases its interim report.	The report acknowledges trauma in relation to First Nations communities (historical trauma) and with regard to refugees and newcomers who have experienced trauma in war-torn countries. The interim report also stated: "Several witnesses stressed that unaddressed trauma is one of the most important causes of mental illness and addictions, particularly in the case of women, immigrants and refugees, and communities that are relatively deprived and suffer from high rates of violence" (p.13). The interim report also acknowledges that individuals with developmental disabilities have a high prevalence of mental illness resulting from the experience of bullying or sexual abuse.
	August: The SC releases its final report: *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*.	Notably, neither trauma nor trauma-informed care are mentioned in this final report despite discussion of trauma in the interim report.
	December: The MAG releases its second report, *Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy*.	Trauma is, again, acknowledged and TIC strongly advocated for.
2011	June: *Open Minds Healthy Minds Ontario's Comprehensive Mental Health and Addictions Strategy* is released. Phase 1 (2011-2014) of the Strategy was led by Ministry of Children and Youth Services.	Trauma is mentioned once as a risk factor for mental illness and addictions. TIC is not mentioned.

	October 6: A liberal minority government is elected under Premier Dalton McGuinty.	
2012	*Moving on Mental Health: A System that Makes Sense for Children and Youth* is released. It outlines an action plan for implementing the strategy.	Neither trauma nor TIC are mentioned in this report.
2014	June: A liberal Majority government elected under Premier Kathleen Wynne.	
	Phase 2 of the strategy begins and is led by the MoH. This phase is inclusive of mental health services across the lifespan with a focus on addictions. The Mental Health and Addictions Leadership Advisory Council (the Council) is established and given a 3-year mandate as part of Phase 2.	
2015	The Council releases its first annual report: *Better Mental Health Means Better Health.*	Part of the Council's recommendations are to address the mental health impacts of intergenerational trauma amongst First Nations and Aboriginal communities.
2016	The Council releases its second annual report: *Moving Forward: Better Mental Health Means Better Health.*	Neither trauma nor TIC are mentioned.
2017	The Council fulfils its three-year term and releases its third and final report: *Realizing the Vision: Better Mental Health Means Better Health*.	Neither trauma nor TIC are mentioned.
2018	June: A progressive conservative majority government is elected under Premier Doug Ford.	

Table 3 – Study participants across the three phases of Ontario's 2011 mental health and addictions strategy

Consultation phase		Development phase*		Implementation phase	
Interviewee	**ID**	**Interviewee**	**ID**	**Interviewee**	**ID**
Manager – Ministry of Health	CM1	Policy advisor – Ministry of Health	D1	Member – Mental Health and Addictions Leadership Advisory Council	I1
Director – Ministerial Advisory Group	CM2	Policy advisor – Ministry of Health	D2	Member - Mental Health and Addictions Leadership Advisory Council	I2
Participant - Ministerial Advisory Group	CM3	Assistant deputy minister**	D3	Member - Mental Health and Addictions Leadership Advisory Council	I3
Director - Ministerial Advisory Group	CM4	Manager, Ministry of Children and Youth Services	D4	Member - Mental Health and Addictions Leadership Advisory Council	I4
MPP – Select Committee on Mental Health and Addictions	CS1	Director, Ministry of Children and Youth Services	D5	Member - Mental Health and Addictions Leadership Advisory Council	I5
MPP – Select Committee on Mental Health and Addictions	CS2			Director – Ministry of Health, involved in Mental Health and Addictions Leadership Advisory Council	I6
MPP – Select Committee on Mental Health and Addictions	CS3				
Total number of participants, N = 18					

*Some participants involved in the development phase also participated in activities relevant to the implementation phase

** The ministry in which this participant worked within in this role has been intentionally not identified in order to ensure participant anonymity as per the requirements of the Hamilton Integrated Research Ethics Board

Note: the level of participants' positions (e.g. manager, director etc.) has been identified when there are multiple such positions across different branches within the same Ministry, thus, the anonymity of the participants is protected in keeping with the requirements of the Hamilton Integrated Research Ethics Board

Table 4 – Drivers of policy inaction at the consultation phase (2009-2010)

Typology	How	Drivers of inaction	Examples
Type I: Calculated inaction	• Trauma intentionally rejected by government during consultation with Ministerial Advisory Group (MAG) and omitted by Select Committee (SC) on MH and Addictions	• Individual-driven: key policymakers (the Premier) were not interested in TIC, likely for politically strategic reasons given the impending 2011 election; this may have flagged TIC as a 'no-go' issue for other policymakers • Government-driven: government perceived TIC as mostly relevant for 'First Nations, poor people and refugees', it is possible TIC was identified as a 'non-core' issue that affects less 'essential' constituents; governments are typically unwilling to assume risks or costs that address non-core issues or affect the less essential constituents, which leads to inaction on these issues	• "*The largest thing at play here was that they were scared of it [trauma]. They were scared of it as an issue because they didn't have the slightest idea what to do about it and stigma against me because of my experience*." – Participant CM3 • "*The minister absolutely embraced my ideas and my approach and I did a lot of work in between the meetings on what we called strategies, where I found my ideas with the minster himself and staff very well received as long as it wasn't about trauma and it was all about process*." – Participant CM3 • [On why trauma was not carried forward] "*The premier's office wasn't interested. Don't forget it was a time of great turbulence politically. It came out in 2010* [Select Committee final report]. *We were facing an election the next year, so it was really late in the mandate and these are things that matter. There was the change in minister, then we were heading into the 2011 election and I don't think it* [TIC] *formed part of that platform. If we'd been able to get it somehow into the platform, but I don't think there was much consultation on what would be in the platform so there wasn't any mechanism to bring it forward. It was a sore point. Then we went into the minority government and there was so much going on, gas plants, ORNGE, it just sort of fell by the way-side."* – Participant CS1 • *"It was mainly First Nations, poor people and refugees who had talked to us about the relationship between trauma and MH."* – Participant CS3
	• Trauma/TIC intentionally omitted by SC because there were	• Government-driven: – TIC was perceived as beyond the Select Committee's mandate	• [On the link between trauma and addictions and why trauma was included in final report] *"We were much more interested in schizophrenia, bi-polar, real psychosis. Addictions overall was a lesser concern. And don't forget it was 10 years again. We weren't into the*

	more pressing issues; trauma was seen as a 'causation' factor and deemed irrelevant to MH services	• Government-driven: – government prioritized 'schizophrenia, bi-polar, real psychosis' while TIC was dismissed	*opiate crisis that has now become more apparent. It was a much lesser topic. If anything, exposure to childhood abuse, sexual abuse, domestic violence, we didn't hear from people who'd experienced that and again those families wouldn't have come to talk to us so we didn't hear that side. And that would have been a slightly different study from the way we saw our mandate. And again I don't remember the exact conditions of the mandate, but from memory it was much more how do we organize services and programs in a more effective way so people can access them easily. It was we need more, people shouldn't be waiting a year to get counseling, what can government do. So, we didn't delve into causation, necessarily, of MH and addictions. I don't think we saw it that way.*" - Participant CS1
Type II: Ideological Inaction	• TIC seen as beyond scope of government policy and decision-making	• Government-driven: TIC perceived as beyond the 'remit' of government, shifting responsibility to non-government mechanisms (e.g. healthcare providers) to address this issue	• [On TIC] *"That's not something we do in government. We don't tell clinicians how to provide care."* - Participant CM1
Type III: Imposed Inaction	• One of the political parties dissented regarding including TIC in the Select Committee final report, thus, it had to be omitted because included content required consensus across all parties	• Individual-driven: one political party created an informal veto point by not supporting the inclusion of TIC, which required unanimous consensus in order to be included in the final committee report	• *"We had to get 100% buy-in from everybody* [all 3 political parties] *before we submitted the final report. I know that trauma was in the interim report, but there wasn't consensus on putting it in the final report, so it didn't make it."* – Participant CS3
Type IV: Reluctant inaction	• Perception that MH system lacks knowledge/capacity	• Government-driven: government is reluctant to act on issues that are poorly understood and	• "*I think our mental health system is enormously ill-equipped to deal with trauma. I think most people working within the system don't know how to approach victims of trauma in any kind of more specialized way than*

	on how to effectively address trauma	do not have a clear, winnable solution - TIC was seen as too ambiguous • Network-driven: lack of positive collaboration across TIC experts and stakeholders to mobilize and provide government with necessary information regarding how to operationalize TIC; no clear leadership or champion within the broader TIC network to highlight research evidence supporting TIC as a policy solution	*just generally enquiry and listening, and all those things are important, but we don't really have a conceptual model on the impact of trauma and aren't familiar with some of the specific treatments that may or may not be helpful*." – Participant CM2 • "*There was one very strong proponent* [of TIC] *and I think he was both consistent and steadfast and I would also say, looking back, he was kind of ahead of his time because from my perspective, if I was involved in the same project now, trauma would feature much more prominently in my thinking than it did then. And I think, generally, we had a fairly superficial concept of trauma, you know, something that was a risk factor, but not the concept that* [he] *was talking about regarding a trauma-informed or trauma-based mental health system.*" – Participant CM2
Type V: Inadvertent inaction	• 'Blind spot' – lack of awareness of epidemiology of trauma	• Individual-driven: lack of awareness regarding prevalence of trauma and TIC's relevance to the broader MH population; it is possible that TIC was overlooked as it threatens the status quo in Ontario's mental health system (trauma historically ignored and overlooked in the mainstream mental health system and TIC does not fit traditional biomedical model)	• **"***I think we just probably didn't appreciate both the scale and consequences of trauma faced by people in the mental health and addictions system*." – Participant CM2 • *We'd come, many of us, from backgrounds and areas where trauma didn't feature prominently in the work that we did where we may not have had the additional skills that were required to assist individuals dealing with trauma so we didn't given it as much attention as we should have done."* – Participant CM2
	• Trauma seen as primarily relevant to Indigenous populations, which falls under jurisdiction of federal government, thus not relevant at the	• Government-driven: trauma/TIC viewed as 'beyond the scope' of the Select Committee, resulting in shifting responsibility onto the federal government and other jurisdictions	• [On why trauma mentioned several times in Select Committee interim report, but excluded from final report] "*Well, it was probably beyond the scope. Indigenous populations from a provincial perspective, don't forget we were doing this as a provincial legislature, I mean we were aware of obviously trauma and the indigenous population. Mind you they didn't have the Truth and Reconciliation Commission at the time, but I think, and I don't know if this was conscious or unconscious, but it was very much well that's supposed to be a federal responsibility. There was always a tension between Ontario and the federal government as it*

	provincial level; government failure to see importance of TIC beyond context of specific population groups		*related to First Nations and who did what and I think that may have played into it, but I'm honestly speculating. It was sort of well of course we all know that, but is it really something we as Ontario can do much about other than to continue to advocate. That was sort of the beginning of...I think Ontario created the first Minister of Aboriginal Affairs. It was an awakening to that, but it wasn't front and centre at all. And in terms of refugees and immigrants, we didn't really feel they needed to be singled out, it was sort of well of course that's obvious of course they've got so many difficulties ahead of that, that was pretty clear. And that was before the Syrian refugee issue where you suddenly had large numbers of refugees. It wasn't that we were thinking we were going to ignore First Nations and refugees or immigrants, but it wasn't really front and centre of our mandate*." Participant CS1
	• Blind spot' – TIC wasn't well understood and trauma dismissed as not seen as a pressing concern	• Government-driven: TIC was too ambiguous and trauma was misunderstood as only relevant to preventative work rather than an important consideration for service design and delivery • Network-driven: the TIC network failed to act cohesively and provide government with robust and comprehensive research evidence regarding prevalence of trauma as it relates to mental illness and effectiveness of TIC	• TIC was viewed as "*just a phrase"* within MoH, "*it didn't mean much."* - Participant CM1 • *There was something driving this and it was experience. It would be without saying that traumatic experiences were having an impact. I think we thought it was understood. The concept of TIC wasn't on the radar in that way, it wasn't stated that way, but there was an understanding that a lot of things had happened to a lot of people and as a result they had ended up with MH and addictions issues. You could draw a straight line just about to the things they'd experienced. You have to think of the times this report was written, it wasn't that long ago but it was a different planet when it comes to mental health issues."* – Participant CS2 • *"Obviously, these people* [interviewees] *were going through traumatic things on a daily basis. The idea of trauma certainly came up from the people who were talking to us. You'll see this in the interim report. But what they were talking about was, I need help right now today, that was their priority. I don't care how I got here, I want to know how you're*

			going to get me through this, where can I get the help. We didn't spend a lot of time on prevention." - Participant CS2

Table 5 - Drivers of policy inaction at the development phase (2010-2011)

Typology	How	Drivers of Inaction	Examples
Type I: Calculated Inaction	• Government perceived TIC as relevant only to addictions, which was not a priority at the time	• Government-driven: TIC conceptualized as relevant to addictions only and not applicable to mental health, which was the focus of the strategy	• "*The strategy was mental health heavy and addictions usually gets the short end of the stick and TIC is something that's heavily in the addictions side of things and hasn't really won over the MH side in the same way. It's starting to make cracks, but in terms of treatment and awareness a lot has happened on the PTSD side of things much more recently. When this came out [the strategy] it [TIC] was only in the preliminary stages*." – Participant D1
Type II: Ideological inaction	• Government felt it was not their role to determine what community services should be provided – left it up to communities to decide if they wanted to fund TIC or not	• Government-driven: via dismissal of TIC under the premise that communities should decide how to utilize government funding	• *"We, government, are not the expert, and we don't know our communities and what services they need and what services work. So, we took a step back to say we think there should be core services of care and TIC definitely fits within that intensive core service, and then left it to the communities to make the decisions as to where the funding should go."* – Participant D4
	• Government does not dictate what type of care practitioners should provide and TIC was conceptualized as a type of care	• Government inaction: by ideology, specifically that government does not prescribe how practitioners should provide care	• "*Generally speaking, and particularly on the mental health file, the government doesn't talk about or prescribe particular interventions or methodologies. It talks more about system-level and financial support and concepts, but not particular interventions or practices and that's because the government isn't the practitioner.*" – Participant D3
Type III: Imposed inaction	• The 2011 election and subsequent change in government (from liberal majority to liberal minority)	• Individual-driven: it is likely that individual policymakers shifted responsibility for TIC decision-making due to the election cycle and change in government	• "*My team, we were focused on getting this up and running* [the strategy], *and then with change of government* [2011 election] *things have been on hold as people start to re-wrap relationships and working with LHINS.*" – Participant D5 • [On why there's been no uptake with trauma/TIC despite the recommendations] "*It would be quite unusual to see a major policy shift close to an election so that could explain it.*" – Participant D5

	imposed inaction regarding TIC	• Government-driven: it likely that TIC was perceived as too politically risky leading up to the 2011 election and immediately afterward given the change in government	

Table 6 - Drivers of policy inaction at the implementation phase (2011-2018)

Typology	How	Drivers	Examples
Type IV: Reluctant inaction	• Too many competing priorities and the other issues were better understood, had more evidence and a clear solution via specific treatment	• Government-driven: governments will deprioritize or dismiss less well-known issues, such as TIC, as it typically does not have the time or resources to ongoingly provide equal consideration of all relevant issues • Network-driven: failure of TIC network to provide evidence of treatment efficacy and cost-effectiveness of TIC	• *"I don't think trauma/TIC has a well-understood evidence base or knowledge base or protocols or standards. My understanding is that it hasn't reached the level of..I don't want to say credibility, but maybe it just hasn't been implemented much, it's still very much a concept, it's something people talked about, but there wasn't that protocol around 'this is how you do it'. We are nowhere near Cancer Care Ontario in terms of here's what you do to address mental health. We know early prevention and intervention is very important and is a lot of what is needed to address trauma. And poverty is a huge driver. It's very complex, it's extremely complex.*" – Participant I6 • "*First you need the evidence because there's a lot of competing priorities. In mental health, we all knew supportive housing was number one, but this could be another piece of the puzzle that not only was there not an common understanding of how to operationalize TIC, so there's a lot of talk about it, but it didn't make it to recommendation. There was a lot of work to try and figure out what's the top 10 list here. We didn't want anyone to not have a very easy at a glance page of our recommendations. This is all about what is actionable and if we have scarce resources, what are the top priorities here. That was our scope, a short report that's actionable and irrefutable."* – Participant D5
	• TIC lacked a 'tight business case' for TIC – unclear how to implement TIC and what TIC could deliver in terms of outcomes	• Government-driven: governments are hesitant to acknowledge and address issues that highlight systemic problems that government has previously failed to adequately address (e.g. poverty, violence and	• On why trauma/TIC didn't surface in implementation reports: "*I really don't know. I can just guess that in order to recommend something you have to go beyond just saying trauma-informed care. Is there a common definition, is there an understanding, if someone is going to implement TIC across the province, where would we start? Is there a recipe or a protocol? If you're doing whatever therapy or protocol, should you not always factor in trauma or is it something unique? Can CBT not be trauma-informed, and*

		discrimination), given TIC was poorly understood, this could potentially explain why it was not acted on • Network-driven: failure of TIC network to present strong case for TIC as evidenced in growing global empirical research	*if so how? How would trauma play into the report in a concrete way, maybe that was part of the situation.*" – Participant I6 • *"There was a lot of discussion that was relevant to trauma-informed, but I would say there needs to be more work to boil down, what is that, can it be scaled up, can it be evaluated, what training is required.*" – Participant D5
Type V: Inadvertent inaction	• Trauma/TIC not viewed as within relevant scope – wasn't included in the 'type of work' the Leadership Council was responsible for	• Government-driven: TIC was not viewed as a 'core' issue • Network-driven: failure of TIC network to provide research evidence demonstrating relevance of trauma and TIC to mental health service delivery	• "*For sure it [trauma] came up but again the type of work we focused on, which was very much at the governance level identifying communities, identifying lead agencies, starting that work around drilling down on core services. It would not have featured predominantly, something like that would have been much more prevalent in subsequent years work as we started to look at priorities and as agencies started to get their feet under them.*" – Participant D5

Table 7 – Trauma-informed care as it relates to structural interests and policy inaction

Driver of Inaction (Individual, Government or Network)	Structural Interest (Dominant, Challenging, Repressed)	Examples
Government-driven inaction	TIC was perceived as misaligned with governmental dominant interests, which are to address issues that are easily quantifiable and have cost-effective interventions with measurable outcomes	• "*If you were going to do a one-page infographic on the impact, on what it takes to implement TIC, who it's good for, how you diagnose that, what the cost-benefit is in terms of are they getting better, is it going to help them get to work and address poverty. That's what we* [government] *need. We need a tight business case so that it's competitive with all the other gaps that are maybe more quantifiable. –* Participant I6 • *"This* [the strategy] *is all about what is actionable and if we have scare resources, what are the top priorities here.*" – Participant I6
	In both the consultation and implementation phase, advocates of trauma and TIC represented marginalized population groups with little power, which contributed to TIC being perceived as a 'non-core' issue and, thus, easier to dismiss	• "*There is so much discrimination against people living with mental health and addictions issues. It has been made more clear with Black Lives Matter that there is a lot of racism in our community and the bigger group that talks about trauma is First Nations and the amount of discrimination against First Nations is systemic. It's in everything. Am I surprised that it* [trauma] *is not talked about? Nothing about First Nations is talked about. Am I surprised that there are 52 First Nations* [communities] *on boiled water advisory for the last 25 years and nobody knows about it, nobody talks about it? I'm disappointed. I wish it was different. But I am not surprised. –* Participant C7 • "*If you're talking about societal trauma of indigenous people, it was like, yes, of course they have more mental health issues. They are poorer, they have no jobs, the federal government hasn't given them proper housing. Of course, of course.*" – Participant C5 • "*It* [TIC] *mainly came from our indigenous representatives. So, you know, the relationship between intergenerational trauma, suicide, youth suicide in particular, also co-occurring mental illness and addiction.*" – Participant I4 • *We were trying to connect the dots and make the system better for everyone, not just a particular group, but we couldn't help not going into the area of trauma of marginalized individuals who've been historically discriminated against or under-represented in terms of service, whether it was indigenous populations, black youth, black individuals, people of colour in general. So, we did go there from time to time and the discussion of trauma did come up as well.*" – Participant I1

		• "*I think we are coming to trauma, this idea of trauma and how you see that in folks and how that get perpetrated on people. That's a recent thing in the mainstream and we're behind. And culture change takes a long time. Increasingly, we're seeing that new folks have a better conceptualization of trauma and how that plays out in services and systems, but there's still an old guard that that's not a priority for a lot of people."* – Participant I4 • "*The question becomes – who are the ones advocating for it* [TIC] *and what positions of power do they have or not have and how are they being included in the conversation? Are they at the table, and if not, why not?* – Participant I2
Network-driven and government-driven inaction	Psychiatry, as the dominant profession in the MH system, is not routinely trained in prevalence of trauma or its impact, thus both trauma and the need for TIC are often overlooked or dismissed, which government validated	• **"***I think we* [clinicians] *just probably didn't appreciate both the scale and consequences of trauma faced by people in the mental health and addictions system*." – Participant CM2 • *We'd come, many of us, from backgrounds and areas where trauma didn't feature prominently in the work that we did where we may not have had the additional skills that were required to assist individuals dealing with trauma so we didn't given it as much attention as we should have done."* – Participant CM2 • [On TIC] *"That's not something we do in government. We don't tell clinicians how to provide care."* - Participant CM1

Appendix 1 - Participant recruitment email script

EMAIL SCRIPT

Subject line: Invitation to participate in research regarding trauma-informed care in Ontario mental health and addictions policy

Dear [formal salutation],

My name is Maria Bargeman – I am a doctoral candidate working with Dr. Steven Hanna at McMaster University. As part of my dissertation, I am conducting a study on the role of trauma-informed care in the development and implementation of Ontario's *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. I am hoping to speak with you regarding your experience related to relevant mental health and addictions policy decision-making in Ontario.

Your participation in this research study would involve a 30-45 minute interview via telephone or Skype to be scheduled at a time most convenient for you. With your permission, the interview will be audio-recorded. Please find attached an information sheet detailing the research study. If you are interested in participating, or have any further questions or concerns, please email me at bargemmj@mcmaster.ca or feel free to call me at 905-818-3403.

Thank you for your consideration and I look forward to hearing from you.

Sincerely,
Maria Bargeman, MSc, RN
Health Policy PhD Candidate
McMaster University

Appendix 2 – Letter of information and consent form

LETTER OF INFORMATION / CONSENT

Exploring the role of trauma-informed care in the development and implementation of Ontario's 2011 mental health and addictions strategy

Investigators:

Local Principal Investigator:
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Email: mulvale@mcmaster.ca

You are being invited to participate in a research study examining the role of trauma-informed care (TIC) in the policy decision-making process related to Ontario's child and youth mental health strategy. This form provides detailed information regarding the research study. Please take your time in reviewing the information provided below.

Purpose of the study
This study is examining whether and how the concept of TIC played a role in the development and implementation of *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (2011). TIC is an emerging concept and remains poorly defined, particularly with regards to its use in policy. This study seeks to provide some understanding into the concept of TIC and its use in Ontario's mental health and addictions policies.

Procedures involved in the research
Your involvement would mean participating in a 45 minute (approximate) semi-structured interview either in-person or via telephone/Skype to be scheduled at your convenience. During the interview, you will be asked about your role in the development and implementation of *Open Minds, Healthy Minds*, what factors led to decision-making regarding the contents of the strategy and what stakeholders were involved in the process. Additionally, you will be asked about decision-making regarding the role of TIC and opportunities when it might have been included but was not. You may find it helpful to review relevant files prior to the interview, which will be sent in advance by the research team. We do recognize, however, that your time may not allow for this. You will also be asked in the interview if you have any relevant documents to share on any relevant topics covered in the interview.

Potential harms, risks or discomforts

There are no physical risks to participating in this study. The only potential risk is that your views and opinions expressed in the interview may become publicly known. As indicated below, multiple precautions will be taken to mitigate against this to the extent possible.

Potential benefits
This research study may not be of any immediate or personal benefit to you. We do hope that the results of this study will better inform and improve service delivery for mental health and you may indirectly benefit from contributing to these findings.

Confidentiality
Every effort will be made to protect your confidentiality and privacy. We will not use your name or any information that would allow you to be identified. Sometimes, however, we can be identified through the stories we tell. As noted above, this is one potential risk to your participation in this study. Your interview and any further information you may provide (in the form of documents or otherwise) that is not available in the public domain will be treated as confidential. With your consent, your interview will be audio-recorded and then transcribed. A unique identification code will be assigned to each transcript and corresponding digital file by the research team. We will ensure all transcripts and confidential material are secured within a locked cabinet inside a locked office and all digital files containing audio-recordings and transcripts will be stored on a security protected computer. The digital files, containing audio recordings and transcripts, as well as any confidential documents will be destroyed 10 years after the last publication of our findings.

Participation and withdrawal

Your participation in this research study is voluntary. You may refuse to participate in the research study entirely or withdraw from the study at any time and the data you have provided will be destroyed, if you wish, without consequence should you initially choose to participate. You may refuse to answer any of the questions throughout the interview process.

Information about the study results
We expect to have this study completed by approximately June 2019. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the study

If you have questions or need more information about the study itself, please contact me at:
Maria Bargeman
Doctoral Candidate
Health Policy
1280 Main St. West, CRL-209
Hamilton, ON, L8S 4K1
Tel: 905-525-9140 ext. 22952
Email: bargemmj@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

Exploring the role of trauma-informed care in the development and implementation of Ontario's 2011 mental health and addictions strategy

I have read the information presented in the information letter about a study being conducted by Maria Bargeman and Dr. Steven Hanna of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a signed copy of this form. I agree to participate in the study.

I would like to receive a summary of the study's results. *Yes* *No*

If yes, where would you like the results sent:

Email: _____

Mailing address: _____

_____

_____

_____	_____	_____
Name of Participant (Printed)	Signature	Date

Consent form explained in person by:

_____	_____	_____
Name and Role (Printed)	Signature	Date

Appendix 3 - Follow-up telephone script

FOLLOW-UP TELEPHONE SCRIPT

*To be used if no reply to initial recruitment letter/email

1. Student PI: Hello [insert official title of individual], my name is Maria Bargeman. I'm a doctoral candidate working with Dr. Steven Hanna at McMaster University. How are you today?

2. Student PI: Do you have a few minutes right now to briefly talk about a research study I am conducting about the role of trauma-informed care in Ontario's *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. If yes, continue to (a)
   - If no, continue to (b)

   a) If yes: Wonderful, thank you for your time. A week ago I sent you an email outlining a study I'm involved with, which is investigating trauma-informed care in recent policy decision-making. Did you happen to receive it and read it?
   - If yes, continue to (i)
   - If no, continue to (ii)

     i) PI: That's great. I'm just following-up on the letter to determine if you are still willing to participate in an interview, about 45 minutes long or so, conducted by myself related to the study outlined in the email. Would you be interested in participating? If you need more time before making a decision, I can call you back at your convenience (book interview or follow-up as needed)
     - If not interested:
       PI: Thank you for your time.

     ii) PI: Not a problem. Do you have a few minutes right now for me to briefly explain the contents of the letter/email?
     - If yes, continue to (i)
     - If no, continue to (b)

     i) (briefly explain purpose of study and outline request for participation)
     PI: Would you be interested in participating in this study? If you need some more time before making a decision, I can call you back at your convenience (book interview or follow-up as needed)

   b) I understand. Is there a better way or time to contact you about the study? (Follow-up with preferred method)

Appendix 4 - Interview Guide

Date: _____ Participant: _____
Time: _____ Place: _____
Interviewer: _____

PI: Thank you for your time in participating in this study. Do you have any questions before we begin?

Questions

1. Could you describe your role in relation to the development and/or implementation of *Open Minds, Healthy Minds*?
   - When and how did your involvement begin?
   - In what capacity?

2. I noticed that trauma and trauma-informed care (TIC) feature in the two preliminary documents leading up to the 2011 launch (2009 - Every Door is the Right Door; 2010 - Respect, Recovery, Resilience). In the development of these documents:
   - How was trauma identified as important and how was TIC discussed as an approach to care?
     - How did the group decide to include TIC?
     - Were any goals for TIC discussed?
   - What factors led to the decision to include TIC?

3. In *Open Minds*, trauma is only mentioned once and as a risk factor for mental health. The strategy doesn't include the Ministerial Advisory Group's recommendations regarding trauma-informed care.
   - Can you provide any insight as to how and why it was decided not to include trauma-informed care in the strategy, despite the recommendations?
     - Use new theoretical framework as prompts for how
   - Were there strong reactions in favour of or against inclusion of trauma or concept of TIC? Could you describe the nature of the discussions regarding trauma-informed care, if and when it was discussed?

4. Since the launch of the strategy, has the concept of trauma or TIC re-surfaced? Why or why not?

5. We are almost out of time. Can you think of any individuals who can also provide insight into these questions? In addition to what is publicly available, are there any documents you'd recommend I should examine in relation to this research? Is there anything else you feel is relevant to this discussion?

6. Is it okay to contact you if I need clarification on your comments or have a few quick follow-up questions? (confirm contact info and preferred way of communication)

Thank you very much for your time, I really appreciate it!!

Chapter 5

Conclusion

This dissertation provides a comprehensive examination of the role of TIC within and across systems of care. Specifically, this dissertation is unique to the current TIC literature in that it provides foundational insight into TIC, both in terms of definitional understanding of the concept and how it can be implemented. Furthermore, the examination of TIC across a range of contexts adds an additional robustness to the new conceptual definition of both trauma and TIC that has emerged from this dissertation. To conclude the dissertation, this chapter consists of five components in summary of the completed work (Chapter 2-4). First, this chapter provides an overview of the principal findings that emerged from the three original research studies. Second, an outline of the dissertation's unique contributions is highlighted. Third, strengths and limitations of the dissertation are discussed. Fourth, the findings of the dissertation specific to implications for policy and practice are reviewed. Finally, the chapter concludes with a brief discussion on next steps for future research as identified by the work completed in this dissertation.

Principal findings

There are several important principal findings that emerge collectively from the dissertation. First, each of the three original studies (Ch. 2-4) highlight the *contextual importance of the political system in which TIC is being operationalized*. Specifically, the political system can act as either a barrier or facilitator in the implementation of TIC. Chapter 2 outlines how the policy legacies, or past decision-making, of institutions can impact whether and how TIC is utilized. As seen in Chapter 3, TIC can also be used as a policy recommendation when there is mounting political pressure via several high-profile focusing events to address the problem of trauma. Of particular importance, Chapter 3 found that while TIC was being routinely recommended, very few policy documents actually define what TIC is, and how it can be implemented. Finally, Chapter 4 details how political ideology, specifically the traditional role of government, can influence government decision-making regarding TIC.

The dissertation also collectively highlights *the role of systems arrangements in influencing whether and how TIC is operationalized*. A common system arrangements barrier to TIC, as discussed in Chapter 2, is insufficient insurance coverage, lack of physician billing codes, and lack of sustainable funding. Chapter 3 found that current judicial system arrangements in Ontario can act as barriers to TIC. Specifically, procedural approaches in both the police services and the court system were found to be potentially harmful to trauma-affected individuals. The lack of accessibility to medical facilities that provide rape test kits was an identified barrier for survivors of sexual assault. Chapter 4 also found that system arrangements can act as a barrier to TIC. Heavy use of the biomedical model within the health system has created challenges for TIC, which incorporates the importance of wider psychosocial factors. Additionally, current system arrangements regarding the way in which psychiatry is trained has created a gap in service provider training in that psychiatrists traditionally receive very little to no formal training on how to assess and treat trauma.

The selected methodological approaches of each of the three novel research studies (Chapter 2-4) have also led to several important findings. The critical interpretive synthesis (CIS) employed in Chapter 2 allowed for an exhaustive review of the TIC literature across a range of contexts and disciplines. Data analysis conducted during the CIS led to three significant findings. First, new definitions for both trauma and TIC emerged to reflect a cohesive understanding of the collective trauma and TIC literature. Through rigorous data analysis, the following novel definition of trauma was developed – "when an event, or series of events, overwhelm an individual's capacity to psychologically self-regulate and can negatively affect the individual's internal well-being, inter-personal relationships and functioning in society". Additionally, the following comprehensive definition of TIC was developed – "a bi-directional relationship between the trauma-affected individual (who can be a consumer or provider of services) and a provider of human services (who can also be affected by trauma) within a culture fostering mutual resilience supported by an integrated referral network which allows the bi-directional relationship to occur vertically, within one system of care, and/or horizontal across other systems of care if needed". A second main finding of the CIS was the

development of a conceptual framework for TIC. The framework outlines a concise, yet comprehensive, overview of how trauma-informed systems can both vertically and horizontally care for trauma-affected individuals. The framework also captures three types of TIC outcomes – service user, user/provider, and provider – and highlights how TIC outcomes are not time-bound meaning that these outcomes may evolve over varying time intervals to reflect the uniqueness of each trauma-affected individual's journey towards wellness. The third main finding of the CIS is the identification of factors that affect the operationalization of TIC. Specifically, this emerged from the development of a theoretical framework in which TIC is situated within the political system and the arrangements of systems of care, both of which have variables that can act as either facilitators or barriers to the operationalization of TIC.

Upon establishing conceptual and definitional understanding of TIC, as outlined in Chapter 2, Chapter 3 moved into more specific examination of TIC by way of document analysis. Specifically, policy documents on adult mental health in Ontario were selected in accordance with pre-determined criteria and this allowed for an in-depth exploration of how and under what conditions do policy documents define and utilize TIC. This study resulted in four principal findings. First, the conceptual framework developed in Chapter 2 was used to analyse how the selected policy documents define TIC, which led to an important finding that while all 24 of the initially reviewed documents recommend TIC, only two provide a specific definition of TIC. Second, these two definitions of TIC similarly consisted of two components: (1) TIC recognises the impact of trauma (2) it then incorporates this awareness of trauma into the delivery of services. Notably, both these definitions are conceptually ambiguous and lack clarity regarding *how* to incorporate TIC into service delivery. Third, data analysis through use of an established political science framework on government agenda-setting revealed that three things must occur for government to act on TIC: (1) the problem of trauma is clearly defined and acknowledged (2) TIC is recognized as a viable policy solution to address the problem of trauma (3) the political climate allows for government to assume a position of action by addressing trauma via TIC. The fourth finding was that while several prominent mental health policy documents acknowledge trauma and recommend TIC, both are

notably absent from Ontario's first province-wide strategy (the Strategy) on mental health and addictions released in 2011.

In chapter 3, an explanatory, holistic, single case study approach was used to more fully examine one of the key findings of Chapter 2. Namely, why was TIC strongly recommended in the consultation phase leading up to the development of Strategy, but was omitted from the Strategy itself? A political science framework on policy inaction in combination with another framework on structural interests were used to analyse the data, which led to several main findings. First, failure of TIC to be included in the Strategy was due, in large part, to government-driven ideological inaction, which was further compounded by network-driven inaction. While government rationale for not including TIC heavily centred around an ideological position that its role was not to interfere with the provision of clinical care, this position was likely heavily influenced by structural interests at play. Specifically, psychiatry has a long history of overlooking trauma and study findings revealed that psychiatry in Ontario largely overlooked both the scale and impact of trauma. Additionally, predominant use of the biomedical model within the health system likely also diminished the probability of government endorsing TIC, which moves beyond the biomedical model to include important biopsychosocial aspects into care. Thus, Chapter 3 identified several variables that can contribute to government opting for a 'no-go' position on TIC, which provides further elucidation as to the potential barriers and limitations to the use of TIC within systems of care.

Study contributions

The three original research studies (Chapters 2-4) collectively presented in this dissertation address gaps in the scholarly literature in the following ways: extensive review and analysis of the TIC literature addressed gaps in understanding regarding how both trauma and TIC can be conceptually defined as well as led to the development of both a conceptual and theoretical framework; a critical examination analyzed how and under what conditions is TIC defined and utilized in Ontario adult mental health policy documents; exploration of why TIC was recommended for inclusion in Ontario's first, province-wide mental health and addictions strategy and yet was omitted from the

Strategy, itself, and its implementation in order to better understand what variables contribute to government 'no-go' decision-making as it relates to TIC. This dissertation, as a whole, also contributes several important substantive, methodological and theoretical contributions, which will be discussed in further detail below.

Substantive

Several important, substantive contributions have emerged from this dissertation's original research studies. First, the conceptual and theoretical frameworks developed in Chapter 2 were informed by a broad range of empirical and non-empirical literature spanning multiple disciplines and systems of care. This allowed for the development of highly versatile frameworks in that both frameworks that are applicable to a wide range of contexts. Thus, the conceptual and theoretical frameworks are a significant contribution to the field as they can be utilized on a granular level in a specific system, but can also be applied on a macro-level to understand the role of TIC in cross-sectoral approaches. Additionally, the findings that emerged in Chapter 3 provide comprehensive understanding as to how and under what conditions TIC can be used, as a policy solution, in emerging mental health documents. This chapter provided tangible insights regarding how the conceptual ambiguity of TIC, as identified in Chapter 2, has directly impacted the operationalization of TIC. And finally, Chapter 4 outlined important insights regarding why and under what conditions governments might take a 'no-go' policy position on TIC, which yielded significant understanding regarding the interplay between TIC and government decision-making. Specifically, this chapter highlighted the importance of understanding how the consideration of TIC can be impacted by both the structural interests within systems of care and larger political factors.

Methodological

This dissertation provides several methodological contributions. First, while there have been several systematic reviews done on TIC within a specific system of care, to our knowledge, this is the first time a critical interpretive synthesis (CIS) has been applied to TIC in which the literature was exhaustively reviewed across multiple disciplines and systems of care. This allowed for a comprehensive and robust review of the TIC literature, which included both empirical and non-empirical documents. Second, the TIC

conceptual framework developed in Chapter 2 was applied in Chapter 3, which allowed for testing of the conceptual framework. Third, to our knowledge, this is the first use of document analysis, in the TIC literature, to explore and understand how TIC is being used as a policy solution within mental health policy documents. Fourth, the novel combination of two political science frameworks – one on policy inaction and the other on structural interests – allowed for rigorous exploration as to why TIC was considered, but ultimately rejected from Ontario's first province-wide mental health and addictions strategy in 2011.

Theoretical

This dissertation advances theoretical understanding of both TIC, itself, as well as the role TIC plays within and across systems of care in several ways. First, the development of the conceptual framework on TIC in Chapter 2 provides novel insight regarding both a precise and comprehensive understanding of what is TIC. This addresses a significant gap in the literature as TIC has received several criticisms for being conceptually ambiguous and vague. Second, the development of the theoretical framework in Chapter 2 furthers understanding regarding how political and system factors can affect the operationalization of TIC. This is an important contribution to the field as, previous to this work, little theoretical knowledge existed regarding a comprehensive understanding of how political and system factors affect the implementation of TIC.

Strengths and limitations

This dissertation consists of several strengths. First, it is the first in the field to comprehensively examine both the conceptual definition and operationalization of TIC *within* and *across* systems of care. This allowed for a rigorous review of the TIC literature across multiple jurisdictions and spanning a variety of disciplines. Second, this dissertation utilized a range of research methods, which allowed for exploration of TIC from multiple angles. Additionally, the sequencing of the dissertation allowed for the theoretical framework developed in Chapter 2 to be tested in Chapter 3. Furthermore, the comprehensive review of the TIC literature in Chapter 2 established a foundational

understanding of both the breadth and depth of TIC, which allowed for nuanced examination of the phenomenon in the following chapters. Additionally, the findings of Chapter 3's document analysis regarding mental health policy in Ontario identified critical gaps in understanding regarding use of TIC in Ontario, which was then further explored in Chapter 4. Finally, the application of various interdisciplinary analytical frameworks throughout the dissertation provided rich insight and understanding as to the variety of variables that influence when, how and under what conditions can TIC be successfully operationalized across a range of settings.

There are two potential limitation to this dissertation. First, as noted in Chapter 2 and Chapter 3, there is a diversity of terminology used to describe the phenomenon of TIC, which is consistent with the lack of conceptual clarity noted within the scholarly literature. Thus, it is possible that relevant literature was unintentionally not captured via the search strategies of both studies. In both chapters, however, search strategy terms were tested to ensure a rigorous and comprehensive search was being employed. Additionally, the electronic database searches in Chapter 2 were based on multiple consultations with an expert librarian and were used to inform the search strategies of Chapter 3.

The second limitation of this dissertation is with regards to participant recruitment challenges that emerged in Chapter 4. Despite exhaustive attempts to recruit a number of key-informants in the first phase of data collection, there was low study enrollment. One potential key informant declined to participate due to political sensitivity and timing as Ontario had just elected a new government and it is likely this is a plausible explanation for overall low recruitment at this phase. The second phase of data collection several months later achieved 100% recruitment of all study invitees.

Implications for policy and practice

This dissertation highlights six implications for policy and practice. First, a criticism within the TIC literature has been that TIC has been applied to policy and practice in a vague and ambiguous manner, often lacking conceptual clarity. The findings of Chapter 2, specifically the conceptual framework, address this by providing important

insights regarding how TIC can be utilized within policy in a meaningful way. In particular, the framework outlines pragmatic components, such as use of a trauma consultant or team in combination with agency walk-throughs to inform TIC policy development, which are necessary for successful utilization of TIC within policy. Second, the conceptual framework developed in Chapter 2 outlines how TIC can be operationalized within and across systems of care, which holds particular significance for the roles of service providers. Specifically, the conceptual framework highlights the need for clear and distinct role delineation amongst service providers involved with the provision of TIC. Third, the conceptual framework also outlines the importance for inter-sectoral and cross-system collaboration regarding TIC policies, procedures and practice to ensure there is no unnecessary overlap, to establish uniform TIC understanding when multiple agencies and/or systems are involved, and to better improve cohesive care. Fourth, the theoretical framework developed in Chapter 2 captures the importance of understanding how political and system factors affect both the development of TIC policy and how well it can be operationalized in practice. Fifth, the findings of Chapter 3 identify a current trend within agency, organization, and governmental policy in which TIC is recommended without any clear understanding of either what is meant by TIC or how it can be operationalized. Thus, it is critical that TIC policy outlines a clear and precise understanding of both how TIC is defined and can be implanted. Finally, the findings of Chapter 4 indicate that systemic issues must be considered in TIC policy development. Specifically, the structural interests of various stakeholders affected by policy need to be considered.

Future research

While the conceptual framework developed in Chapter 2 was applied in Chapter 3, more research is needed into the framework's applicability and usability across services and systems of care. It is hoped that Chapter 3 is just the beginning of additional research in which the conceptual framework is applied in the TIC literature in order to add to its validity and credibility. Regarding Chapter 3, an important next step is to examine the use of TIC in policy documents across various jurisdictions at a regional,

national and global level. Comparative study into how other communities and countries are, or are not, utilizing TIC in policy documents, is an important next step to more comprehensively inform the policy discourse on TIC. Finally, Chapter 4 highlights the need to more comprehensively examine why psychiatry has historically overlooked trauma and how insight into this professional positioning can better inform understanding regarding imbedded systemic barriers to the use of TIC.