ARTICLE

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Integrating Trauma-Informed Practice into Quality Improvement Processes

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Abstract:

In light of the prevalence and impact of trauma amongst individuals seeking care for mental health and substance use concerns, there is a growing recognition of the need for services to become more trauma-informed in the delivery of care (Harris & Fallot, 2001a; Hopper, Bassuk, & Olivet, 2010). Trauma-informed practice (TIP) is an approach to service delivery that recognizes the prevalence of trauma amongst service users and providers, and is responsive to the impact of trauma by seeking to avoid re-traumatization and promote safety in the processes of care (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Harris & Fallot, 2001a). Best practice guidelines on the implementation of trauma-informed principles at the practice, organizational, and systems level exist (SAMHSA, 2014; Jean Tweed Centre, 2013; Klinic Community Health Centre, 2013; Poole & Greaves, 2012). However, little is known about how programs can integrate a trauma-informed lens to quality improvement (QI) processes. A preliminary scan of the literature indicates that, in the context of QI, TIP has often been conceptualized as either an outcome of a QI initiative or as part of a process to improve quality outcomes, but there is a gap in the literature that addresses the integration of TIP principles into the QI process itself. This paper seeks to provide a discussion on the integration of trauma-informed principles into QI as a matter of ethical practice, and provides concrete examples of how TIP principles can be integrated into QI processes.

Background and Overview:

The impact of trauma on the lives of individuals who come into contact with the mental health and health systems is pervasive and, historically, often under-recognized by service providers (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Harris & Fallot, 2001a). However, over the past several years, there has been a significant upturn in the recognition of the needs of trauma survivors and a growing commitment to overcome this blind spot. Evidence of this shift is visible in the surge of trauma-informed articles and best practice guidelines being published (Harris & Fallot, 2001b; Jean Tweed Centre, 2013; Klinic Community Health Centre, 2013; Poole & Greaves, 2012; Schachter, Stalker, Teram, Lasiuk, & Danilkewich, 2008). A trauma-informed framework that is founded on principles of safety, trust, collaboration, choice, and shared power underpin a primary intention of services to realize the prevalence and impact of trauma in the lives of service participants and providers and seeks to respond in ways that avoid re-traumatization/traumatization in the routine processes of service delivery (SAMHSA, 2014; Jean Tweed Centre, 2013). A trauma-informed approach to service delivery continually seeks to integrate an awareness of trauma prevalence and impact into its structures, processes, and ways of working, which requires an orientation toward equity, inclusion, and inquiry into how processes enable or hinder safety, choice, collaboration, trust, and shared power. In this article, we consider the application of the principles of trauma-informed practice (TIP) as a guiding framework to guide quality improvement (QI) processes as a matter of ethical practice. The risk of not integrating a trauma-informed lens to guide QI from the beginning can lead to potentially missing the mark on bringing awareness to factors that may not align with core principles of TIP; this may result in unintended consequences of inadvertent re-traumatization or barriers to enacting TIP principles which are integral to how care is experienced by both providers and participants as well as intended outcomes. By integrating a TIP framework into QI processes, it is argued that potentially what is evaluated, how, and what matters most in a QI initiative becomes grounded in a trauma-informed lens that puts at the center of the process the impact of trauma of clients and providers. We hope to demonstrate the relevance and benefit of integrating a TIP as routine to QI initiatives, but also bring to the forefront the potential inadvertent risks of not integrating a trauma-informed approach to QI processes.

What is Trauma-Informed Practice?

TIP is a framework that allows us to consider the needs of individuals who have been impacted by trauma. When we commit to TIP, we commit to providing services in ways that are "welcoming and appropriate" (Harris & Fallot, 2001b, p. 5) to the needs of trauma survivors. A trauma-informed mandate requires us to consider the survivor's experience from the point of entry through to the departure from service. In general, to be trauma-informed means having a solid understanding of the impacts of trauma and how to apply the principles of trauma-informed care. Trauma symptoms are seen as strategies to cope with the effects of trauma, a view which necessitates agencies to take measures to avoid re-traumatization wherever possible. Within a trauma-informed framework, trauma is understood to be a "defining and organizing experience" (Harris & Fallot, 2001b, p. 11). It can affect many aspects of a person's life, including their interactions with others, cognition, affect, perception, sense of self, relationships, physiology, spirituality, self-care, and world view. Trauma Matters (Jean Tweed Centre, 2013), a publication that provides guidelines for TIPs in women's substance use services, synthesizes some of the existing literature, including principles of trauma-informed care. These principles are:

- *Acknowledgment:* This principle involves the acknowledgement of the pervasiveness of trauma among those seeking health services, and the impacts trauma has had on their lives. It includes the recognition and reframing of "problem behaviours" as coping strategies or survival skills. To actualize the principle of acknowledgment requires some competency in recognizing trauma responses as they occur. Doing so allows for a contextualized response and the opportunity to respond in ways that promote safety.
- *Safety:* The concept of safety in the context of trauma-informed care encompasses physical, emotional, and cultural safety (Jean Tweed Centre, 2013). Core to the experience of trauma is the feeling of being overwhelmed in which one's fundamental sense of safety is broken in the face of a terrifying, overpowering experience (Clark, Classen, Fourt, & Shetty, 2015; Herman, 1992). This fear of danger often extends beyond the event(s) into the person's present where there may be a number of potential triggers awaiting them in their interactions with others and within physical environments. As Janina Fisher noted, "When we get triggered, we experience sudden and overwhelming feelings, sensations, and impulses that convey 'I am in danger – right now!' not 'I was in danger then'" (Fisher, 2016). Bringing this

principle to life requires attention to promoting safety within an organization's practices, procedures, and physical environment, thereby minimizing or avoiding triggers that could create a trauma response. Where a trigger has occurred that has resulted in re-traumatization, it involves taking steps to re-establish safety as much as possible.

- *Trustworthiness:* Survivors of trauma often feel service providers are not "safe, trustworthy or understanding" (Women, Co-Occurring Disorders & Violence Study, 2003). The onus is always on the service provider to conduct themselves in ways that uphold the utmost in integrity: to be clear, consistent, and ethical. In the context of TIP, service providers go further to not expect trust in return.
- *Choice and control:* Because traumatic experiences overpower a person's control at the most primal level, it is vital to support and integrate choice and control at every interface and in every decision that impacts a survivor. A rigid, authoritarian approach is eschewed for one that emphasizes mutuality, flexibility, and client-centred care. The aim is self-efficacy. The experience of choice and control within the service setting supports the engagement and retention of clients in services, which positively affects outcomes (Jean Tweed Centre, 2013). In practice, this means asking for input, asking for permission, and working at a client's pace according to their goals.
- *Relational and collaborative approaches:* Psychological trauma breaks a trauma survivor's connection on a fundamental level, to "family, friendship, love and community" (Herman, 1992, p. 51). In contrast, trauma-informed care embraces interpersonal frameworks that are relational and which emphasize collaboration with the client at any juncture that affects their care (Jean Tweed Centre, 2013). The process of building relationships with and developing trust in service providers is understood to be a struggle for a trauma survivor for whom the world is a dangerous place. Working from this understanding, critical attention is paid to building relationships through engagement, respectful boundaries, consistency, and transparency.
- *Strength-based and empowerment modalities*: Alongside disconnection, disempowerment is one of the deepest experiences of psychological trauma (Herman, 1992). Empowerment is both a principle of trauma recovery (Herman, 1992) and of trauma-informed care. Traditional models of care that have been complicit with the exercise of power over clients are rejected in a trauma-informed framework for ones that encourage empowerment, embrace a

strengths-based perspective, and focus on the capacity for growth and change (Jean Tweed Centre, 2013).

Scan of the Literature:

A scan of the available literature focusing on a trauma-informed approach to QI was conducted in the following databases: Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE, Embase, PsycINFO, Ovid Healthstar, Joanna Briggs Institute EBP Database, Health and Psychosocial Instruments, Journals@Ovid Full Text, and Books@Ovid. Keywords and subject headings associated with TIP and QI were used in each database. Search terms were limited to "Trauma-Informed Practice" and "Quality Improvement". Separate searches for each term yielded 172586 citations for "Quality Improvement" and 920 citations for "Trauma-Informed Practice". Combining the search results for "Quality Improvement" and "Trauma-Informed Practice" resulted in 31 citations. A review of the titles and abstract for relevance to QI and TIP further reduced the results to 11 relevant articles of which, after further review of abstracts, resulted in 6 relevant citations that addressed QI and TIP to some extent (Table 1). Three broad thematic categories of studies emerged: 1) one study of a QI initiative that integrated a trauma-informed lens, 2) studies where TIP was an outcome of a QI initiative, and 3) studies where training addressing TIP was part of the process of a QI initiative. General descriptions of the studies are outlined in Table 1. Only one citation by Lewis-O'Connor and Chadwick (2015) addressed a QI initiative that integrated a trauma-informed framework to ask clients about their experience of care in a gender-based violence clinic. Another study by Weiss and colleagues (2017) described a QI initiative that involved TIP training of staff in a large pediatric hospital whereby the outcomes of interest were changes in staff attitudes and confidence in TIP. Four of the seven citations involved QI initiatives where TIP training directed at staff was a component of a QI initiative (for example, the reduction of seclusion and restraints as a quality outcome).

Table 1: Results of Literature Scan

Databases Searched: Ovid MEDLINE: Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE® Daily and Ovid MEDLINE® 1946-Present, Embase Classic+Embase 1947 to July 14, 2017, PsycINFO 1806 to July Week 2 2017, Ovid Healthstar 1966 to May 2017, Joanna Briggs Institute EBP Database - Current to July 12, 2017, Health and Psychosocial Instruments 1985 to April 2017, Journals@Ovid Full Text July 14, 2017, Books@Ovid June 5, 2017.

Theme	Citation	Study Focus	Setting	Target Population	Intervention/Program	Key Outcomes
QI initiative that integrated TIP or was driven by principles of TIP	Lewis-O'Connor & Chadwick, 2015	QI initiative in an effort to understand client perspectives of receiving healthcare services.	Gender-based violence (GBV) clinic	Patients who had received services from the GBV clinic	Using a patient- and trauma-informed relationship-based framework, survivors of GBV who were referred for follow-up care were asked to participate in QI project to learn about their experience of care and suggestions for improvement.	Patients affected by GBV require an improved coordinated and trauma-informed approach. Explicit consent related to evidence collection is needed. Not all patients who have been sexually assaulted should have evidence collected. More extensive research and program evaluation including outcomes research are warranted.
Initiative where TIP was an outcome	Weiss, Kassam-Adams, Murray, Kohser, Fein, Winston, & Marsac, 2017	Examination of a three step framework for implementing spread/uptake of QI initiative where TIP was an outcome via training of staff and and clinician in a pediatric health care network.	Pediatric hospital	440 health care professional from 27 health care teams	QI project involved assessing changes in attitudes amongst staff who attended 1-hour training covering TIP principles and impact on patients and families and how to respond. QI assessed change in favorable attitudes toward TIP and confidence delivering TIP after training.	Compared with pre-training, staff demonstrated increased favorable attitude toward TIP and confidence delivering TIP.
QI initiative where TIP component of intervention/ training was delivered to achieve an outcome related to quality	Azeem, Reddy, Wudarsky, Carabetta, Gregory, & Sarofin, 2015	QI initiative that utilized TIP training to staff to reduce the use of restraints.	52-bed pediatric psychiatric inpatient hospital unit.	Health care providers	Primary prevention principles based on trauma-informed and strength-based care were utilized to provide care for children and adolescents. Hospital leadership played an instrumental role in bringing positive culture change. Staff involvement and training in restraint reduction and prevention tools played a key role in this project. Debriefing and problem solving were effective interventions for the	Over a 10-year period, mechanical restraints decreased by 100%, from 485 in 2005 to "zero" in 2014 and none in the last 3 years. Physical restraints decreased by 88%, from 3,033 in 2005 to 379 in 2014.

					prevention of restraints. Involvement of youth and family in treatment planning built stronger relationships with staff and paved the way for better communication and trust, and improved understanding of strengths and needs of children and adolescents.	
	Blair, Woolley, Szarek, Mucha, Dutka, Schwartz, Wisniowski, & Goethe, 2017.	QI and safety pilot initiative that implemented training that included TIP training to staff aimed to reduce seclusion/ restraint.	120-bed inpatient psychiatric service	Health care providers	Training aimed to reduce incidents of seclusion and restraints that included TIP as part of the training. Also, intervention involved implementation of evidence-based therapeutic practices for reducing violence/aggression that involved mandated staff training in crisis intervention and TIP, routine Broset Violence checklist and increased physician reassessment of need for seclusion or restraints and environmental enhancements to support sensory modulation.	Statistically significant associations found between intervention and decrease in number of seclusion and restraint events.
	Brown, Baker, & Wilcox, 2012	Examines the impact of the curriculum-based Risking Connection (RC) trauma training on the knowledge, beliefs, and behaviors of 261 staff trainees in 12 trainee groups at five child congregate care agencies.	Child welfare/ residential agencies	261 staff	TIP training for staff using the RC trauma-informed care curriculum to increase staff awareness of and skill in integrating a trauma-informed approach to care.	Results showed an increase in knowledge about the core concepts of the RC training consistently across groups, an increase in beliefs favorable to trauma-informed care over time, and an increase in self-reported staff behavior favorable to trauma-informed care in the milieu.
	Goetz & Taylor-Trujillo, 2012	Development of model of safety resulting from implementation of safety measures in an inpatient psychiatric facility.	80-bed behavioural health facility within a larger hospital institution	Staff	The model was developed over a 5-year period in a freestanding 80-bed behavioural health facility. The model has nine components that the nursing leadership team saw as integral to maintaining a safe environment. The nine elements include trauma-informed care principles, aggression management, code event review, leadership involvement, quality feedback, recovery orientation, patient assessment, education,	Created a sustained change in culture related to patient and staff safety and reduction of patient violence events and staff injuries.

					and collaboration. The metrics collected to determine the effectiveness of the model included patient violence events and staff injuries. This article describes the development of this model and its impact.	

Applying Trauma-Informed Practice to Quality Improvement: An Integrated Approach

What is Quality Improvement?

QI in health care refers to the systematic application of formal tools and processes to make changes that will lead to better client outcomes, enhanced experiences with care, and improved overall health system performance (Batalden & Davidoff, 2007). As such, "quality" is broadly conceived and includes the following domains or goals[1]:

- Safety – Promotion of physical, emotional, and psychological safety at all times
- Effectiveness – Clients receive the most appropriate services to improve their health
- Acceptable – Client goals and preferences are respected. Clients and their caregivers are treated with respect and dignity.
- Efficiency – Care is well-coordinated and efforts are not duplicated. Client time is respected.
- Timeliness – Time spent waiting for service is safe and appropriate.
- Equity – Clients are treated fairly and can access services that benefit them, no matter who they are or where they live.

Integrating Trauma-Informed Practice and Quality Improvement

There is a symbiotic relationship between the goals of QI and the principles of trauma-informed care (see Figure 1). This can be seen both in terms of commonalities (e.g., "safety"; "patient-centred care" and "choice and control") as well as in terms of cause and effect (e.g., TIPs

[1] Adapted from Health Quality Ontario (2017)

improving service effectiveness; timely access to services supporting client safety). In current practice, however, it is still more common for trauma-informed care to be viewed largely as a target for QI efforts, and typically within the domain of safety – for example, by enhancing staff competencies to avoid re-traumatizing clients. TIPs, however, are not limited to service delivery alone and should be integrated at all levels of an organization (Jean Tweed Centre, 2013). A natural and strategic way to do this is through their integration within an organization's overall QI framework whereby the principles of trauma-informed care become both a means to, and an end of, QI. In this section, we explore the application of trauma-informed principles within the various stages of the QI framework (adapted from the Addictions and Mental Health Ontario (AMHO), Canadian Mental Health Association, and Health Quality Ontario (HQO) Quality Improvement process) and suggest concrete examples of how the principles can be integrated (Table 2). We conclude with a practical a checklist to ensure that all engagement and connections with clients are safe and trauma-informed.

Figure 1. Integrating Trauma-Informed Principles with Dimensions of Quality:

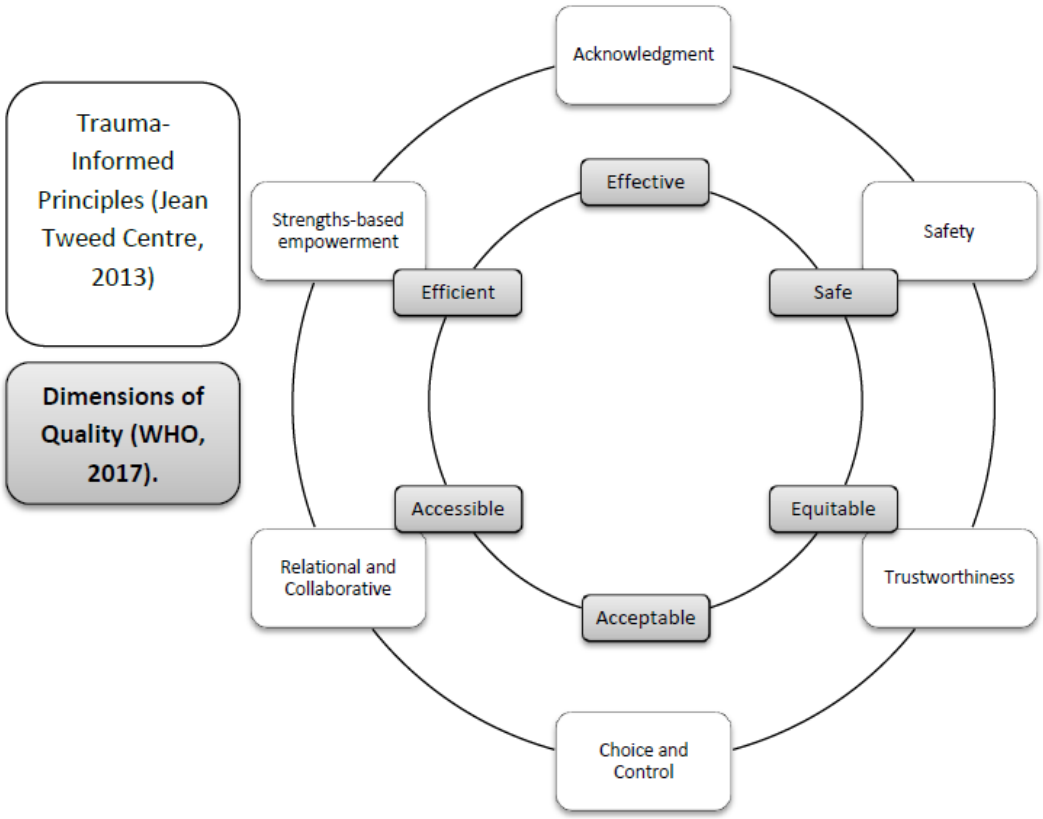

Table 2: Integration of Trauma-Informed Care into the Stages of Quality Improvement

Stages of Quality Improvement	Description of Stage	Trauma-Informed Integration
Preparing for QI	This stage sets the foundation for the QI project by creating a Project Charter to briefly explain the problem and/or opportunity that the QI project is focusing on. The Charter outlines the project scope, team members, and potential barriers for implementation/change.	Planning for QI should begin with an initial exploration of the extent to which clients are directly (or indirectly) impacted by a particular quality concern. Where there are clear connections, planning should prioritize client engagement in all stages of the QI process. One practical approach to encourage this focus is to dedicate a section in an agency's QI Project Charter template regarding plans for client engagement and involvement. In cases where it is deemed that client engagement is (or may not be), feasible, mitigating strategies should be identified for each stage. (*Relational and Collaborative*)
Defining the Problem	This stage helps to differentiate between a problem and a symptom. Through a number of diagnostic tools (e.g. Process Map, Fishbone Diagram, 5-Why, and/or Pareto Chart), the root problem and where the process needs improvement can be narrowed down.	The working assumption should be that any current or future client affected by a quality issue may have also been impacted by trauma. Diagnostic processes and tools should be applied in such a way that encourages an explicit focus on the assumed potential relationship (either causal or correlational) between trauma and all

		identified quality issues. One way to do this, when applying a particular diagnostic exercise to identify a problem, is to ask the question: "how might individuals who have experienced trauma be impacted differently by this problem?" (*Acknowledgement)*
Measuring and Understanding	The focus of this stage is on understanding the current scope of the problem by establishing a quantifiable baseline as well as on identifying appropriate measures that will be used in subsequent phases to determine whether QI changes have resulted in targeted improvements. Typically measures include outcome measures (to show impact), process measures (to demonstrate how a change is working in a specific setting), and balancing measures (to identify any unintended consequences from the improvement work).	Measurement methods and/or tools that directly involve clients should empower them to feel comfortable and supported to share their experiences and insights about a problem. This would include: ensuring that any staff involved in data collection is trained to recognize and respond to clients who show signs of distress, offering multiple ways of sharing experiences as relevant and appropriate (e.g., interviews, surveys), and respecting assurances of privacy and confidentiality. (*Safety, Choice and Control)*
Developing and Planning Solutions	This stage examines what changes can be made that will result in improvement. Source for ideas might include: evidence/literature, the staff	As with all stages of QI work, clients (and service providers) should be involved, whenever possible, in identifying potential solutions to problems that directly (or indirectly)

	team, clients/consumers/family members, brainstorming, or benchmarking. Change ideas should be clearly communicated, explicit, and visible to those responsible for implementing the change.	impacts them. (*Relational and Collaborative).* This requires creating an atmosphere of trust without demanding their trust in return. Trust can be supported by being transparent about QI goals, sharing information as appropriate, and emphasizing consent and the limits of confidentiality. It also requires a commitment to ensuring that client involvement is meaningful, that their input carries weight, and that there is transparency regarding why and how a particular solution(s) was chosen. (*Trustworthiness).* Regardless of the quality issue, the psychological, emotional, and physical safety of clients and service provides should always be prioritized for consideration when developing change ideas. (*Safety)*
Testing and Implementing Change	In this stage, each change idea is independently tested to see whether it results in any measureable improvement. This is most commonly done using the Plan-Do-Study-Act (PDSA) cycle, beginning with identifying specific and concrete steps to implement a change (Plan), carrying out a test (Do), observing and learning about the process (Study) and	The PDSA cycle is inherently forward thinking, strategic, and designed to achieve success. As such, it is a natural complement to the goal of supporting clients to develop a full range of empowerment skills. Of note, it is important to be attentive to the potential unintended impacts of steps taken in the PDSA process that may affect clients and providers. Being mindful of integrating TIP principles into the PDSA

	making necessary adjustments (Act). The cycle is repeated until the desired improvement is achieved or it is determined that the change idea does not result in an improvement and should be replaced with a different change idea.	cycle itself is essential. Meaningfully engaging clients in this testing and implementation process invites them to be a part of something that can instill hope and optimism and, ultimately, provides a tool to support their own resilience (*Strengths-Based Empowerment)*
Sustainability and Spread	This stage is focused on identifying and implementing strategies to sustain and spread QI changes and improvements across a system/organization. This can be done through a number of mechanisms including supportive management practices, formal capacity-building initiatives, creating a culture of improvement, and staff engagement, etc. It is important to consider and incorporate sustainability and spread strategies as early in the QI process as possible, where relevant and feasible.	As in all stages, it is important that clients be involved, whenever possible, in identifying strategies for sustainability and spread. Client perspectives will be particularly important in anticipating whether a QI process that worked in one setting/program will be effective/ acceptable in other areas. As with the "Developing and planning solutions" stage, client engagement requires meaningful, equitable, and transparent involvement. (*Trustworthiness, Strength-Based Empowerment)*

Throughout the QI process, there will be many moments of connection with various stakeholders (e.g. clients and staff). To create an environment that is safe, builds trust, and fosters collaboration, it is important to engage with stakeholders in a trauma-informed way. The following checklist is not

exhaustive but offers some guidance on ways that a QI specialist can engage in respectful and sensitive ways with others involved in the process.

Checklist for trauma-informed stakeholder engagement (based on trauma-informed principles and practice techniques):

- Ask permission
- Check in during a conversation as needed
- Be sensitive to signs of overwhelm
- Prepare to step back if participant appears uncomfortable
- Support identification and awareness of trauma-related triggers
- Always be mindful of safety
- Be self-aware
- Use encouraging language
- Use task-focused inquiry[2]
- Pay attention to the physical environment
- Avoid going too deep into the trauma story
- Expect some unease
- Teach/use safety regulation skills, such as grounding

Summary and Implications for Quality Improvement Processes:

Principles of TIP are not only closely aligned with QI goals but also bring attention to the processes required to introduce change in the service of evidence-based, quality care. To date, the literature has focused on TIP either as a quality outcome or as one aspect of achieving a larger

[2] Schachter et al., 2008

quality initiative. In this paper, we argue for a broader perspective whereby TIP principles are integrated into all stages of the QI framework, including defining the quality issue, engaging stakeholders in meaningful, responsible, and supportive ways, identifying measures that are safe and valid, and implementing and spreading change. Considering the widespread prevalence of trauma amongst individuals with mental health and substance use concerns, the strategic and meaningful integration of trauma-informed principles into QI work, from planning through to the completion of QI projects, ensures both effective *and* ethical practice. Without this integration, we risk inadvertently dismissing the impacts of trauma as well as missing opportunities to engage with stakeholders in ways that promote choice, trustworthiness, and collaboration. In short, adopting an integrated trauma-informed QI framework is an ethical approach to effectively meet the needs of clients and the service providers who support them.

References

Azeem, M. W., Reddy, B., Wudarsky, M., Carabetta, L., Gregory, F., & Sarofin, M. (2015). Restraint reduction at a pediatric psychiatric hospital: A ten-year journey. *Journal of Child and Adolescent Psychiatric Nursing, 28*(4), 180-184.

Batalden, P. B., & Davidoff, F. (2007). What is ‘‘quality improvement’’ and how can it transform healthcare? *BMJ Quality & Safety, 16*, 2-3.

Blair, E. W., Woolley, S., Szarek, B. L., Mucha, T. F., Dutka, O., Schwartz, H. I., Wisniowski, J., & Goethe, J. W. (2017). Reduction of seclusion and restraint in an inpatient psychiatric setting: A pilot study. *Psychiatric Quarterly, 88*(1), 1-7.

British Columbia Centre of Excellence for Women’s Health. (2009). Trauma-informed approaches in addictions treatment [PDF file]. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2014/02/2010_GenderingNatFrameworkTraumaInformed.pdf

Brown, S. M., Baker, C. N., & Wilcox, P. (2012). Risking connection trauma training: A pathway toward trauma-informed care in child congregate care settings. *Psychological Trauma Theory Research Practice and Policy, 4*(5), 507-515.

Clark, C., Classen, C. C., Fourt, A., & Shetty, M. (2015). *Treating the trauma survivor: An essential guide to trauma-informed* care. New York: Routledge.

Fisher, J. (2016, May). Attuning to your clients: A clinician's guide to choosing the right approach. Talk presented at Leading Edge Seminar in Toronto, Canada.

Goetz, S. B., & Taylor-Trujillo, A. (2012). A change in culture: Violence prevention in an acute behavioral health setting. *Journal of the American Psychiatric Nurses Association*, *18*(2), 96-103.

Harris, M., & Fallot, R. D. (2001a). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *89*, 3-22.

Harris, M., & Fallot, R. D. (Eds.). (2001b). *Using trauma theory to design service systems: New directions for mental health services.* San Francisco: Jossey-Bass.

Herman, J. L. (1992). *Trauma and recovery*. New York: Basic Books.

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

Jean Tweed Centre. (2013). *Trauma matters: Guidelines for trauma-informed practices in women's substance use services.* Toronto, Canada: The Jean Tweed Centre.

Klinic Community Health Centre (2013). *Trauma-informed: The trauma toolkit* (2nd ed.). Winnipeg, Canada: Manitoba Trauma Information and Education Centre.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396-404.

Lewis-O'Connor, A., & Chadwick, M. (2015). Engaging the voice of patients affected by gender-based violence: Informing practice and policy. *Journal of Forensic Nursing*, *11*(4), 240-249.

Mental Health Coordinating Council. (2013). *Trauma-informed care and practice: Towards a cultural shift in policy reform across mental health and human services in Australia - a national strategic direction.* Lilyfield, Australia: Bateman, J., Henderson, C., & Kezelman, C.

Poole, N., & Greaves, L. (Eds.). (2012). *Becoming Trauma Informed*. Toronto, Canada: Centre for Addiction and Mental Health.

Schachter, C. L., Stalker, C. A., Teram, E., Lasiuk G. C., & Danilkewich, A. (2008). *Handbook on sensitive practice for health care practitioners: Lessons from adult survivors of childhood sexual abuse*. Ottawa, Canada: Public Health Agency of Canada.

Substance Abuse and Mental Health Services Administration (2014). *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Weiss, D., Kassam-Adams, N., Murray, C., Kohser, K. L., Fein, J. A., Winston, F. K., & Marsac, M. L. (2017). Application of a framework to implement trauma-informed care throughout a pediatric health care network. *Journal of Continuing Education in the Health Professions*, *37*(1), 55-60.

Women, Co-Occurring Disorders, & Violence Study. (2003). *Creating trauma services for women with co-occurring disorders: Experiences from the SAMHSA women with alcohol, drug abuse and mental health disorders who have histories of violence study*. Delmar, NY: Moses, D. J., Reed, B. G., Mazelis, R., & D'Ambrosio, B.

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