# From Trauma-informed to Trauma-and violence-informed practice

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## Goals

- To share 'in process' thoughts on the evolution of the concept of trauma- and violence-informed practice
- To assist you to extend and integrate your understanding of trauma-informed practice into your work,
- To support shifting your thinking from trauma-informed to trauma- and *violence*-informed care,
- To discuss some practical approaches to integrating TVIC and structural competence in health care.

**ER Nurses' responses to violence against women**

Study of ER nurses' recognition and responses to violence against women (ethnography)



**Project Violence Free**

Participatory action research with ~ 40 women, including Aboriginal, immigrant and Euro-Canadian women who experienced partner violence (Institutional/ethnography)

BCHRF



**Risks of HIV and Violence**

Community engaged study of the intersecting risks of violence and HIV for rural and Aboriginal women (ethnography)

**Rural Aboriginal Maternity Care**

Participatory action research with 4 Aboriginal communities on women's experiences and preferences for rural maternity care (ethnographic)

**Women's Health Effects Study**

Longitudinal study of the health and economic effects of violence for women after leaving an abusive male partner (quantitative: SEM, growth curve analysis, economic analysis)

**Urban Aboriginal Health Clinic Study**

Identification of the key dimensions of equity oriented PHC and related indicators (multiple methods: qualitative, quantitative, participatory, delphi consensus)

**Aboriginal Women's Intervention Study**

Two –group cross-over cohort study testing the effectiveness of a health promotion intervention on the agency, physical and mental health of Aboriginal women experiencing violence. (Quantitative longitudinal analysis)

**Safety Decision Aid**

RCT testing the effectiveness of a internet safety decision aid on mental health of women experiencing violence. (Random assignment, quantitative longitudinal analysis)

**EQUIP Primary Health Care Programmatic Research**

Three studies:

1. Refining equity oriented PHC indicators
2. Complex organizational intervention to promote equity (participatory, qualitative and quantitative longitudinal)
3. Analysis of policy and funding context

## Next: Promoting Health Equity for Indigenous and non-Indigenous People in Emergency Departments in Canada

**Key Dimensions of Equity-Oriented PHC Services**


**4 General Approaches**
- Partnerships with Indigenous peoples
- Action at all levels (client-provider; organization; systems)
- Attention to local and global histories
- Attention to unintended and potentially harmful impacts of each strategy

**10 Strategies**
- Explicitly commit to fostering health equity
- Develop supportive organizational structures, policies, and processes
- Optimize use of place and space
- Re-vision use of time
- Attend to power differentials
- Tailor care, programs and services to local Indigenous contexts
- Actively counter racism and discrimination
- Ensure meaningful engagement of clients and community leaders
- Tailor care to address inter-related forms of violence
- Tailor care to address the social determinants of health

## Trauma- & Violence-Informed Practice

Extends the notion of Trauma-Informed Practice/Care:

- Trauma and violence (interpersonal, structural, gendered) are root causes of poor mental and physical health
- Looks beyond the psyche of people who have experienced violence to also consider acts of structural violence and conditions that support those acts; violence can be historical and ongoing
- Recognizes client responses (including health problems) as predictable consequences of highly threatening events and as connected to structural violence

**Structural violence** encompasses the forms of violence that are **embedded in social, political and economic policies and organizations** (Farmer, 2003).

- Social inequalities are at the heart of structural violence. Racism of one form or another, gender inequality, and above all brute poverty in the face of affluence…. (Farmer, 2004)
- Inequities are structural because they are embedded in the political and economic organizations of our social world, and they are violent because they cause injury to people (Farmer, 2004)
- Structural violence is "generally invisible because it is part of the routine grounds of everyday life" (Scheper-Hughs & Bourgois, 2003, p. 4)

## Inter- and intra- personal violence and structural violence are interrelated

- For example, homelessness has both structural (e.g. poverty), intra-personal (e.g., mental health problems) and inter-personal causes/influences (e.g., child abuse)
- Rural inequities such as lack of access to violence services are continuous with gender inequities and gender-based violence

## Key ideas:

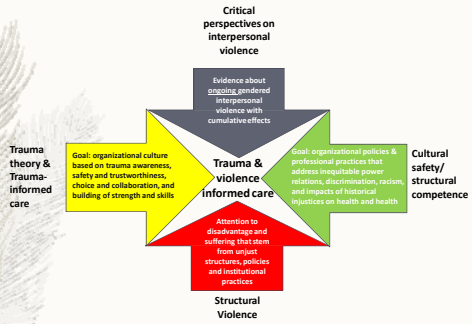
- Violence is commonly understood and approached within societies dominated by liberalism as an ***individual*** problem, with ***identifiable*** victims and perpetrators;
- In keeping with liberal ideology, both 'victims' and 'perpetrators' (dichotomized) are held to have (unfettered) ***choice and agency;***
- Violence is seen as deviant and abnormal rather than everyday and common;
- This view of violence a) keeps the focus on individuals, b) leads to a presumption of the need for identification, c) obscures patterns (e.g. gendered, raced, classed) and systemic violence.

# Argument

Given the prevalence of violence, all persons should be treated in a way that is "trauma- and violence-informed";

Given the dynamics of stigma, discrimination, etc., a non-judgemental approach is required;

Given power dynamics, providers must avoid disempowering; a TVIC approach can be used without requiring "disclosure"




# Trauma Definition

*"Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation. The terms violence, trauma, abuse, and posttraumatic stress disorder (PTSD) often are used interchangeably. One way to clarify these terms is to think of trauma as a response to violence or some other overwhelmingly negative experience (e.g., abuse). Trauma is both an event and a particular response to an event. The response is one of overwhelming fear, helplessness, or horror. PTSD is one type of disorder that results from trauma"*

Covington, 2008

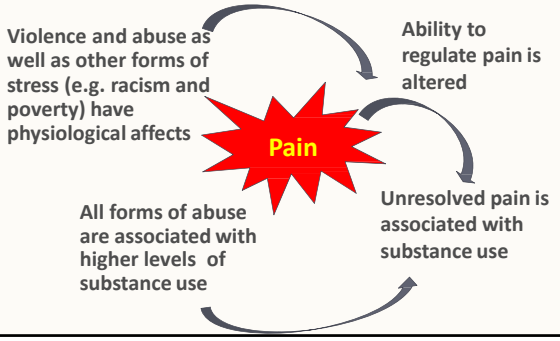
## Why trauma and violence informed care?

- Integrates attention to violence as causative, and as both historical and ongoing,
- Lessens the potential to locate 'the problem' only in the psyche of those who have experienced violence rather than also in the acts of structural violence and conditions that support those acts,
- Recognizes intersections among structural violence, trauma and health issues (such as substance use, chronic pain)
- Frames the relationships between abuse histories, structural violence, and health issues (e.g. substance use) at an individual level.

## Brings the pathophysiological mechanisms into view

Chronic diseases as related to the physiological consequences of trauma and poverty


## Focuses Attention on Intersections



## …moves beyond individual pathology


## Key ideas to guide practice

- Any person you encounter may have a history of, or be experiencing interpersonal violence
- Disclosure is **NOT** required to provide safe care; safe care creates trust that enables disclosure
- People experiencing stigmatizing conditions expect and fear judgement
- People may under estimate, but never over estimate danger
- Good practice IS a good and adequate response to violence (you don't need to be a specialist)

## Key Principles of Trauma- and Violence- informed Care

**All services taking a trauma- and violence- informed approach begin with building awareness among staff and clients of:**

- The high prevalence of trauma and violence
- The significance of historical (collective and individual) and ongoing violence (intrapersonal and structural)
- How the impact of trauma can be central to one's development
- The wide range of adaptations people make to cope and survive
- The relationship of trauma and violence with substance use, physical health and mental health concerns.

This knowledge is the foundation of an **organizational** culture of trauma- and violence-informed care

**4 Key Principles**

**1. Trauma and violence awareness**

**Trauma Survivors:**

- Likely have experienced boundary violations and abuse of power
- Need to feel physically and emotionally safe
- May currently be in unsafe relationships (ongoing violence)
- May live in unsafe conditions (e.g. racism, poverty, stigma)

**Safety and trustworthiness are established through:**

- Welcoming intake procedures
- Adapting the physical space
- Providing clear information and predictable expectations about programming
- Ensuring informed consent
- Creating crisis plans
- Cultural safety
- Understanding of historical and contextual conditions

**4 Key Principles**

**2. Emphasis on safety (including cultural safety) and trust-worthiness**

**Service Providers:**

- The safety and mental health needs of service providers are also considered within a trauma- and violence-informed service approach.

**Key component of Service Provider safety:**

- Education and support related to secondary (vicarious) trauma
- Attention to provider's experiences of interpersonal and structural violence.

**4 Key Principles**

**2. Emphasis on safety and trust-worthiness (Part 2)**

Trauma-informed services create safe environments that foster a client's sense of efficacy, self-determination, dignity, and personal control.

**Service providers are encouraged to:**

- Communicate openly
- Equalize (mitigate) power imbalances
- Allow the expression of feelings without conveying judgment
- Provide choices as to treatment preferences
- Work collaboratively
- Provide culturally safe services
- Advocate for structural change

**4 Key Principles**

**3. Opportunity for choice, collaboration and connection**

**Service providers:**

- Help clients identify their strengths
- Further develop resiliency and coping skills
- Acknowledge the effects of historical and structural conditions
- Teach and model skills for recognizing triggers, calming, centering and staying present
- Support an organizational culture of 'emotional intelligence' and 'social learning'
- Maintain competency-based skills, knowledge, and values that are trauma informed (including cultural safety and structural competency)

**4 Key Principles**

**4. Strengths based and skill building**

## What does this mean for practice?

**A woman goes to the ER for the 3rd time in the past month complaining of "vague" abdominal pain. No organic cause is found.**

| What often happens | VS | TVIC |
|---|---|---|
| – assume that she is "drug seeking", attention seeking, has underlying mental health problems | | – Question the root cause of her pain |
| – Redirect her to her primary care provider (dismiss her) | | – Explore her safety and history of pain |
| | | – Acknowledge her pain as real |
| | | – Discuss non-narcotic alternatives for pain |

**A family doctor or NP is frustrated with a woman who has not had a routine PAP test in 8 years. She repeatedly makes and cancels or misses appointments.**

| What often happens | | TVIC |
|---|---|---|
| – Assure her that the procedure is routine, fast, and has few risks but many benefits | | – Talk to her about her comfort/discomfort |
| – Note that missing appointments is against clinic policy and isn't fair to others | VS | – Suspect a hx of violence/trauma? |
| – Charge a "no show" fee | | – Take it slowly – don't push and be prepared to back off |
| | | – Initiate grounding exercises or other comfort measures |

## Trauma and violence informed care in action



## Structural Competence: Five core competencies

1)recognize the structures that shape clinical interactions;

2)develop an extra-clinical language of structure (e.g. link diabetes to trauma and poverty)

3) rearticulate "cultural" formulations in structural terms (e.g. Indigenous art)

4) Imagine and implement structural interventions (e.g. EMR, staff meetings); and

5) Develop structural humility.

Metzl & Hanson, 2013

## Trauma and cultural safety "walk-through"

In your setting

- Review the generic 'walk through' guidelines Imagine a walk-though using a TVIC and CS lens: in your chosen setting, ask:
  - What is a 'typical' client experience? What common trauma triggers might be encountered?
  - What is it like to enter the space?
  - How are safety and welcome promoted in the setting?
  - How is safety promoted in intake, screening and assessment?
  - How are client choice and empowerment promoted?
  - How is safety promoted and violence and secondary trauma prevented for staff?

https://ncsacw.samhsa.gov/files/trauma_walkthrough_rprt_508.pdf

https://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

## Discussion

- What structural conditions in the work context(s) mitigate against a TVIC approach? (hierarchy, workload, policies)
- What dominant ideas in the work context(s) mitigate against a TVIC approach? (stereotypes, judgements – who gets judged?)
- Where do the health effects of violence most 'show up'?
- Who would be most advantaged by a TVIC approach?
- From this, what is one key action that you should take?

## Health Equity Tool Kit

Available at:

**www.equiphealthcare.ca**

Top 10 things Any Provider Can Do To

# Support Women Experiencing Violence

## WITH WOMEN:

1. **Listen to wom[illegible]enand believe** the mi -
   "That sounds like a horrible experience"

2. **Affirm/valida te**
   "No one deserves..."

3. **Express concern** -
   "I am ex: lly concerned for yoursafety.. "; "I am concerned that these hea dachas are connected to your circumstances at [illegible] horne "

4. **Recogniz e strength** -
   "You have really survived a lot..."

5. **Offer collaborative safety planning** -
   "I d like io helpyoumake a safety plan... "Would ii be OK if I got us some advke f[illegible]..."

## YOURSELF:

6. Examine your own privileges and assumptions - e.g., education, position, power, wealth, experiences of violence

7. Learn about health effects of violence, danger assessment, safety planning

## WITHIN YOUR ORGANIZAT ON:

8. Chall enge language that objecti fi es, judge s or blames -
   - Use "woman", "man", "people" - [instead of "bc ttered wom an","clbuser",.. "IDU", "d risk,"
   - Switch from "she doesn't wont help" to "our helpisn'fr meeting her needs. "
   - Switch from "non-com pl ant patient" to "unsu itable can

9 Anti c"pate and miti g ate disem[illegible] pa[illegible] e ig pract ces - e.g., evaluate rout'ine instructionsto undress. cancellation polic"es; waiting spaces

10 Contr"bute to organim tiona conditions to support good care e.g., provide /patient rafos; policies, culture

Source: Varcoe, C. (2014). Interpersonal violence assessment. In A. J. Browne, J. MacDonald Jenkins, & M. Luctkar-Flude (Eds.), Physical Examination and Health Assessment by C. Jarvis (Second Canadian Edition, pp. 120-137). Toronto. Elsevier.

EQUIP ea hcare
Research to quip Primary Healthcare for Equity

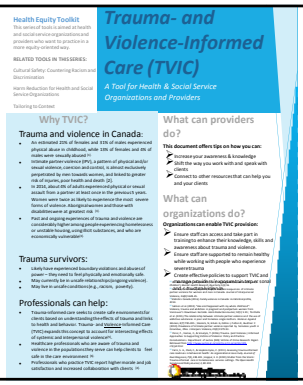
CIHR

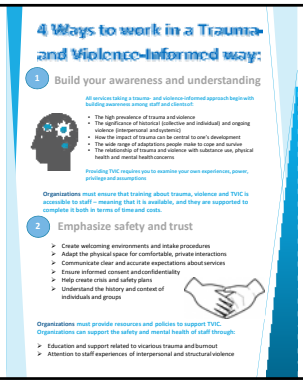
Top 10 things your clinic, practice or [illegible] degaatdti

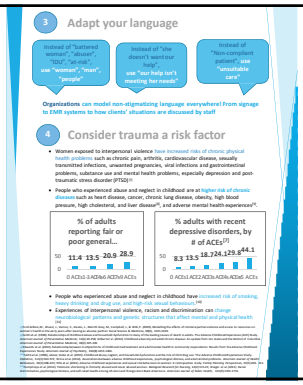
# Create a [illegible]ve coming environment

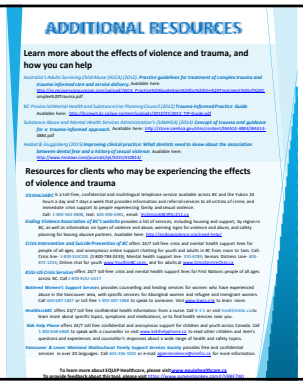

## TVIC Tool

- 4 pages
- Tips for org's & providers
- First in a series



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* References in material from Provincial Health Services Authority of BC. (2014). Trauma-informed practice guide are available at: http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf