VEGA VIOLENCE EVIDENCE GUIDANCE ACTION

a public health response to family violence

@VEGA_Canada www.projectVEGA.ca

Briefing Note
Trauma- and Violence-Informed Care

The traumatic impacts of exposure to family violence (for VEGA defined as child maltreatment, intimate partner violence (IPV) and children's exposure to IPV), have long-term effects, whether the violence itself is ongoing or in the past. When serving people who have experienced family violence, systems and providers that lack understanding of its complex and lasting impacts risk causing further harm.

Trauma-informed care (TIC) seeks to create safety for clients/patients by understanding the effects of trauma, and its close links to health and behaviour. Unlike trauma-specific care, it is *not* about eliciting or treating people's trauma histories[1] but about creating safe spaces that limit the potential for further harm for all people (Covington 2008, Savage et al. 2007; Strand et al. 2015, Hopper, Bassuk, & Oliver 2010, Dechief & Abbott 2012).

Trauma- and violence-informed care (TVIC) expands the concept of TIC to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life[2] (Elliott et al., 2005). This shift is important as it brings into focus both historical and ongoing interpersonal violence and their traumatic impacts and helps to emphasize a person's experiences of past and current violence so that problems are not seen as residing only in their psychological state (Williams & Paul, 2008), but also in social circumstances.

The main differences between TIC and TVIC are that the latter brings an explicit focus to:

- broader structural and social *conditions*, to avoid seeing trauma as happening only "in people's minds"; e.g., discriminatory systems will break the bonds of trust that need to exist in a service context;
- *ongoing violence* including "institutional violence", i.e., policies and practices that perpetuate harm ("system-induced trauma"), e.g., making people re-tell their trauma to satisfy the needs of the system, rather than those of the person;
- the responsibility of organizations and providers to *shift services* at the point of care supported by *policies and systems* that enable these shifts.

TVIC expands on TIC to bring attention to:
- broader social conditions impacting people's health
- ongoing violence, including institutional violence
- discrimination and harmful approaches embedded in the ways systems & people know and do things
- the need to shift services to enhance safety & trust

Viewed this way, responses to trauma, including substance use and mental health problems, are seen as expected, or at least predictable, consequences of highly threatening events. This is especially the case when systemic inequities and system-induced trauma are ongoing. Staff knowledge and skill are key to addressing the traumatic effects of harmful institutional practices, including all forms of discrimination. Organizational leadership to support such staff is essential.

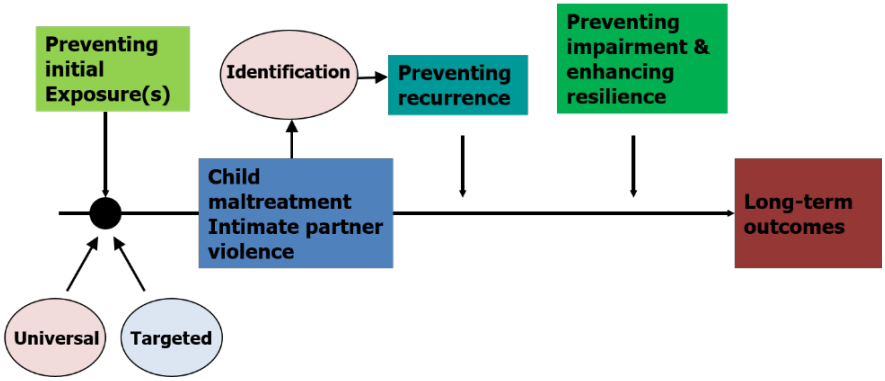
TVIC strives to make practices and policies safe, especially by preventing further harm. In this Briefing Note, we discuss the principles of TVIC integrated with the concepts of health equity and cultural safety. This integrated approach explicitly positions experiences of violence and trauma as social determinants of health, and provides a foundation for a public health approach to family violence.

[1] The effectiveness of interventions for identification and treatment of trauma specific to exposure to child maltreatment (CM), IPV and children's exposure to IPV is under review by VEGA. This evidence will be presented to NGIC members at future meetings, with discussion of how intervention-specific guidance is integrated with a TVIC approach.
[2] "Structural" and "systemic" refer to the fact that these ways knowing and acting are embedded in the political and economic organizations of our social world – this often makes them invisible or "taken-for-granted".

Framing TVIC in a Public Health Response to Family Violence

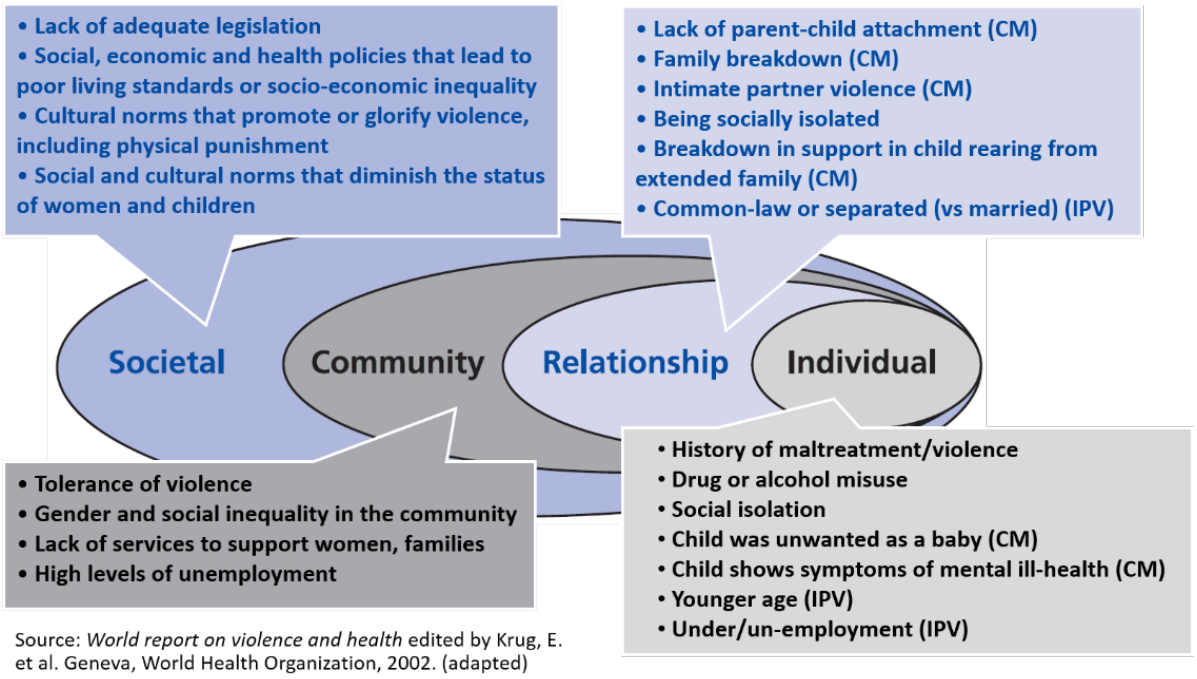
The public health response to family violence looks at three "prevention points" – preventing initial exposure (primary prevention), preventing abuse recurrence once identified (secondary prevention) and preventing the negative consequences of violence exposure (tertiary prevention). This is shown in Figure 1, and can be thought of as opportunities for systems and individual providers to provide resources, support and assistance.

Figure 1: The Public Health Approach to Family Violence Prevention



Broadening from individually-focused interventions, it is important to understand the multiple, intersecting and overlapping risks for family violence that operate at the individual, relationship/family, community and social/system levels. The World Health Organization's Ecological Framework is helpful, as shown in Figure 2.

Figure 2: WHO Ecological Framework Adapted for Family Violence Risk and Consequences
[IPV = intimate partner violence; CM = child maltreatment, including children's exposure to IPV]



Source: *World report on violence and health* edited by Krug, E. et al. Geneva, World Health Organization, 2002. (adapted)

As indicated above, risks for traumatic harm can come from how health and social service organizations and systems treat individuals. This is where guidance and curriculum based on TVIC, equity and cultural safety can integrate the public and population health approach to social determinants of health to help individual providers, working in various organizational settings and contexts, to more safely, equitably and effectively interact with individual clients/patients who have experienced, or are still experiencing, family violence.

Key concepts

Trauma is both the experience of, and a response to, an overwhelmingly negative event or series of events, from wars and natural disasters, to individual events such as accidents and loss (e.g., of a parent) (Ponic et al., 2016). Events become traumatic due to complex interactions between the person's neurobiology (affecting, for example, their ability to self-regulate), their previous experiences of trauma and violence, including the role of others in supporting (or not) self-regulation and recovery, and the interaction of broader community and social structures, per Figure 2.

In the context of family violence, trauma can be acute (resulting from a single event) or, more likely, complex (from repeated experiences). Trauma can change brain and nervous-system functioning, and while these neurobiological changes may not be permanent, they can be long-lasting, and impact child and adult behaviour (Green et al. 2015). For example, adverse childhood experiences (called ACEs), including maltreatment and exposure to IPV, can have long-term effects including stress, anxiety, depression, risky behaviours and substance misuse (Anda et al. 2006, Felitti & Anda 2010, Cloitre et al. 2009). Complex trauma can also impact child development, leading to internalizing, externalizing, and attachment disorders (Haskell 2012), which can persist into adulthood.

Experiencing interpersonal and systemic racism can also change neurobiological patterns, and even genetic structures (Humphreys et al., 2012), leading to impacts on mental and physical health and wellbeing (Krieger et al. 2011). **Cultural safety** draws attention to these harms, and the continuity between systemic and organizational structures and interpersonal forms of discrimination. Cultural safety does not focus on the person's "culture" but on the ongoing effects of history and historical forms of trauma at collective and interpersonal levels; it strives to make policies and practices safe regardless of how a person is identified, or identifies themselves, culturally (Ponic et al., 2016).

Health inequities are systematic disadvantages in health that arise from the conditions in which people grow, live, work, and age (also called the "social determinants of health") and the systems put in place to address illness. These are shaped by political, social and economic forces. Inequities are differences in health and well-being that are avoidable, modifiable and unjust (Whitehead & Dahlgren, 2006). Health inequities are **structural** because they are embedded in the political and economic organizations of our social world, and they are **violent** because they cause harm (Farmer, 2003). Redressing inequities requires an emphasis on serving those with most need rather than "treating everyone the same"; at the population level, **the greatest health gains can be made by helping those with the greatest needs**.

Why are equity and cultural safety integral to TVIC? Marie's Story

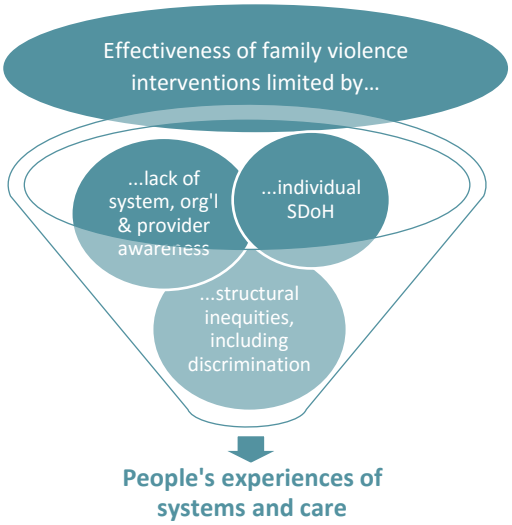
Marie is a single mother with four children under age 10, one of whom needs trauma-focused cognitive -behavioural therapy (TF-CBT) for severe PTSD symptoms as a result of having been exposed to his father's abuse of Marie. Despite the fact that the treatment is available at no cost, she is unable to afford bus tickets to get to the appointment across town, and can't access babysitting for her three daughters; the service doesn't provide child care. Marie is being harassed by her ex-partner, who ignores restraining orders requiring that he not contact her or the children. He has threatened to call child protection services, and she is afraid he will use the fact that their son needs therapy as evidence of her "bad parenting". Given her own poor experiences with formal services, where she has felt judged and stigmatized, Marie wonders if treatment for her son will actually do more harm than good, especially with these extra risks and costs to her family.

*Trauma **can also result from what doesn't happen**, for example, when systems fail to recognize and intervene in family violence and its related health, and social, causes and consequences.*

Connecting the Dots: Intersections among TVIC, Cultural Safety & Equity-Oriented Care

Approaches to family violence in health care are rapidly evolving from a narrow focus on "interventions" for individual "victims", to a broader understanding of family violence as a pervasive social problem embedded in social and structural inequities. The effectiveness of interventions to prevent family violence and its consequences is therefore limited by the broader circumstances of people's lives. Further, the capacity of providers to respond to family violence is reduced when they do not take these circumstances into account. So, interventions to prevent and mitigate the effects of family violence must include an understanding of the circumstances of people's lives. Similarly, interventions to promote equity in health and health care must attend to all forms of violence. Interpersonal violence should be understood within broad social circumstances, as well as systemic forms of violence and inequity. We must also consider that structural forms of violence *filter down* to everyday experiences, including interactions with health care and social services (Varcoe et al., in preparation). For example, people who live in extreme poverty often face class-based assumptions and stigma.

What this Means for Practice & Educating Service Providers



Trauma- and violence-informed, equity-oriented and culturally safe health and social service is about more than *access* to care, it also considers social and political conditions that shape people's health, including ***what*** care is offered and ***how*** it is provided, with a focus on improving the health and living conditions of those who face the greatest disadvantage (and risk of poor health). It means:

- Being aware of how immediate and more subtle (structural) factors, including historical and ongoing exposure to various types of violence, shape people's real life experiences;
- Being open to consider how our practices and policies may *unintentionally* harm people, especially those experiencing social exclusion and discrimination, and changing these policies and practices.
- Working in ways that are respectful and inclusive of peoples' diverse histories and contexts and placing the responsibility for emotional and physical safety in the care encounter on the practitioner, with particular emphasis on racism and other forms of discrimination.
- A good way to think about these practices is as "universal precautions" in place to ensure that all clients/patients, including those who are already vulnerable because of past or ongoing trauma/violence, are not re-traumatized ("triggered") or harmed. Practicing in this way **also means that disclosure or knowledge of history of trauma/violence is not necessary** – everyone gets the same respectful, safe care.
- At times, making choices to allocate more time and resources to address the greatest needs, rather than treating everyone "equally".

The Principles of TVIC in the table that follows build on those of trauma informed care to show how this can be enacted at the organizational and individual provider level (Provincial Health Services Authority of BC, 2013).

How to cite this document:
Varcoe, CM, Wathen, CN, Ford-Gilboe, M, Smye, V, Browne, A. VEGA Briefing Note on Trauma- and Violence-Informed Care. VEGA Project and PreVAiL Research Network. 2016.

Principles of TVIC – Organizational and Individual Provider Levels *(adapted from Ponic et al., 2016)*

Principle	Organizational	Provider
1. Understand trauma, violence and its impacts on people's lives and behavior	• Develop structures, policies, processes (e.g., hiring practices) to build culture based on understanding of trauma and violence • Staff training on health effects of violence/trauma, and vicarious trauma	• Be mindful of potential histories and effects ('red flags') • Handle disclosures appropriately: - Believe the experience - Affirm and validate - Recognize strengths - Express concern for safety and well-being
2. Create emotionally and physically safe environments for all clients and providers	• Create a welcoming space and intake procedures; emphasize confidentiality and client/patient priorities • Seek client input about safe and inclusive strategies • Support staff at-risk of vicarious trauma (e.g. peer support, check-ins, self-care programs)	• Take a non-judgemental approach (make people feel accepted and deserving) • Foster connection and trust • Provide clear information and predictable expectations about programming
3. Foster opportunities for choice, collaboration and connection	• Have policies and processes that allow for flexibility and encourage shared decision-making and participation • Involve staff and clients in identifying ways to implement services/programs	• Provide appropriate and meaningful options/real choices for treatment/care • Consider choices collaboratively • Actively listen …..and privilege the person's voice
4. Use a strengths-based and capacity-building approach to support clients	• Allow sufficient time for meaningful engagement • Program options that can be tailored to people's needs, strengths and contexts	• Help people identify strengths • Acknowledge the effects of historical and structural conditions • Teach skills for recognizing triggers, calming, centering (developmentally appropriate)

References

Anda, R. F., Felitti V.J, Bremner J.D., Walker J.D., Whitfield C., Perry B.D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry & Clinical Neuroscience* 256 (3):174-86.

Cloitre M., Stolbach B.C., Herman J.L, van der Kolk B., Pynoos R., Wang J., Petkova E. (2009). A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress,* 22 (5):399-408.

Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, 377-85.

Dechief, L., Abbott, J. (2012). Breaking out of the mould: Creating trauma-informed anti-violence services and housing for women and their children. In *Becoming Trauma-informed*, edited by N. Poole and L. Greaves, 329-338. Toronto, ON: Centre for Addiction and Mental Health.

Elliot, D.E., Bjelajac P., Fallot R.D., Markoff L.S., Reed B.G. (2005). Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *Journal of Community Psychology,* 33 (4):461-477.

Farmer, P. (2003). *Pathologies of power: Health, human rights, and the new war on the poor. Berkeley: University of California Press.*

Felitti V.J., Anda R.F. (2010). *The Relationship of Adverse Childhood Experiences to Adult Health, Well-being, Social Function, and Healthcare*: Cambridge University Press.

Green, B.L., Saunders P.A., Power E., Dass-Brailsford P., Bhat Schlbert K., Giller E., Wissow L., Hurtado-de Mendoza A., Mete M. (2015). Trauma-informed medical care: CME communication training for primary care providers. *Family Medicine* 47 (1):7-14.

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

Humphreys J, Epel ES, Cooper BA, Lin J, Blackburn EH, Lee KA. (2012). Telomere shortening in formerly abused and never abused women. Biological Research for Nursing, 14(2):115-23.

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

Ponic, P., Varcoe, C., Smutylo, T. (2016). Trauma-(and violence-) informed approaches to supporting victims of violence: policy and practice considerations. *Victims of Crime Research Digest, 9*. Department of Justice (DOJ); Canada. Available: http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd9-rr9/p2.html

Provincial Health Services Authority of British Columbia. (2013). Trauma-informed practice guide. Retrieved from http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Savage, L., Quiros A., Dodd S., Bonavota D. (2007). Building trauma informed practice: appreciating the impact of trauma in the lives of women with substance abuse and mental health problems. *Journal of Social Work Practice in the Addictions,* 7 (1-2):91-116.

Strand, V., Popescu M., Abramovitz R., Richards S. (2015). Building agency capacity for trauma-informed evidence-based practice and field instruction. *Journal of Evidence-Informed Social Work*, 1-19.

Varcoe, C., Browne, A. J., Wathen, N., Smye, V., & Ford-Gilboe, M. (in preparation). Trauma and violence informed care for approaches to family violence in health care: theoretical foundations.

Whitehead, M., & Dahlgren, G. (2006). Levelling up (part 1): A discussion paper on concepts and principles for tackling social inequities in health. Univ Liverpool: WHO Collaborating Centre for Policy Research on Social Determinants of Health. http://www.who.int/social_determinants/resources/leveling_up_part1.pdf

Williams, J., Paul J. (2008). Informed gender practice: Mental health acute care that works for women. National Institute for Mental Health in England.