Rate Your Organization: A Discussion Tool

10 Strategies to Guide Organizations in Enhancing Capacity for Trauma- and Violence-Informed Care (TVIC)

Use this worksheet to assess your own organization, agency, or setting in terms of the 10 strategies below. The goal is to support dialogue and action among all staff to enhance capacity for trauma- and violence-informed care (TVIC).

This is designed as a group activity, with all staff. It can be used across organizations, and is intended as a prompt for discussion and action-planning among people within the same organization or unit. Please use it to contribute to processes of organizational change by

(a) creating space and opportunity for ongoing collective and individual self-reflection and input,
(b) assessing where the organization or unit is 'at' with respect to trauma- and violence-informed care
(c) engaging in priority-setting, action planning, and monitoring

Trauma and Violence Informed Care is a key dimension of equity-oriented health care (EOHC), which aims to promote health equity. **Health equity** is not the same as health "equality". Health equity means providing the right amount and kind of care to people who are experiencing the greatest health challenges. For example, people who experience structural violence (e.g., systemic racism, poverty) are more likely to be exposed to interpersonal violence, and thus require extra attention to their safety during care encounters. TVIC is an approach to improve care for everyone, especially those with greater need, and is based on 4 principles:

1. Understand trauma and violence, including structural/systemic violence, and its impacts on peoples' lives and behaviours;
2. Create emotionally, culturally and physically safe environments for service users and providers;
3. Foster opportunities for choice, collaboration, and connection; and
4. Provide strengths-based and capacity-building ways to support service users

Instructions:
Take about 10 minutes to individually score your organization on each strategy. After everyone is done:

1. Each person identifies whether they would like to start discussion with the first strategy, or another strategy, and why (less than 1 minute per person).
2. Aim for group consensus about the first strategy to discuss.
3. Each person gives their rating, and why, on the first strategy (~1 minute each). Ideally, the order of speakers should be volunteer-based, and nobody should be forced to speak – it's important for people to feel safe and comfortable from the start!
4. As a group, consider the following questions:
   - What are the similarities among ratings?
   - What are the differences among ratings, and what accounts for these differences?
   - What does the group learn from the discussion of the ratings?
   - What are the implications for action?
5. After about 10 minutes, repeat with a second strategy, ensuring that each person can discuss their rating and rationale, if they wish. Depending on the group and time available, work through the strategies in order, OR focus on two or three strategies that are most relevant.
6. A next step can be to conduct an "Equity Walk Through" and/or start to gather the insights gained from this discussion into a SWOT (Strengths, Weaknesses, Opportunities, and Threats) format or SOAR (Strengths, Opportunities, Aspirations, and Results) format.

To further discussion and planning, take guidance from experts, including people who access and/or have accessed care. An example of a patient experience survey, the Equity-Oriented Health Care Scale, can be found here.

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On a scale of 0 to 10, rate your organization, where 0 = "not at all acting on this strategy", and 10 = "fully acting on this strategy".

1 **Trauma and violence informed care is identified as an explicit commitment in mission, vision, or other foundational policy statements of your organization.**

Attention to the extent and impact of trauma and violence, **including structural/systemic violence,** is a strategic priority of the organization and leadership is committed to TVIC at all levels of the organization, including for service users and providers.

2 **Policies and processes are in place, or being developed, to support commitment to TVIC.**

Policies and processes, including resources, to support emotional, physical and cultural safety of service users and staff, to optimize choice and control, and to ensure consequences and accountability of service providers are in place.

3 **Places and spaces are used optimally to make all people feel emotionally, physically and culturally safe.**

Intake spaces and practices are confidential; signage conveys safety and respect (rather than conveying assumptions about service users such as "violence will not be tolerated"), and is useful (e.g., how to access washrooms) and welcoming, not punitive (e.g., puts limits on questions per visit).

4 **Time is used in a flexible way to meaningfully engage with people.**

Time is used to optimize people's abilities to provide consent for care, have choice and control over their care, and connect meaningfully. Flexibility is shown with scheduling appointments, accepting that people who have or are experiencing interpersonal and structural violence must deal with multiple competing priorities. Time should also be provided for staff to rest or debrief when needed.

5 **Power differentials are attended to.**

People who have experienced trauma and violence have experienced abuses of power. Care providers must be supported to take a 'power with' rather than a 'power over' stance toward service users, regardless of whether their histories are known, and regardless of their apparent "social position".

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6 Care, programs and services are tailored to local contexts.

Context refers to the broader cultures, structures, economic, legal and political systems, and history of a particular place. With respect to trauma and violence, this means knowing the histories of the populations served (e.g. people with refugee status, Indigenous people) and how those populations are currently treated (e.g. limited or no access to health care, children likely to be apprehended by the state).

7 Racism, discrimination and stigma are actively countered.

Experiencing violence can make people feel shame and stigma, and is interrelated with other forms of stigma: racism, ageism, classism, heterosexism, sizeism, etc. Everything from signage, to intake forms, to language used, is scrutinized and modified; for example, stigmatizing issues (e.g. lice) should not be associated with particular groups. Claims of racism and discrimination are considered seriously and addressed, regardless of intention.

8 Service users and community leaders are authentically engaged in strategic planning decisions.

Advisory groups, whether standing or ad hoc, are formed and consulted, with their suggestions meaningfully integrated into programs/services, care protocols and organizational policies. The advisors as representative as possible of the local community, service users and those with lived experiences of trauma and violence.

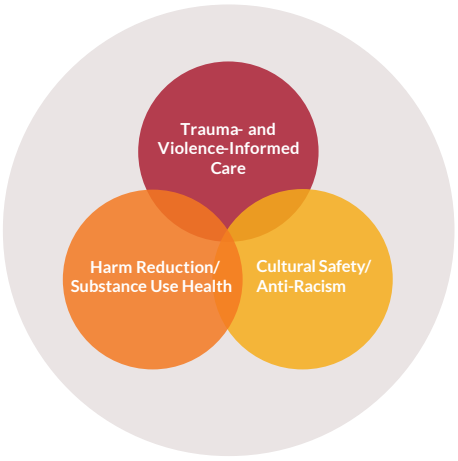
9 Care, programs and services are tailored to address inter-related forms of violence, including violence in the past that continues to affect the present.

Historical and structural forms of violence such as systemic racism and poverty are understood, acknowledged as being beyond the control of individuals (e.g., being on social assistance is not a "choice"), and efforts are made to mitigate harms including specific strategies to facilitate access to social determinants of health. Service providers have knowledge of histories of trauma and violence common in the community (e.g. people from a war-torn country or confined to reserves).

10 Care is tailored to address the structural, systemic and social determinants of inequity and harm.

Circumstances of peoples' everyday lives have major impacts on their exposure to violence. Care interactions should support access to resources that prevent or mitigate the harms of violence, such as affordable, safe housing, income above the poverty line (social assistance/disability incomes are not), and interactions be respectful, non-stigmatizing, and non-discriminatory.

Key Dimensions of Equity-Oriented Health Care



Tailored to context and responsive to inequities

Modified from: Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Smye, V., Jackson, B. E., Wallace, B., Pauly, B., Herbert, C. P., Lavoie, J. G., Wong, S. T., & Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health, 17(1), 154. https://doi.org/https://doi.org/10.1186/s12939-018-0820-2

10 Strategies to Guide Organizations in Enhancing Capacity For Equity-Oriented Services

- Explicitly commit to equity
- Develop supportive organizational structures, policies, and processes
- Re-vision the use of time
- Attend to power differentials
- Tailor care, programs and services to local contexts
- Actively counter racism and discrimination
- Actively seek input from community partners and people with living and lived experience
- Tailor care to address inter-related forms of violence
- Enhance access to the social determinants of health
- Optimize use of place and space

References

The evidence-base used to inform this discussion tool is:

- Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N., Smye, V., Jackson, B. E., Wallace, B., Pauly, B., Herbert, C.P., Lavoie, J. G., Wong, S. T., & Blanchet Garneau, A. (2018). Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. International Journal for Equity in Health, 17(1), 154. https://doi.org/https://doi.org/10.1186/s12939-018-0820-2

- Ford-Gilboe, M., Wathen, N., Varcoe, C., Herbert, C., Jackson, B., Lavoie, J., Pauly, B., Perrin, N., Smye, V., Wallace, B., Wong, S., Browne, A.J. (for the EQUIP Research Team) (2018). How equity-oriented health care impacts health: Key mechanisms and implications for primary care practice and policy. Milbank Quarterly, 96(4), 635-671. https://doi.org/10.1111/1468-0009.12349

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For more TVIC resources from the Gender, Trauma & Violence Incubator at Western University, please visit https://gtvincubator.uwo.ca/

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