“IT CHANGES THEIR OUTLOOK ON EVERYTHING”:

STAFF PERSPECTIVES ON THE IMPACTS OF TRAUMA- AND VIOLENCE- INFORMED

CARE ORIENTATION AND TRAINING IN TWO PRIMARY CARE SETTINGS

by

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Abstract

Trauma and violence are common, and they are linked to multiple health problems. Trauma survivors may be re-traumatized when seeking health care. Trauma- and Violence-Informed Care (TVIC) is care that is safe and accessible to trauma survivors. While there is a growing body of literature on trauma-informed care (TIC), prior studies have not explored how nurses and other multidisciplinary health care staff understand TVIC, which has an explicit focus on structural violence and ongoing interpersonal violence. Furthermore, few researchers have studied either TIC or TVIC in primary health care (PHC) settings.

This analysis explores the perspectives of PHC staff on the impacts of orientation and training sessions on TVIC. These TVIC sessions were one component of a larger intervention to promote equity. This secondary analysis uses interpretive description to analyze fourteen in-depth interviews with multidisciplinary staff at two PHC clinics.

While the impact of the TVIC sessions varied greatly across different participants and sites, all of the staff described enhancements in their awareness, knowledge and/or confidence about trauma and violence. For some, this contributed to a shift in perspective that impacted their personal lives, their clinical practice, their organizational culture, and their motivation to address structural determinants of health. Intrinsic factors including presentations of data, facilitated discussions, the presence of researchers, and the timing of sessions influenced how participants understood, remembered and prioritized TVIC. Importantly, structural, organizational and personal contexts significantly influenced how participants took up and enacted TVIC in practice.
This study contributes to knowledge about TVIC in PHC, and explores how health care providers understand and enact TVIC concepts. The findings point to the importance of challenging the biomedical paradigm in PHC and surface some of the difficulties health care providers may face when using a structural lens to inform clinical practice. Recommendations include assessing and planning for diverse contexts for TVIC implementation; explicitly attending to the biomedical paradigm that shapes PHC practice, framing TVIC as a paradigm shift but incorporating concrete tools and mentorship into TVIC sessions; attending to clients’ voices; and research-practice collaborations for sustainability and evaluation of TVIC.
Preface

This thesis is a secondary study of a subset of qualitative data from staff interviews conducted for the Equity-oriented Quality Primary Health Care study (EQUIP). The identification and design of the research program was done by the primary author of this thesis, Sarah Levine, in collaboration with my thesis committee members Dr. Colleen Varcoe and Dr. Annette Browne, primary investigators (PIs) on EQUIP. The data examined here is from in-depth interviews with fourteen primary care staff members at two of the four sites participating in EQUIP.

The EQUIP PIs developed and delivered the TVIC training and orientation sessions, and I observed one of these sessions. Working with the EQUIP team, I developed prompts for the interview guide about the TVIC orientation and training and its impacts. These prompts were embedded in an interview schedule prepared by the EQUIP team focusing on impacts of the EQUIP intervention as whole. I conducted seven of the fourteen interviews in my role as an EQUIP research assistant. Other researchers or research assistants on EQUIP conducted the other seven interviews. I conducted this qualitative analysis of a subset of EQUIP research data with ongoing input and feedback from my thesis committee: Drs. Coleen Varcoe, Annette Browne and Vicky Bungay.

The UBC Research Ethics Board for Human Ethics approved this secondary study in December 2014, under the project title “Levine Thesis” and the certificate number H14-02065.
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Dedication

For Liz James and the Street Nurse Team, who exemplify trauma- and violence-informed nursing, and for my daughter Deborah Tova Pettigrew.
Chapter One: Introduction

The prevalence and profound health impacts of trauma and violence are well documented in health and nursing literature (Anda et al., 2006; Muskett, 2014). Many clients of health care services are survivors of past or ongoing physical or psychological trauma (Elliott, Bjelajac, Fallot, Markoff & Reed, 2005). Tragically, trauma survivors may face being triggered or re-traumatized in their interactions with the health care system (Elliot et al., 2015). This can be harmful in itself, and may also have the effect of decreasing access to health care for trauma survivors, who feel unsafe seeking care (Browne, Varcoe, Ford-Gilboe, Walthen, and on behalf of the EQUIP Research Team, 2015).

A growing body of literature underscores the importance of Trauma-Informed Care (TIC) in nursing practice and health care more generally (Cleary, 2015; Kassan-Adams et al., 2015, Muskett, 2014). TIC is care that is safe, accessible and appropriate for trauma survivors (Harris & Fallot, 2001). As key providers in health administration, policy, education and direct care, nurses are increasingly being called to employ TIC to better support clients and to avoid re-traumatizing survivors of trauma and violence (Cleary, 2015; Kassan-Adams et al., 2015).

Trauma-and Violence-Informed Care (TVIC) is an approach to health care that takes into account the impacts of trauma and violence on health and works to create health services that are safe and accessible for trauma survivors (Browne et al., 2012). TVIC builds on TIC, but places additional emphasis on the impacts of structural violence
and ongoing interpersonal violence in clients’ lives (Ponic, Varcoe, & Smutylo, in press). As part of the Equity-oriented Quality Primary Health Care (EQUIP) research project, Browne et al. (2015) developed and implemented a theory- and evidence- based orientation and training on TVIC at four primary care sites. The study described in this thesis is a secondary analysis of data from EQUIP, exploring the perspectives of primary care staff on the EQUIP orientation and training to TVIC.¹

**Statement of the problem**

Primary health care is the first point of health care contact for many trauma survivors (Browne et al., 2015). While TIC has been studied in mental health and substance abuse services (Markoff, Reed, Fallot, Elliott & Bjeljac, 2005), little is known about the implementation of TIC in primary health care settings. In addition, despite a growing body of knowledge on TIC, few studies have looked at the *impacts* of staff training in this area (Hopper, Bassuk & Olivet, 2010). Finally, the TVIC orientation and training developed for EQUIP differs from most TIC curricula in that it has an explicit focus on the effects of structural violence and ongoing interpersonal violence (Browne et al., 2015). Prior studies have not explored how nurses and other multidisciplinary health care staff understand and enact these concepts in practice.

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¹ Throughout this thesis I refer to the orientation and training on TVIC as the *TVIC sessions*.

² Concurrent to the qualitative interviews, EQUIP collected quantitative survey data on the impacts of this training for staff members, which showed some statistically
Purpose of study

The purpose of this analysis is to explore the perspectives of multidisciplinary primary care staff on the impacts of the TVIC orientation and training component of the EQUIP study. As outlined above, this study addresses a gap in the literature on trauma-informed care in the area of primary health care. This study contributes to an understanding of how health care staff interpret and implement curriculum on TVIC for marginalized populations. The results of this study allow for appraisal and improvement of this new evidence- and theory-based curriculum on trauma and violence informed care.

Research questions

The research questions that guided the study were:

1. What are staff members’ perspectives on the impacts of TVIC orientation and training?
2. What are the intrinsic and contextual factors that influence the impacts of TVIC orientation and training?

The EQUIP study

The TVIC orientation and training sessions studied here were embedded within the larger EQUIP intervention and study. EQUIP is an “innovative multi-component, organizational-level intervention designed to enhance the capacity of PHC clinics to provide equity-oriented care, particularly for marginalized populations” (Browne et al., 2015, p. 2). EQUIP was implemented at four PHC sites in British Columbia and Ontario.
beginning in 2014. The intervention combined staff education on TVIC, equity-oriented primary care, and Indigenous Cultural Safety (ICS) to build staff capacity to address inequities. Along with staff education, each site underwent a process of organizational integration and tailoring (OIT) through which they assessed their policies and practices with regard to equity, set priorities for change, and implemented practice and policy changes with support from a practice consultant. EQUIP has provided a grant to each organization to assist them in implementing their priority changes.

The theory guiding the EQUIP intervention posited that combining staff education on equity, ICS and TVIC with the OIT process would increase the organizational capacity to provide equity-sensitive care (see Figure 1: EQUIP intervention theory, Browne et al., 2015, p. 5, reproduced with permission below). Specifically, researchers theorized that staff education on equity, TVIC, and ICS would contribute to:

1) Enhanced knowledge, confidence, and awareness of these concepts, and

2) Shifts in attitudes and perspectives among PHC staff.

Researchers further theorized that these shifts, along with changes in clinic structures and policies, would contribute to improved equity-oriented care for clients in the short term and improved health outcomes and reduced health inequities in the long term. The EQUIP study used a participatory, mixed methods, multiple case study design to examine the impacts of this intervention for both patients and staff members.
The EQUIP TVIC orientation and training sessions

The EQUIP TVIC orientation and training was developed by the EQUIP Primary Investigators, and delivered in a workshop format to multidisciplinary staff at each participating site (Appendix B: Agenda for EQUIP TVIC sessions). An initial 6-hour face-to-face workshop included pre-readings from trauma literature, group discussion and case studies. A 2-hour face-to-face follow-up session was held 2 weeks to 2 months later at each site. The course objectives stated that on completing the sessions, participants should be able to:
1. Explain how multiple forms of structural violence (e.g., racism, poverty) intersect with interpersonal violence (e.g., sexual assault, partner violence, child abuse).

2. Identify the short and long-term health consequences of various and multiple forms of violence, for example, the emergence of chronic pain.

3. Understand the physiological and health effects of trauma and violence.

4. Understand how trauma and violence underlie many of the physical and mental health disorders that people present with at primary healthcare organizations.

5. Understand how various contexts, values, and ideologies shape social and health care responses to violence and trauma.

6. Understand the implications of the differences between trauma-informed care and standard approaches to health care for practice with individual clients and for organizational practices, including the implications for prescribing practices.

(Appendix B: Agenda for EQUIP TVIC sessions).

**Organization of the thesis**

In this chapter I have discussed the background for this research project, outlined the problem I wish to address, and stated the purpose of this research. Chapter two outlines the research literature related to this problem, situating my study within what is currently known about TVIC. In chapter three I explain the design of this research project, including the theoretical framework, research approach, methods, and limitations. In chapter four I describe the findings of my analysis. In chapter five, I
discuss the implications of these findings, and make recommendations for future research on and practice of TVIC.
Chapter Two: Review of the Literature

In the previous chapter I introduced the problem of trauma- and violence-informed care (TVIC) in primary health care (PHC) settings, and I outlined my study of the impacts of health care staff orientation and training on TVIC. In order to develop an understanding of the issues relevant to TVIC, I have also conducted a review of the literature using the CIHAHL and Web of Science database search engines. This review situates my study within the existing literature on health inequities, trauma, trauma-informed care, and structural and ongoing violence. Finally, I review the literature on health care staff education on trauma and violence.

Trauma- and violence-informed care

Trauma- and Violence-Informed Care (TVIC) is “respectful, empowerment practices informed by understanding the pervasiveness and effects of trauma and violence” (Browne et al., 2012, p. 5). TVIC has been identified as a key dimension of equity-oriented primary health care for populations who are marginalized by poverty, racism or other structures (Browne et al., 2012).

Health inequities

Health inequities are avoidable, unfair differences in health status between groups in society (Whitehead & Dahlgren, 2006). In Canada, we continue to see stark health inequities for groups of people who are marginalized by structures such as poverty, racism and colonialism (Browne et al., 2012). Because of these inequities, there have been repeated calls for health care that is “equity oriented” – that is, for
policies and practices that prioritize the needs of disadvantaged groups (Browne et al., 2012).

**Trauma and health**

The concept of trauma has particular relevance when working with people who are marginalized by poverty, stigma, racism and colonialism, many of whom are trauma survivors (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Hopper et al., 2010; Pearce et al., 2008). Trauma has been defined as “an experience that is emotionally painful, distressful or shocking... that includes an overwhelming experience of helplessness or powerlessness” (Centre for Addiction and Mental Health, 2009, para. 1). While much of the trauma literature focuses on individual experiences of trauma, trauma can also be conceived of on other levels. Intergenerational traumas, such as that experienced by children of Aboriginal residential school survivors, may impact families; historical traumas such as war, genocide and colonialism may traumatize entire communities and populations (Urquhart et al., 2013; Waldron & McKenzie, 2008).

Numerous studies have established the connections between trauma and mental health problems such as post-traumatic stress disorder (PTSD), substance use disorders, depression, and suicide (Anda et al., 2006; Corso, Edwards, Fang & Mercy, 2008; Gilbert et al., 2009; Liebschutz et al., 2007; van Ameringen, Mancini, Patterson & Boyle, 2008). Furthermore, trauma is associated with a panoply of other health conditions, including heart disease, chronic pain, obesity, liver disease, smoking, diabetes and HIV risk (Dong, Dube, Felitti & Giles, 2003; Edmondson, Kronish, Shaffer, Falzon & Burg, 2013; Gilbert et al., 2009; Liebschutz et al., 2007; Pearce et al., 2008).
According to Elliot et al., (2005) “trauma survivors are the majority of clients in human service systems” (p. 462). Despite its prevalence and impact, trauma often goes unrecognized or is denied in health care (Elliott et al., 2005; Liebschutz et al., 2007). Trauma symptoms may interfere with care or cause survivors to avoid care out of a fear of being re-traumatized (Elliott et al., 2005). This has led to a call to make health settings “trauma-informed.”

**Trauma-informed care (TIC)**

Although there is no one model of TIC, Hopper et al., (2010) synthesized the following consensus-based definition from themes in the literature:

Trauma-informed care is 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. (p. 82).

TIC is distinct from trauma-specific services (TSS) such as psychotherapy or trauma counseling offered by specialists (Harris & Fallot, 2001). In fact, TIC is meant as an overarching “paradigm shift” for all staff in an organization - from receptionists to administrators to clinicians - challenging them to incorporate an understanding of trauma into their work (Harris & Fallot, 2001). Principles of TIC include an awareness of the impacts of trauma; an emphasis on safety; relationships of trust and respect; greater integration of services; increased access to and engagement with services;
attention to cultures and contexts; family-centered services; and the use of an empowerment model that solicits guidance and feedback from trauma survivors (Drabble, Jones & Brown, 2013; Elliot et al., 2005; Hopper et al., 2010; McKenzie-Mohr, Coates & McLeod, 2012).

Best practices in implementing TIC include an organizational commitment to TIC, a “trauma walk through” that looks at the organization’s policies and day-to-day work through a trauma lens, trauma awareness training for all staff, follow-up support and consultation, changes to hiring practices, and concrete strategies for involving service users in designing services (Drabble et al., 2013; Harris & Fallot, 2001; Hopper et al., 2010; Elliot et al., 2005).

TIC models have now been implemented in many settings, including mental health and substance abuse treatment services, homeless services, psychiatric inpatient units, and family courts (Hopper et al., 2010; Drabble et al, 2013; Markoff et al., 2005). As research on TIC develops, preliminary studies suggest that TIC improves health outcomes, is cost effective, and is highly valued by both staff and service users (Hopper et al., 2010).

**Structural violence and ongoing interpersonal violence: the “V” in trauma- and violence- informed care**

The EQUIP TVIC curriculum builds on existing trauma-informed models, but makes explicit reference to *violence-informed care*. This draws attention to the traumatic effects of ongoing violence, including structural violence (Browne et al., 2015). Primary health care recipients may be both ‘survivors’ of various forms of
violence with traumatic effects, and experiencing current and ongoing interpersonal violence (including intimate partner violence, interpersonal racial violence) and ongoing structural violence, including systemic and organizational racism, absolute poverty, and other forms such as colonialism (Browne et al., 2015). Farmer (2006) describes structural violence as “social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential” (Farmer, 2006, Box 1). Trauma-and violence-informed approaches are those that acknowledge that violence is not only in clients’ pasts, but may be an ongoing part of their lives. Such an approach also highlights the impacts of trauma and violence beyond the level of individual pathologies, such as PTSD (Ponic et al., in press). Browne et al. (2012) give the following example of a trauma- and violence- informed approach taken at a health centre: “in recognition of the devaluing of Aboriginal culture as a result of Canada’s colonial history, one of the Centres featured signage in a local Indigenous dialect to convey a valuing of Aboriginal identity” (p. 11).

**Health care staff orientation and training on trauma and violence**

Training on violence has been shown to increase clinicians’ confidence, knowledge and efficacy in providing care for patients who have experienced violence (Baird, Salmon & White, 2013; Edwardsen, Dichter, Walsh & Cirulli, 2011). However, health professional training and continuing education curricula vary widely in their coverage of the topics of trauma and violence (Wathen, 2009). For example, a study of 931 physicians and nurses in Ontario found that over 60% reported they had no formal training on dealing with patients who have experienced intimate partner violence (IPV)
(Gutmanis, Beynon, Tutty, Wathen & MacMillan, 2007). Conversely, a study of 232 American pediatric nurses found that nurses were knowledgeable about and favourable toward trauma-informed care, and showed the most variability in their confidence in teaching clients about trauma (Kassam-Adams et al., 2015).

Staff training in the prevalence and effects of trauma and the principles of TIC is a fundamental step in creating trauma-informed services (Elliot et al., 2005; Harris & Fallot, 2001; Hopper et al., 2010). Elliot et al., (2005) specifically recommend that basic training on trauma for all staff is a priority over specialized trauma training for clinicians. Brown, Harris & Fallot (2013) and Drabble et al., (2013) advocate a “trauma walk-through” as a collaborative, non-judgemental approach to improving practice and making trauma-informed organizational change. A 2015 study found that health staff trained on the use of a tool for screening and intervening for IPV and reproductive coercion both “value and struggle with” using the tool in practice (Burton & Carlyle, 2015). Staff in this study recommended “reminders” and “championing” as strategies in improve the training (Burton & Carlyle, 2015). A 2012 Cochrane review of 81 trials on the impacts of continuing education meetings and workshops in medicine found that meetings and workshops can improve practice, but are likely to have small effects, and that “educational meetings alone are not likely to be effective for changing complex behaviours” (Forsetlund et al., 2012, p. 2).

Summary

In this review of the literature, I have outlined concepts relevant to TVIC and reviewed previous studies on trauma-informed-care. This literature review reveals
several gaps in our knowledge about trauma- and violence-informed care. First, trauma-informed approaches have been implemented in specialized mental health, addictions and court settings, but little is said about the adoption of TIC in primary care, general healthcare settings or in nursing. Second, existing trauma-informed approaches have been largely focused on improving care for individual clients who are known survivors of past trauma. Little is known about how to equip health care practitioners to address ongoing or structural violence. Finally, as Drabble et al. (2013) point out, there is a need for studies that explore the outcomes of trauma-informed systems change, from the perspectives of both service providers and service users.

EQUIP researchers have drawn on the literature on inequities, trauma-informed care, and structural violence to develop TVIC orientation and training sessions for staff working in primary care. My own secondary study of interviews with participating PHC staff explores their perspectives on the impacts of these sessions, what influences these impacts, and what this can teach us about future implementations of TVIC in health care settings.
Chapter Three: Research Design

In the previous chapter I reviewed the literature that relates to TVIC and the TVIC curriculum being studied here. In this chapter I outline the design of my research project. I describe the critical social justice framework and constructivist learning theory that underpin my study. I then describe my sample, recruitment and data collection methods. Finally I explain the interpretive description approach I took to analyzing the data, the efforts I made to ensure the quality of my findings, and some of the limitations of this study.

Theoretical framework

As outlined in chapter one, my study was a secondary analysis of data from the EQUIP study, and my approach, methods and findings remain connected to the other components of the larger study. The EQUIP study as a whole is grounded in critical social theory, feminist intersectionality, and complexity theories (Browne et al., 2015). These approaches have informed the development and implementation of the TVIC curriculum. In particular, this theoretical grounding necessitates a focus on structural violence and the contribution that violence makes to trauma and health inequities (Browne et al., 2015).

Similarly, my secondary study adopts a social justice perspective based on critical social theory (Kirkham & Browne, 2006). A social justice perspective attends to fair distribution of benefits, burdens, and representation of groups in society (Rawls, 1971). It prioritizes the needs and voices of people who are most socially and
economically disadvantaged, while attending to social systems and structures, in particular focusing on health inequities (Bell, 2007; Kirkham & Browne, 2006). Emphasis is placed on the experience of people as situated in social groups, on the structural causes of inequities and harms, and on changes that can be made at a systemic level (Kirkham & Browne, 2006).

I also drew on constructivist learning theory to design my evaluation of the EQUIP TVIC orientation and training. Constructivist learning theory sees all learning as “context-bound,” with learners incorporating new knowledge into existing mental constructs (Vandeveer & Norton, 2005). In keeping with constructivist approaches, this study examines the impacts of the TVIC orientation and training and also the context for staff learning about TVIC and implementing what they learn in practice.

Research approach

In this study I was interested in examining the perspectives of staff on the impacts of the TVIC orientation and training. Through an analysis of qualitative interviews with staff members, I had an opportunity to learn about the staff members’ perspectives on the impacts of the TVIC sessions, exploring how this training brought about some of these impacts, and what influenced these outcomes.²

² Concurrent to the qualitative interviews, EQUIP collected quantitative survey data on the impacts of this training for staff members, which showed some statistically significant increases in staff’s self-reported knowledge, confidence and attitudes about
I took an interpretive description approach to this study. Interpretive description is a qualitative research approach that was developed to examine practice-based questions in the applied health disciplines (Thorne, 2008). According to Thorne, Kirkham and McDonald-Emes (1997), this approach “acknowledges the constructed and contextual nature of much of the health–illness experience, yet also allows for shared realities.” (p. 172). I felt this was a useful research approach that could combine a social-justice based, constructivist lens with a method to develop insights about “what nursing can do to make a difference” (Thorne et al., 1997, p.173). Although I was studying the impacts of TVIC orientation and training on a multidisciplinary PHC team, the insights gained about how staff take up TVIC concepts can inform nursing practice in many settings.

**Setting for study**

The EQUIP study was implemented at four primary health clinics in two provinces. This secondary analysis analyzes data from interviews with staff members from the two British Columbia sites. Both of these sites are “inner-city” primary care clinics that offer multidisciplinary services to patients who face barriers to health care such as poverty, homelessness, substance use, and other forms of marginalization (Browne et al., 2015). These sites operate within not-for-profit societies, and their trauma and violence following the EQUIP intervention (Browne, Varcoe, Ford-Gilboe & Wathen, in progress).
funding comes from regional health authorities, other funders, and from directly billing for services from provincial Ministries of Health (Browne et al, 2015).

**Sampling and recruitment**

For this analysis I drew on a subsample of EQUIP’s data from interviews with staff members at the two British Columbia (BC) sites in EQUIP. I chose the sites in BC because I was able to visit them, participate in EQUIP data collection, observe one of the TVIC sessions and personally conduct interviews with staff. EQUIP investigators and research assistants (of which I was one) conducted semi-structured interviews with nineteen staff members from these sites. Staff members were recruited by purposive sampling for a variety of disciplines and levels of involvement with EQUIP: all of the staff were invited to participate in qualitative interviews by EQUIP through an invitation letter sent out by the administrative leaders at each site. Staff were also invited to participate in person at staff meetings. Because the EQUIP team were interested in the impact of this education on staff coming from various backgrounds, EQUIP researchers attempted to interview staff from as many different disciplines as possible.

I chose to analyze seven interviews from each site from the EQUIP data set. I chose these particular interviews though an iterative process that was ongoing during my analysis. Guided by my supervisors, I initially looked at interviews with participants who had been heavily involved in EQUIP at each site, and who could provide rich data on their experience in the study. As my analysis proceeded, I looked for cases
(particularly from different sites and disciplines) that could confirm or contradict the patterns that I was finding in the data (Thorne, 2008).

**Study sample**

The final sample for this study is comprised of fourteen staff from a wide variety of disciplines in primary care, including medicine, nursing, pharmacy, social work, counseling, administration and leadership. Ten of the staff interviewed were full time employees and four were part-time employees at the clinics. Twelve of the staff in the sample were female and two were male. There was a wide variation in how long staff had worked in the clinics with an average length of seven years (range: 1-14 years). One staff member in the sample self-identified as Aboriginal.

**Data collection method**

Qualitative data were collected through semi-structured interviews with staff conducted ten to twelve months after the implementation of the EQUIP TVIC sessions. Interviews lasted approximately sixty minutes and took place at each PHC centre. Working with the EQUIP team, I developed prompts for the interview guide about the TVIC session and its impacts. These were embedded in an interview schedule covering the entire EQUIP intervention, including education on TVIC, Equity and Indigenous Cultural Safety, and the process of Organizational Integration and Tailoring (OIT). I personally conducted seven of the interviews in my role as an EQUIP research assistant and other research assistants or the EQUIP primary investigators conducted the other seven interviews. Analysis and data collection occurred concurrently. Thus, as I conducted and/or listened to recorded interviews I began to develop hunches and
ideas about the data. This led me to seek out participants from different sites and disciplines and probe on certain questions in subsequent interviews. Along with the EQUIP team, I revised the interview schedule between conducting interviews at the first site and the second (See Appendix A: Interview Guide).

**Data analysis**

Qualitative interviews were recorded, transcribed verbatim and checked for accuracy. I then read through all of the data line by line, making memos of units of meaning. As I began to notice patterns in the data, I noted potential theoretical codes in the margins as well. After two initial passes through the data, I wrote a summary of each interview that captured the *gestalt* of the interview from each participant, paying attention to anything that was related to my phenomenon of interest: the outcomes of TVIC training in PHC practice. I then worked with the summaries and the list of preliminary theoretical codes, asking myself “what is going on here?”.

I developed a preliminary diagram of my analysis of the data from each site. I initially represented three main themes - “Context”, “EQUIP intervention”, and “TVIC impacts” - as three intersecting “gears”. I then essentially started over. Building on the scaffolding provided by the EQUIP theory, I revised my research questions to focus on the impacts of the TVIC session, the contextual influences on these impacts, and the implications for the future.

I went back and coded the interviews and the summaries again. To get beyond the semantic level of what participants were saying, I asked, “What is this an example of?” for each code. I began trying to organize an outline of what I saw as the most
important themes, asking myself “What ideas are starting to take shape such that I think they will have to have a place in my final analysis if it is to do justice to the research question?” (Thorne, 2008, p. 160). This iterative process of refining and revising my themes and subthemes continued as I began to articulate in writing what I had learned from the data.

Assessing Validity in Qualitative Analysis

I made several efforts to ensure the validity of this study. Although the issue of validity in qualitative research remains a topic of intense debate, it is important for qualitative nurse-researchers to ensure that their conclusions go beyond mere “opinions” and represent some credible knowledge useful to the discipline of nursing (Thorne, 2008). Several authors have advanced criteria for ensuring and assessing the quality of qualitative research. For this study, I took Whittemore, Chase and Mandle’s (2001) synthesis of validity criteria as a guide. I employed techniques to address Whittemore et al.’s (2001) four primary criteria of validity: credibility, authenticity, criticality, and integrity. Whittemore et al. (2001) further synthesized several secondary criteria that may be applied in a more flexible way depending on the nature of the study. In this study about the impacts of TVIC orientation and training for PHC staff, it was important to focus on secondary criteria of thoroughness and congruence. I have also considered some additional criteria suggested by Thorne (2008): moral defensibility, disciplinary relevance and pragmatic application.

Credibility
Credibility in qualitative research refers to whether the data, interpretations and conclusions are represented in a manner that is believable (Whittemore et al., 2001). I employed techniques of data triangulation to enhance credibility in my study on TVIC, seeking data from multiple informants from multiple sites and disciplines. I was able to continually check the themes I was developing against confirming or contradictory data by engaging in constant comparative analysis and by memo-ing and maintaining a clear audit trail. I worked to refrain from making truth or generalizability claims based on the experiences of this limited sample of participants. Finally, credibility of the analysis was assessed by inviting my thesis committee members to analyze some of the interviews with a view to discussing different “readings” of the data, and working toward a shared understanding of how to make sense of the themes represented in the data.

**Authenticity**

Authenticity refers to the extent to which a researcher faithfully represents the multiple realities and voices of the participants (Whittemore, 2001). According to Whittemore et al., (2001), “multiple, socially constructed, and sometimes conflicting realities may ultimately be exposed through attention to authenticity.” (p. 530). To maintain authenticity in this study, I continually reflected on my own social location and the positionality of each of the participants, considering what this revealed about how TVIC concepts are taken up in different contexts. I worked to hold myself back from wrapping my findings up into a “tidy package” that would obscure the multiple experiences of this intervention.
Criticality

Restraining myself from a “tidy” interpretation of the impacts of this curriculum also contributed to criticality in this study. In order to ensure that I was reflecting critically on my own analytical hunches and theories, I kept memos, notes and journals tracking my ideas and my preconceptions. I considered alternative hypotheses, sought contradictory cases, and at one point started my analysis over almost from scratch.

Integrity

The criterion of integrity relies on the researcher’s capacity to interrogate and critique her own analysis. While a researcher’s own thoughts and ideas are integral to qualitative analysis, a study demonstrating integrity must build in checks to ensure the analysis remains grounded in the data rather than in the preconceptions of the researcher. In this study I maintained an audit trail of my memos, codes and ideas so that anyone can clearly follow how I arrived at my final set of themes and subthemes.

Thoroughness

The criterion of thoroughness refers to how effectively the researcher is able to answer the research question through adequate sampling and data collection and an in-depth analysis that can explore the connections between themes (Whittemore et al., 2001). In order to enhance thoroughness in this study, I sought a relatively large and diverse sample from two PHC sites. In analyzing my themes, I pushed beyond my initially simplistic diagram of themes and subthemes to find connections among themes.
Congruence

Congruence refers to the fit between the researcher’s approach, the research question, the research methods, and the conclusions (Whittemore et al., 2001). In this study I worked to bring a social justice and constructivist perspective to a question about the impacts and implication of TVIC education in primary care. This approach led me to seek out and take note of data about social location, power, voice, and context. I took an interpretive description approach to my research questions, seeking results that could answer pragmatic questions about how TVIC education can be done well. Although my aim was not to generalize my findings as in quantitative studies, my hope is that I have arrived at conclusions that can influence future practice in other settings.

Moral defensibility, disciplinary relevance and pragmatic application

In addition to considering criteria for quality, Thorne (2008) calls for a critique of research products in terms of their moral defensibility, disciplinary relevance and pragmatic application, among other criteria. As I understand them, these three imperatives ask certain questions of any piece of research: Why do we need this knowledge? What do we plan to do with it? What good could come out of it? How is it of use to nursing? What new angle does it offer on practice? What would be the implications of applying this knowledge? These criteria were very much in my mind at every stage of this study.

I am a practicing nurse, nurse educator and researcher. I have been working with populations marginalized by poverty, racism and discrimination for the last 15 years. My goal in doing this study, above all, was for my small piece of research to
contribute in some useful way toward reducing inequities. This goal drew me to work on the EQUIP study and to work on a secondary analysis rather than produce primary research. Working this way created some wonderful opportunities and also some limitations to my ability to design an “ideal” study. In the end, my hope is that asking about how to do TVIC well and connecting my research to the ongoing research program of my supervisors means that this work will do more than just advance my own capacity to do research. I hope that this study can contribute to implementing TVIC in other sites in the future.

**Limitations**

There are several limitations to this study that should be taken into account. First, this study draws from a small sample of staff in two particular clinics. Small samples like this one are not uncommon in qualitative research, which aims to gain in-depth insights into the nature of the phenomenon under study rather than to prove or disprove a hypothesis (Thorne, 2008). In this case my aim was to explore how and why orientation and training on TVIC impacted these participants with an eye to improving future efforts at TVIC. With this in mind I sought a sufficiently large and varied sample to synthesize a meaningful description of the impacts of these TVIC sessions for different individuals, sites, and disciplines.

A second limitation is that although the larger EQUIP intervention is a multi-year study, this secondary study is limited to interviews at one time point only, representing a limited engagement in the field. Follow-up interviews might have revealed more information about the longer-term impacts of the TVIC sessions.
However, I was able to get a broader sense of the context at these sites by observing one of the TVIC sessions, visiting each site, and participating in data collection for EQUIP more generally (including conducting some of the client surveys).

This analysis is limited by my own inexperience as a researcher. Thorne (2008) writes that in good qualitative analysis, “findings never ‘emerge’ from the data on their own, and if they are to be worth something in the end, they always come about because a human mind has engaged strategically and constructively in the business of active analysis.” (p.155). As a novice analyst, I was vulnerable to making “rookie mistakes”: jumping to premature conclusions, remaining at a surface level of analysis, or allowing my own biases to dominate my thinking. In particular, my disciplinary orientation and long experience as a community and public health nurse working in clinics very similar to those studied meant that I had my own preconceptions about the practice of the people I interviewed. I worked to mitigate this by tracking my preconceptions, critically reflecting and journaling, and seeking input from more experienced researchers.

Finally, because the TVIC sessions were being implemented alongside other components of the larger intervention, it is not possible to tease out the impacts of the TVIC curriculum alone. In particular, the process of Organizational Integration and Tailoring is explicitly meant to integrate the three training components and catalyze organizational changes that support applying this training in practice. While this study focuses on the TVIC component, the sessions on TVIC were not meant as a “stand alone” component and were not implemented as such.
Summary

In this chapter I have outlined the design of this research project. I have defined the theoretical frameworks of social justice and constructionism that underpin this study. I have described the setting for the study; sampling, recruitment and data collection procedures; and the interpretive description approach I took to data analysis. I have further outlined the techniques I employed to ensure the quality of my findings, and clarified some of the limitations of this study. In the next chapter, I explain the findings from my analysis of the study data.
Chapter Four: Findings

This study looks specifically at the impacts of the TVIC-related aspects\(^3\) of the EQUIP intervention through an analysis of interviews with 14 staff members at 2 participating sites. In this analysis, I explore the impacts of the TVIC sessions and the possible influences on these impacts. In this chapter, I will describe my findings from this analysis. First, I explain the two broad themes that address my first research question about the impacts of the TVIC sessions. Second, I will describe the two themes addressing my second research question, which asks what influenced the impacts of the TVIC sessions.

1. What are staff members’ perspectives on the impacts of TVIC orientation and training?

Through my analysis I identified two broad themes on the impacts of the TVIC sessions that were common across practitioners and sites. The first theme was that the TVIC sessions contributed to changes in awareness, knowledge and/or confidence about trauma and violence. The second theme was that these changes led to shifts in

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\(^3\) Although I look specifically at TVIC, I want to emphasize that orientation and training about TVIC, Indigenous Cultural Safety (ICS), and Equity, along with the process of Organizational Integration and Tailoring (OIT), were all interconnected in the EQUIP intervention. The impacts of these different components are similarly interconnected with one another.
perspective for some staff, which had impacts at multiple levels in participants’ lives: personal, clinical, organizational and political.

Enhanced awareness, knowledge, confidence about trauma and violence

While the impact of the TVIC sessions varied greatly across different participants and sites, all of the staff described enhancements in their awareness, knowledge and/or confidence about trauma and violence. I have divided this broad theme into three separate but related subthemes: awareness, knowledge and confidence.

Awareness: Putting trauma and violence “front and center”

One theme common to all the staff interviewed was an increase in their awareness of trauma and violence. Although some staff were already familiar with TVIC concepts, participating in EQUIP raised the profile of these issues for them and their teams. As one physician explained: “I may have thought about [trauma and violence] but this put it more front and center for me, to really start noticing it when it happened.” However, some practitioners described increased awareness as having a fairly minor impact on their thinking and practice. One nurse explained; “I mean the point again that really sticks to me is the idea about not treating trauma but using it as a context. But beyond that I didn’t get a ton out of it.” While all of the respondents spoke of increases in their awareness of trauma and violence, this had profound impacts for some, and minor impacts for others.
Knowledge: Sessions contributed to enhanced knowledge for some staff, but did not provide the anticipated skills training

Several participants described an increase in their knowledge about trauma and violence. This increase was modest for some, and for some did not match with their expectations of “skills training” on TVIC. For some staff, learning about the prevalence and impacts of trauma and violence gave them more information about the contexts of their clients’ lives. One Medical Office Assistant (MOA) explained,

I feel like I’m a very open person but I just didn’t realize all the things that have kind of happened, right? So going through all that I think personally for myself has made me be even more accepting of our clientele.

Participants also commented on learning about the differences between the concepts of “equality” and “equity”:

Something I think was good to learn was not so much about being non-biased but being sensitive. So not to just have like, yeah, like equality but sort of being sensitive to the different cultural needs of, yeah, people as opposed to coming at it from just like everyone is equal like which isn’t necessarily the case.

One nurse explained that she had already learned about trauma in university, but that EQUIP was an opportunity to learn more about structural violence: “it was good to look at [trauma and violence] in more detail and... look at it from a point of structural like what the client would perceive as structural... prejudices, roadblocks to them.”

Some staff members had expected to come out with a more concrete “toolkit” for TVIC, rather than an orientation to concepts. A social worker said:
I mean I try to approach people now in a, with that kind of awareness of the trauma and structural violence kind of informed practice but really do I really know what that is really supposed to look like in practice? You know, maybe I need more guidance around like, like specifics.

This kind of experience was particularly notable amongst staff who explained they were already familiar with the concepts of trauma, violence and structural through previous training or experience.

**Confidence: Validation, reinforcement, and confidence to speak up**

Several participants described TVIC orientation and training as a reinforcement or validation of their existing knowledge. A counselor described the impact as “validation that our awareness is the same, the EQUIP study is actually examining some of the stuff that we run into as a hazard, as a problem on a daily basis.” A nurse described how TVIC concepts are foundational to her approach, and said that EQUIP reinforced this: “I think that in the sense of justice, where it’s always been my foundation actually where I work from. But that [EQUIP] really influences me more and more to be quite bold.”

Some participants described how participating in EQUIP made it easier for them to speak up about trauma and violence with their colleagues. A counselor described how she had been trying to raise the issue of trauma with her colleagues, and how after the team participated in EQUIP she was finally able to do so:

I was going to do this hour and a half presentation or whatever it is to the staff on trauma. And so it kept getting postponed and it kept getting postponed and I just kept getting really frustrated and finally it did happen.
In this case, EQUIP and the TVIC sessions may have validated the perspective and amplified the voices of staff that were raising issues of trauma and violence.

The first main theme that I identified in the data about the impact of the TVIC sessions was that there were changes in awareness, knowledge and/or confidence about TVIC concepts for these staff members. The extent and effect of these changes varied greatly across staff and sites. For some staff, shifts in awareness, knowledge and confidence were the main impact of the TVIC sessions. For others, these shifts led to a shift in perspective, or “seeing through a TVIC lens” – the second broad theme in this analysis.

**A shift in perspective: Seeing through a TVIC lens has impacts on multiple levels**

The second broad theme was that some practitioners experienced a shift in their perspectives which had impacts in multiple aspects of their lives. One participant commented on how seeing through a trauma- and violence-informed lens had broad impacts for her colleagues that went beyond their work with clients: “what it does is it changes their outlook on everything.” I have conceptualized these impacts as shifts on four different levels: personal, clinical practice, organizational and structural.

**Personal level: Caring for self and family**

Many practitioners described changes in their personal lives as they increasingly saw through a lens of trauma and violence. A counselor explained that she saw that learning about TVIC made these abstract concepts personal for her colleagues: “when they dealt with patients they, they could see it and they… knew that it was trauma-related but what they didn’t tie it to was themselves”. Learning more about TVIC
spurred some staff to seek support to cope with their own reactions to vicarious trauma. A physician explained, “I mean [the EQUIP training] for me is a big opportunity to look at myself and how I deal with things. And I mean the only real way that I have to change the system is to look at myself first.” Another staff member explained how she has prioritized taking time to listen and connect with others in her family life: “So it’s played in at work, it’s played in at home where I just go ‘those things really don’t matter, take five minutes and sit down and have a cup of tea with your kid.’”

While the TVIC sessions were directed toward practice in primary care, they had impacts on several participants’ personal and family lives. This underscores how for some practitioners, learning about TVIC led to a shift in perspective rather than the acquisition of a new “skill”. For many, this TVIC lens carried over into their clinical practice in a similar way – as a new view on practice, rather than a clinical tool.

**Clinical practice level**

Seeing through a TVIC lens also had impact on clinical practice. I identified two subthemes about the impact of the TVIC sessions on the clinical practice of the participants. Firstly, some practitioners began seeing, naming and addressing structural violence in their practice. Second, some practitioners made efforts to take more time with clients, despite the challenges this presented in busy clinics.

Seeing, naming and addressing structural violence in the practice setting

Several staff described how they became more attuned to structural violence and began to connect structural violence to health and their work as health care providers. Conceiving of structural inequities as a form of violence seemed to increase
some practitioners’ abilities to describe and react to some of the inequities they were seeing – or contributing to – in practice:

Whereas before it was like, okay, I know I’ve got to get all this stuff done before I go…. but then I realize I’m going well wait a minute, if I’m just spewing something back or I’m not making eye contact, you know, or I’m typing like whatever that is, I’m causing that person trauma, you know. (MOA)

I think it made me more aware of to keep it in the forefront of my mind how it makes clients feel when I say no, I can’t see you today…They see it as you’re being racist because you don’t have time to see me right now. So it made me more aware of that perception. (Nurse)

Here again, seeing through a TVIC lens shifted how practitioners saw structural inequities. Perceiving poverty, racism or discrimination as forms of violence encouraged staff to take these on as issues to address in primary care practice.

Taking more time

Similarly, several staff members described how “seeing through a TVIC lens” encouraged them to take more time with clients. A nurse described this change and the tension this created for her in a busy clinic:

I’m aware of also when I’m to slow down and give people ample time to respond to me. And that was a bit of a challenge because you’re in a hurry, right, especially when there’s eight people waiting to be seen.

While workload and other structural constraints made this a challenge, “seeing through a TVIC lens” encouraged practitioners to prioritize taking enough time to help clients feel safe and heard.
Organizational level

Shifts in perspective had many impacts at the organizational level as well. I identified four subthemes on the impacts of seeing through a TVIC lens for the two PHC organizations studied here. These were: challenging the dominance of the biomedical paradigm; connecting trauma and violence to colonialism; taking a new view on clinic spaces and policies; and incorporating new modalities to address the health effects of trauma and violence.

Challenging dominance of the biomedical paradigm

In one clinic in particular, open discussions about trauma, violence and particularly structural violence led to some shifts in power dynamics among staff. Several participants described how these discussions brought psychosocial aspects of health into the foreground, challenging the dominance of the biomedical paradigm in PHC practice. One counselor said:

[Our team meetings] didn’t work because it was so medically oriented, and I said that. And one of the doctors really asked me about that and he asked me if that’s what I believed and I said, yeah. And it, it’s true and it’s always been like this.

Another staff member explained that impacts of this shift for her team were both subtle and profound: “But, doctors, and others, are also aware that the psychosocial component is extremely important, and maybe sometimes more important than medical…. but there’s a slight, some insight that I do see that I haven’t seen before, ever.” For this staff member’s organization, seeing through a TVIC lens led to fundamental discussions about the scope and purpose of PHC and the importance of the psychosocial aspects of health.
Connecting trauma and violence to colonialism

The TVIC sessions, alongside the interconnected component of Indigenous Cultural Safety (ICS), also helped staff to connect trauma, intergenerational trauma, and ongoing violence with racism and colonialism. An Aboriginal staff member described how structural violence operates in her workplace and how EQUIP raised challenging questions:

Structural violence is everywhere and I think even in the clinic here ... it’s like there’s a certain control when people at the top control things and make it to the way that they want it. Even if they’re nice, it still impacts everybody in a negative way... if we’re serving native people it needs to have native people in leadership.

Both PHC sites made efforts toward indigenizing their organizations after orientation and training on TVIC and ICS. This included acknowledging local Indigenous territory and displaying Aboriginal maps and art in clinic spaces. However, some staff raised concerns that these changes might be too superficial.

I think that it needs to be more client-led, more client-driven. So, you know, the superficial stuff about like the [Aboriginal] art and ...the map and all that sort of stuff is, is good, but [I wonder] whether there’s client involvement in deciding those changes and what its going to look like?

An administrator described her concern that Aboriginal perspectives could be taken on in a tokenistic way:

What I’m hearing is that it’s not okay that we’re ninety-five percent western and we’ve got this culture piece that we can say we do... In this place what
[Aboriginal perspectives] should do is it should be infused throughout everything that we do. And it should be really a foundational value that we have.

At this site, efforts toward fundamentally indigenizing the organization included grappling with the complexities of addressing tensions within their Aboriginal advisory and trying to re-instate a position for an Aboriginal elder on staff.

Taking a new view on clinic spaces and policies

In one of the TVIC sessions, the staff were asked to map how clients move through their sites and to reflect on how their spaces could be made more trauma- and violence-informed. Staff began to see more fully how their clinic spaces and policies might contribute to trauma, structural violence, and a feeling for clients of being unwelcome or unsafe. As a result both organizations made changes to their waiting rooms. One clinic made a very significant change, eliminating the morning line up by opening their doors earlier. One MOA described how she saw this impacting the clients at the clinic:

They’re definitely more relaxed in the morning so that would make them, you know, feel a little happier and more comfortable. Just to have a place to come in and relax and not have to stand outside in a lineup on the street. So it sort of changes just like that concept of, you know, lining up like cattle.

For both sites studied here, seeing their organization’s spaces and procedures through a trauma-and violence-informed lens underscored how their services might traumatize or re-traumatize their clients. This led organizations to make some significant changes to the way clients moved through their spaces.
Incorporating new modalities to address the health effects of trauma and violence

Organizations also made changes to the clinical services they offered. Seeing through a TVIC lens opened the organizations to new and diverse modalities for addressing pain, trauma and addiction in primary care. A physician explained how thinking has shifted about clients who complain of vague symptoms: “Just think about the context where all this stuff is coming up and let’s talk to [a client] about some of those traumatic, painful, violent, abusive things that happened to her.” Practitioners described how they began making more use of services such as physiotherapy, group counseling, and mindfulness to address the links between trauma, chronic pain and addiction.

At one site, participating in the Organizational Integration and Tailoring (OIT) process through EQUIP led to the formation of a client group focused on managing chronic pain. A staff member explained the importance of this change: “The pain group [would not have been started] without [EQUIP]. And it’s such a predominant issue in our clinic that it really should have been addressed earlier in a more systematic way. So I appreciate that.”

At both of the sites studied here, shifting perspectives to focus on trauma and violence led to the use, or increase in use of diverse modalities and services.

**Structural level: Momentum to advocate for structural change**

Finally, seeing through a TVIC lens had impacts on a structural level, orienting practitioners to focus on health on a societal scale. Several respondents spoke of EQUIP increasing “momentum,” “acuity,” or “focus” to take on structural inequities in society. A social worker described the TVIC sessions as a reminder to be an advocate:
“reminding me that... I really should be doing more around advocating... for the change piece right, because that stuff needs to change.” A physician gave an example of addressing structural violence at work:

It made me sort of feel confident enough to start doing something about [trauma and violence] when I see it. So we had a discussion today about, in a sharing circle, about First Nations people and their interactions with police.

Several participants acted on this momentum by bringing a TVIC perspective into hospitals and health authorities. One physician described the “snowball effect” she has seen after raising issues related to trauma and addiction with her colleagues in the hospital:

You can almost see a light click on for them. And it’s like oh, oh, that changes everything. And they go, okay, for a patient who is not following the rules and being difficult to a patient who has a struggle... And, having those discussions, and then what was really interesting to me was the snowball effect, I had that discussion with one nurse and then she had it with another nurse, and that nurse had it with a nurse so then all of a sudden [this client] got more compassionate care, because people had a better understanding of his addiction.

While this momentum to take advocate galvanized some staff into action, others struggled with how to address structural violence within their roles in the clinic. One nurse explained: “I mean all of these things around pain and suffering and trauma, they’re structural, they’re much bigger than any of us so, you know, it’s hard to deal with those at that level as well.” This nurse further described the struggle to balance the
immediate needs of clients with the imperative to address trauma and structural violence:

You know, when you’re dealing with trauma sometimes you wonder how much you should be doing at any particular moment. And somebody comes in because their ankle is sprained and they sprained their ankle fleeing an abusive partner.... do you just... help the person with the ankle because that’s what they came in for or do you try to remove them from a violent situation?

Momentum to take action on structural violence created a dilemma for some practitioners, who were unsure how to take concrete action on a structural level, while continuing to meet the needs of their clients.

In summary, I identified two broad impacts of the TVIC sessions. First, these sessions contributed to enhanced awareness, knowledge and/or confidence about the concepts of trauma and violence for some PHC staff. Second, this led to shifts in perspective that had effects on multiple levels in participants’ lives. These effects included personal changes in self-care and relationships; new approaches in individual practice with clients; shifts in organizational paradigms, practice, and policy; and an increased sense of momentum to advocate for structural change.

2. What are the intrinsic and contextual factors that influence the impacts of TVIC orientation and training?

The impacts described above were influenced by factors that were both intrinsic and contextual to the TVIC sessions. Intrinsic influences included the strengths and challenges connected to the TVIC sessions themselves: data, discussions, researchers’
presence and the timing of sessions. Contextual influences included structural, organization and personal factors which either facilitated or constrained participants’ abilities to enact TVIC in practice.

**Intrinsic factors: Data, discussions, presence, and timing influence how participants understand, remember and prioritize TVIC**

Certain aspects of the way the TVIC sessions were delivered were described as having a major influence on participants’ how participants understood, remembered and prioritized what they learned about TVIC. Data on local patient populations, externally facilitated discussions, and the presence of researchers were described as supporting participants to understand and enact TVIC, while the timing of sessions was described as a challenge.

**Data from local patient populations: “A really really important reminder”**

Because the TVIC sessions were provided as part of the broader EQUIP intervention, the researchers who had facilitated the TVIC sessions visited PHCs at regular intervals to collect data from patients as well as from staff. As part of the EQUIP intervention, researchers presented baseline patient data on trauma symptoms and prevalence, satisfaction with care, and other TVIC-related measures to staff meetings and leaders at the sites during these visits.

This data had a profound influence on many practitioners at both of the sites studied here. Staff members were struck by the prevalence and severity of trauma symptoms or chronic pain in their client populations, and they were curious about the
differences between the sites in the study. One staff member commented on how patient data motivated the team and helped them focus their efforts:

I really like the feedback from the patient surveys, client surveys; getting that data has been tremendous. Having the really skilled researchers around to give us an idea about what the issues are, finding out the levels of pain and disability in our clients that were from that first survey was a really, really important reminder of what we’re working with and maybe some shortcomings.

Local client data also provided leaders with a tool in advocating for increased funding for TVIC and for other services. One leader commented:

I think there’s a lot of value in having things, things that you, you sort of instinctively know and you see every day when talking to patients. But to have it documented…. I think to have those kinds of figures in black and white and to see the amount of trauma, to see the levels of mental health issues is very valuable.

Presentations of data were part of the broader EQUIP intervention, and were not explicitly part of the curriculum for the TVIC sessions. However, multiple participants saw these presentations as important factors in their thinking about trauma and violence. Local data underscored the impacts of trauma and violence for the specific population of clients at each site.

*Externally facilitated discussions: Getting “closer to the truth”*

A second influence that was common to both sites was that staff members saw profound impacts from participating in externally facilitated team discussions about TVIC. Although some staff members struggled to recall the content of the presentations
at the TVIC sessions, almost all the staff interviewed commented on the impact of the discussions they had with their team members during the session. Several staff made particular note of the value of having “outsiders” host these discussions, ensuring that multiple voices and perspectives were heard. A staff member explained, “There seemed to be lots of room to hear, you know, from the docs and the nurses, from counselors and nutritionists, everybody was given an opportunity to get in there if they had something to say.” Another staff member described how revolutionary one such discussion was for her: “we probably went as a team like my colleagues and I closer to the truth than at any point where I’ve worked in the clinic.”

At one site in particular, group discussions in the TVIC session opened up complex, honest conversations about different perspectives on trauma, violence, and PHC practice. At both sites externally facilitated discussions enabled participants were able to consolidate their learning about TVIC and conceptualize how TVIC could work in their practices.

**The presence of external researchers at the site: Support and surveillance**

Another aspect of the intervention that participants noticed was the impact of having trauma- and violence- focused researchers (who were also the TVIC session facilitators) make regular visits to their sites. Having researchers on-site was described as a both a support and a reminder to staff to pay attention to these issues. One leader described how researchers collaborated with clinic staff:

“Having the research team here, it’s like having like five really smart people on our team... we feel as if we’re very much part of the team and that you want to make a difference in the work that we do.”
A nurse explained that the presence of researchers, and the knowledge that they are collecting data on patient satisfaction puts TVIC front-of-mind for her team:

Well, I think for one thing, that the fact that you are coming and doing this, really puts us all who work at [clinic], in a bit of a more acute state... especially when you come, or we have e-mails, you think, yeah, you know, we do need to look at our own practice; we do need to look at the sensitivities and the barriers that we still do put up.

For many participants, being engaged in an ongoing relationship with trauma- and violence- focused researchers helped them remember and prioritize what they learned in the TVIC sessions.

**Timing of sessions was a challenge**

Several staff members noted the importance of how the intervention was timed. Some touched on the practical challenge of closing their clinics for educational sessions for the whole team at the same time. Many also commented on the long time between EQUIP sessions, which may have led to a loss of momentum:

It’s a fairly lengthy timeframe between when you’re here and when you’re not here. That the whole idea of trauma and structural trauma somehow or other in people’s mind got separated, it was a disconnect somehow. And probably had we had an intensive week we’d have all been exhausted collectively but, but I think, I think it might have helped.

Overall, most staff members suggested sessions be timed closer together, and shortened if possible. At one site, participants remarked that it was difficult to take on
difficult and emotional concepts late in the week when practitioners were already exhausted.

**Contextual influences: Structural, organizational and personal contexts influenced how TVIC was understood and taken up in practice**

Contextual factors influenced how TVIC was conceptualized, taken up and enacted at each site and by each participant. Structural contexts served as both barriers and facilitators to enacting TVIC. Organizational mandates and cultures influenced trauma- and violence-informed practice at each site. On a personal level, practitioners’ values, knowledge, learning styles and engagement with facilitators influenced their experiences of learning about TVIC.

*“The system that we have”: Structural factors were both barriers and facilitators to enacting TVIC*

External factors functioned as both barriers and facilitators to enacting TVIC at these sites. For example, one practitioner noted the amplifying influence of other trauma-informed initiatives in the community, saying: “There’s been lots of information and training within the community, the community organizations just like us and I think that it’s making a difference in how we work.”

Conversely, practitioners discussed how structural constraints, particularly a lack of time and funds, counteracted efforts to provide trauma-and violence-informed care. One participant explained how heavy workloads leave practitioners with little energy to reflect on and change their practices:
Everybody, their days are very full and so creating time and space for reflection, for new programming is very difficult. When people get to work and then they run their asses off until they leave it’s very hard to say ‘hey can you also think about your practice and make some changes’.

Another participant described how funding shortages can mean that best practices are not implemented in trauma-informed care for people with substance use problems:

We know what’s needed in terms of treatment centers and addictions sort of support and work and it doesn’t happen, it just doesn’t happen. So it’s not that we don’t have the information, it just that it’s not followed through at a higher level and generally speaking the funding, you know, legislated poverty and people put into situations where they can’t possibly survive. And then the question is asked ‘well how come it’s not working?’ Well, it’s not funded.

Political and regulatory structures were also described as barriers to providing TVIC. A physician explained how regulations requiring drug screens from his clients prevent him from being as trauma- and violence-informed as he would like to be:

I really try to say this is not about you, and this is not about what I am thinking or assuming about you, this is unfortunately, you know, the system that we have to operate, and the government is funding us to provide care for people with addictions issues, and not everybody here has issues of addictions but, you know, that’s part of what we need to do and it’s part of me being able to continue to be able to provide these medications for you, there are things unfortunately we need to do from time to time. It’s not about punishing you...
Participants at these two sites described how the structural contexts for practice could be both supportive and inhibiting of TVIC. Increased awareness of trauma throughout the health and social service sectors supported participants to use TVIC concepts in their work. At the same time, structural factors such as funding and legislation also constrained practitioners’ abilities to practice TVIC.

**Organizational context: Clinic mandate and culture influenced how easily TVIC was taken up and what kinds of differences it made**

Multiple participants spoke about how the contexts at their particular clinics helped or hindered their efforts at TVIC. The fact that the clinic mandates and culture often aligned with TVIC concepts facilitated TVIC at these sites. Furthermore, the extent to and ways in which TVIC was taken up in each organization was influenced by the existing tensions and power dynamics at each site.

Alignment with clinic mandate: “We are a little bit different here”

Several participants explained these “inner-city” PHC clinics were particularly receptive to TVIC, as they were already oriented to concepts of trauma, marginalization and equity. One nurse said: “With our staff we’re preaching to the choir.” Several staff members contrasted the support for TVIC at these sites with “mainstream” health services where they might have a less supportive group of staff, or less time, resources, support, or voice: “We are a little bit different here, we are not for profit, we have time” explained one staff member. Another said:
I know for myself I’ll never ever work at a regular GP’s office. I love it here because the people that I work for and work with we’re just an open team, you know, like no one is better than anyone.

Practitioners and leaders noted that TVIC was easier to bring into these sites than would be the case in a more conventional PHC context because of the congruence of TVIC concepts with their mandates and the populations they serve. One nurse explained that advocacy is a point of pride in her clinic: “It’s absolutely what we should be doing is being that voice for the patient and being an advocate for patients... [Isn’t that] what makes us different?” Others noted that they didn’t see dramatic changes at their sites because TVIC principles were already guiding their work: “I think, the trouble is that the majority of my colleagues are people at this point who ... who have already started thinking this way.”

Another participant highlighted how the particular mandate and context at their clinic allows for the time to practice TVIC, giving the example of supporting a client while she made a very difficult report to the police. “I’m lucky enough to work in [clinic D] where I have the time to do this. Regular, a regular family practice does not offer people opportunities to do this.”

“It has to be into a receptive organization”: Leadership and organizational culture

The particular leadership and cultural context at each site also had a profound influence on how TVIC was interpreted and taken up at different clinics. One leader described how she saw her role in creating a culture that was receptive to TVIC:

It’s not education as much as helping to develop a culture, a culture where staff are open to sometimes examining themselves but also of feeling everybody has a
voice to some degree within that, within the organization. So it’s a style of leadership but the style of leadership also perhaps develops the culture.

In a site with a cohesive team and strong support from leadership, the clinic was able to implement trauma- and violence- informed policies and practices fairly quickly. Staff at this site noted that the supportive, flexible culture and common philosophy at their clinic enabled them to provide TVIC:

We have a supportive staff and we have a type of work environment that allows us to be supportive of each other so that we can have the emotional reserves to be able to provide trauma informed care. I think we’re flexible if you have somebody that comes in that’s in a particular trauma or crisis our colleagues are always really good about accommodating that time. .... so I think we’re conscious, we trust that we’re practicing from the same philosophy and that the things that we’re doing, the clients are appropriate for that particular visit.

At another site, TVIC was superimposed onto existing tensions and perceived dichotomies in the team, for example, between “psychosocial” and “medical” staff, and between Aboriginal and non-Aboriginal staff. One staff member paints this picture of the diverse and competing perspectives at this site:

I think it’s, it’s challenging because, you know, we’re not Aboriginal people that are calling a lot of the shots. And then the doctors [who are] calling the shots for the patients are not Aboriginal. And that’s always about the right fit and the willingness of people to experience things in a different way or behave in a different way and be open to different ways of being. And, you know, getting to be the right kind of person where I don’t know if we have all the right kind of
people. And that’s a challenge because people were sort of set in their ways ...

So, you know, it’s not that we’re all on the bus for the same purpose.

In this context, TVIC was taken up as a foundational conversation about the vision and values of the organization. Another staff member describes this change:

I mean the change has been slow and gradual so it’s kind of hard to really see because what it also does I think it upsets the apple cart... I think with this trauma stuff and the other stuff it’s like, it brings out the issues I guess, it brings out the issues where you talk about them and maybe deal with them but there’s other stuff it brings out.

These tensions and discussions made it difficult to see immediate impacts from the TVIC sessions at this site. However, these conversations led to significant shifts in organizational culture, centering the voices – notably, Aboriginal voices – that had previously been marginalized in the organization.

**Personal context: Values, knowledge, learning styles and engagement influenced how participants understood and enacted TVIC**

Alignment with practitioner’s values: Validation, struggles, resistance

Individual staff members also brought their diverse personal, educational and professional backgrounds to the TVIC sessions, which influenced how they reacted to learning about TVIC concepts. For some staff, TVIC concepts aligned closely with their values and their motivations for practicing and provided some validation and language for the way they approached practice. A social worker explained her reaction to the
material on structural violence: “It kind of justifies... I mean it sort of like frames... what the whole crux of my work is like.”

For others, TVIC concepts such as harm reduction were a challenge to their values. One practitioner who was in recovery from addiction talked about the struggle to reconcile the abstinence-based approach that worked for him personally with TVIC and harm reduction:

I mean the harm reduction concept is so much bigger than I even understand, I’m still struggling with some aspects of it. So [EQUIP] really sort of took it to another level for me. So that opened my eyes and actually I mean my initial response was like “Are you nuts?” And my second response was “well wait a second, listen to the reality that they're dealing with, number one, and what are they doing?” They're trying to engage this person and like if they succeed in getting a relationship with this person maybe this person will sort of come with them over to the clinic and have some blood work or I don’t know what.

TVIC met resistance from practitioners when it clashed with their perspectives and experiences. One staff member discussed the challenges he saw for colleagues in incorporating a trauma- and violence- informed approach to pain and opioid prescription:

People have their own philosophies about how you manage pain and suffering and having somebody come in and hold a couple of talks is not going to change that, when their philosophies are based on decades of experience as well as their own personal values and beliefs.
In summary, structural, organizational, and personal contexts influenced the ways that TVIC was understood and taken up at each site. These factors functioned as both barriers to and facilitators of providing trauma- and violence informed care. As noted above, practitioners brought their own personal and disciplinary orientations to education on TVIC, and their individual reactions to TVIC education varied widely.

Alignment with previous knowledge and learning styles: Need for clear goals

Some staff members wanted a more concrete idea of the learning objectives of the TVIC session. One participant explained:

I’m the type of person that likes learning goals laid out, I want to know what the content is, I want to know what I’m supposed to be getting out of this and how it’s going to apply to my practice.

As discussed in theme one above, some participants were expecting a more concrete “toolkit” on TVIC, and many people at these clinics were already familiar with some of the concepts. One participant noted, “I think maybe some people felt like, you know, they weren’t sure what exactly they were getting out of it like more than what they were already doing.” It’s possible that the TVIC sessions were not meeting the needs of participants who were already knowledgeable about trauma and violence.

Engagement with facilitators: A strength for some, a weakness for others

Some staff members also commented on the degree to which the session facilitators themselves were able to engage participants. One staff member commented on this as a strength of the intervention, saying: “You have to have the personality to do that... you might have a different person do it and it might not be as good.”
participant had a contrasting experience, and suggested more involvement from frontline providers:

I think sometimes front line workers respond better to other frontline workers that are kind of in the trenches... People want to know that you’re legit... how have you earned your stripes... “If I’m going to change my practice then the person that’s telling me to change my practice or asking me to reflect... I need to value their opinion.”

In conclusion, both the delivery of and the context for the TVIC sessions influenced their impacts. Local data, externally facilitated discussions, and the presence of researchers on site were described as impactful aspects of the intervention, whereas a long time frame was seen as a challenge. In addition, the structural, organizational and personal contexts for the TVIC sessions shaped how these concepts were taken up at each site and by each practitioner.

Summary

In this chapter I have described my findings from an analysis of interviews with fourteen staff members at two PHC sites participating in the EQUIP study. I identified two broad themes about the impacts of the EQUIP TVIC sessions for these staff members. First, the TVIC sessions enhanced some participants’ awareness, knowledge and/ or confidence about trauma and violence. Second, this contributed to a shift in perspective for some participants, that had effects on personal, clinical, organizational, and structural levels. I also identified several intrinsic and contextual factors that influenced these impacts. Intrinsic factors - data, discussions, researchers’ presence, and timing - influenced how TVIC was understood, remembered and prioritized by
participants. Structural, organizational, and personal contexts influenced how participants took up and enacted TVIC in their practice. In the next chapter, I discuss these findings and their implications for future work in this area.
Chapter Five: Discussion and Recommendations

Summary of findings

In this analysis I have identified several impacts of the TVIC orientation and training component of the EQUIP intervention. Many of these impacts were consistent with the outcomes that researchers expected in designing the EQUIP intervention (see Figure 1: EQUIP Intervention Theory (Browne et al., 2015, p. 5) (reproduced with permission)). In keeping with EQUIP’s hypothesis, several staff members described that their awareness, confidence and/or knowledge of trauma and violence were enhanced by participating in the TVIC sessions. In addition, EQUIP researchers had expected to see “shifts in perspective and attitudes” with TVIC orientation and training. In this analysis I identified a shift in perspective that I conceptualized as “seeing through a TVIC lens”. This shift had impacts in multiple aspects of practitioners’ lives.

My analysis also explored the intrinsic and contextual factors that influenced the impacts of TVIC education. I found that presentations of local data, externally facilitated discussions, the presence of researchers on site and the timing of sessions were all influences on how TVIC concepts were understood, remembered and prioritized by participants. I also identified structural, organizational and personal contexts influenced the extent to and the ways in which TVIC was taken up and enacted at each site and by each practitioner.

Discussion

These findings give rise to several issues for discussion. Many of the themes identified in this study are consistent with the findings of other studies on trauma-
informed-care (TIC). However, the findings of my study differ from the TIC literature in some interesting ways. First, the importance of client empowerment or “client voice”, which is prominent in the TIC literature, did not seem to be taken up as a central feature of TVIC in this study. Second, in this study, I identified that TVIC concepts posed a challenge to the dominant biomedical paradigm, an issue that I have not seen explored in the TIC literature. Third, I identified a dilemma faced by staff trying to take a structural perspective to a clinical role. This is another issue I have not seen in the TIC-related literature. The ways that this study on TVIC aligns with and yet differs from the TIC literature sheds some light on the differences between TVIC and TIC, and gives rise to some recommendations for future efforts at implementing TVIC.

**Consistency of the findings with TIC literature**

The impacts of, and influences on implementing TVIC in this study echo many themes in the literature on implementing TIC. The impacts of “seeing through a TVIC lens” described in this study align with literature describing TIC as a “trauma lens” or a “paradigm shift” (Drabbe et al., 2013; Harris & Fallot, 2001). As in Elliot et al., (2005), many of the impacts that I identified in the study were shifts at an organizational level. In addition, themes on the influences of social and organizational contexts, values, and visions have been described in other studies that emphasize the importance of leadership and organizational commitment to TIC (Hopper, 2010; Markoff et al., 2005).

**Client voice: Lost in the discussion?**

The literature on TIC places great emphasis on the empowerment of clients or service users as a central component of TIC (Harris & Fallot, 2001; Hopper et al., 2010).
In other settings, adopting a trauma-informed approach has included establishing formal systems for soliciting client feedback or including clients in the design of services. In contrast, client voice did not seem to be taken up as a theme or priority for organizational change for most of the participants interviewed for this study.

This does not necessarily imply that client empowerment is not a concern for these organizations. One of the two sites studied here already has formal mechanisms in place to get input from clients, and might not have seen a need to make any further changes. It’s also possible that these sites saw EQUIP’s collection of patient data as a sufficient mechanism for gaining clients’ perspectives. It may simply reflect that this topic was not adequately probed in the interviews studied here. However, it is notable that that such a central feature of TIC (as described in the literature) did not appear as a prominent feature of TVIC implementation at either of these sites.

**TVIC as a vehicle for disrupting biomedical dominance**

Conversely, a separate issue arose in this study that I have not seen explored in the TIC literature. In this study, TVIC seemed to challenge the dominance of the biomedical paradigm in these clinics. The biomedical model has been the dominant paradigm in medicine since the turn of the 20th century (Duffy, 2011). According to Baum et al. (2013), “Biomedicine sees diseases as residing in the bodies of individuals and so actions to address them are directed at curing the individual or persuading them to reduce their risk factors for disease, emphasizing curative and rehabilitative therapies” (p. 1). This paradigm grows out of European scientific rationalism and it is reinforced by individualism (Baum et al., 2013). In addition, this paradigm supports a
hierarchy in healthcare that places medicine and physicians in a dominant position over other disciplines (Anaf et al., 2014; Baum et al., 2013; Bleakley, 2013).

While biomedicine has enabled major scientific advances and reductions to global morbidity and mortality, this paradigm has come under increasing criticism for imposing a narrow, a-contextual view of health and illness (Baum et al., 2013; Duffy, 2011; Fertonani et al., 2015). Comprehensive PHC—community-based, multidisciplinary care that addresses social determinants of health—is among the alternative models that some suggest may address the limitations of biomedicine (Baum et al., 2013; Fertonani et al., 2015). However, tensions between biomedicine and alternative perspectives persist in PHC settings, with biomedicine often maintaining dominance (Baum, 2013; Fertonani, 2015).

This context of ongoing tension around biomedical dominance was evident to some extent at both sites in this study, and it contributes to many of the personal, organizational and structural influences on TVIC seen here. For example, the biomedical perspective marginalizes the care and control of pain (Duffy, 2011); upholds a “culture of busy-ness” (Thomson, et al. 2008); and underpins funding models that make physical health care more accessible than mental health services (World Health Organization, 2003). A biomedical paradigm may have also contributed to some practitioners seeking a “trauma and violence skill set” rather than a “trauma and violence lens” from the TVIC sessions.

Multidisciplinary discussions about TVIC concepts challenged the hegemony of the biomedical paradigm at one site in particular. Other studies have shown that open discussions and common language can serve to flatten hierarchies among PHC staff
(Hilts et al, 2013, Supper et al., 2014). However, other authors describe how health professionals in multidisciplinary settings may resist alternatives to biomedicine (Supper et al., 2014). Furthermore, multidisciplinary settings may be sites for overt or latent conflict between professions making competing claims to legitimacy (Sanders & Harrison, 2008). As TVIC is brought into other PHC or health settings, it is worth considering how it will come up against dominant paradigms and how this may influence its implementation.

**The dilemma of taking a structural lens to a clinical setting**

A related issue arising from these findings is the tension created for practitioners taking a structural lens to their day-to-day work in clinical practice. Taking such a lens to practice can create a “dilemmatic space” for PHC practitioners: “They understand the importance of a social view of health but work in a broader health system that reinforces a largely bio-medical view.” (Baum et al., 2013, p. 10). Moreover, clients’ immediate needs often take precedence over action on the social determinants of health (Baum et al., 2013).

The TVIC curriculum in this study placed particular emphasis on structural violence and social determinants of health. Respondents described how learning about TVIC assisted them in naming and acting on structural violence and oriented them toward advocacy at a structural level. At the same time they explained how structural constraints such as regulations, funding, and time pressures limited their abilities to put these ideas into practice.

Respondents at these PHC clinics negotiated this dilemma by taking action largely at the organizational level, re-orienting their services to take structural violence
into account. They also described how learning about TVIC created a sense of momentum to press for broader structural change. Future efforts at TVIC may want to consider strategies such as reflexivity or alliance-building to cope with this dilemma and harness momentum for structural action (Baum et al., 2013; Commission on Social Determinants of Health, 2008). This might involve prompting practitioners to journal about contradictions they face in practice, for example, or to seek out partnerships with research, practice and policy actors who take action on the social determinants of health.

Summary of discussion

This study explored the impacts of TVIC education in two PHC clinics. The findings of “seeing through a TVIC lens” and seeing impacts at organizational levels were aligned with much of the TIC literature. However, while other TIC models focus on client voice or empowerment, this did not emerge as a strong theme in this study. The findings in this study also raised the issue of biomedical dominance and show the dilemma that can arise for practitioners taking a structural lens to clinical practice.

Recommendations

The findings of this study and the ensuing discussion give rise to several recommendations for future study and implementation of TVIC. The findings here and suggest that the EQUIP approach to TVIC orientation and training was successful in raising awareness of trauma and violence and in shifting the perspectives of some PHC staff. This analysis has also explored the complexity of bringing TVIC to PHC settings, describing the intrinsic and contextual factors that may influence TVIC implementation.
As TVIC is brought into diverse health care and human service settings, what are the implications of these findings for future implementations of TVIC?

**Assess for and tailor TVIC sessions to specific site contexts**

The findings from this study underscore the importance of considering the structural, organizational, clinical, and even personal contexts for introducing TVIC. In the case of this study, both of the clinics studied here are explicitly mandated for underserved inner-city populations. By virtue of their leadership, care models or organizational cultures, the staff at these sites were already familiar with many of the concepts central to TVIC. Indeed, some practitioners felt validated by TVIC education, and some felt it was “preaching to the choir.” Nevertheless, one effect of TVIC sessions in these settings was to “upset the apple cart,” stirring up personal and organizational tensions and dilemmas at the sites.

Future efforts to implement TVIC ought to take personal, organizational and structural contexts more thoroughly into account before orienting staff to TVIC or engaging staff in training. This would entail a thorough assessment of each site, taking note of structural, organizational, and leadership barriers and facilitators. Such an approach would also call for flexibility and tailoring of any TVIC to the context at each organization. Further, TVIC education should take diverse individual backgrounds, values, and learning styles into account in curriculum design.

**Explicitly attend to practice paradigms and how they affect and are affected by TVIC**

This study has highlighted the ways that TVIC concepts can challenge the dominant paradigms of biomedicine and individual-level care in PHC. The findings in
this study further highlight how working in a biomedical paradigm can hinder practitioners' efforts to take action to address structural violence. Future efforts at TVIC should assess and explicitly attend to the dominant worldviews in practice settings, and consider how a biomedical paradigm might impact or be impacted by looking at practice through a TVIC lens. Further research is warranted to explore how practitioners and organizations manage TVIC in the context of conflicting worldviews.

**Frame TVIC orientation and training as a paradigm shift, but include tools and frontline mentors**

While TVIC orientation and training should be flexible and tailored, educators should also be clear with practitioners about what they can expect from TVIC education and how it may benefit their practice. One finding in this study was that some participants were expecting a TVIC “toolkit” to use in individual practice, when in fact the emphasis in this curriculum was on perspective shifts and organizational change. This points to the importance of carefully considering how TVIC is framed, both for practitioners and organizations. The goals of TVIC orientation and training could be more explicitly framed as an organizational shift rather than as an individual clinical skill.

Without taking away from the importance of a paradigm shift for organizations, however, TVIC sessions could be strengthened with the addition of some concrete “take-aways” for practitioners. The practitioners in this study, particularly those who were already familiar with TVIC concepts, were hungry for concrete TVIC tools and for advice from frontline staff experienced in TVIC. Future TVIC sessions could include or simply point to scripts or tools for TVIC, and could incorporate experienced frontline
staff who could provide clinical mentorship in TVIC. However, training in concrete skills, scripts or tools should never detract from the importance of TVIC as a shift in perspective at an organizational level.

**Plan for sustainability and evaluation through ongoing research collaborations**

This study found that the presence of researchers and access to local client data at both sites were important influences that raised the profile of trauma and violence for practitioners. In the case of EQUIP, these factors were enabled because TVIC was one component of a large, multi-year study at these sites. Future research- or practice-based efforts at TVIC will need to incorporate feasible strategies to ensure trauma- and violence-informed changes are sustained and build in means of evaluating these changes both for staff and for clients. Diverse organizations may take this up in different ways, collecting their own data, gathering client feedback, or working with practice consultants.

Building on the success of EQUIP, one possible model is to foster long-term collaborative relationships between researchers and practitioners working to end inequities. Such a model would give sites access to data on their own patient populations, assisting them to set priorities and evaluate quality improvement initiatives. Research collaborations may also provide an opportunity for practitioners to contribute to data that has impacts on a policy level.

**Attend to client input, empowerment and voice**

Although client empowerment is a key component of TVIC, the data studied here was limited on the concept of client input on services. This suggests that client voice
might be emphasized more strongly in future TVIC orientation and training. Further research is warranted on practitioners’ perspectives on involving service users in service design and oversight.

**Summary of recommendations**

Based on the findings of this study, I have made six recommendations for future efforts at implementing TVIC in PHC or other settings. First, I recommend assessing and tailoring for diverse contexts for TVIC at each organization. Second, I suggest that TVIC facilitators and researchers explicitly attend to practice paradigms, and how they may impact or be impacted by TVIC. Third, I propose that TVIC sessions are best framed as a paradigm shift, but should include some concrete tools and mentorship. Fourth, I recommend that future efforts at TVIC education build in mechanisms for sustainability and evaluation through ongoing research collaboration. Finally, I advocate that the client voice receive more attention in future research on and implementations of TVIC.

**Conclusion**

Trauma and violence have wide-ranging impacts on health (Anda et al., 2006). Because trauma survivors can be re-traumatized when seeking health care, nurses and other health care providers have been encouraged to take trauma and violence into account in their practice (Elliot et al., 2005; Muskett, 2014). TVIC is an approach that recognizes the impacts of trauma, structural violence and ongoing interpersonal violence, and aims to make health services safe and accessible for survivors (Browne et al., 2015). TVIC orientation and training sessions for health care providers were developed and implemented in two PHC clinics as one part of a multi-component
equity-promoting intervention. This secondary analysis of qualitative interviews with fourteen PHC providers has explored what can be learned from perspectives of primary care providers on the impacts of these TVIC sessions.

The findings of this analysis suggest that the TVIC sessions contributed to increases in some PHC providers’ awareness, knowledge and/or confidence about trauma and violence. The findings further suggest that this constituted a shift in perspective for some of these PHC providers, shifting their views on personal, clinical, organizational, and structural aspects of their practice.

In this analysis I also explored the intrinsic and contextual influences on the impacts of the TVIC sessions. I identified that site-specific data, externally facilitated discussions, the presence of researchers, and the timing of the TVIC sessions influenced how participants understood, remembered and prioritized TVIC. I have also explored the ways that structural, organizational, and personal context influenced how TVIC was understood and taken up in practice.

This analysis adds to a growing body of literature on implementing trauma-informed approaches in health care settings. The findings echo some of the themes in the literature, including the impact of “seeing through a trauma lens” and the importance of considering personal, organizational, and structural contexts when implementing TIC. In contrast to some of the TIC literature, this study did not find that efforts to increase “client voice” or autonomy were a major impact of having been oriented to TVIC concepts. However, this study highlighted how TVIC orientation and training problematized the dominance of the biomedical paradigm in these PHC sites, which has not been found in previous literature on TIC. In addition, this study surfaced
some of the tensions created for PHC staff attempting to address structural
determinants of health in their roles as clinical care providers.

Based on the findings of this study, I make five recommendations for
implementing TVIC in the future. First, any implementation of TVIC should assess and
be tailored to the personal, organizational, and structural contexts at each site. Second,
we must consider and explicitly attend to how TVIC comes up against the dominant
paradigms in health care settings. Third, TVIC orientation and training should be
framed as a paradigm shift, but include some concrete tools and mentorship for
practitioners. Fourth, future efforts at TVIC should build in strategies to sustain and
evaluate the impacts TVIC orientation and training. Lastly, TVIC orientation and
training should emphasize the importance of client empowerment and input in service
design.

Trauma- and violence-informed approaches are important to safe, ethical
nursing practice. This analysis has explored the impacts of orienting and training
healthcare practitioners on TVIC. My hope is that this work contributes to TVIC in
nursing practice and helps to make health services safer, more accessible, and more
equitable for survivors of trauma.
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Appendix A: Interview Guide

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Purpose of Initial Interviews:

To explore the impact, if any, of the EQUIP intervention, particularly the training and integration components, on:

a. staff members’ practices, knowledge, attitudes, ways of working with patients or with other staff, etc.
b. the organization, process of care, clinical guidelines, policies and structures, etc.

Questions to ask all participants:

1) Review what EQUIP consists of and which components of EQUIP they participated in by starting with a review of the EQUIP Intervention Handout listing the activities:

   o Ask staff to identify which components they completed in whole or in part, and whether they reviewed the Site reports/narratives.

   o EQUIP’s 3 Training Components
   o The various integration discussions led by the Practice Consultant
   o The PHSA Bystander module offered at some of the Sites
   o the Site Reports/Narratives
   o Planning or implementing changes under Organizational Integration and Tailoring (OIT)

Probes:

Explore whether they may be in a leadership role in relation to EQUIP, or have only attended training and completed the staff surveys, etc
2) Tell me a bit about what stands out for you overall, thinking about all the components of the intervention?

Probe: Specifically can you tell me what aspects of that training/session/information most impacted you?

Probe: How have you applied this in your work?

Can you give me an example of how this has impacted your practice?

Was there anything else about that component that stands out?

These were the key areas – is there any part of that that you could connect to the training?

What’s changed? What role did you think the training have in that?

TVIC

One of the core components of the EQUIP intervention was an emphasis on Trauma and Violence Informed Care. How do you think your own approach has changed over the past year in terms of taking trauma and violence into account (if at all)?

Can you give me an example of something you are doing differently?

Probe: How do you think your organization has changed in its approach to trauma and violence?
Can you think of an example of what has changed in your organization’s approach to trauma and violence?

One of the topics that was discussed at the session on trauma and violence was the idea of “structural violence”. Tell me about what you made of that idea?

ICC⁴

Another core component was culturally safe care.

How do you think your practice has shifted in this area over the past year? (Give examples, ditto for organization)

a) TVIC and ICC Training:

• How (if at all) has the ways in which you are taking trauma into account in the provision of care, or in organizational processes/policies?

• What supported this change? What made it difficult to use what you learned?

• How are you taking into account the experiences of everyday discrimination (on the basis of being poor, racialized, mentally ill, substance use) that so many of the patients experience?

• What role do you have in articulating needs, meeting needs specific to your population?

• How might have your clinical practices/work at the clinic have shifted or changed over the past year, if at all?

• What changes may have occurred within the organization over the last year?

What supported this change? What made it difficult to use what you learned?

⁴ At the time of the interviews, the Sanyas Indigenous Cultural Safety (ICS) course was called the Indigenous Cultural Competency (ICC) training, and so is referred to as “ICC” through this interview guide.
• Underlying the ICC training is the focus on anti-racism training. How did that aspect of the training impact you, the organization, your work as a team, etc.?

b) Clinic profile(s)/narrative(s) and/or presentations with patient data and contextual information

• Narrative profiles:
  • Have the profile(s) been useful so far? How have you used them? (probe for utility specific to EQUIP intervention/OIT, and other uses, related to their knowledge, attitudes, practices)
  • What are your thoughts on how it’s presented (probe: the kinds of information, the order presented, the mix of text, images, graphs and tables, the format-hard copy etc.)?
  • Have there been any challenges or potential limits or downsides to having a document like this?
  • Anything else about the Narrative Profiles?

• Presentations or other times you may have seen EQUIP patient data:
  • What were your impressions of the data you saw? Was this helpful in any way? If so, how?
  • What are your thoughts on how the data was presented to you (e.g. format, who was included, was there enough discussion or explanation)?
  • Are there other ways that we could make the EQUIP patient data available to your organization? What might be helpful?
c) Organizational changes implemented with support from EQUIP:

Part of the EQUIP Intervention included your organization identifying specific areas for organizational change and implementing those changes with the support of EQUIP. This part of the intervention is referred to as Organizational Integration and Tailoring (OIT for short). At [clinic], you chose to focus on [briefly list OIT components for that clinic]

- What role, if any, did you play in planning and implementing these changes?
- What impacts do you expect to see from these changes? [prompt re: impacts for staff and how they work together, impacts for patients, other?]
- What challenges, if any, have you encountered in planning and/or implementing these changes?

Information about you:

Please tell us a little about yourself.

8) Are you a staff member or board member in this clinic?

○ Staff member

○ Board member

○ Other, please specify... _______________

9) What is your current position?

○ Administrative Leader (e.g., Executive Director)

○ Drug and Alcohol Counsellor
10) What is your employment status?
   - Full-time
   - Part-time
   - Casual
   - Other, please specify... ____________________

11) How long have you worked in your current organization?
   Years ____________________ Months ____________________

12) How do you identify your culture or ethnicity?
   ____________________

13) If you identify as an Aboriginal person, are you:
   - Status
- Non-status
- Metis
- Other, please specify... ____________________
- I am not Aboriginal

Thank you for your time!
Appendix B: Agenda for EQUIP TVIC sessions

Prepared by Annette Browne, Colleen Varcoe, Marilyn Ford-Gilboe and Victoria Smye, reproduced with permission

Trauma/Violence Informed Care (TVIC) Training Schedule/Curriculum

Assumptions

✓ There are multiple and intersecting forms of oppression, including racial, gendered, and sexual.
✓ Trauma and violence informed care occurs both at the point of individual interactions and at the level of organizational structures and supports.
✓ Interpersonal and structural forms of trauma and violence are inseparable.
✓ People marginalized by social and/or structural inequity who access primary healthcare services often present with a wide range of physical and mental health disorders that are directly attributable to their experiences of violence and trauma.
✓ Curriculum supports change at the point of individual interactions as well as organization structures and supports.

Overarching Purpose

The overarching purpose of this training curriculum is to support individual staff members and primary healthcare organizations to achieve a ‘vital paradigm shift’ (if not already achieved) (Huntington, Moses, & Veysey, 2005) in how they understand and respond to behaviors and health conditions related to experiences of violence and trauma in the people who access their programs and services.

To enhance awareness among practitioners and organizations who provide PHC services in BC to persons marginalized by social and structural inequity.

Session One: TVIC Preparation (Post ICC Sessions)

Ends in View:

After reading the articles (2) as chosen by the participant from the list below, participants will be able to...

1. Provide a brief synopsis of two of the required readings of choice.
2. Have the foundational knowledge necessary to engage in the workshop dialogue related to trauma/violence informed care.

Required Pre-reading List: (List Articles)


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<tr>
<th>Time</th>
<th>Activity</th>
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<tr>
<td>Independently, on the participant’s own time:</td>
<td>Each participant will read two research articles selected from the options above.</td>
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**Session Two: Face-to-face Training (6 hours)**

**Ends in View:**
By the end of **Session Two** participants will be able to...

**(Module #1)**
1. Describe the concept and history of psychological trauma.
2. Identify the range of perspectives on trauma/violence including: biomedical, clinical, health services and social determinants of health perspectives, and their implications.
3. Discuss various definitions of trauma, and how they are linked to these perspectives on trauma to increase awareness and understanding of different stances.
4. Describe trauma/violence-informed and trauma/violence-specific practice, and how they are linked in a responsive and effective system of care.
5. Define and discuss trauma/violence informed principles.

**(Module #2)**
6. Describe trauma/violence effects in a range of areas, including physical, mental, behavioral, relational and spiritual.
7. Describe and discuss a range of variables that can influence trauma/violence responses.
8. Describe how the effects of trauma/violence may influence how survivors present when accessing PHC.

**(Module #3)**
9. Discuss examples of how trauma/violence- informed practice principles might be applied in PHC.
10. Identify how trauma/violence effects can influence interactions with service providers and demonstrate trauma/violence- informed strategies that can be used to support engagement and safety, especially during early interactions.
11. Describe and/or demonstrate trauma/violence- informed ways of safely acknowledging the effects of trauma and validating experiences without discussing trauma details.

**(Module #4)**
12. Identify how trauma/violence- informed practice is implemented at the organizational level.
13. Identify specific ways to strengthen trauma/violence-informed practice at the organizational level (within the scope of their role) including ways to influence organizational culture and/or policy.

14. Describe specific ways that organizational cultures of wellness can be supported, including strategies for managing vicarious trauma.

15. Describe a personal plan for strengthening TVIC within their own practice and discuss how they will promote TVIC within their organization

**Overarching Ends in View:**
Participants will be able to…

- Explain how multiple forms of structural violence (e.g., racism, poverty) intersect with interpersonal violence (e.g., sexual assault, partner violence, child abuse).
- Identify the short and long-term health consequences of various and multiple forms of violence, for example, the emergence of chronic pain.
- Understand the physiological and health effects of trauma and violence.
- Understand how trauma and violence underlie many of the physical and mental health disorders that people present with at primary healthcare organizations.
- Understand how various contexts, values, and ideologies shape social and health care responses to violence and trauma.
- Understand the implications of the differences between trauma-informed care and standard approaches to health care for practice with individual clients and for organizational practices, including the implications for prescribing practices.

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<tr>
<th>Time</th>
<th>Activity</th>
<th>OVERVIEW</th>
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<tr>
<td>9:00 – 10:30 a.m.</td>
<td><strong>Overview of schedule and ends in view</strong> (5 minutes)</td>
<td>In this module the participant is invited to consider diverse perspectives on trauma and violence, and examples of trauma/violence-informed practice within the context of PHC settings.</td>
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<tr>
<td><strong>Small groups</strong></td>
<td>Participants will form groups (4 people in each group, each having read at least one different article) to present a synopsis of key ideas from the pre-readings (Record on Flip Charts). (see Session One: TVIC Preparation). (20 minutes)</td>
<td>Purpose</td>
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<tr>
<td><strong>Large group</strong></td>
<td>Building on small group work we will clarify fundamental definitions and provide a brief historical look at trauma: e.g., trauma, structural and interpersonal violence; the health and physiological effects of trauma, trauma-informed, violence-informed and trauma-specific practice (15 slides). (25 minutes)</td>
<td>a) To begin establishing a complex historical context, linking multiple perspectives and events as contributors to contemporary thinking about psychological trauma</td>
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<td>We will illustrate stances on trauma using the following video clips (10 minutes): Dr. Anne Bullock – (Chippewa) <a href="http://www.youtube.com/watch?v=Ei95WkJ0g_Y">http://www.youtube.com/watch?v=Ei95WkJ0g_Y</a></td>
<td>b) To support increased understanding of trauma-informed practice and its implications for practice</td>
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<td>Time</td>
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<td>10:30 – 10:45 a.m.</td>
<td><strong>BREAK</strong></td>
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<td>In this module the participant will have the opportunity to explore</td>
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<td>the physical, emotional, behavioral, spiritual and relational effects</td>
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<td>of trauma and violence and consider the implications for PHC services.</td>
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<td><strong>Purpose</strong></td>
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<td>10:45 – 11:45 a.m.</td>
<td><strong>Large group</strong> An intro to the ‘health effects’ conversation:</td>
<td>a) To provide information about the many “symptoms”, responses or</td>
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<td>Stilettos to Moccasins – Effects of Trauma on Spirituality</td>
<td>effects experienced by people who have been traumatized that will</td>
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<td><a href="http://www.youtube.com/watch?v=1QRb8wA2iHs">http://www.youtube.com/watch?v=1QRb8wA2iHs</a></td>
<td>enhance trauma awareness and strengthen capacity for trauma-informed</td>
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<td>service responses.</td>
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<td>b) To increase awareness of factors that are known to play a role in</td>
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<td>shaping how posttraumatic effects (severity) will be</td>
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**Large group reflection activity**
Participants will bring what they have learned about trauma/violence to a group discussion (30 minutes) and reflect on the following questions:
1) What was learned about trauma/violence?
2) What surprised you, if anything?
3) Implications for practice. Would you do anything differently given this knowledge?

**Small group**
We will begin the small group activity by presenting case studies from practice to provide exemplars of the physical, emotional, behavioral, spiritual and relational effects of trauma and violence (three composite case studies from each of the sites) – (PI will prepare) –
- There is a common framework but we know there will be different foci related to trauma/violence on the different sites but that the health effects will be similar.
- Each group will be asked to contribute 2 concrete perspectives brought to bear on the case studies, bearing in mind the different roles (Physician, RN, NP, dietician, social work, psychologist, counselor, MOA, admin assistant etc.) and they will be asked to bring awareness and understanding of multiple theoretical contributions and perspectives, building on the historical context and supporting awareness of the contributions made by those working within different health and research systems.
- c) To introduce the concept and principles of trauma/violence-informed practice.
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<th>Time</th>
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| 11:45 a.m. – 12:30 p.m. (Module #3: TVIC in Action) | **Large group**  
Short slide presentation: Overview of the principles of TVIC as a reminder (handout laminated). (5 minutes)  
**Small groups** (4-5 people in each)  
**Mapping activity (large paper activity)** (10 minutes):  
Participants will be asked to map out the key contact points that people go through when they access their services.  
**Large group**  
Quick report back with the maps on the wall… (5 minutes) |

**OVERVIEW**  
In this module the participant will be invited to deepen their knowledge and build basic skills to support the application of trauma/violence-informed principles into practice. This will include examination of key points in the service continuum with an emphasis on how TVIC can be used to support engagement during experiencing. This will support capacity among service providers in engagement and retention of people who may have many ‘risk factors.’
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<th>Time</th>
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<td>We will ask – at each of these points:</td>
<td><strong>intake and assessment.</strong></td>
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</table>
|              | What has worked well from a TVIC perspective? What could be adjusted/added to emphasize TVIC more fully? Given the principles we have discussed, how could you shift that? (e.g., line ups at the door at Cool Aid)… (Think about experiences that people have had in other contexts – identify ways in which PHC (practices) might unintentionally open up a trauma reaction). (25 minutes) | a) By revisiting the TVIC principles, initially introduced in section one and examining how they have been integrated into programs and practice within a variety of service settings, participants will have an opportunity reflect on translating the principles into practice.  
b) To provide an opportunity for participants to consider how TVIC may be applied at the very first points of contact that people have with service providers and program environments.  
c) To increase awareness of practitioner skills that can be developed to support and maintain safety for people who may have experienced trauma and who are accessing services. |
<p>|              | In an informal way we will attend to signage, language, environmental impact etc.                                                                                                                                                                                                                                           |
|              | Consider the service setting and practice and think about if there are there specific things that practitioners are already doing or could do to support engagement of people more fully?                                                                                                                                     |
| 12:30 noon – | LUNCH                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                   |
| 1:30 p.m.    |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                   |</p>
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<td>1:30 – 3:00 p.m.</td>
<td><strong>Large group</strong>&lt;br&gt;Slides … We will use slides to present material re: organizational culture and a commitment to TVIC organizational culture as per the 10 commitments related to equity-informed approach or Bloom or another) (10 minutes) – We will note that we know the participants are committed to this BUT, there is a risk in thinking that they are already fully there…. when the participants look at how people are treated in the emergency or in other places it is easier to look at practitioners and practices in those settings rather than at their own organization so as we work through these slides we are going to ask them to do something very challenging… to move to the absolute ideal … to consider what it would mean to push their organization and their own practice to the ideal…</td>
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<td><strong>Small group</strong>&lt;br&gt;Participants will be asked to consider one or two of the items in the list of commitments (or other commitments based on previous discussions) and reflect on the following questions:&lt;br&gt;a) Who are the most marginalized people and how do we get them exceptional care that brings them to a better place? Contrast exemplar – the guy on the street for 40 years who feels very unsafe (a tad crusty, perhaps a bit smelly, very quiet) or do you sit beside the 27 year old guy who is easy to be with ……&lt;br&gt;b) What do you find challenging in enacting your commitment to equity in your practice? Where do you use your privilege to take the easy route?&lt;br&gt;c) Consider what role staff can play in this?&lt;br&gt;d) List the types of organizational support that would be helpful in moving towards this goal?&lt;br&gt;e) Consider the ways in which individuals can inspire and contribute to TVIC at the organizational level? (15 minutes)&lt;br&gt;{Within the context of this discussion, participants will be asked to think about those things that work well in the organization, the language used with clients and the physical space}&lt;br&gt;<strong>OVERVIEW</strong>&lt;br&gt;This module focuses on implementation of trauma/violence-informed practice at the organizational level.&lt;br&gt;&lt;strong&gt;Purpose&lt;/strong&gt;&lt;br&gt;a) To provide participants with the opportunity to reflect on trauma/violence-informed practice as it might be implemented at the organizational level.&lt;br&gt;b) To provide some practical examples of how TVIC is translated into practice at the organizational level.&lt;br&gt;c) To increase or strengthen awareness of vicarious trauma and it’s impacts, as well as to provide some strategies for managing the cumulative effects of jobs that include ‘emotional labor’ (supporting recovery and healing for people working in PHC) and promoting wellness.&lt;br&gt;d) To provide some basic examples of how supervision can support TVIC at both the practice and organizational levels. Not sure this is necessary but could be something incorporated into Session Four</td>
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<td>Time</td>
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<td>Small group feedback (20 minutes). Then participants will be asked to identify the ideal organizational culture to support TVIC in PHC.</td>
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<td>a) How would the group develop the organization: brainstorm individual and collective actions toward a supportive culture (10 minutes)</td>
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<td>Slides (vicarious trauma) (5 minutes)</td>
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<td></td>
<td>Video Clip</td>
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<td></td>
<td>Dr. Laurie Pearlman - discussing strategies for managing vicarious trauma (5 minutes)</td>
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|                 | [http://www.youtube.com/watch?v=wVDSdta0mbM&list=UUjY3NJMnTSZc_VqtDWFv0A](http://www.youtube.com/watch?v=wVDSdta0mbM&list=UUjY3NJMnTSZc_VqtDWFv0A)
| Large group     | Participants will be asked to consider                                                                                                 |
|                 | a) What strategies the organization might consider to ensure personal and organizational wellness? (20 minutes)                           |
|                 | **Preparation for next session** (10 minutes)                                                                                           |

**Session Three: Linking Learning to Practice – Independent**  
**Ends in View:**  
By the end of Session Three (Independent Learning) participants will be able to...  
1. Present a practice scenario and lessons learned related to TVIC (that they would like to share).

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<td>Independent exercise</td>
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<td>o Participants will reflect on what they learned in Session Two and consider how TVIC may apply to real-life patients or clients they have worked with.</td>
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<td>o Each participant (or groups of participants who may wish to present a scenario together) will come to Session Four prepared to talk about an example from their practice where they have used, or might want to use, some of the principles and techniques learned in Section Two.</td>
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**Session Four: Linking Learning to Practice – Face-to-face (2 hours)**  
**Ends in View:**  
By the end of **Session Four** participants will be able to...  
1. Develop a personal action plan to enhance practice and the organization’s practices and policies toward universal trauma and violence informed care.
2. Enact trauma-informed practice approaches in the care of individuals with varying trauma histories.

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<tr>
<th>Time</th>
<th>Activity</th>
<th>Purpose</th>
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<tr>
<td>9:00 – 10:00 a.m.</td>
<td>Overview of the day</td>
<td>To support people to reflect on specific goals that they can strive for to integrate TVIC conceptually and define some concrete actions to strengthen TVIC that they can take within their scope of practice.</td>
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<td><strong>Small groups</strong></td>
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<td>Participants will be prepared to present a case scenario from practice (consideration across roles) for discussion (as per Session Three). The group members will:</td>
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<td>a) Identify specific actions to strengthen TVIC in practice as per this scenario.</td>
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<td>b) Consider the organizational features that need to be addressed to support their actions.</td>
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<td>c) Consider the structural factors that need to be addressed (all will be recorded on flip charts) (25 minutes)</td>
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<td><strong>Large group</strong></td>
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<td>Participants will share commonalities across the group and what the group members learned from each other.</td>
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<td>How for example, scheduling can feel discriminatory for some (30 minutes)</td>
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<td>10:00 – 11:00 a.m.</td>
<td><strong>Large group</strong></td>
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<td>Participants will be given time to identify one or two strategies or skills related to each of the TVIC areas that they plan to continue; begin doing; learn more about or strengthen (as above). (10 minutes) – <strong>give a paper handout – organizational ... continue, begin, strengthen</strong></td>
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<td>Participants will be asked to think about their goals both individual and organizationally and right them down on the handout (10 minutes)</td>
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<td><strong>Individual exercise</strong></td>
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<td>Participants will be provided with the opportunity to share the organizational goals they want to work on and the support they hope for. They will be asked to write down personal /professional goals related to TVIC areas important to the organization, and next steps they wish to take. They will also consider areas of organizational support that may be necessary to implement the</td>
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<td>plan. (30 minutes)</td>
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<td>Write down your personal commitment as you move forward.</td>
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**Large group discussion of above** (30 minutes):
You have heard ...You have your personal goals written – so now what are you going to do?

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<tr>
<th>Post Session Evaluation</th>
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<tr>
<td><strong>Participants will be asked:</strong></td>
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<tr>
<td>o Would you like to have individual and/or organizational follow-up?</td>
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<td>o What types of supports do you envision now?</td>
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<td>o Working on a plan with the clinical leaders, what would it look like to pull meetings together?</td>
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<td>o What does integration and tailoring look like?</td>
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<td>o What would be helpful in terms of moving forward with the $10,000?</td>
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<tr>
<td>o What would the next step be in terms of your goals?</td>
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