Trauma Informed Health Services Research

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Intention

Facilitate a conversation on equity, inclusion, gender bias and trauma in health services research and share ideas about interventions

Overview

- Part I.
  - Quick terminology and principles
  - The role of bias, gender informed and partner defined quality
- Part 2
  - The role of trauma: SELF, Sanctuary and embedding trauma informed best practices
- Part 3
  - Self analysis and feedback
  - ‘Do’s”

Before we begin, take two minutes and:

- Write down a less than optimal outcome you've experienced (or are concerned might experience) with your research.
- I will ask you to share with a partner this issue, through the lens of trauma, gender and partner defined quality.
- Specifically, I'll ask you to critically analyze the situation :
  - What role might there be due to bias?
  - Is this as gender informed as I hoped it might be?
  - What is/are the impact(s) of trauma in the research collaborators? The team? The organization?
- What are action steps I can take to explore/address these issues?

DIVERSITY

Office of Diversity, Equity & Inclusion

EACH ONE OF YOU!!!

Optimize your team's impact, learn more effectively and more efficiently and enhance your skills as a physicians in a diverse society

DIVERSITY INCLUDES ALL OF US!!!

Equal versus Equitable

1. Equality: is giving people the same thing/s.

2. Equity: is fairness in every situation.

Here, it is assumed that everyone will benefit from the same supports. They are being treated EQUALLY

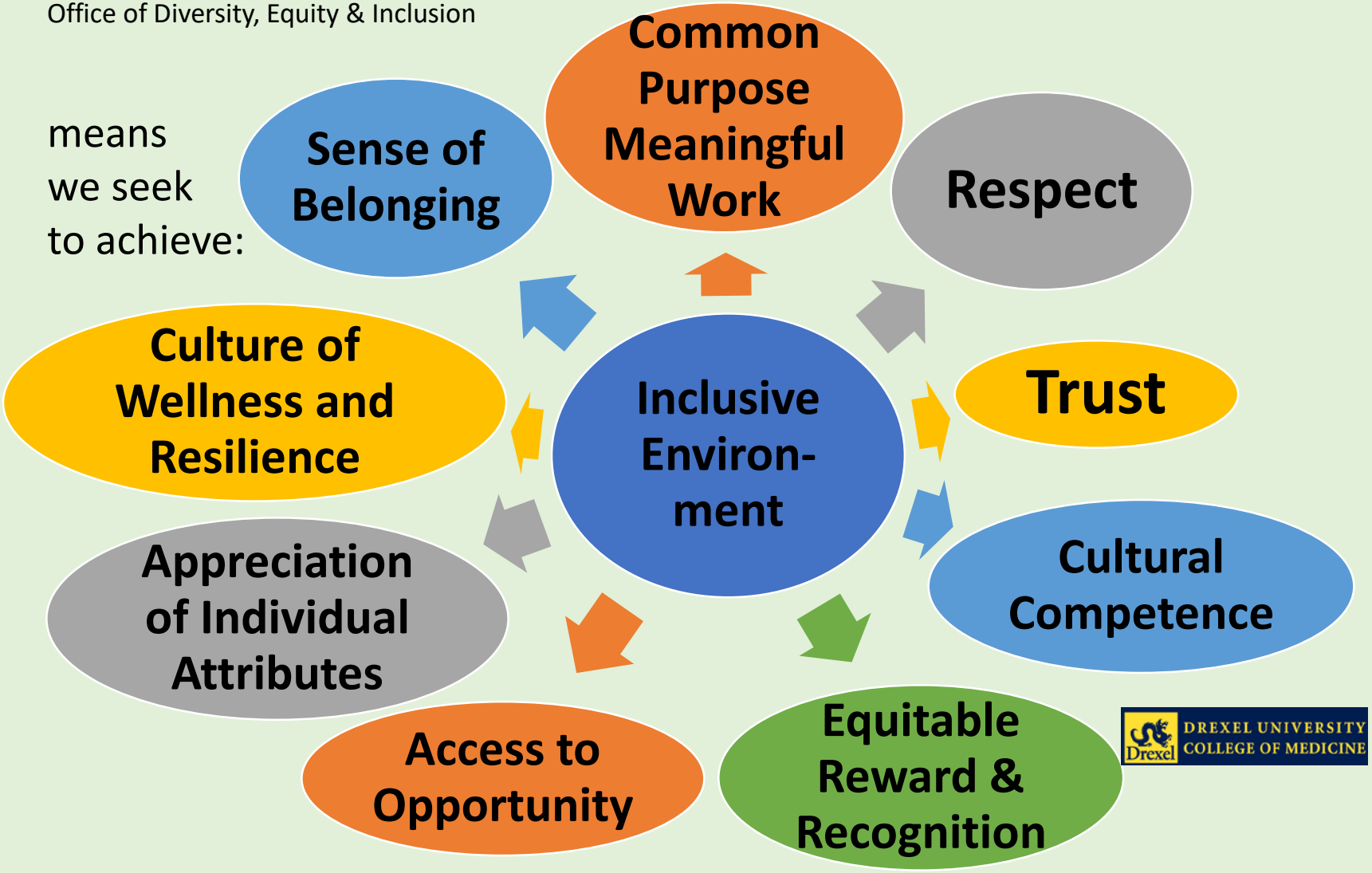
Here, all are given different supports to make it possible for them to have equal access to the game. They are being treated EQUITABLY

Here, all three can see the game without any supports or accommodations because the cause of the inequity was addressed. The SYSTEMIC BARRIER WAS REMOVED.

Inclusion

Office of Diversity, Equity & Inclusion

means
we seek
to achieve:



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Team Composition Diversity Leads to More Ideas and More Productivity

The Casualty of (laser) focus

Using eye-tracking technology, the Yale study found that in a typical classroom setting, preschool teachers were on the lookout for “challenging behaviors” from black boys 42 percent of the time, much more than they watched other children, including white boys and girls. The behavior occurred, the researchers concluded, even if no children were acting up.

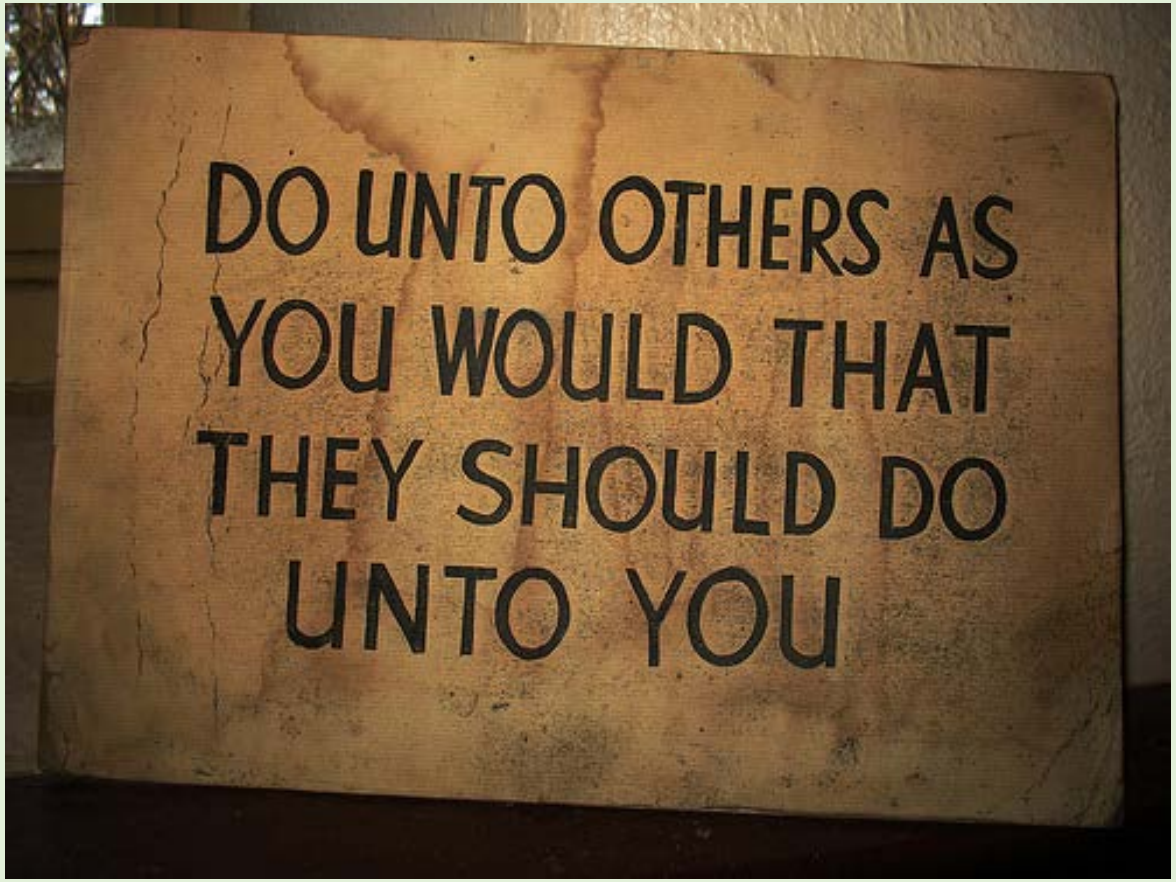
http://www.takepart.com/article/2016/09/30/racial-bias-starts-preschool-its-not-only-teachers-fault

Good Intentions Does not Equal Good Outcomes

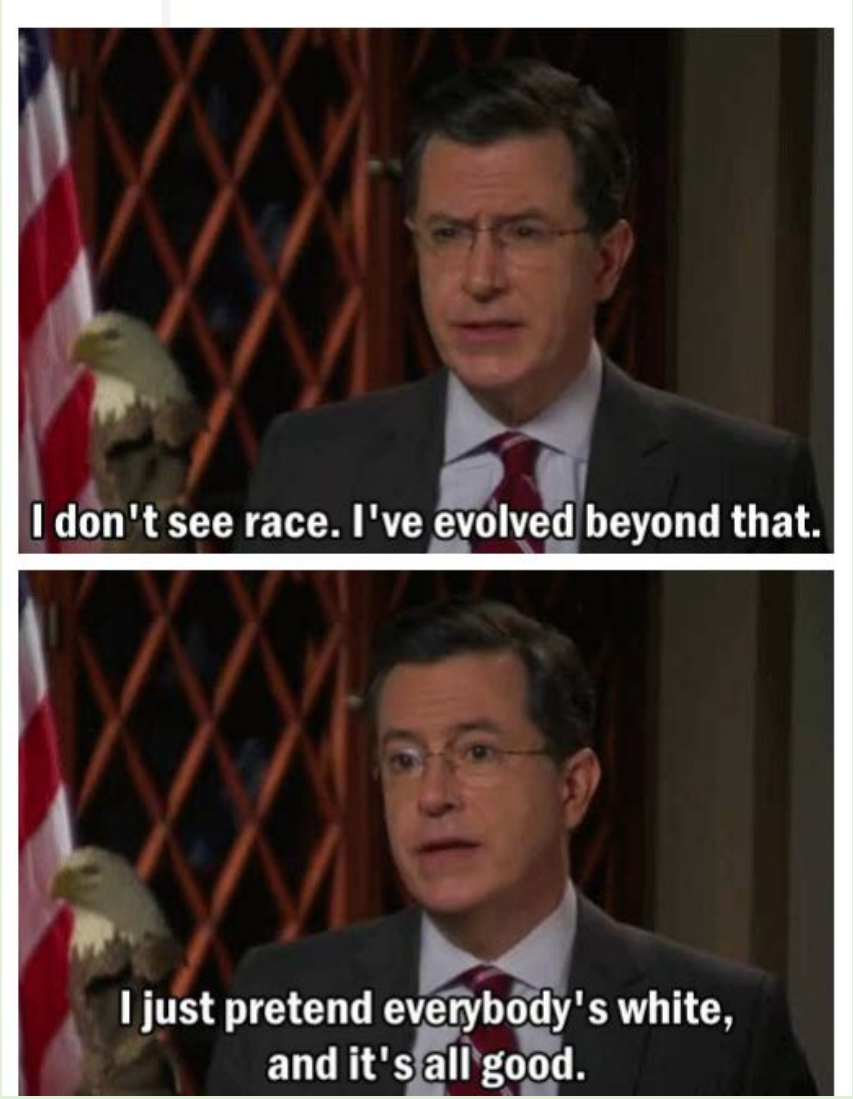
Photo A.Núñez 2008

The Golden Rule Makes Assumptions

Tweaking the Golden Rule



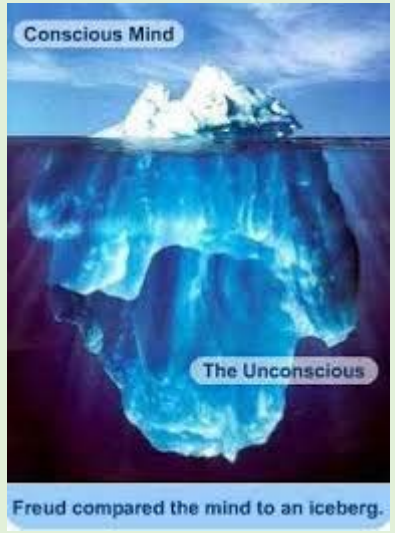
Color Blind – Not A Useful Approach



One Size Rarely Even Fits One!!!

BIAS

Conscious and Unconscious

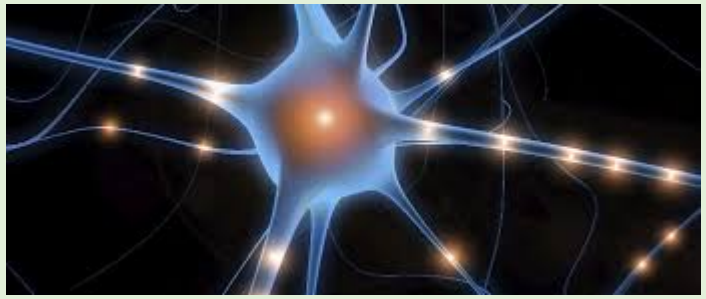


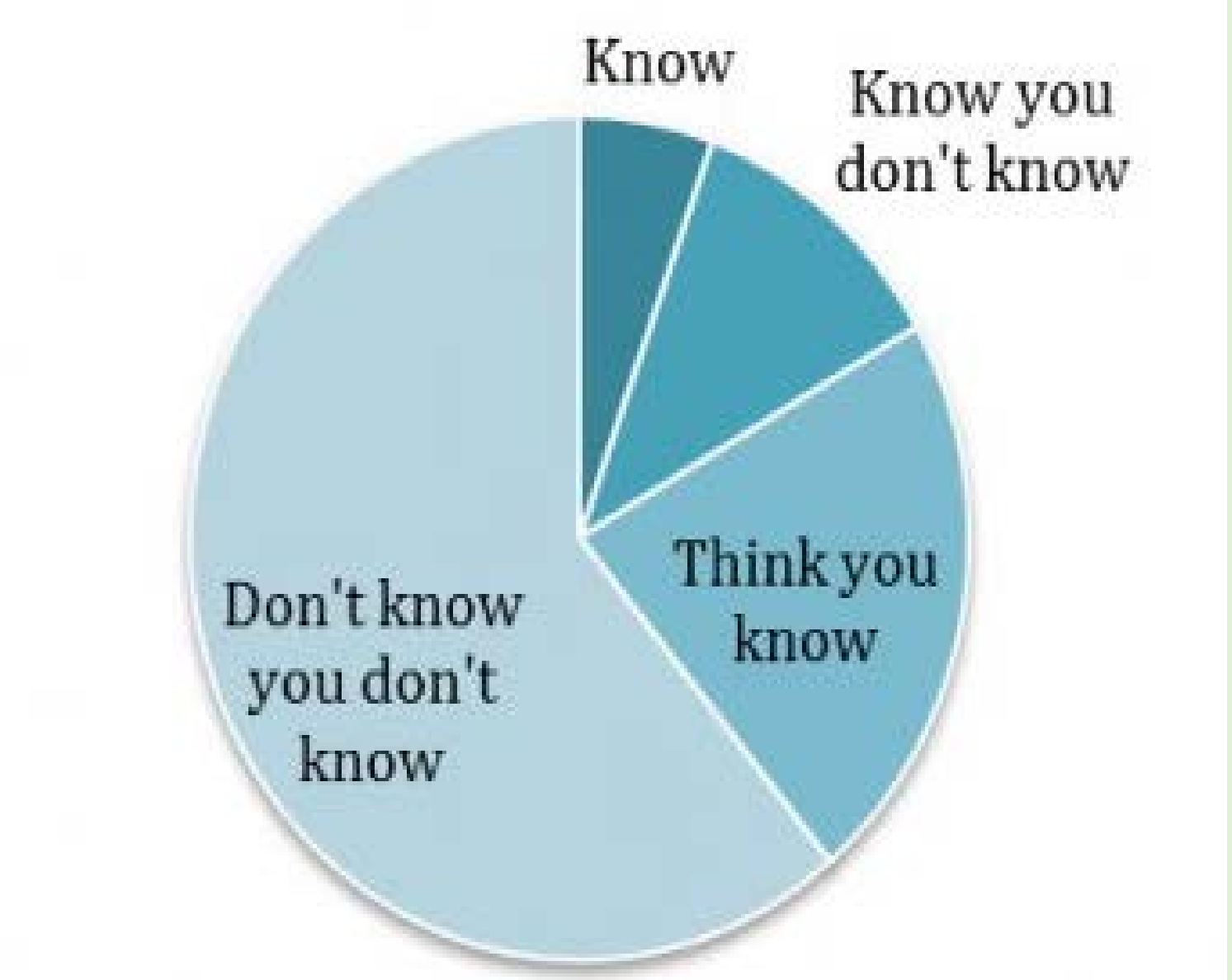
Cognitive Bias

- Bias is a human experience
- Bias drives behavior
- Unconscious bias and medicine plays a role in being effective in your role and in leadership
- We see who we are, not who you are..
- Becoming aware of unconscious bias results in getting the outcomes you say you want

Neurocognitively Speaking, Unconscious Bias (UCB):

- Is a type of rapid cognition that finds patterns supported by small bits of information (of the rapid reflex/ danger detector type)
- Refers to social stereotypes about certain groups of people that individuals form outside of their own awareness (Fiske & Taylor, 1991, Valian 1998, 1999)




Know
Know you don't know
Think you know
Don't know you don't know

HOW DO WE REASON?

Dual Processing Theory Reasoning Model

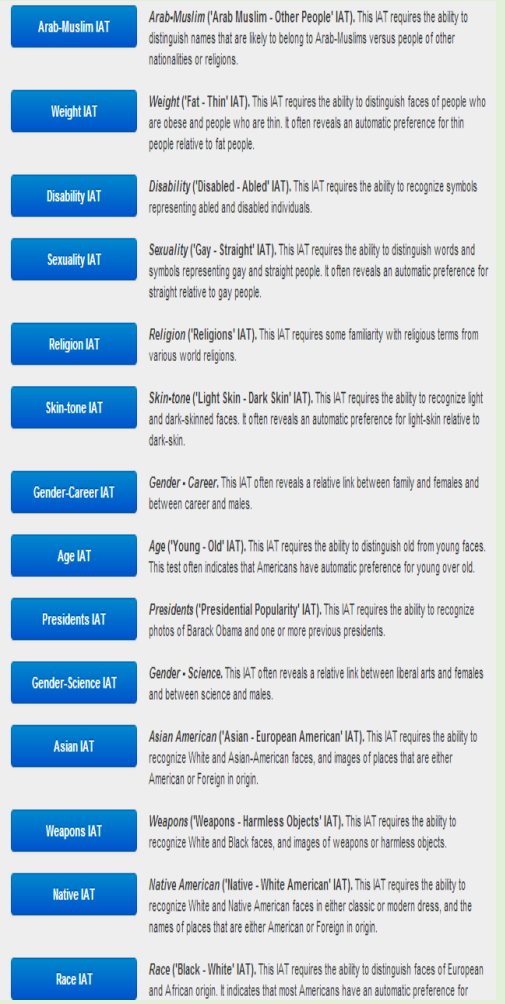
- System 2 - Analytical Reasoning - Described analytical, deliberate, rational, slow, explicit, purposeful, and generally more reliable.
- System 1- Intuitive Action - Described as intuitive, tacit, experiential, pattern recognition, a shoot-from-the-hip" approach, and a gut reaction.
- And posits that we toggle between these two

Pelaccia T,TardifJ,TribyE,CharlinB.Ananalysisofclinical reasoning througharecentandcomprehensiveapproach:the dual-process theory. Med EducOnline 2011:16. 4. National PrescribingCentre,NationalHealthService.Making decisions better. MeReC Bull 2011;22(1):1–8. 5. Croskerry P,NimmoG.Betterclinicaldecisionmakingand reducing diagnosticerror. J RCollPhysEdinb 2011;41(2): 155–62.

How does the world shape your good intentions?
Implicit Bias – when it's hidden from you, by you unknowingly

IMPLICIT APTITUDE TEST

https://implicit.harvard.edu/implicit/selectatest.html



Sex/Gender Bias

- "*Women's bodies are valued as ornaments. Men's bodies are valued as instruments*" – G. Steinem
- Research literature finds characteristics of successful leaders are often stereotypically masculine (e.g. assertive, forceful, dominant, competitive). Whereas stereotypical female characteristics are communical (e.g. warm, compassionate, gentle).
- These descriptors find their way into letters of recommendation.

1.Anne M. Koenig, Alice H. Eagly, Abigail A. Mitchell, and Tina Ristikari (2011) "Are leader stereotypes masculine? A meta-analysis of three research paradigms," *Psychological Bulletin*, 137(4): 616-642.
2.Alice H. Eagly and Steven J. Karau (2002) "Role Congruity Theory of Prejudice Toward Female Leaders," *Psychological Review*, 109(3): 573-598.

Sex Stereotypic Role Congruity or Incongruity

- I'm Nicole (not Martin) – his week as a woman

- "Ask Keith" – women owned firm creates fake co-owner and increases profits

Diversification at work –

Pre 1970, The New York Philharmonic story

TODAY

How Might Biased Duality Play a Role in IA's

Biased duality – privilege, can do opposites but negative doesn't stick or impact; lesser – negative sticks

Biased Duality - Biased Duality (gender) - a group with privilege can be two different things at no jeopardy

*At the extreme, a young man can sleep with many women (be “a player”) and be a ‘good catch’ as a husband. Not true for a young woman.
*A young man can make a mistake, but that does not indelibly write him off as ineligible. This may not be as true for a woman (or other group)

Benefit of the Doubt, Risk and Optimism

- Bias, including unconscious, of good hearted people is rarely meant to be hurtful.
- We extend the benefit of the doubt on people for whom we have confidence. (e.g. think they can ‘do it’, expect them to ‘know the rules’, expect them to be predictable by our own perspectives)
- We rarely extend the benefit of the doubt of people who seem foreign, different, unpredictable – who might not follow ‘the rules’. We rarely extend benefit of the doubt if we feel that there is a risk (e.g. safety related)

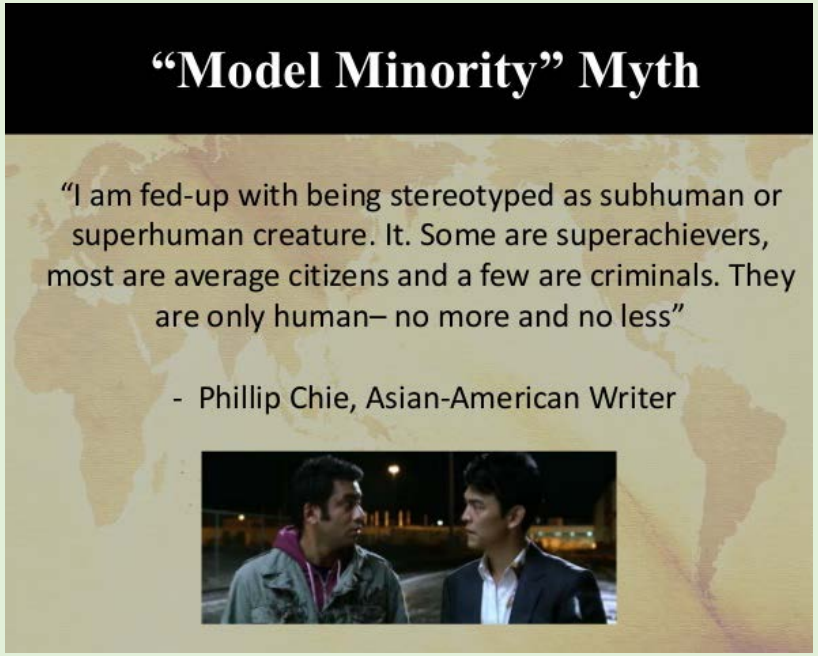
Cultural Bias – Model Minority Trap

Model Minority - Individuals in the ‘Model Minority’ group are misperceived as uniformly excelling in math and sciences (therefore ‘sure bets’ regarding graduation performance).

This bias flies in the face of reality. All groups live within a bell curve of great to at-risk.

Those who ‘trip up’ are viewed as unusual for ‘their group’ (“what a surprise!”) – which augments the burden on those individuals.

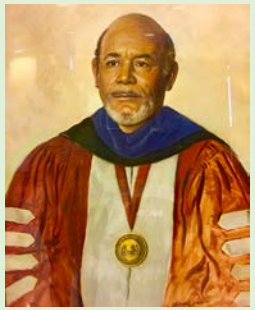
Avoid the Bias Trap by thinking where they fit in the bell curve…



Minority as Deficit

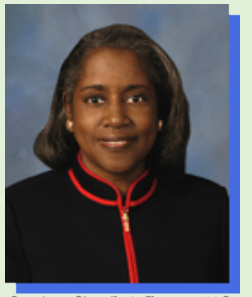






- As humans, we more easily see disadvantage more than advantage.
- To what degree do we worry about the burden of advantage?
- Often language that includes ‘taking a risk’ on candidates are used on groups with whom minority is seen as a deficit. It serves as a justification ‘it is important to bring them in so they can take care of their populations and do primary care” rather than they’d be good in their leadership role. The diversity challenge here, in our College of Opportunity, do we support diversity leaders?





Courtesy Claudia L. Thomas, M.D.

Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity and Gender

Sabin, Nosek, Greenwald, Rivara,

MD Attitudes about Race

Self-Report by Gender

Implicit Report by MD Race/Ethnicity

Sabin, 2009

Implicit Attitudes about Race

By Gender

MD’s IA by Race/Ethnicity and Gender

Bias and Race/Ethnicity

- Getting a job or an AirBnB acceptance
- About health status regardless of income
- About safety while driving (and shopping and…)
- Getting promoted in academics

http://race.bitc.org.uk/all-resources/infographics/racialbiasinfographic

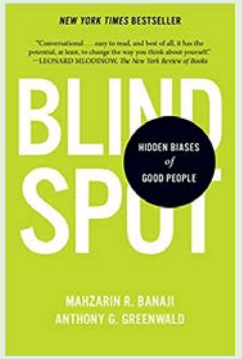
So some take home’s:

- Humans favor men, whites, youth, heterosexual, physically able over each group’s counterpart.
- Unconscious bias affects hiring, evaluation, leader selection and daily interactions.
- We can prevent being unaware of UCB driving our behavior – if we actively do things about it.

Three Sure Fire Triggers of Unconscious Bias

- Time Constraints
- “Shooting from the hip” proclamations
- Inability of being able to see pros and cons (even if you are heavily weighted either way)

Strategies - Bias Mitigation



- **Education:** Full training on unconscious bias
- **Think of counter-stereotypic examples**: Identify scientists of diverse backgrounds in your field (Blair et al).
- **Perspective-taking**: Imagine what it is like to be a person who experiences people questioning your ability or skills because of your social identity (Galinsky & Moskowitz).
- **Interrupt automatic biased thoughts:** Identify when you may be most influenced by implicit bias (e.g., evaluating performance) and create an action plan (e.g., review evaluation criteria before assessing each person's performance in the form of IF and THEN statements) to increase mindfulness of, or mitigate the influence of, implicit bias (Stewart & Payne).

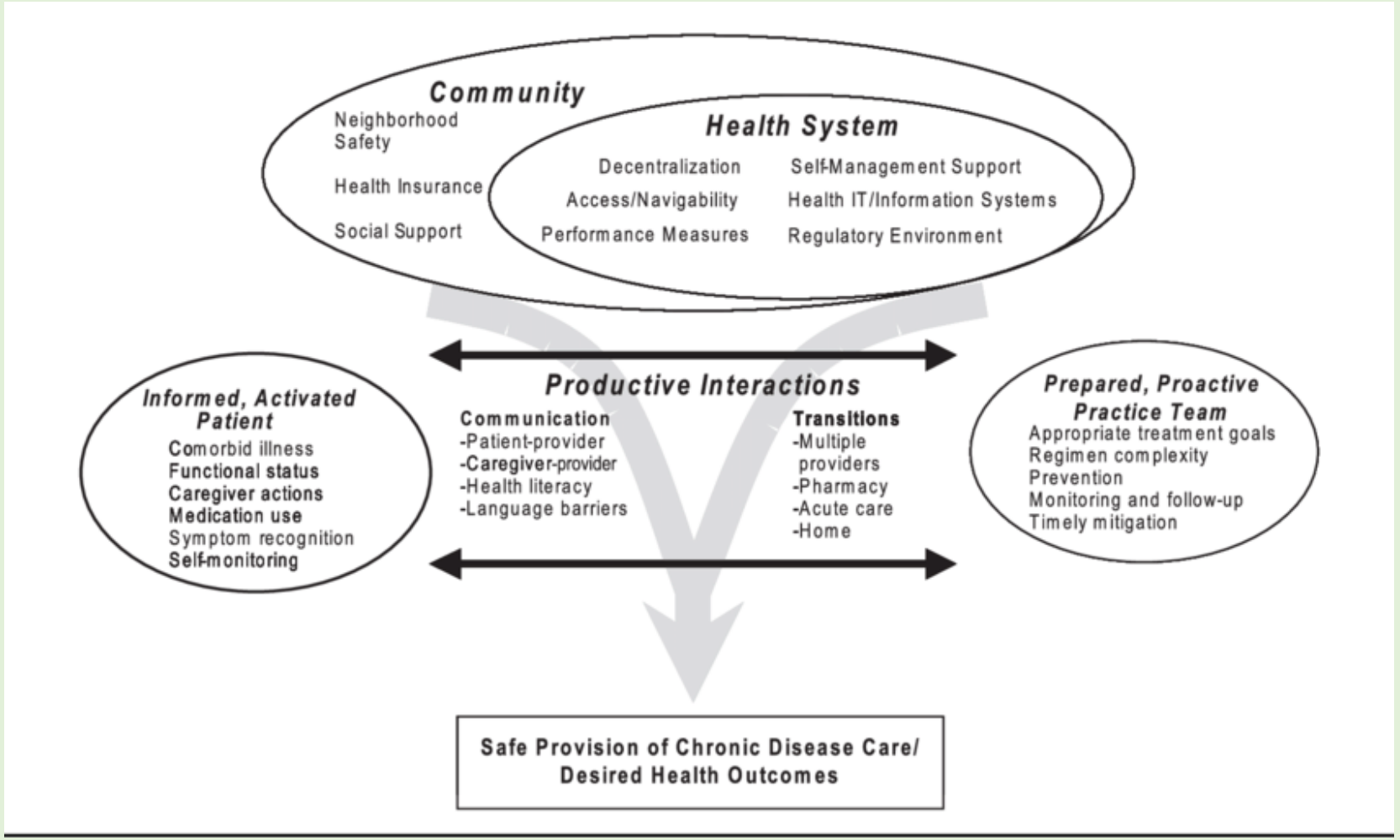
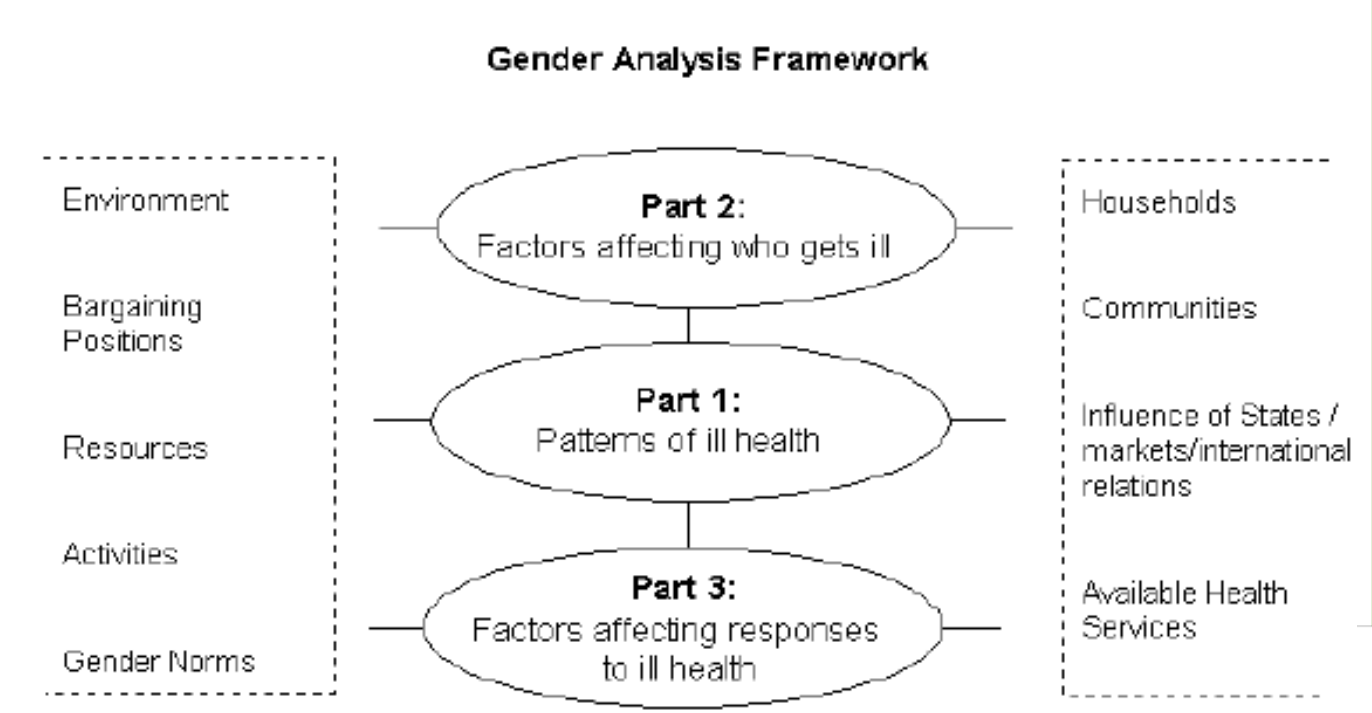


Figure 1. The ecological model for ambulatory patient safety in chronic disease represents an extension

Sarkar, et al. 2009 Joint Commission on Accreditation of HealthCare Organizations, Vol 35; No. 7

Gender analysis framework – iterative; dynamic



This is the first step in designing, implementing and evaluating health policies, projects and research in a gender sensitive way. The gender analysis helps to identify:

1. who suffers from ill-health (Patterns of ill-health)
2. why particular groups suffer from ill-health (Factors affecting who suffers from ill-health)
3. how men and women's responses to ill-health are influenced by gender (Factors affecting responses to illness)

- ENVIRONMENT
- ACTIVITIES
- BARGAINING POSITIONS
- RESOURCES
- GENDER NORMS

Why do different groups of men and women suffer from ill-health?	Household	Communities	Influence of States / markets international relations
How does the ENVIRONMENT influence who becomes ill?			e.g. lack of health and safety legislation to protect workers
How do the ACTIVITIES of men and women influence their health?	e.g. washing clothes increases women's exposure to schistosomiasis		
How does the BARGAINING POSITIONof men and women influence their health?		e.g. male community members decide to use funds to build a meeting house, not to build a well as favoured by the women members	
How does access to and control over RESOURCES influence the health of men and women?		e.g. women's lack of income earning opportunities may lead them to commercial sex work as a livelihood strategy	
How do GENDER NORMS influence health?	e.g. son preference may mean that daughters are fed last and receive less nutritious food		

Matrix Factors Affecting Who Gets Ill

How are men and women's responses to ill-health influenced by gender?	Household	Communities	Available health services
How do the ACTIVITIES of men and women influence responses to illness?	e.g. women are responsible for caring for sick family members		e.g. formal care schedules may not fit the schedules of different groups of men and women
How does the relative BARGAINING POSITIONS of men and women influence responses to illness?	e.g. a man with an STD may be able to decide to seek care without his wife's knowledge but she would need to ask him before seeking care		
How does access to and control over RESOURCES influence how men and women respond to ill-health?			e.g. traditional healers may accept payment in kind, while cash is required for user fees at formal services
How do GENDER NORMS affect responses to illness?		e.g. men and women with stigmatised diseases may be treated differently	

note: Do your answers apply across different social groupings /identities (e.g. race, class, age, religion)?

note: Have you thought about information gaps/ bias?

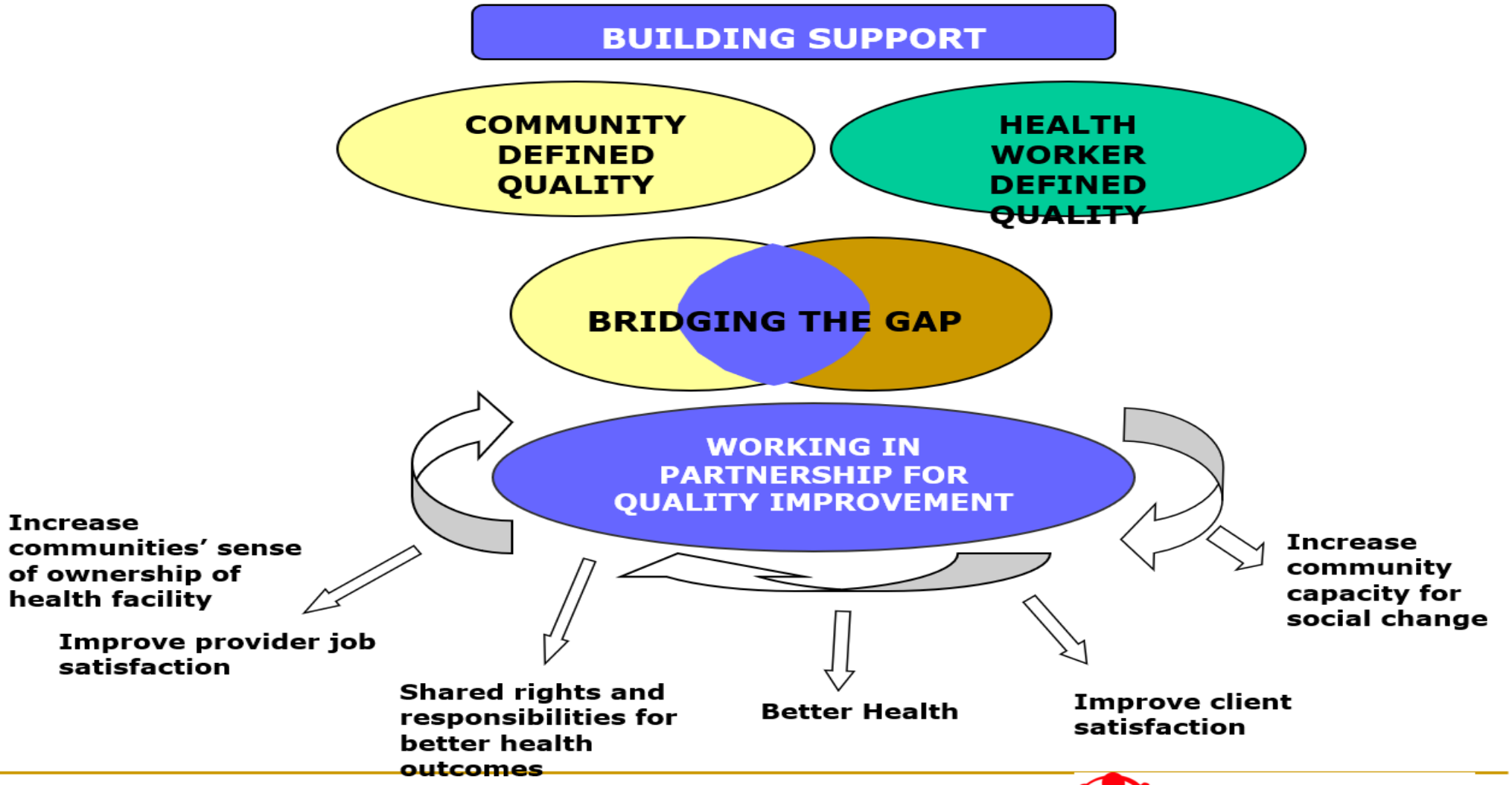
Co-Creating the Solution

- ***“Go in search of Your People***
- **Love them, learn from them**
- **Plan with them, serve them;**
- **Begin with what they have;**
- **Build on what they know.**
- **But of the best leaders,**
- **When their task is accomplished,**
- **Their work is done,**
- **The People all remark:**
- **‘We have done it ourselves’”**

PDQ Defined

- A quality improvement process.
- Goal - increase quality and accessibility of services
- Methodology greater involvement of the community in defining, implementing and monitoring.
- Focuses upon mutual responsibility for problem identification and problem solving

PDQ PROCESS



https://www.savethechildren.org/content/dam/global/reports/health-and-nutrition/pdq-manual-nigeria.pdf

Save the Children

PDQ Optimally Deployed When:

- Action is needed (not just information).
- Change is needed and wanted from providers and community.
- All are willing to be flexible.
- Garnered key stakeholder support.
- Time sufficiently resourced to achieve goals.

Value Proposition of PDQ

- Helps eliminate social and cultural barriers to better health
- Strengthens community’s capacity to improve health
- Creates mechanism for rapid mobilization around health priorities

The role of mixed methodologies

- Why, how?
  - Process informing
- How much?
  - Impact informing

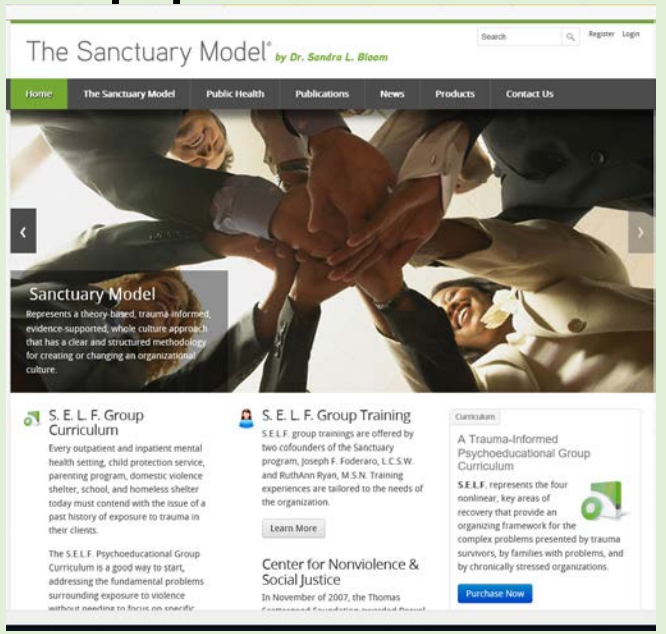
HOW??

WHY??

Impact of Trauma and Repetitive Trauma

Trauma, S-E-L-F, Sanctuary Approach

- Safety
- Emotion identification and regulation
- Loss
- Future



"what happened?" vs "what's wrong with you?"

whathappened

http://www.sanctuaryweb.com/

S.Bloom

Principles

- Safety
- Transparency, Authenticity, Trustworthiness
- Choice / Options
- Collaboration and Mutuality
- Empowerment

Safety and Transparency

- Safety

- Transparency, Authenticity, Trustworthiness

- Place, space – culturally, emotionally, physically safe and aware of an individual's discomfort or unease. Team members represents your outreach group.
- Full disclosure in more than one communication vehicle with intentional repetition, cuing ('what's next'), foreshadowing ('this might be tough to talk about'). Authentic, clear communication.

Choices and Collaboration

- Choice / Options

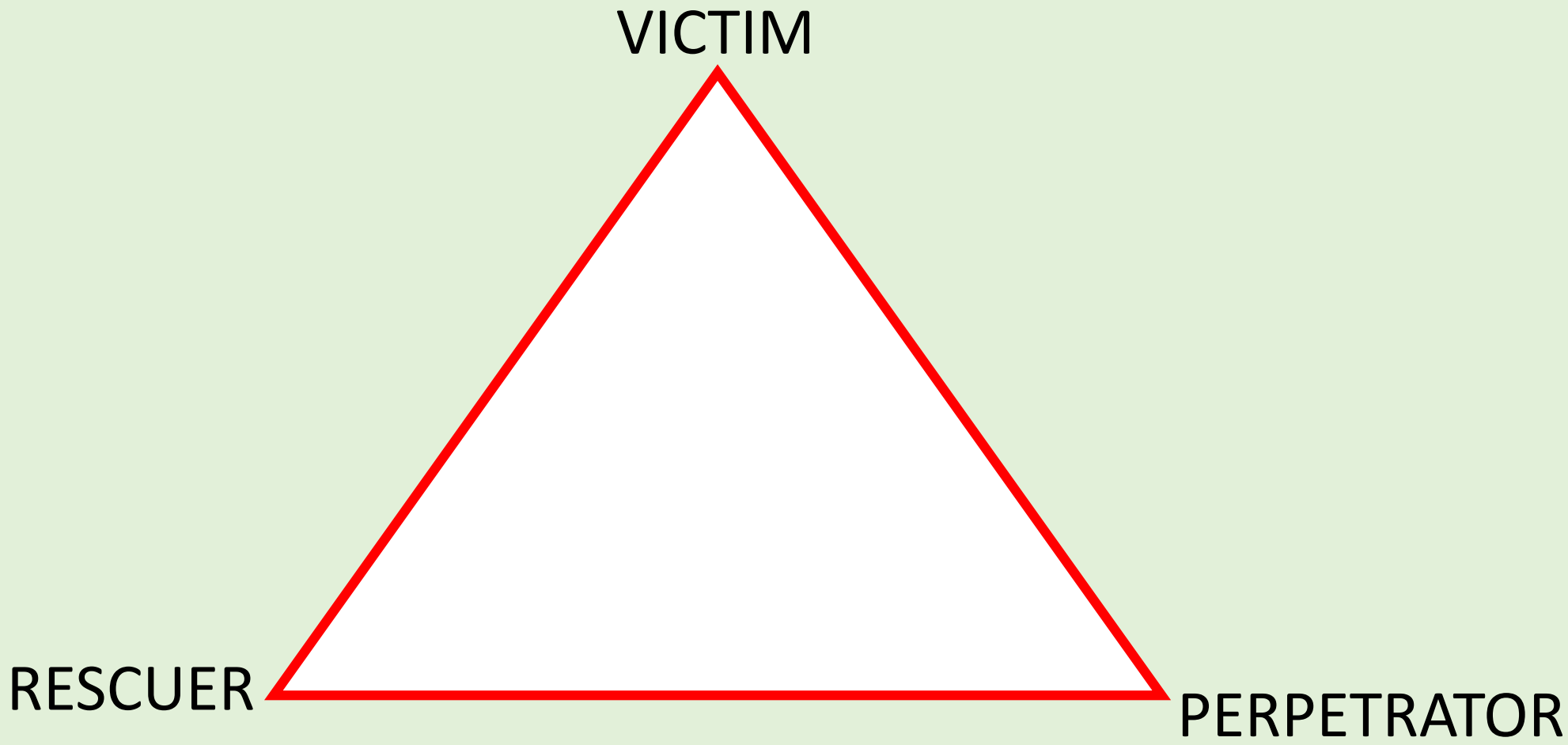
- Collaboration and Mutuality

- Critically designing options and choices vs singular ‘best practice’. ‘best of the worst’, at times
- Collaboration – not mine, not yours but the ‘birthed’ third combining our two. Relationship development, reinforcement and forging. Dedicated time and processes to facilate shared decisionmaking. Mutuality derives from being in ‘others mind’ not reciprocity.

Empowerment

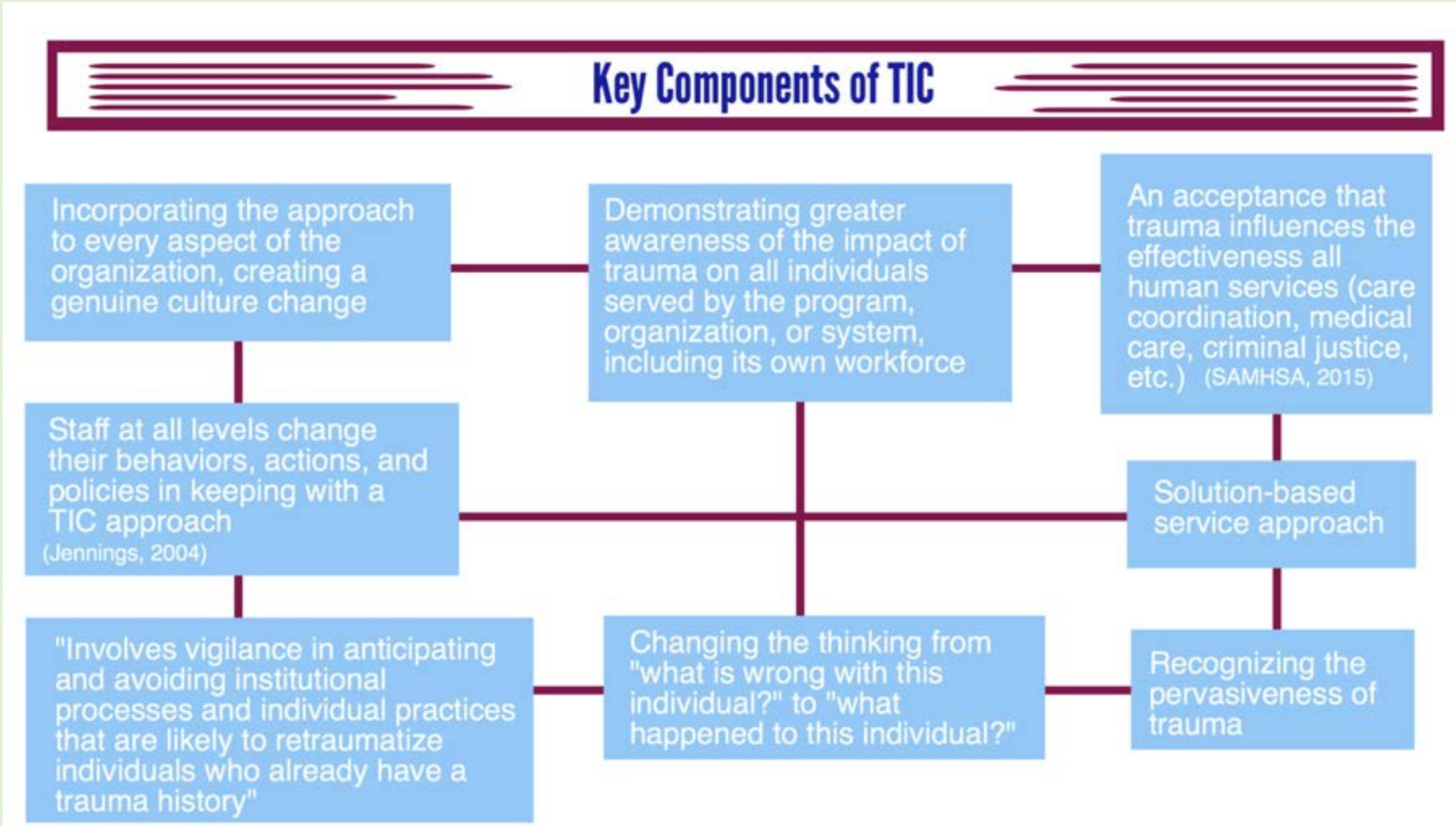
Strengths based from the start (vs deficit based). Validation of expertise of the lived experience and their potential and contributions. Concrete acknowledgements, awards, celebrations of successes and milestones. Building on collective successes and ongoing validation

The Triangle and (Invisible) Role of Family



In search of a trauma informed approach… S.Bloom Sanctuary

https://traumainformedoregon.org/roadmap-trauma-informed-care/

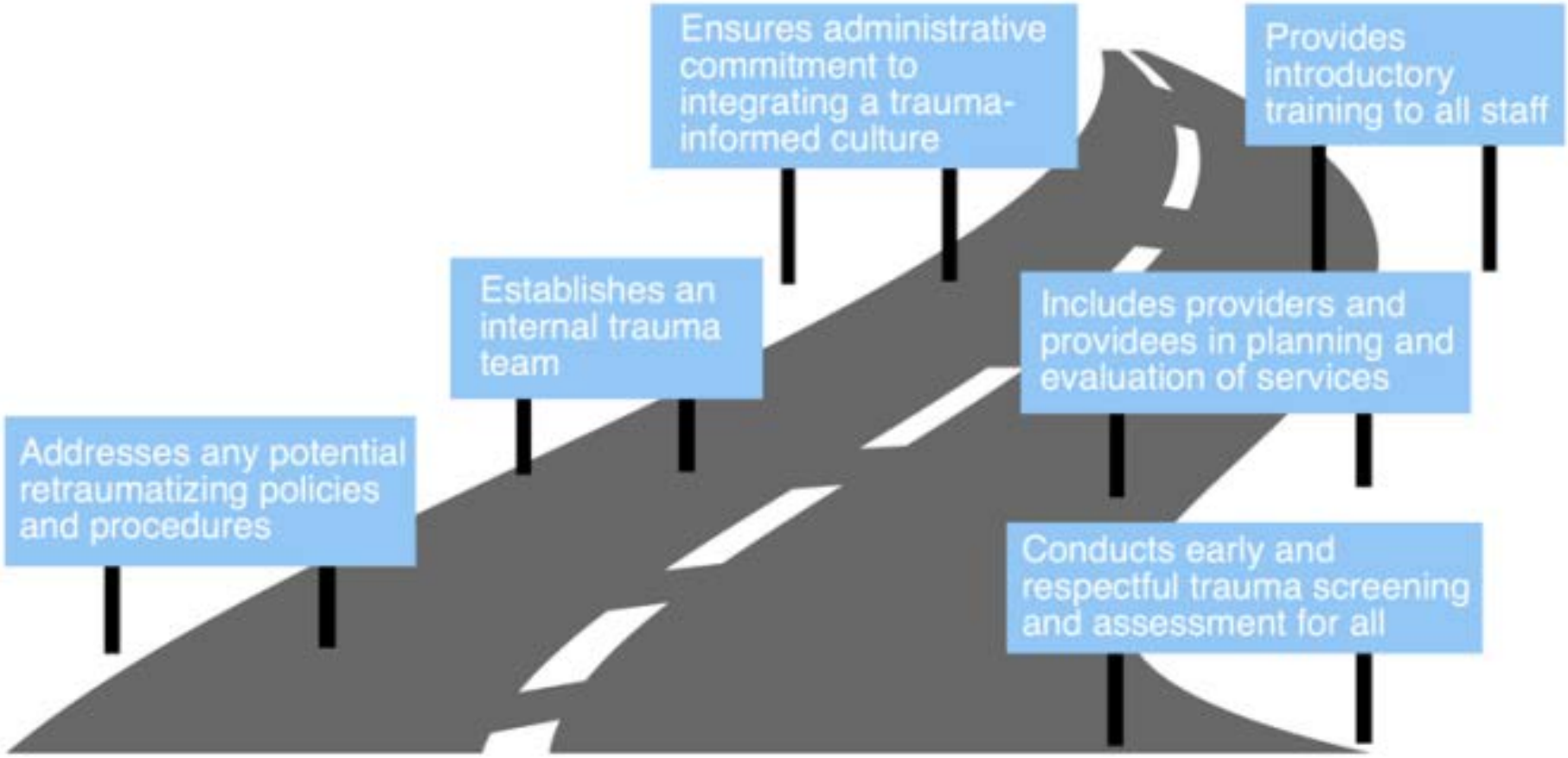


https://www.google.com/search?q=trauma+informed+health+services+research&source=lnms&tbm=isch&sa=X&ved=0ahUKEwjLgoXw59LhAhXkzVkKHQltD8oQ_AUIDygC&biw=1536&bih=711#imgrc=pr_tmYiKgqxAAM:&spf=1555355803906

The Road to Trauma-Informed Care (TIC)

Trauma-Informed Care calls for a change in organizational culture, where an emphasis is placed on understanding, respecting and appropriately responding to the effects trauma at all levels.

(Bloom, 2010)

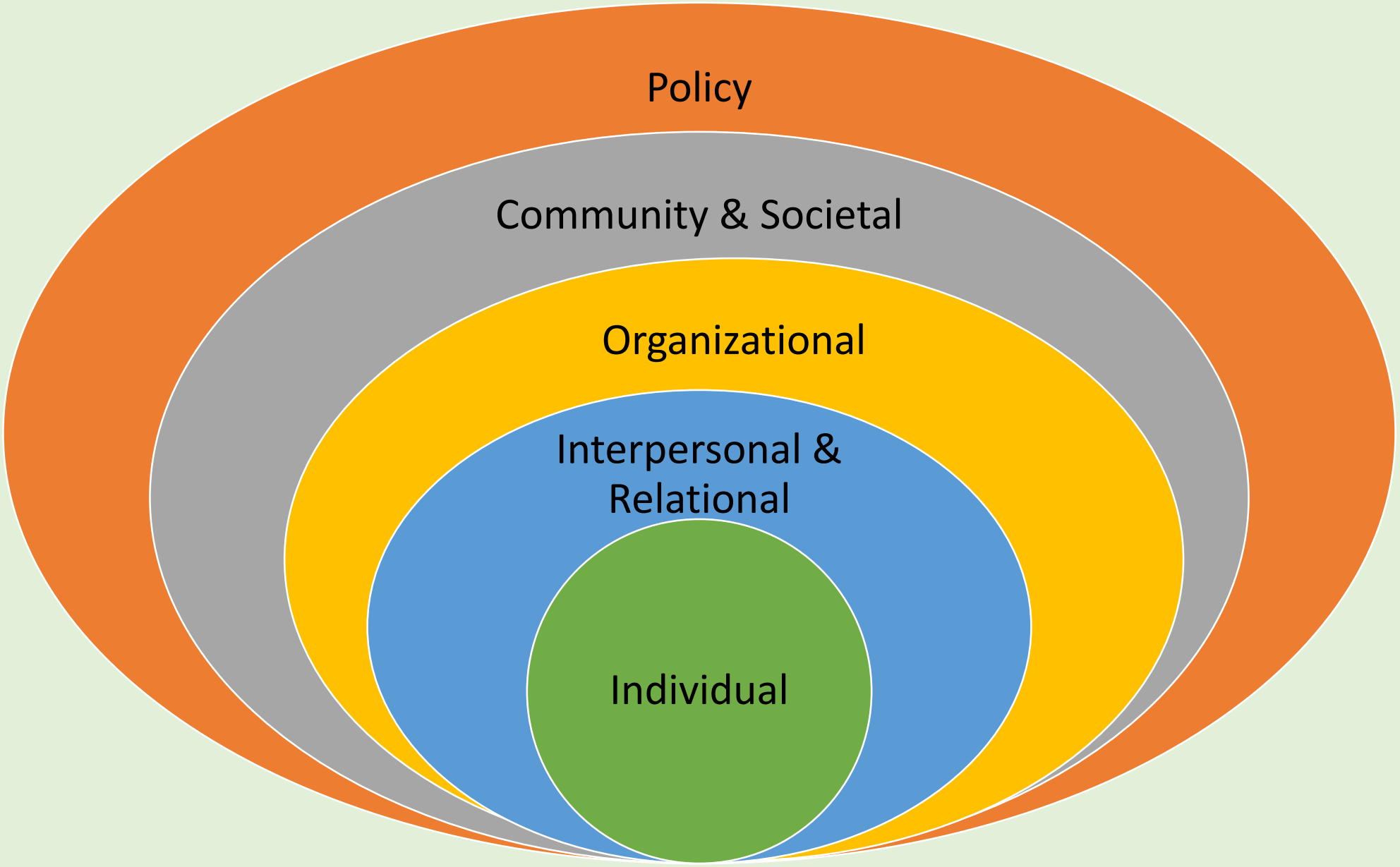


(Fallot & Harris, 2001)

Retraumatization

WHAT HURTS?

SYSTEM (POLICIES, PROCEDURES, "THE WAY THINGS ARE DONE")	RELATIONSHIP (POWER, CONTROL, SUBVERSIVENESS)
HAVING TO CONTINUALLY RETELL THEIR STORY	NOT BEING SEEN / HEARD
BEING TREATED AS A NUMBER	VIOLATING TRUST
PROCEDURES THAT REQUIRE DISROBING	FAILURE TO ENSURE EMOTIONAL SAFETY
BEING SEEN AS THEIR LABEL (I.E ADDICT, SCHIZOPHRENIC)	NON COLLABORATIVE
NO CHOICE IN SERVICE OR TREATMENT	DOES THINGS FOR RATHER THAN WITH
NO OPPORTUNITY TO GIVE FEEDBACK ABOUT THEIR EXPERIENCE WITH THE SERVICE DELIVERY	USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE


Policy
Community & Societal
Organizational
Interpersonal &
Relational
Individual

Interventions and Activities At All Levels

- Individual – those in target audience; with need for intervention, intentions of intervention (and unintentional); with risks and benefits; considering access and overall impact
- Interpersonal & Relational – interactions (e.g. how impacts social, cultural, gender norms); individual-level barriers; impact of other people (family, friends, HCPs, community workers, research team members) and how they interact; trauma informed (TI) training on messages and support
- Organizational – impact on system and policies that result in group and individual behavior change; engagement by organizations regarding TI messages and support
- Community – TI developed community and coalition collaborations with activities, events, communication campaigns all themselves TI
- Policy – State, local, federal, tribal agencies and policies engaged to promote health behavior change

Stress for your team:

includes burnout; vicarious trauma; secondary traumatic stress; compassion stress

Risk Factors

- Personal trauma history
- Type of trauma story
- Length of employment
- ‘always on’ – always being empathetic
- isolation

Protective

- Team spirit
- Seeing change as a result of the work
- Training
- Supervision
- Balanced workload
- Stress inoculation training
- Space for self care
- Practice of gratitude and ‘shout outs’
- Workplace wellness rituals (walks, lunch)

From good to great…

- Take your situation you wrote down and consider the following, with a critical eye:
  - What role might there be due to bias?
  - Is this as gender informed as I hoped it might be?
  - What is/are the impact(s) of trauma in the research collaborators? The team? The organization?
- What are action steps I can take to explore/address these issues?

- Spend 3 minutes thinking and 2 minutes sharing with a partner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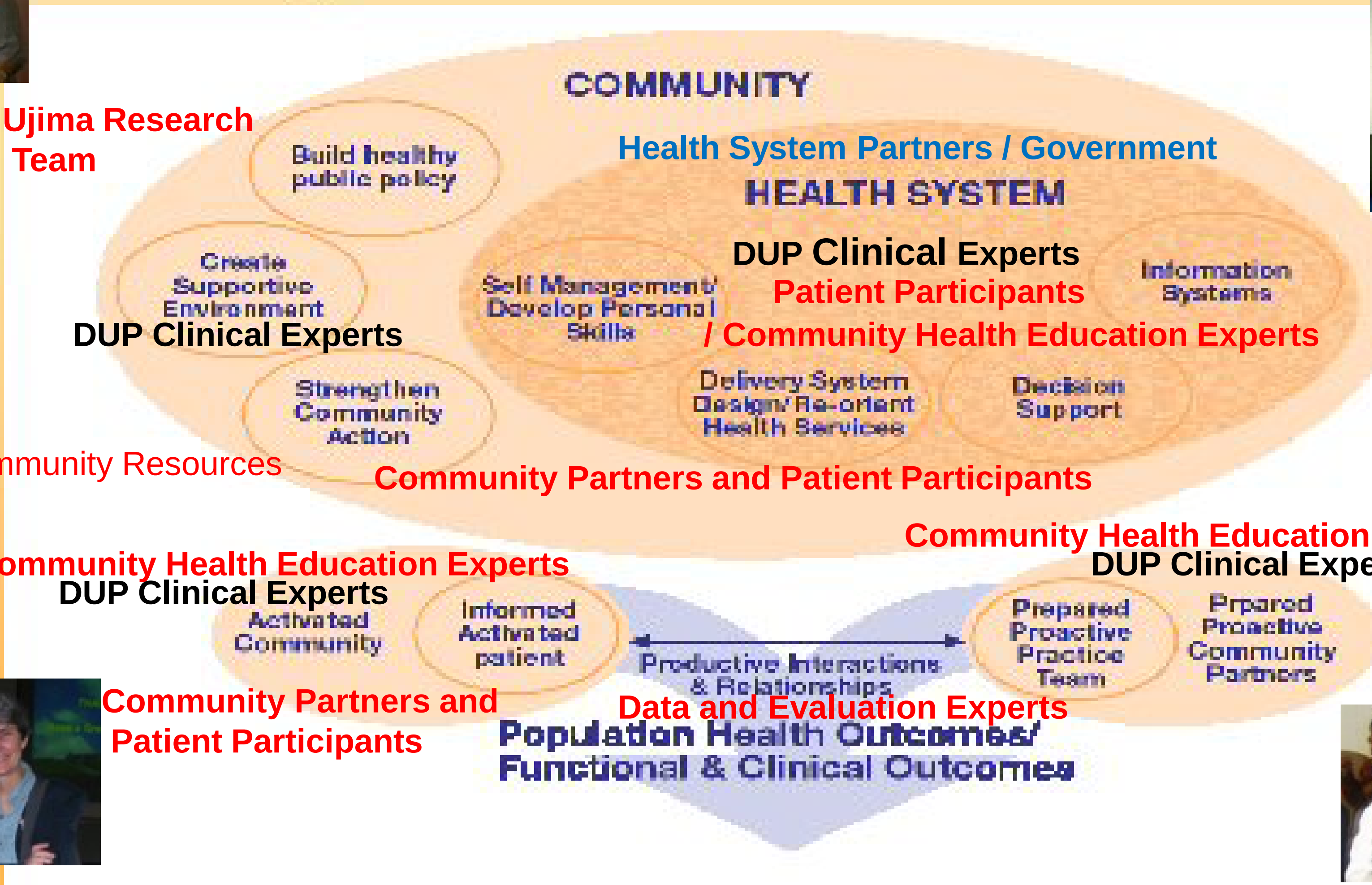
ABOUT
WHAT WE DO
HEALTH RESOURCES
CURRICULUM/TRAINING
PUBLICATIONS
PRODUCTS
TEENS
PROJECT TLC
SOCIAL MEDIA INTERNSHIP

Expanded Model for *Philadelphia Ujima*



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly, 79(4), and World Health Organization, Helath and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Improving the Culture of Health - Philadelphia Ujima:

Cultural of Health Focus

- Making Health A Shared Value
- Fostering Cross-Sector Collaboration
- Creating Healthier, More Equitable Communities
- Strengthening Integration of Health Services and Systems
- Improved Population Health, Wellness and Equity

Philadelphia Ujima Focus

- Wagner Chronic Disease model & the Ujima model
- Inclusion from onset of cross sector collaborators (from needs assessment, community health assessments to outcomes)
- Engaged communities promote healthier communities
- System level and individual navigation of health complexity
- Take a loved one to work

Philadelphia Ujima™ Principles

- Good health flourishes across sectors (geographic, demographic, social)
- Attaining best health possible is valued
- Individuals & families have the means & opportunity to make healthiest life promoting choices
- Collaboration of sectors (business, government, individuals, organizations) build healthier communities & lifestyles
- No one is excluded

- ➢ Principle reinforced by Ujima community network and lay health ambassadors
- ➢ Best health, best cost, best access (or strategies to overcome barriers)
- ➢ Family system (and social hub) engagement an imperative
- ➢ Ujima model based upon cross sector collaboration
- ➢ All in!

If you don’t know or understand – equity is elusive…

If you can't and/or don’t engage – it remains so…

Selected Resources

- **Promoting Policy Development through Community Participatory Approaches to Health Promotion: The Philadelphia Ujima Experience.** Robertson-James C[1], Sawyer L[2], Núñez A[2], Campoli B[3], Robertson D[4], DeVilliers A[5], Congleton S[6], Hayes S[7], Alexander S[8].Womens Health Issues. 2017 Oct 17;27 Suppl 1:S29-S37. doi: 10.1016/j.whi.2017.09.001.
- **Coalition for a Healthier Community: Lessons learned and implications for future work**. Manorama M. Khare, **Ana E. Núñez**, Barbara F. James. Evaluation and Program Planning Volume 51, August 2015, Pages 85–88
- **Exploring the role of gender norms in nutrition and sexual health promotion in a piloted school-based intervention: The Philadelphia Ujima™ experience.** Núñez A[1], Robertson-James C[2], Reels S[1], Jeter J[3], Rivera H[3], Yusuf Z[3], Liu[3].Eval Program Plann. 2015 Aug;51:70-7. doi: 10.1016/j.evalprogplan.2014.12.010. Epub 2014 Dec 18.
- **Multilevel and Urban Health Modeling of Risk Factors for Diabetes Mellitus: A New Insight to Public Health and Preventive Medicine.** Longjian Liu, Ana E. Núñez. p.1-7. Advance in Preventive Medicine. Vol 2014, Article ID 246049, 7 pages. November 2014. DOI: 10.1155/2014/246049
- **Multilevel and Spatial-Time Trend Analyses of the Prevalence of Hypertension in a Large Urban City in the United States. Journal Urban Health.** Longjian Liu, Ana E. Núñez**,** Xiaoping Yu, Xiaoyan Yin, and Howard J. Eisen, PMID: 23897041, July 30,2013 (Epub ahead of print) (IMF= 1.9)
- **Conducting a Needs Assessment for Women and Girls Using a Gender Analysis Framework: The Philadelphia Ujima Coalition for a Healthier Community Experience.** Núñez, A., Robertson-James, C., Reels, S., Weingartner, R., Bungy, BVol. 22; Issue 6. Pp e527-e534. Women's Health Issues. November-December 2012. doi:10.1016/j.whi.2012.08.002.

Recommended 'Do's'

- Do get trained in bias mitigation and unconscious bias; do get your team trained.
- Consider getting formal trauma and gender informed training across all your spheres of influence.
- Consider giving yourself sufficient time in program development to ensure PDQ can happen and is embedded.
- Keep asking yourself 'how are WE doing?" "what can we, collectively do, to make it better?"

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