Structural Violence: The role of poverty, trauma and stress in mental health and addictions
Acknowledge the unceded, traditional and ancestral territories of the Coast Salish First Nations

Musqueam, Tsleil-Waututh, and Squamish
Agenda

• Introductions (5 mins)

• Presentation (35 mins)
  
  Jenny Morgan
  Director, Indigenous Health, BC Women’s + Children’s Hospitals
  Sessional Instructor, UBC School of Social Work

  Vanessa Brcic
  Family Physician & Registered Therapeutic Counsellor
  Clinical Assistant Professor, Department of Family Practice, UBC

• Discussion/ Questions (10 mins)

• Closing Remarks (5 mins)
Presentation Outline

• SDOH & Structural Violence
• Trauma & Violence Informed Care
• Embedding Cultural Safety and Humility into all health services for First Nations and Aboriginal Peoples in BC
• Impacts on the Person & Clinical Approaches
Introductions:

Why are we interested?

Photo: Andrew Querner
What we know about the connections of substance use and experience of trauma

The inter-relationships of trauma/violence, mental illness and substance use in women have been described by researchers as “profound” and “staggering” [1, 2]. As many as 2/3 of women with substance use problems report a concurrent mental health problem (e.g. PTSD, anxiety, depression) and they also commonly report surviving physical and sexual abuse either as children or adults [3]. A Washington DC study showed that over 70% of women with mental disorders have co-occurring substance use problems and virtually all women with co-occurring disorders have a history of trauma [4].
Social Determinants of Health

3 opportunities for intervention:

Individual $\leftrightarrow$ health $\leftrightarrow$ environment

+ support for the *chronic stress response*
Structural Violence

Political, economic and social structures that disregard values & beliefs, and result in silencing and marginalization.

Marginalized groups are left with little power; the power they do have is constantly challenged and contested.

Farmer 2004: Anthropology of Structural Violence
Farmer 2006: Structural Violence & Clinical Medicine
Photo: Andrew Querner
What is Structural Violence?

• Colonialism, and any condition that perpetuates discrimination, oppression, or stigma.

• “A host of offensives against human dignity, including extreme & relative poverty, social inequalities from racism to gender inequality, and more spectacular forms of violence.”

• “Exerted systematically—that is, indirectly—by everyone who belongs to a certain social order.”

How do we Address Structural Violence?

• People impacted by social inequities often experience multiple forms of violence; structural conditions increase the risk of interpersonal violence, and of experiencing challenges in accessing supports to improve physical and emotional safety.

• Structural violence can be addressed through Trauma and Violence-Informed Care (TVIC).

• TVIC locates ‘the problem’ of trauma in the acts of structural violence rather than in the psyche of the person.

Wong et al 2014, Browne et al 2015 with the EQUIP study
What is Trauma and Violence-Informed Care?

- TVIC isn’t trauma therapy, but a general approach which aims to mitigate the potential harms and traumatizing effects of seeking health care or other services by creating safe and trusting environments.
- TIC prioritizes the need to create an emotionally safe environment based on an understanding of the health effects of trauma. Adding violence into this model emphasizes that negative impacts of trauma are compounded by interpersonal and structural forms of violence (poverty, racism), that are both historical and ongoing, compounding the negative impacts.

Wong et al 2014, Browne et al 2015 with the EQUIP study
TVIC engages all staff and organizational policies to deliver care that responds to inequities, is tailored to the context of a person’s life, and creates safety through culturally competence.
Embedding Cultural Safety and Humility into health services...

July 16, 2015: 5 regional health authorities, 2 provincial health authorities, + deputy minister for the BC Ministry of Health

DECLARATION of COMMITMENT

CREATE A CLIMATE FOR CHANGE
- Articulating the pressing need to ensure cultural safety within First Nations and Aboriginal health services in BC.
- Opening an honest and convincing dialogue with all stakeholders to show that change is necessary.
- Forming a coalition of influential leaders and role models who are committed to the priority of embedding cultural humility and safety in BC health services.
- Leading the creation of the vision for a culturally safe health system and developing a strategy to achieve the vision.
- Supporting the development of workplans and implementation through available resources.

ENGAGE & ENABLE STAKEHOLDERS
- Communicating the vision of culturally safe health system for First Nations and Aboriginal people in BC and the absolute need for commitment and understanding on behalf of all stakeholders, partners and clients.
- Openly and honestly addressing concerns and leading by example.
- Identifying and removing barriers to progress.
- Tracking, evaluating and visibly celebrating accomplishments.

IMPLEMENT
- Empowering health innovators, develop cultural humility.
- Allowing organizational address problems.
- Leading and enabling cultural humility at levels of the health system.
March 1, 2017
The BC Health Regulators signed the Declaration of Commitment – Cultural Safety and Humility in the regulation of health care professionals.

Declaring their commitment to integrating cultural safety and humility into their practices as health profession regulators.
“I can’t believe how often I refer patients to the Sacred Space.”

“Never mind him, he is probably just drunk!”

“What’s the problem? Our program treats everyone exactly the same!”

“I think it is essential to have Aboriginal perspectives here.”

“It has taken a lot of work, but the numbers of Aboriginal patients has increased dramatically!”

“I can’t believe how often I refer patients to the Sacred Space.”

“Training shouldn’t just be about Aboriginal people. Other people have experienced oppression too.”

“Never mind him, he is probably just drunk!”

“What’s the problem? Our program treats everyone exactly the same!”

“I think it is essential to have Aboriginal perspectives here.”

“It has taken a lot of work, but the numbers of Aboriginal patients has increased dramatically!”

“Training shouldn’t just be about Aboriginal people. Other people have experienced oppression too.”

Adapted from Terry Cross, 1988
Used with permission
A Spectrum of Approaches

Cultural Awareness

Cultural Sensitivity

Cultural Competency

A Safe & Equitable System

Knowledge Self-Awareness Skills

Interpersonal and Structural Interventions

Equitable & Culturally Safe Providers and Organizations

“the Other”

“the What”

“the How”

“the Goal”
Everyday Discrimination is positively associated with:

- **Coronary artery calcification** (Lewis et al., Psy Med, 2006)
- **C-reactive protein** (Lewis et al., Brain Beh Immunity, 2010)
- **Lower birth weight** (Earnshaw et al., Ann Beh Med, 2013)
- **Cognitive impairment** (Barnes et al., J Intl Neuro Psy Soc, 2012)
- **Poor sleep [objective & subjective]** (Lewis et al, Hlth Psy, 2012)
- **Visceral fat** (Lewis et al., Am J Epidemiology, 2011)

Credit: David Williams, PhD MPH (NAPCRG 2013)
“When I speak my truth and say ‘This is the way I’m feeling’ or ‘This is the symptom I’m feeling,’ I’m told that it’s different [than what I am experiencing] . . . . He [the doctor] told me . . . it was all in my head and it was ‘phantom pain.’ And he said it was a ‘post-traumatic disorder from [my] sexual abuse from when [I was] a young child.’ I’m sorry I can’t digest that, I can’t. And I’m having a hard time with it. I’m really angry right now.”

“I lost my children to doctors... because no one was believing how they got hurt, injured... [then] I lost my little children to the Ministry.”

Adapt your language

Instead of “battered woman”, “abuser”, “IDU”, “at-risk”, use “woman”, “man”, “people”

Instead of “she doesn’t want our help”, use “our help isn’t meeting her needs”

Instead of “Non-compliant patient”, use “unsuitable care”

Organizations can model non-stigmatizing language everywhere: from signage to EMR systems to how clients’ situations are discussed by staff.
Clinical interventions: Cautions

• The biomedical approach can amplify patient’s worries by dividing a person into multiple body systems with multiple pathologies and diagnoses, without providing a framework for understanding their complex suffering.

• The experience of trauma is subjective and stored in the “implicit memory”, often poorly understood and described through cognitive processes, with symptoms manifesting as emotional and sensori-motor responses; we often treat the response.

Levine, P., 2010: In an Unspoken voice; Ogden, P. 2006: Trauma and the Body
Clinical interventions: Cautions

• CULTURAL SAFETY is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health-care system. It results in an environment free of racism and discrimination, where people feel safe when receiving and making decisions about their health.

• Shifting focus that there’s something “inherently wrong with Indigenous peoples”, to awareness there’s something inherently wrong with the health-care system.
Mechanisms of Chronic Stress

“The brain is like velcro for the bad and teflon for the good”:

• Traumatic experiences and ongoing ‘toxic’ stress are overwhelming, perpetuating the chronic stress response.
• People get stuck in a reactive/survival mode, they are constantly fighting/fleeing/freezing – this prevents human connection and long term planning.
• Amygdala sends alarm messages to hypothalamus (triggering release of stress hormones: cortisol, adrenaline, NE) and to the ANS for a fight/flight/freeze response.
• Emotional reactions come from implicit memory not accessible by the executive centers or left brain – chronic stress/fear pattern is ready to be awakened by any trigger.

Mariah Moser 2015; Bessel Van der Kolk 2013; Badenoch 2008; Toomey & Ecker 2007
Symptoms of Un-Discharged Traumatic Stress

Cumulative Violence

Traumatic Event

Stuck on “On”

Anxiety, Panic, Hyperactivity
Exaggerated Startle
Inability to Relax, Restlessness
Hyper-vigilance, Digestive problems
Emotional flooding
Chronic pain, Sleeplessness
Hostility/rage

Stuck on “Off”

Depression, Flat affect
Lethargy, Deadness
Exhaustion, Chronic Fatigue
Disorientation
Disconnection, Dissociation
Complex syndromes, Pain
Low Blood Pressure
Poor digestion

Normal Range
POPULATION ATTRIBUTABLE RISK

A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.

ACE reduction reliably predicts a decrease in all of these conditions simultaneously.
Post-Traumatic Resilience

• ‘Resilience is the “capacity to be bent without breaking, and the capacity, once bent, to spring back” (Vaillant). Resilience is the relationship between risk, and protective factors that counteract that risk.

• **Resilience only exists in the present of risk.**

• Interventions should lower risk and strengthen protective factors; should be strengths-based, non-pathologizing, and address oppression directly.

• Aboriginal peoples have had to endure trauma, and at the same time were deprived of the tools of resiliency (beliefs, rituals and institutions) which help traumatized societies to reconstruct their identity.

Stout 2003: AHF Aboriginal People, Resilience & the Residential School (Chapter 2: Understanding Resilience)
Tousignant 2009: Resilience and Aboriginal Communities in Crisis;
Address Trauma as a Determinant of Health

“go away, you don’t matter”  “you belong, you matter”

1. Safety First
2. Normalize
3. Expect that health care will be a trigger
4. Directly address SDOH & structural violence

www.thischangedmypractice.com/trauma-as-a-determinant-of-health
Clinical Approaches: Safety First

1. Provide Safety as a top priority:
   - Counter physiological overwhelm;
   - Validate, actively build the relationship;
   - Find opportunities for choice/control, and identify strengths (notice not only vulnerability);
   - “Resist the righting reflex”
   - Work with boundaries, preferences and choice around health care decisions and visits.

Credit: Mariah Moser MA, Somatic Psychotherapist & Educator; 2009 BCCEWH Discussion Guide
Clinical Approaches: Normalize

2. Normalize emotions & symptoms:
   – Present time experiences may be associated with the past; refocus on present time (notice safety).
   – Implicit memories involve hypo OR hyper-arousal: helplessness, shame/depression/freeze; or fear/rage/anger/anxiety. (All survival responses!)
   – Expect decreased capacity to integrate/modulate physiological responses, limited communication & executive function. (Listen first; Set simple goals!)

Credit: Mariah Moser MA, Somatic Psychotherapist & Educator
Clinical Approaches: Anticipate feelings of threat

3. Expect that health care is an unsafe space:
   - Institutional & Colonial history; ongoing discrimination;
   - Illness involves uncertainty, vulnerability, navigating a maze of services, new relationships & environments;
   - A sense of ongoing threat and lack of safety is a normal response to trauma;
   - Work in the present time.

“[Residential schools and Indian hospitals] are rather like nodes in a larger web of incarceration, segregation, marginalization.”

- Maureen Lux
Clinical Approaches: History-taking & Action Plans

4. Ask about SDOH & structural violence:
   - We can’t separate past experiences of stress and overwhelm from present experiences;
   - Stressful, overwhelming experiences are cumulative;
   - *The problem is the environment, not the person*; help create greater safety in the environment and find strengths in the person;
   - Develop action plans in clinical visits to increase safety & supports.
<table>
<thead>
<tr>
<th>Patient Group</th>
<th>Ask</th>
<th>Educate</th>
<th>Intervene &amp; Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors</td>
<td>“Do you receive Old Age Security (OAS) and Guaranteed Income Supplement (GIS)?”</td>
<td>Individuals over age 65 who live in poverty should receive at least $1,200/month in income through OAS, GIS, and grants from filing a tax return.</td>
<td>Start with <a href="https://www.canada.ca/en/humanservices/financial-assistance.html">Canada Benefits</a> to identify and access income supports for patients and families. Use this in your office with patients and provide them with the link.</td>
</tr>
<tr>
<td>Families with Children</td>
<td>“Do you receive the Canada Child Benefit on the 20th of every month?”</td>
<td>Income supports can be obtained by applying for Canada Child Benefit when filing income tax returns. Eligible families can receive up to $6,400/year for each eligible child under the age of six, and $5,400/year for each eligible child aged 6 to 17. Families may be eligible for additional benefits through certain provincial programs.</td>
<td></td>
</tr>
<tr>
<td>Indigenous peoples (First Nations, Inuit, Metis)</td>
<td>“Are you registered under the Indian Act or recognized by an Inuit Land Claim organization?”</td>
<td>Indigenous peoples registered under the Indian Act or recognized by the Inuit Land Claim organization can qualify for <a href="https://www.insuredhealthbenefits.ca/">Non-insured Health Benefits (NIHB)</a>, which pays for drugs and extended health benefits not covered by provincial plans.</td>
<td></td>
</tr>
</tbody>
</table>
| Social Assistance Recipients | “Have you applied for extra income supplements?”                                            | Additional benefits available include: transportation, medical supplies, diet supplements, employment supports, drug & dental, vision, hearing, women’s transition housing and supports, Advanced Age Allowance, community participation, and other discretionary benefits. | Speak with patients’ social services workers.  
- Apply for [Income Assistance](https://www.canada.ca/en/humanservices/financial-assistance.html)                                                                 |
| People with Disabilities     | “Do you receive payments for disability?”                                                  | Major disability programs available: CPP Disability, EI Sickness, Disability Tax Credit (DTC), WorkSafe BC, Veterans Benefits, Registered Disability Savings Plan (RDSP).  
DTC can provide up to ~$1,800/year in tax savings (plus retroactive payments) and it is required to receive other benefits including the RDSP, which provides up to $20,000 in grants. | Use a detailed social and medical history to determine the programs to which you can connect your patients.  
Complete forms such as:  
- Canada Revenue Agency [Form T2201](https://www.canada.ca/en/cra-arc/services/forms.html)                                                                 |

Centre for Effective Practice BC Poverty tool: [www.thewellhealth.ca/poverty](https://www.thewellhealth.ca/poverty)
“What good does it do to treat people’s illness and then send them back to the conditions that made them sick?”

Questions & Contact:

vanessa.brcic@ubc.ca

jmorgan6@cw.bc.ca
Thank you for joining the webinar!

Please visit www.b4stage4.ca to access a recording of today’s webinar and learn more about how you can #GetLoud for better mental health in BC.