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Trauma-Informed Care (TIC) in Recreational Sport Programmes for Female Refugees

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Sports Equity Lab

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Our Work:

This project has been completed as part of the broader work that is carried out at the Sport, Human Rights & Safeguarding, Canterbury Christ Church University.

The aim of the research group is to produce translational work that improves policies and practices in sport, health and social care.

The SHRS Scope

The SHRS Research Group has experience in:

- Asia
- Canada
- Europe
- Latin America
- United States

USA · UK · Canada · Greece · Mexico · Uganda · Colombia

Mission

Foster social justice, decency, and equity within the realm of sports. Through research, community engagement, and creative content, create opportunities for all individuals, irrespective of race, gender, socioeconomic status, or any other form of marginalization.

Anchoring Question

How can we make sports and movement **feel like home** for equity-deserving athletes*?

Leadership

Dr Yetsa Tuakli-Wosornu
Founder and Chair

Associate Professor at Yale, Sports Medicine physician, and former Ghanaian national team long jumper (her 1st love). Global sports equity consultant, author, and expert. Lives in Accra, Ghana.

Dr Edwin Moses OLY
Vice Chair

Global sports icon. Olympic gold and world record holder x 4. Hand-picked by Nelson Mandela to lead Laureus Sport for Good. Member of the IOC Athletes' and Ethics Commissions as well as USADA. Lives in Atlanta, USA.

Dr Katharina Grimm
Director

Medical Lead at FIFA. Over 16 years of leadership in international sports, research, and health organizations. Lives in Switzerland, South Africa, and wherever the next World Cup takes place.

Sarah Klein Esq
Director

Global attorney who exclusively represents survivors of sexual abuse. Former competitive gymnast, leading voice on sexual abuse and other legal issues on TV, radio, and in print media. Lives in Philadelphia, USA.

Loren Seagrave
Director

Most renowned speed and conditioning coach in the world. Focuses in human performance optimization. Consultant to Olympic and World Championship medalists, NBA, NBL, FIFA, NFL teams. Yetsa's coach. Lives in Shanghai, China.

SPORTS EQUITY™ Lab

Cross- & Trans-Disciplinary Research

- Integrity & intersections of types of violence
- Governance, policy & politics
- Legal frameworks / challenges
- Sociology: issues of power, definitions
- Psychology (psychological safety and wellbeing)
- Child-first, rights-based coaching
- Trauma-informed Pedagogy
- Disability

Diverse Beneficiaries

- Children and young athletes in Uganda

- Female athletes in Colombia

- Female refugees in Greece

- Women of ethnic minorities in Malaysia

- Athletes and coaches in Canada, UK

- Global reach

The power of sport for equity-deserving communities

Beneficial tool for promoting physical and mental well-being among individuals, regardless of their background

A valuable avenue to reach out to equity-deserving communities.

Sexual violence (SV) and female refugees

- Sexual violence (SV) is a pervasive issue that affects numerous individuals, including female refugees who have been exposed to traumatic events in their home countries.

- Across Europe, where a significant number of refugees seek asylum, the prevention of SV revictimization is of utmost importance.

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Aim

This paper aims to present a case study of a sports recreational programme for female refugees in Greece that unpacks what trauma-sensitive practices can be beneficial in this context.

Key focus

This work aims to explore the role of trauma-informed care in sports to **prevent revictimization and promote healing among female refugees.**

Learning objectives

Recognise	Recognise how TIC can be applied, and be beneficial, to sport recreational programs for female refugees or any youth with adverse childhood experiences (ACEs).
Develop	Develop better understanding of the intersections between organisations and sectors of health, social care and sport.
Be equipped	Be equipped with a set of 'how to implement' guidance for sharing with the relevant stakeholders.

Methods

Interviews with sport participants, coaches, administrators (n=4)
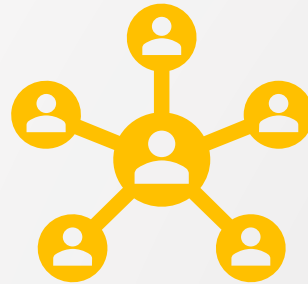
Focus group sport participants, coaches, administrators (n=1)

Observation

(training, game)

Trauma-Informed Care

TRAUMA-INFORMED

CULTURAL AND HISTORICAL CONTEXT

RELATIONSHIPS MATTER

REALISE PREVALENCE

RECOGNISE IMPACT

RESIST RETRAUMATISATION

RESPOND

RESPECT RESILIENCE

GENDER

POLICIES, SYSTEMS, ENVIRONMENTS AND PEOPLE

Choice

Collaboration

Empowerment

Trust

Safety

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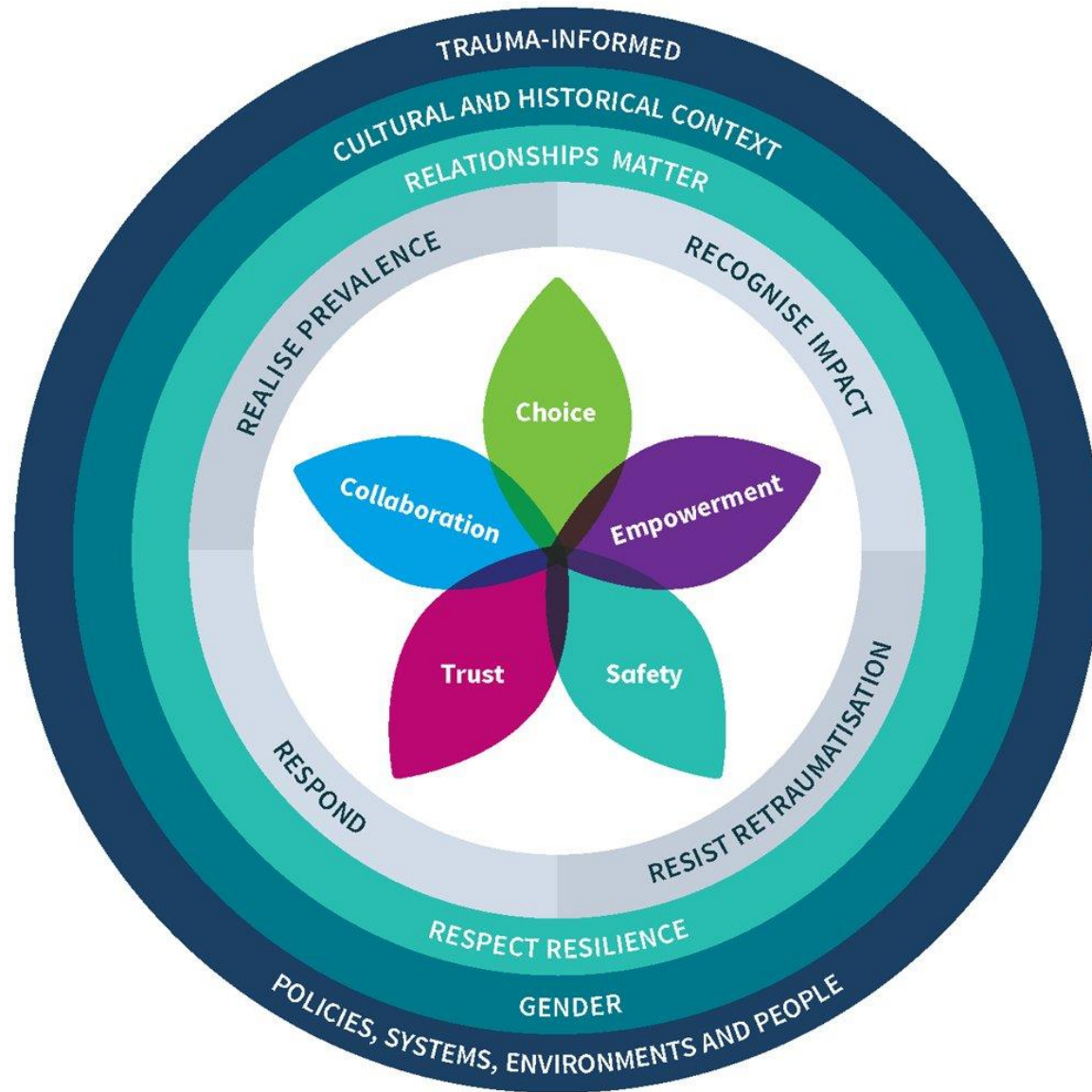
Positive lived experiences

- Empowerment
- Physical and mental wellbeing
- Social support
- Coping skills

Voices

"I have very bad memories from my home country…had experiences of sexual and physical abuse, and of neglect. After coming here, I joined the sports team and that was it. I felt so empowered to follow my dreams and have done so many of them already". (Athlete 1)

The negative abusive experiences had demoralised me but after joining the team I could 'keep going' towards building new and positive experiences. (Athlete 1)

"We all come here to play together…we share so many similar experiences…this makes us feel connected with each other". (Athlete 1)

"The training programs make them feel active and helps them to escape from any problems of their everyday life".

(Coach)

" I am also getting stronger through playing and coaching sport".

(Coach)

"The team is "a group of friends" that is my main social network of support away from her home country.

(Athlete 2)

"What those girls have gone through is tough, but sport equips them with skills to get tougher and more resilient".

(Senior administrator)

Key gaps of TIC for female refugees participating in sport

- Lack of awareness and training

- Limited access to mental health services

- Language and cultural barriers

- Lack of gender-specific approaches

"There is no specific trauma-informed practice training among coaches or other personnel working with the female refugees. Many of our coaches are refugees and they are aware of how to deal with individuals with trauma because they have also lived it themselves. But it would help if some special trauma-informed practice awareness was raised, some kind of training". (Senior administrator)

"Those girls have experienced all sorts of trauma…it is not easy to build a trustworthy relationship with them. You need to know how to do it…for me I think it helped that I had felt I was not human when I was back in the country I was born – which I cannot call 'home'. I had really felt I was not human. Had to work on myself to feel human when I sought refuge here. Coaching them was a healing process as much as for me as for them. But it can go wrong with the wrong people". (Coach)

ROAD MAP TO TRAUMA INFORMED CARE (TIC)
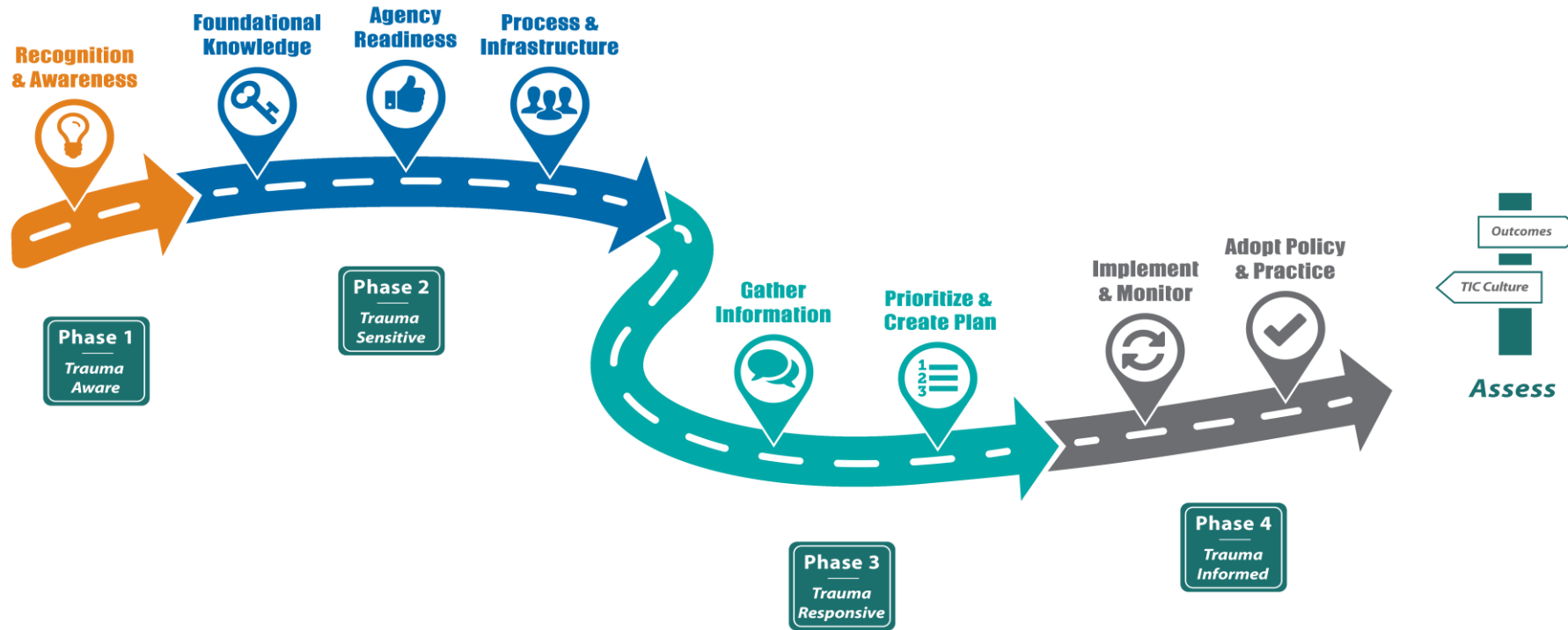
Trauma-informed Oregon, 2024

THANK YOU

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Striving Out of Restraints

Second-phase Mental Health Service Transformation in Lambeth

Nozomi Akanuma   Guy Swindle   Robert Horton

NHS
South East London

Lambeth

South London and Maudsley **NHS**
NHS Foundation Trust

CERTITUDE.
LONDON
FOR THE
LIFE YOU
WANT

Living Well
Network
Alliance

ThamesReach

healthwatch
Lambeth

Lambeth
Black
Thrive

Our Vision

We will provide the context within which every citizen, whatever their abilities or disabilities, can flourish, contribute to society and lead the life they want to lead.

3 Big Outcomes

1. to recover and stay well

Recovery

2. to make their own choices

Control

3. to participate on an equal footing in daily life

CAN DO
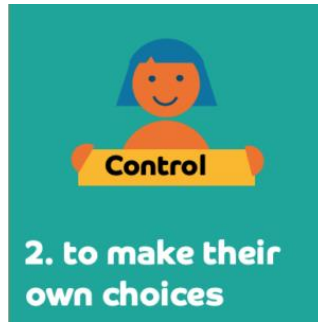
6 Principles

- Collective responsibility

- To make decisions on a "best for people using services" basis

- To commit to unanimous, principle and value- based decision making on all key issues

- To adopt a culture of "no fault, no blame"

- To adopt open book accounting and transparency in all matters

- To appoint and select key roles on a best person basis

Living Well Network Alliance

Population 332.250
Area 27.5 km²

Lambeth Together

Delivery Alliances
Living Well Network
Neighbourhood and Wellbeing
Children and Young People

Programmes
Homeless Health
Staying Healthy
Learning Disabilities and Autism
Substance Misuse
Sexual Health

41 GP practices forming 3 PCNs
2 Acute Trusts – GSTT and KCH
1 Mental Health Trust - SLaM

Lambeth

Findings

332,250	70,000	Densely populated	A young population	Population growth slowing
people living in Lambeth	difference resident and GP populations			
ONS, 2018-based subnational population projections, 2022	ONS population vs registered resident GP	Twice as densely populated as London	42% of residents aged 20 to 39 years	2% increase in the population over the next 10 years
An aging population	**Fewer children**	**Reducing birth rate**	**3,542 live births**	**1,774 deaths**
30% increase in the 60+ population next 10 years	8% decrease in the under 15 population next 10 years	30% reduction in births over the last 10 years	8% reduction in births between 2019 and 2020	26% increase in deaths between 2019 and 2020
A mobile population	**A diverse population**	**Young and old most diverse**	**Large LGBTQI+ communities**	**Other groups** socially excluded, multiple risk factors, and experience stigma and discrimination
21% of the population changes each year	60% of the population non-White British ethnicity	80% of 10 to 19 years from a non-White British ethnicity	Estimated 11.4% of Lambeth population identify as LGB	
Food insecurity	**A deprived borough**	**Black** community more likely to live in the most deprived areas	**2 in 5 children income poverty**	**Significantly higher crime**
At least 7% of households suffer food insecurity	70% residents live in 40% most deprived areas nationally	Third of people living most deprived areas Black ethnicity	39% of children income poverty after housing costs	33,575 offences in Lambeth

The Living Well Network

HUB

WELCOME

LWN Provider Alliance Group

North Lambeth pilot **2013**

Whole borough **2015**

Living Well Network Alliance

2010

2013

2015

2018

2019

2024

Voluntary Sector Providers

Primary Care

Clinicians

Public Health

Carers

Social Care

The COLLABORATIVE

People Who Use Services

Mental Health Trust

Commissioners
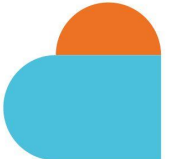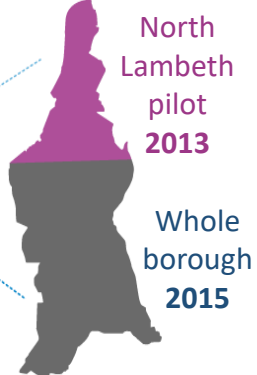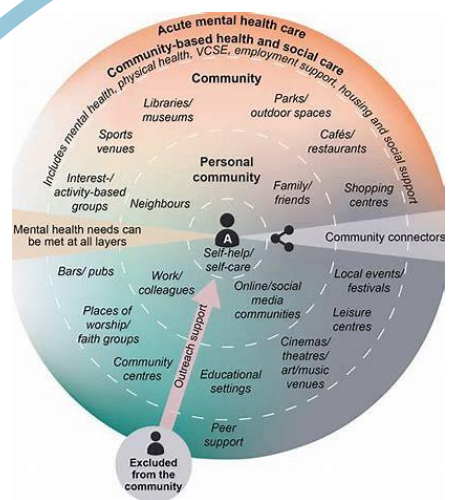
ipsa
Integrated Personalised Support Alliance
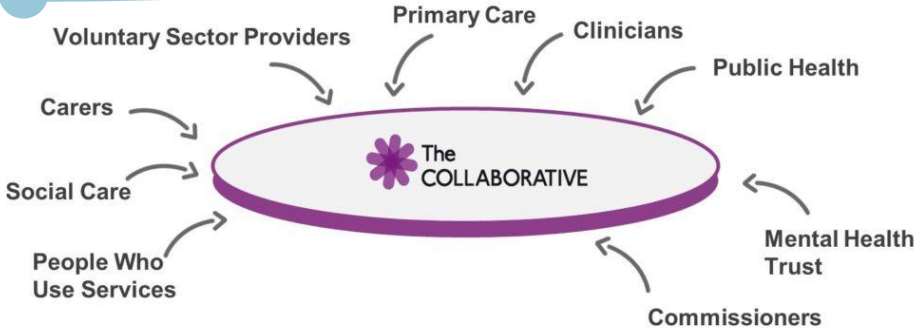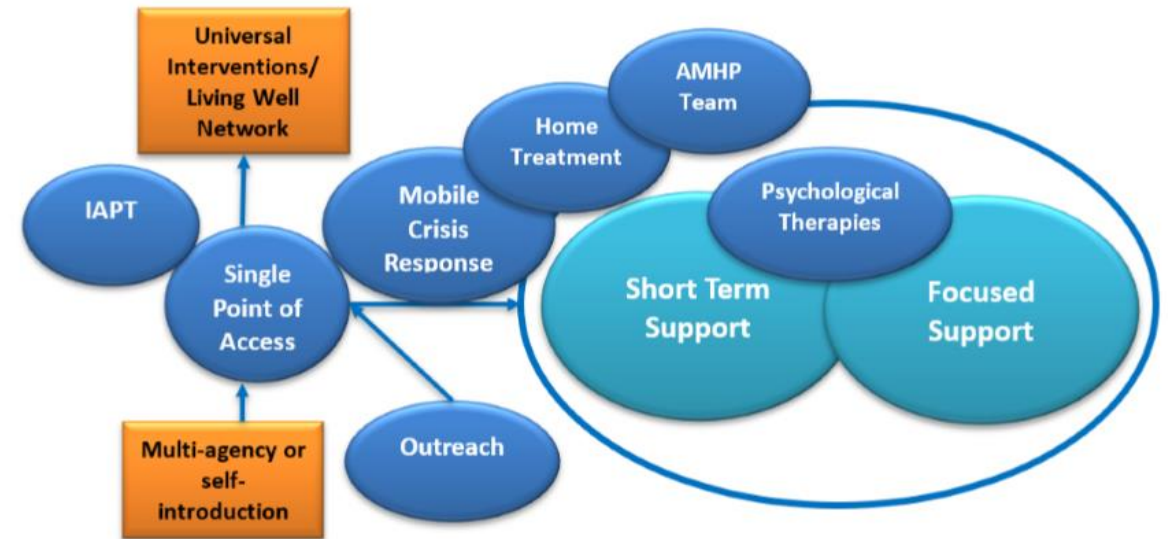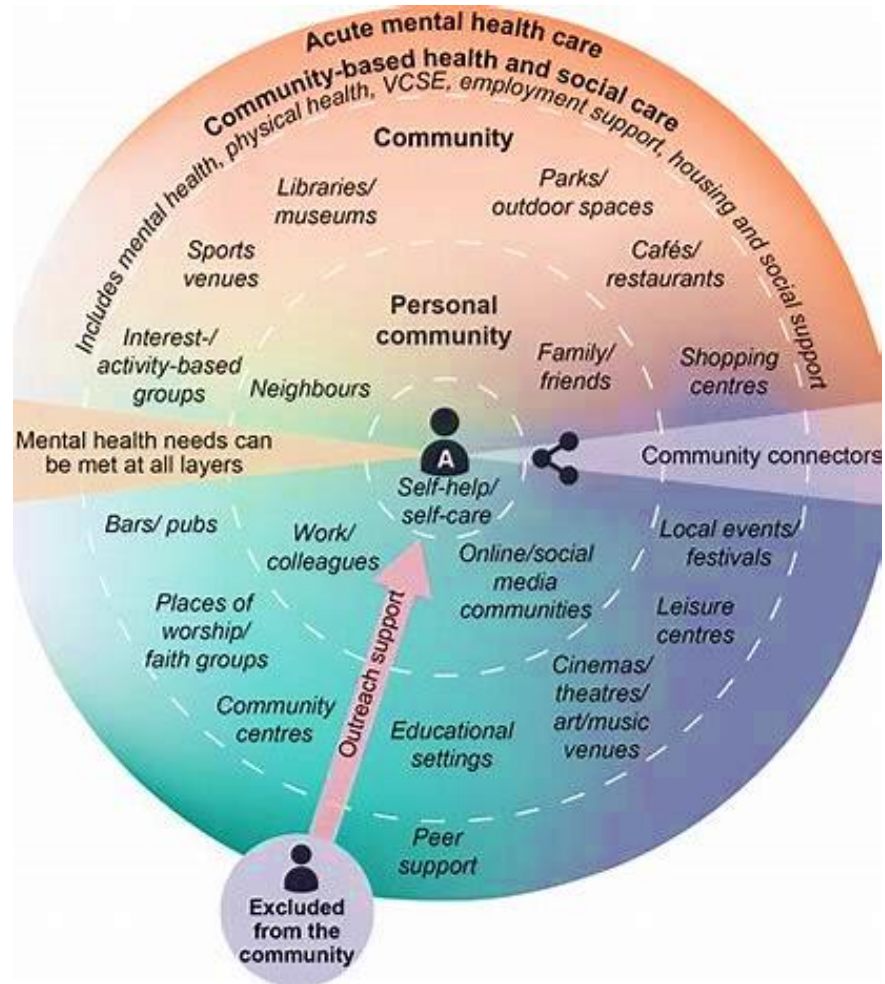
Change projects

- CLaSS (Community Living and Support Service)

- Staying Well

- PCAN (Primary Care And living well centre Network meeting)

- CAPSA (Culturally Appropriate Peer Support Advocacy)

Where we are now

Mainstreamed since 2022, taking a central role of flow and discharge coordination.

Budget £470K (2023/4), staffing 9 WTE

The service model is disseminated as an agile, solution-focussed and integrated team approach.

Problems

People stay in hospital even after they become clinically ready for discharge (CRfD).

Hospital discharge teams are led by clinicians when most discharge barriers are not clinical.

CLaSS

Improvement process

A team was formed in spring 2020 and a 12-month pilot started in April 2021.

A 12-month evaluation showed increase in successful discharge and a reduction of aLoS.

"CLaSS has been the best example of a discharge team that I have ever seen in the past 30 years" – consultant psychiatrist

What good looks like

An expert hospital discharge team proactively removes discharge barriers alongside clinical teams.

The average length of stay (aLoS) and the number of people who are CRfD decrease.

Where we are now

Mainstreamed since autumn 2023 – currently supporting 76 people.

Budget £155K (2023/4), staffing 4 WTE

The team accept people from a wider range of services with more diverse needs.

Problems

People cannot go back to the primary care as no support as long-term clinical and/or practical care needs is available.

People deteriorate in their mental state when support is not swiftly arranged.

Staying Well

Improvement process

A 12-month pilot started in February 2020.

30 people with long-term low intensity care needs returned to the primary care and only 1 person could not stay.

Administrative and governance processes were optimised.

What good looks like

Low-intensity mental health and practical support is easily accessible in the primary care.

More people can go back to and stay in the primary care successfully; less people return to the secondary care due to lack of support.

Where we are now

All 9 PCNs now have regular PCAN meetings by month 6 of the pilot.

Incorporated with primary care based mental health practitioners in 7 PCNs.

30% SPA referrals were aborted, and positive experiences were reported by most.

Problems

People need to be referred via Single Point of Access (SPA) for secondary care input and wait for triage assessment.

"Inappropriate" referrals and discharges happen between primary and secondary care as no joint problem solving.

PCAN

Improvement process

A 12-month pilot with 2 PCNs in 2021 showed 11% reduction in SPA referrals and improved satisfaction among practitioners.

Following a further 2-year pilot to develop sustainable models, a 12-month whole-borough pilot started in May 2023.

What good looks like

Primary Care Networks (PCNs) and secondary care teams have regular meetings to discuss shared care and solve problems together.

Fewer inappropriate referrals are made to SPA and fewer inappropriate discharges are made to GPs.

Where we are now

The service is now mainstreamed with future options of tendering.

Budget 280K, staffing 6 WTE

The model is disseminated nationally.

Problems

Health inequalities continue – access, restrictive practice, choices.

Lack of staff's awareness of cultural needs result in unsatisfactory quality and safety of care offered and its effectiveness.

CAPSA

Improvement process

A 12-month pilot started in 2021, which was extended for further 2 years.

"I've learnt that this process hasn't been tokenistic…" – a working group member

The final year pilot offered activities, advocacy and co-facilitation of groups and staff training consistently.

What good looks like

More people access peer advocacy in line with their cultural identify.

People have more choices to attend culturally appropriate activities.

Staff have better understanding of cultural needs.

Takeaway messages

- We need different people and ideas to get different results.
- The ability to test ideas quickly is crucial to create change in a risk averse system.
- Small teams with new approaches can have a significant impact.
- Conflict and disruption are necessary for innovation and improvement.
- Co-production and co-creation help focus us to stay focussed.
- Data, data, data
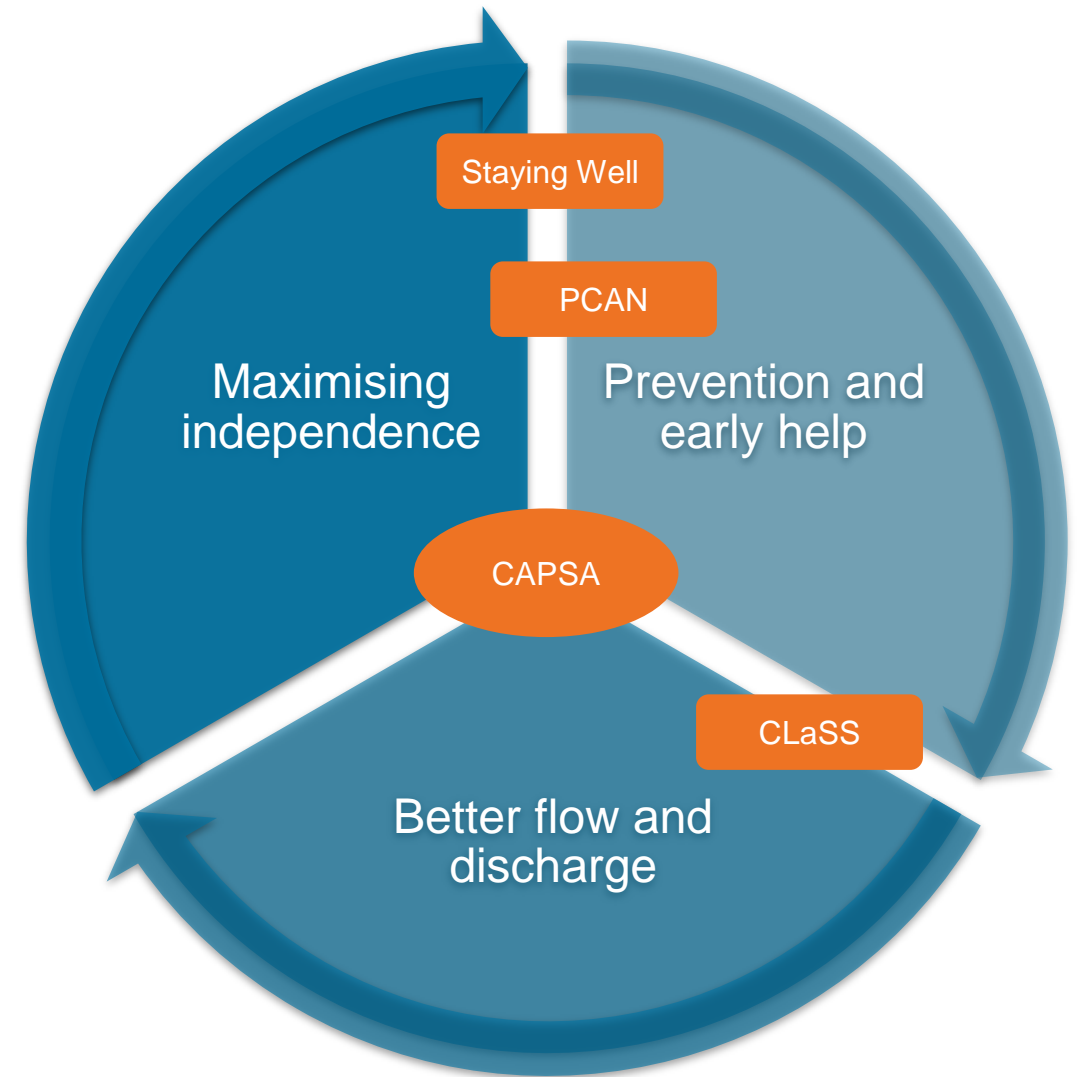
Innovation Circle
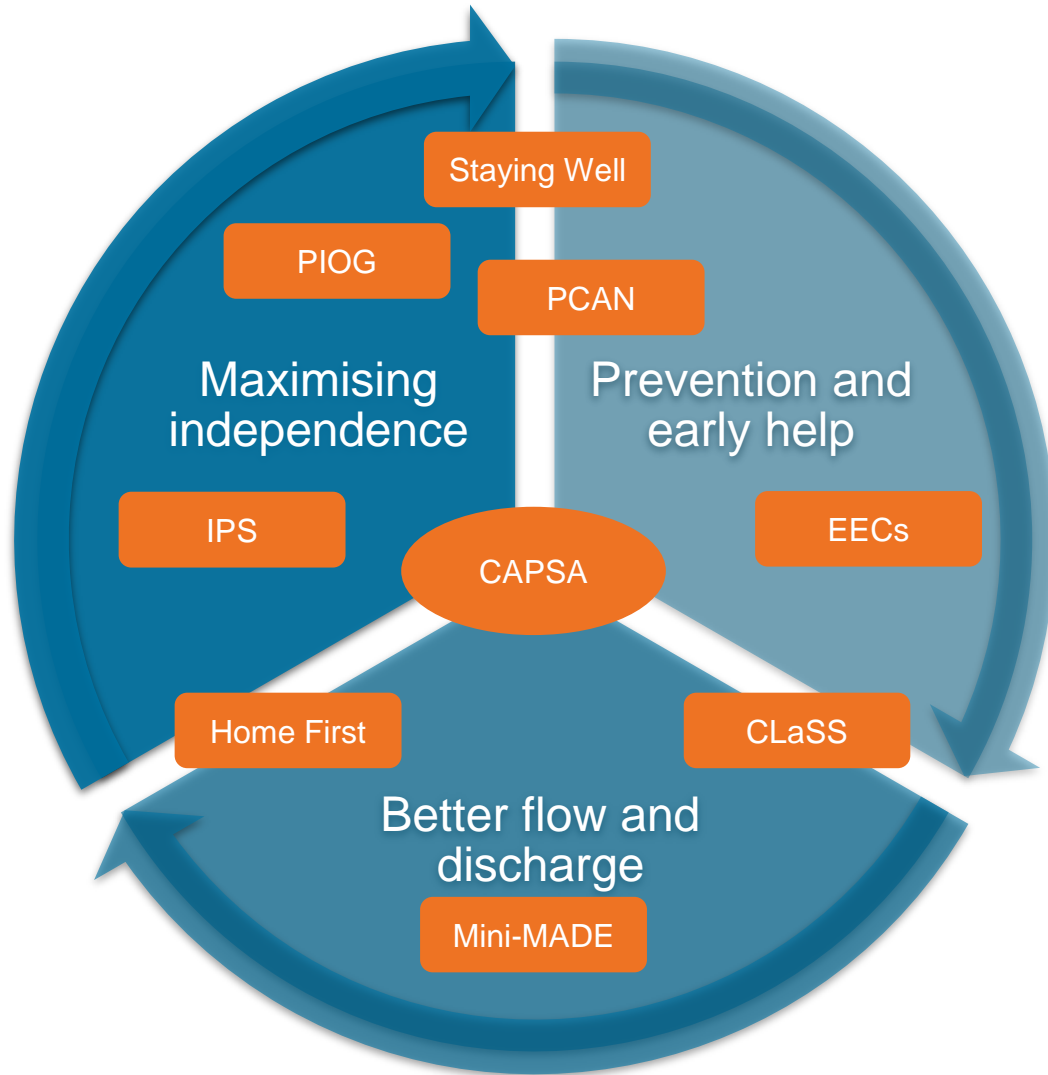
PCAN	Primary Care Alliance Network – fortnightly meetings between Alliance and PCN colleagues to support more people in their homes and communities
Staying Well	A small VCSE-led team, working with Alliance and Primary Care to support more people in their homes and communities
EECs	Emotional Emancipation Circles – culturally based groups to address discrimination and build confidence
CAPSA	Culturally Appropriate Peer Support and Advocacy – co-produced and co-delivered by Black people for Black people
CLaSS	Community Liaison and Support Service – a practical team to maximise flow and discharge in acute beds
Mini-MADE	Multi-Agency Discharge Event – twice-weekly meeting of Alliance partners to maximise flow and discharge
PIOG	Promoting Independence Oversight Group – ensures appropriate support at best value, already delivered £2.8m savings
IPS	Individual Placement and Support – employment support for those with serious mental illness, with 67 job starts since July 2022
Home First	A new way of working to encourage discharge to home from an acute bed rather than to supported accommodation

Disclosure Statement

I make the following declaration in relation to this presentation:

- There is NO Conflict of Interest
- There is no bias, either commercial or non-commercial
- There is no plagiarism or copyright infringement
- I was not paid to give this talk, and no one paid me for advice.
- I am presenting on programmatic work, therefore, it is not funded research
- My employer, Institute for Healthcare Improvement (IHI) paid all necessary expenses for me to attend the conferences. The organizers of this conference paid for my 2-day registration fee.

Learning Objectives

At the end of this session, participants will be able to

- Describe the use of universal Tuberculosis (TB) testing of a targeted group of patients to identify more TB cases during the COVID-19 pandemic and beyond

- Understand the modified Quality Improvement (QI) approach known as " Sprint or just enough QI concept" used for this work

- Explore the virtual platforms used for real-time learning, coaching and sharing.

- Describe the project design used to promote scale-up and spread

The Major Public Health Concern

In South Africa, TB is the number one cause of death, accounting for 7% of all deaths. Gaps in diagnosis, treatment, and care continuity for patients with TB contribute to high rates of TB-related mortality.

Global TB Report, WHO, 2022
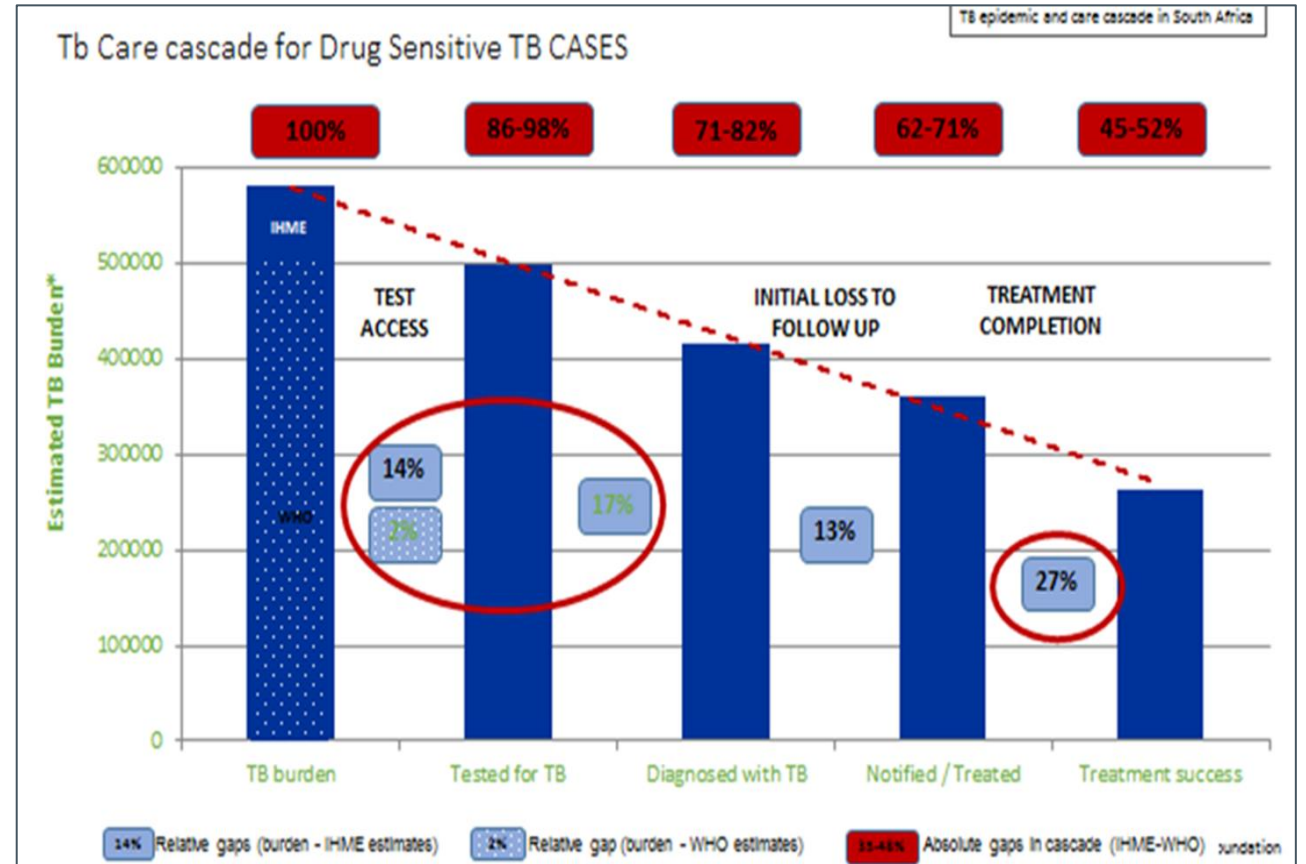
The Challenges that Hindered the Improvement Efforts

- KwaZulu Natal (KZN) Province has the most TB cases and deaths caused by TB
- COVID-19 pandemic made the situation worse
  - Major decrease in TB case-finding
  - Limited patient mobility due to in-country-imposed lockdown
  - Face-to-face meetings for quality Improvement technical support was limited/not possible
- The initial quality improvement project was ending in four months (later extended by 18 months)
- There was a need for a modified approach to tackle these challenges
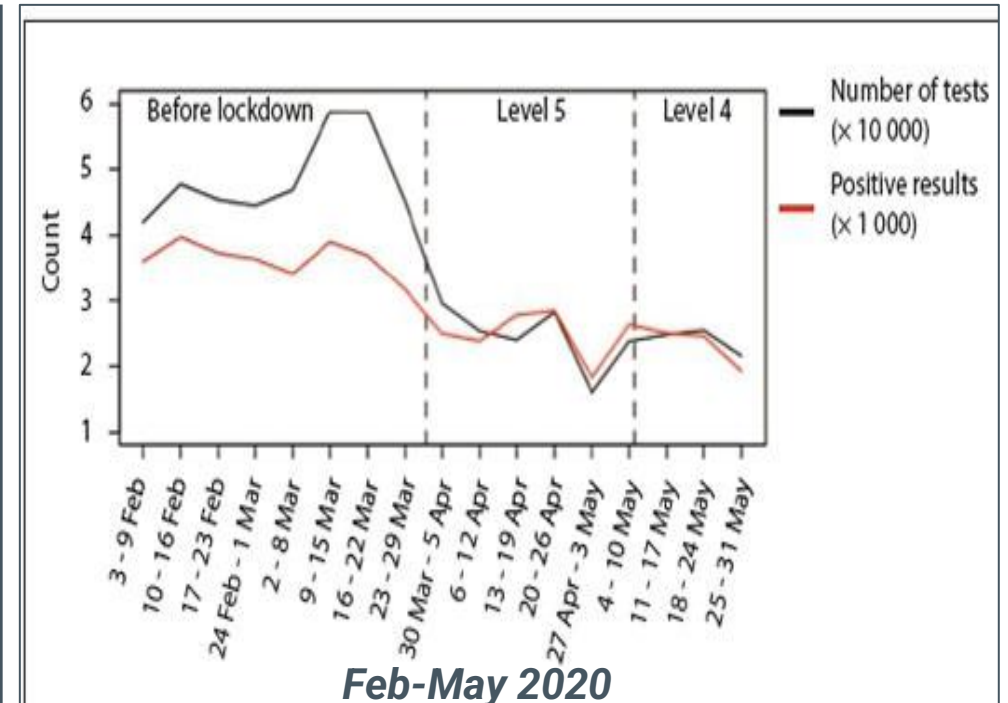
Feb-May 2020

Number of TB tests (x 10 000) and number TB positive (x 1000) at the start of the COVID-19 lockdown in South Africa (Feb-May 2020)

The Initial Quality Improvement Initiative (2017-2020)

- Aimed to contribute towards 2022 National TB Plan's goals
  - 50% reduction in TB deaths
  - 30% reduction in TB incidence
- Using QI methods to close gaps in the entire TB cascade
  - Learning/Innovation phase: 5 districts, 50 facilities (over 4 provinces)
  - Adaptation Phase: 5 district, 5 sub-districts, 94 sites
  - Scale-up phase: 5 districts, 20 sub-districts, 233 sites
  - **Total Sites: 377**
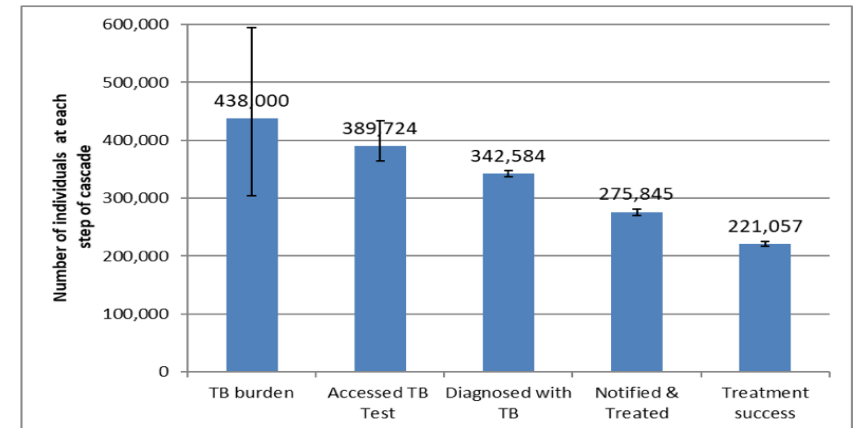
Ref: Pren Naidoo

National TBQI Project Summary

Phase 0: Set-up

Phase 1A: Learning Phase - targeted support to 5 SDs, **50 sites**

Phase 1B: Adaptation Phase - across 5 full Ds (22 SDs) using change package, **94 sites**

Phase 2A: Scale-up Phase – **233 sites**

Phase 2B: KZN Sprint

| Launch May 2017 | February 2019 | January 2020 | March 2020 | December 2020 | June 2022 |
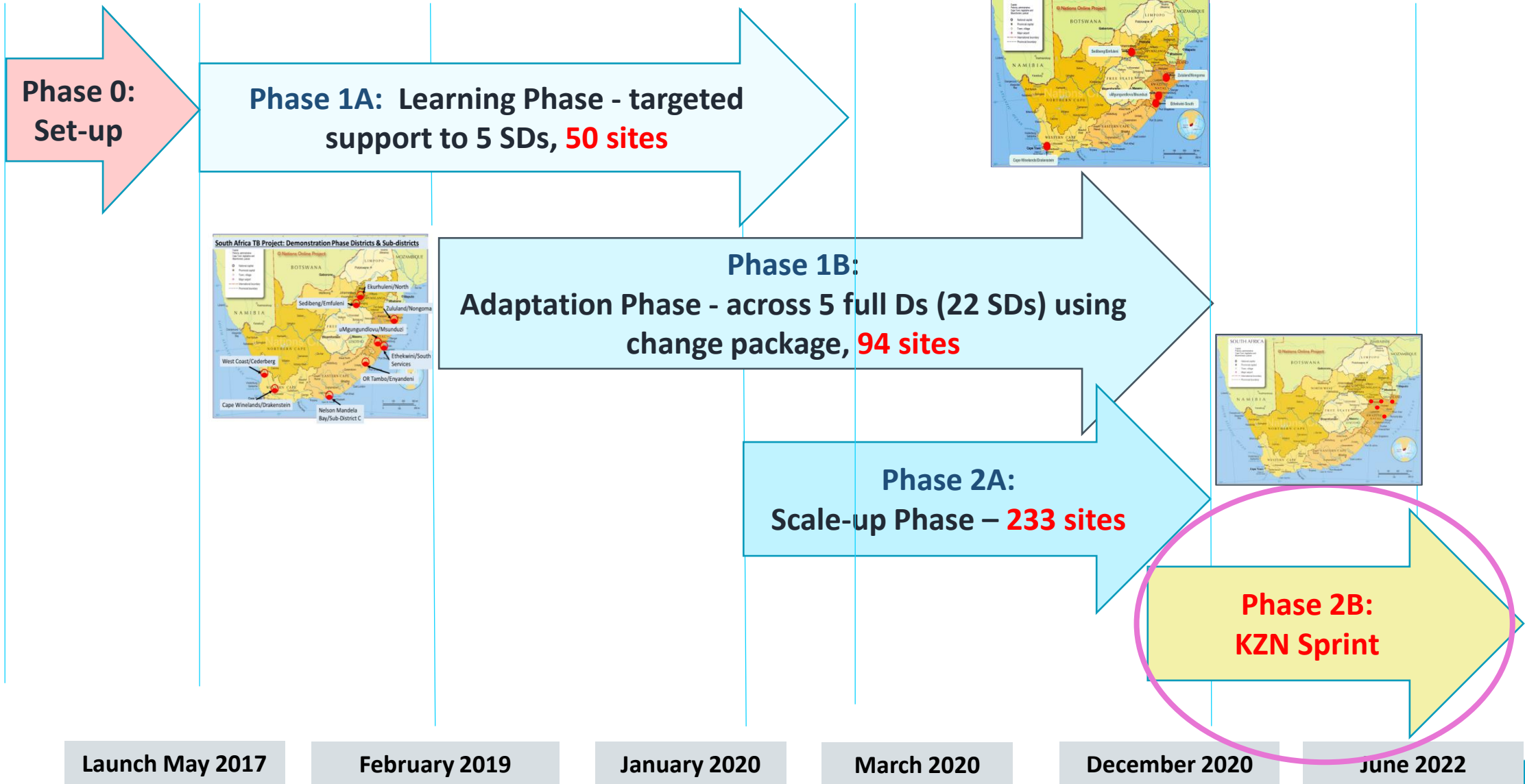
Initial QI Initiative: Development of a Change Package

Classical Breakthrough Series model
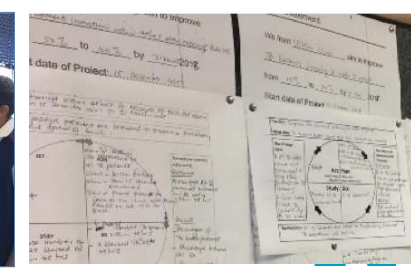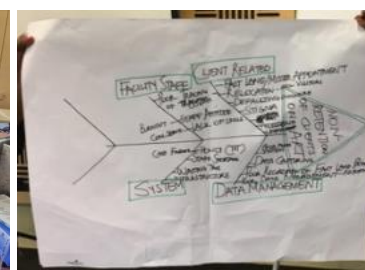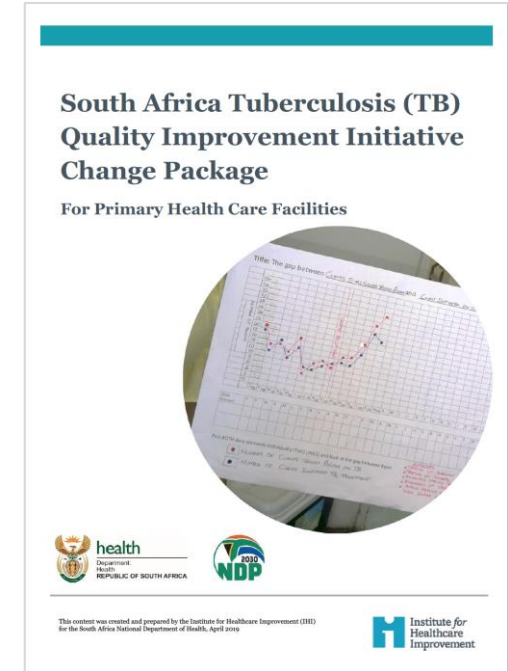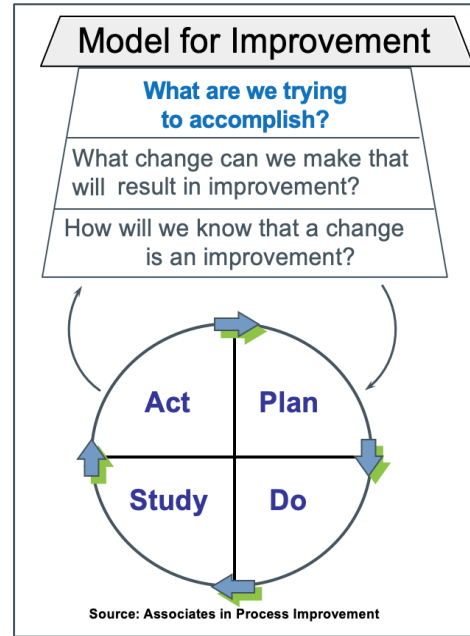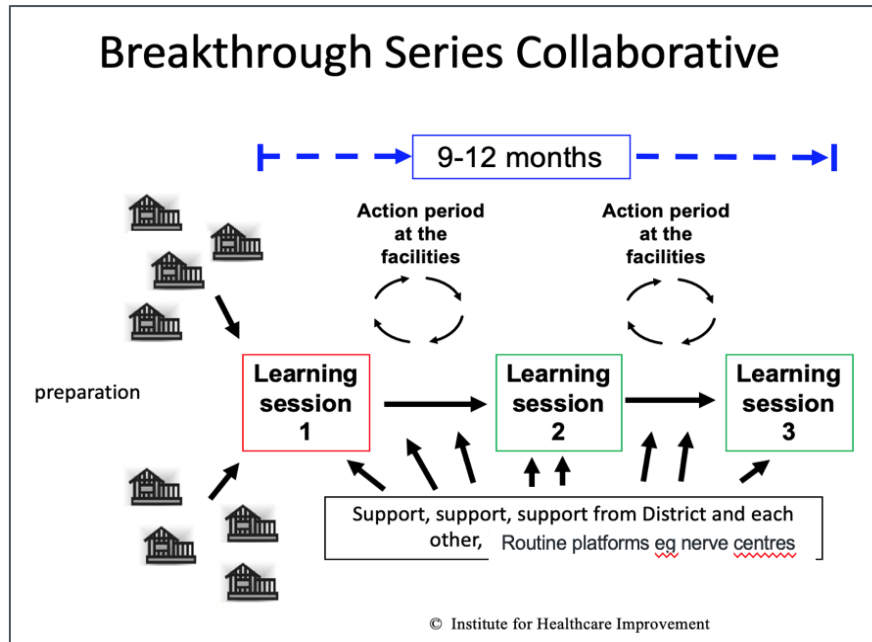
What we learned: Initial Phase Conclusions

- Classical QI worked very well in the innovation phase to
  - uncover process gaps and develop ideas for change

- Classical method was challenging for spreading and sustainability due to huge number of sites and COVID-19

- Access to TB testing was *only* through symptom screening (national TB guideline) and missed asymptomatic TB patients

- Targeted Universal Test and Treat (TUTT) study & prevalence survey – showed the importance to address the issue of the asymptomatic TB patients' group

- COVID-19 posed a huge challenge and risked all efforts and improvements made

The Development of A Modified Quality Improvement Approach

- A response to COVID-19 pandemic

- This new model was called "SPRINT" – to convey urgency

- Tested in five districts in KZN Province
  - Comprising four QI-naive districts and one district from initial QI project
  - It had 23 sub-districts and over 100 facilities

Sprint districts in KZN
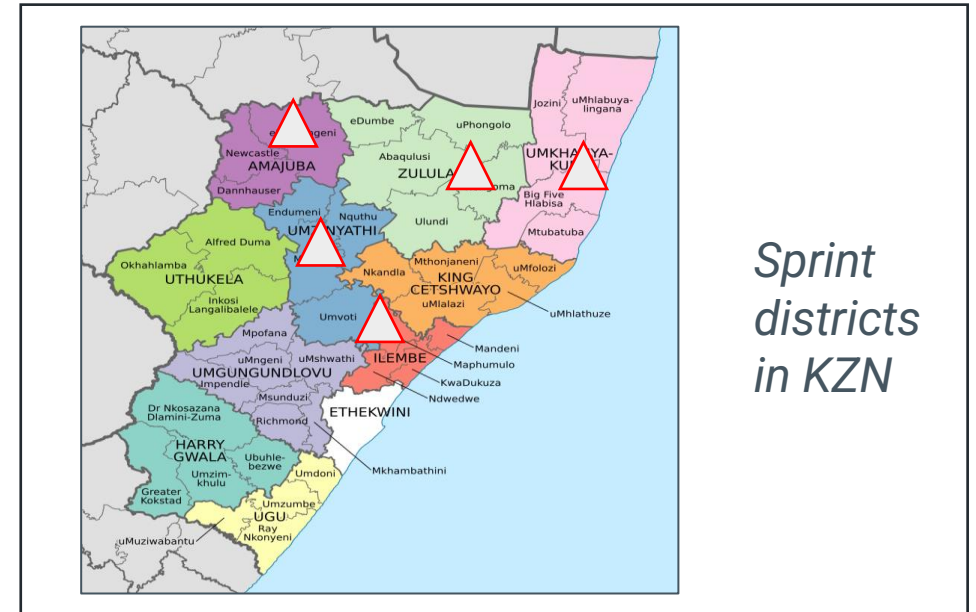
Aims For the Modified QI Approach

1. To restore TB case-finding to pre-COVID-19 baseline levels in a subgroup of facilities within 12 months; and
2. Establish local capability to scale the improvements across the districts within 12 to 18 months.

Content Theory: Use of Two Key Change Concepts

1. **Focus case-finding on HIV-positive patients attending health facilities irrespective of symptom status.**

- High rates of asymptomatic TB patients (58%) (Prevalence Survey).

- HIV patients at highest risk (60%) for TB

The targeted three HIV-positive groups:

1. All HIV-positive Antenatal clients at their first antenatal visit **(HIV ANC 1st visit group)**
2. All clients newly diagnosed with HIV **(HIV New group)**
3. All clients on antiretroviral therapy (ART) at their **annual viral load visit (VL Visit group)**

Figure 10 Symptoms and/or abnormal CXR among survey cases, N = 234
*CXR was not done because the participant declined to consent, or was pregnant, or had disabilities that made it impossible to take the CXR, or was bedridden and not able to attend the screening site.
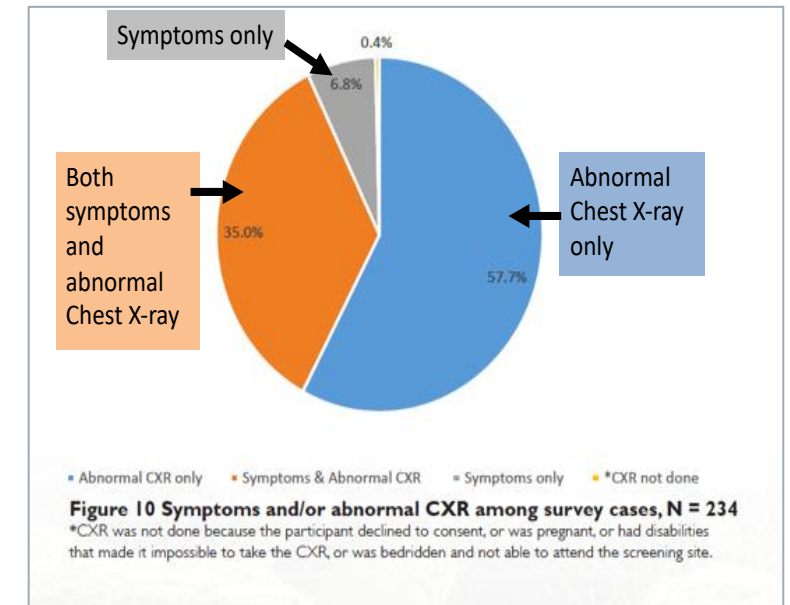
Adapted from the First National TB Prevalence Survey, South Africa 2018. Short Report

Content Theory: Use of Two Key Change Concepts

2. Double Sputum collection for sputum culture in HIV-positive patients

- Collected two sputum specimens at the first visit

- Reserved one specimen in the refrigerator at the facility for
  - culture if GeneXpert (GXP) results returned negative
  - Acid-fast bacilli (AFB) if GXP positive

Execution Theory – Adapted Breakthrough Series (Collabs)

Main Adaptations

- Increased frequency of Learning Sessions
- Designed eight worksheets for implementation at the facilities (QI theory implicit rather than explicit)
- Mixture of face-to-face and virtual support
- WhatsApp platform for group of facilities in each district
  - Analysis of worksheet data posted on WhatsApp groups

Breakthrough Series Collaborative

9-12 months

Action period at the facilities

Action period at the facilities

preparation

Learning session 1

Learning session 2

Learning session 3

Support, support, support from District and each other, WhatsApp, nerve centres

© Institute for Healthcare Improvement
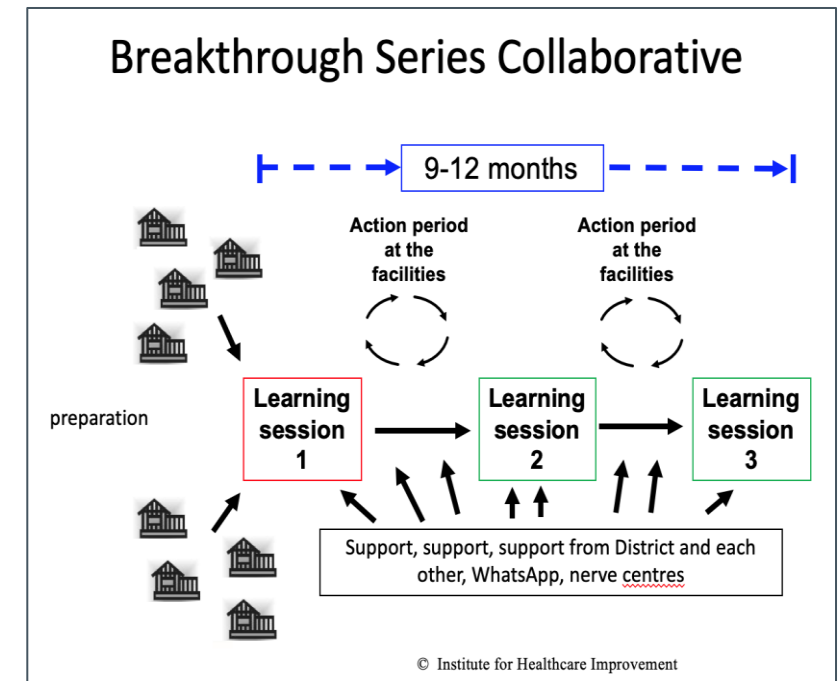
Execution Theory –work done through existing structures

1. Training and coaching of DoH managers as change agents:
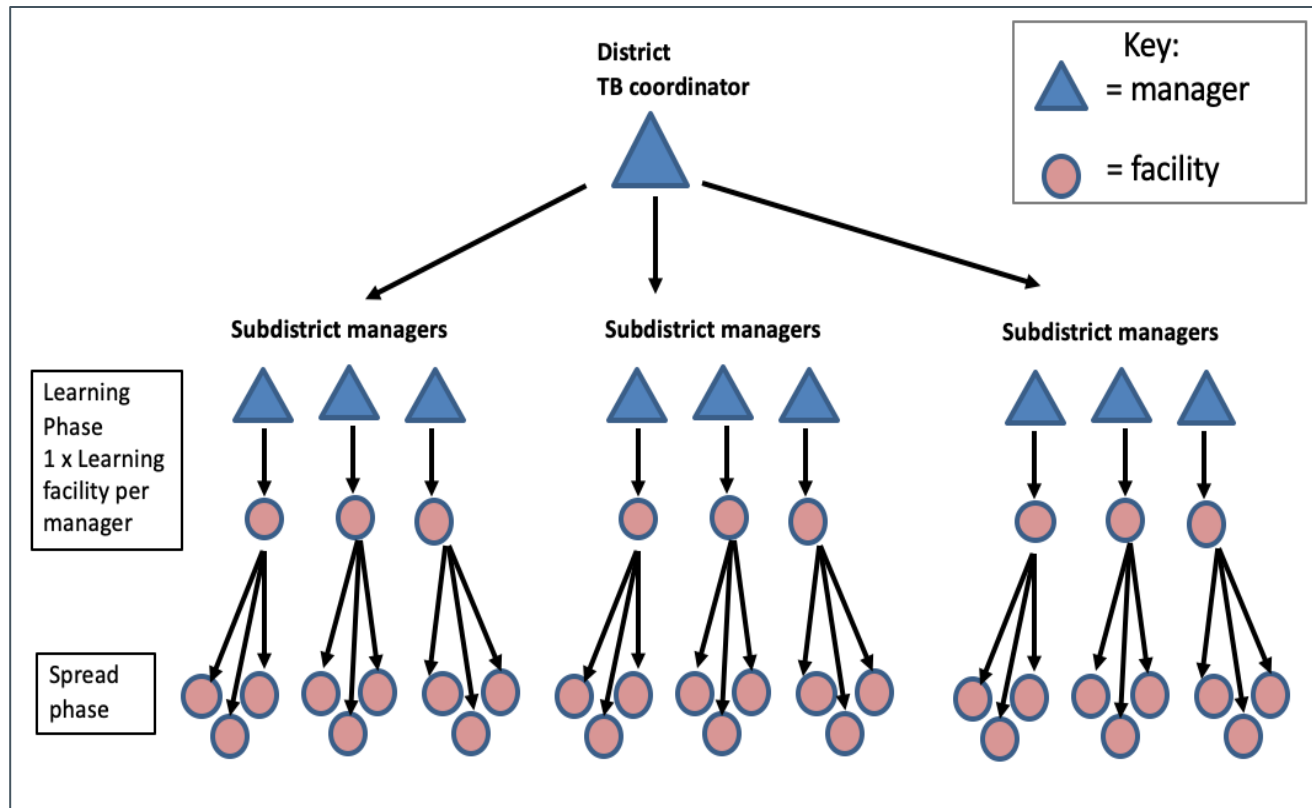
Improvement Advisors (IAs) capacitated managers at a single 'learning' facility

Managers spread to other facilities when capacitated

Execution Theory – change driven through the worksheets

2. 'Just enough QI'

- QI theory was implicit rather than explicit
- QI was integrated into the design of a standard set of 8 worksheets for implementation at the facilities

- Worksheets were completed monthly by the facility QI teams.

- Gaps were closed immediately (e.g., outstanding sputum results were tracked fast), or plans were made to close the gaps.

The Four Worksheets for Foundation Phase

Aim Statement

Line graph
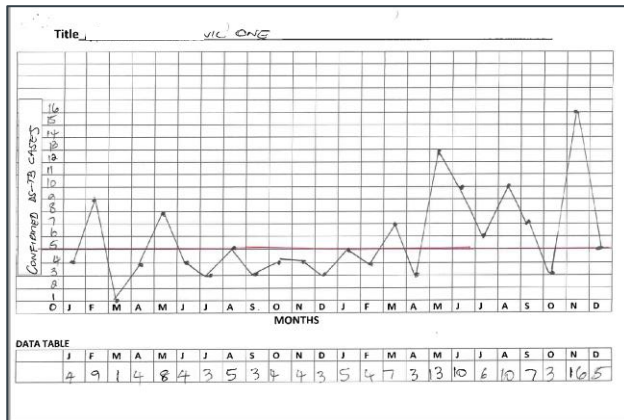
TB Case Identification Checklist

Mini data validation tool

The Four Worksheets for Implementation Phase

Implementation
worksheet design

Implementation worksheet

One A4 implementation worksheet for each of the 4 groups:
1. HIV ANC
2. HIV New
3. Viral Load Visit
4. Double Sputum for culture

Description of the change idea for specific HIV group

QI team members responsible for
- Implementation
- Measurement

Data table with
- Time period (month)
- Denominator (# need testing)
- Numerator (# tested)
- Number TB confirmed

CHANGE IDEA # 2 Routine TB investigation for all HIV new patients

The Change:
Investigate all HIV new patients for TB (GXP, X-ray, U-Lam)

Do the TB investigation the same time as HIV bloods are taken.

In the TB ID Register:
- i. Record names and HIV status
- ii. Write *symptomatic*/or/*asymptomatic* in the appropriate column
- iii. Record investigation done as usual (GXP, X-ray, U-Lam, etc)
- iv. Consider doing an X-ray if sputum cannot be produced even if asymptomatic
- v. Do LPA for *TB symptomatic* HIV positive clients if GXP is negative

NOTE: For newly diagnosed HIV positive clients who do not have TB symptoms continue ART and IPT initiation as per the standard management protocol for TB asymptomatic clients.

Who is responsible (write the names)

1. For conducting the change:

2. For monitoring the change:

Monitoring the change

Make a list of the **number of newly diagnosed HIV positive patients** in a specified time period (**HTS Register**). Tick off **how many of these** had a sputum test or other investigation done (**TB ID Register**).
Was everyone tested?
Was anyone TB positive?
Note whether the HIV Newly diagnosed client was recorded 'symptomatic' or 'asymptomatic' in the **TB ID Register**.
Keep your list in the TBQI file. Post the worksheet with the data table.

CLINIC NAME:			Routine TB testing of all HIV newly diagnosed		
Date started:		HTS Register	TB ID Register	Calculate	TB ID Register
Month	Time period (e.g. 1-17th of the month)	Number HIV new	Number Investigated (GXP, X-ray, U-LAM, etc.)	Number not investigated	Number TB confirmed
January 2022	1 – 31	25	20	05	02

# Execution Theory - adapted Breakthrough Series

3. hybrid face-to-face *and* virtual platforms to support Learning.

- Face to face

Execution Theory: Adapted Breakthrough Series

- Virtual
  - Learning Session on Microsoft Teams, Zoom etc.,
  - Site support visits by phone call or WhatsApp Video
  - WhatsApp group in each district
  - WhatsApp group for IHI coaches
  - Email communication with managers
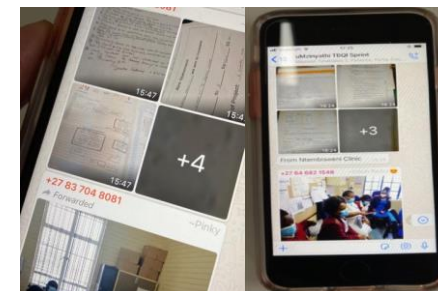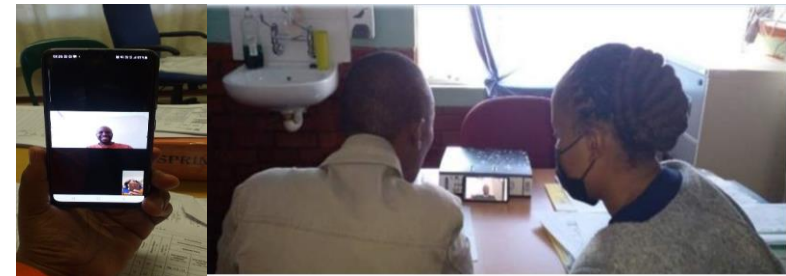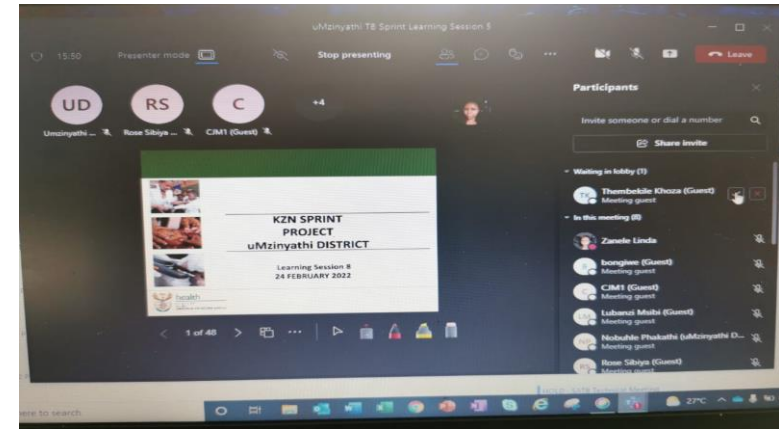
Execution Theory – the WhatsApp groups

- The worksheets posted on WhatsApp allowed real time coaching.

- Analysis of the worksheets provide a level of detail not previously possible in more traditional projects including:
  - Ongoing engagement of facilities in the project
  - TB register management (& sputum rejections)
  - Uptake of the change ideas
  - Immediate identification of facilities needing support
  - Quick measurement of the implementation rate and TB yield in each group
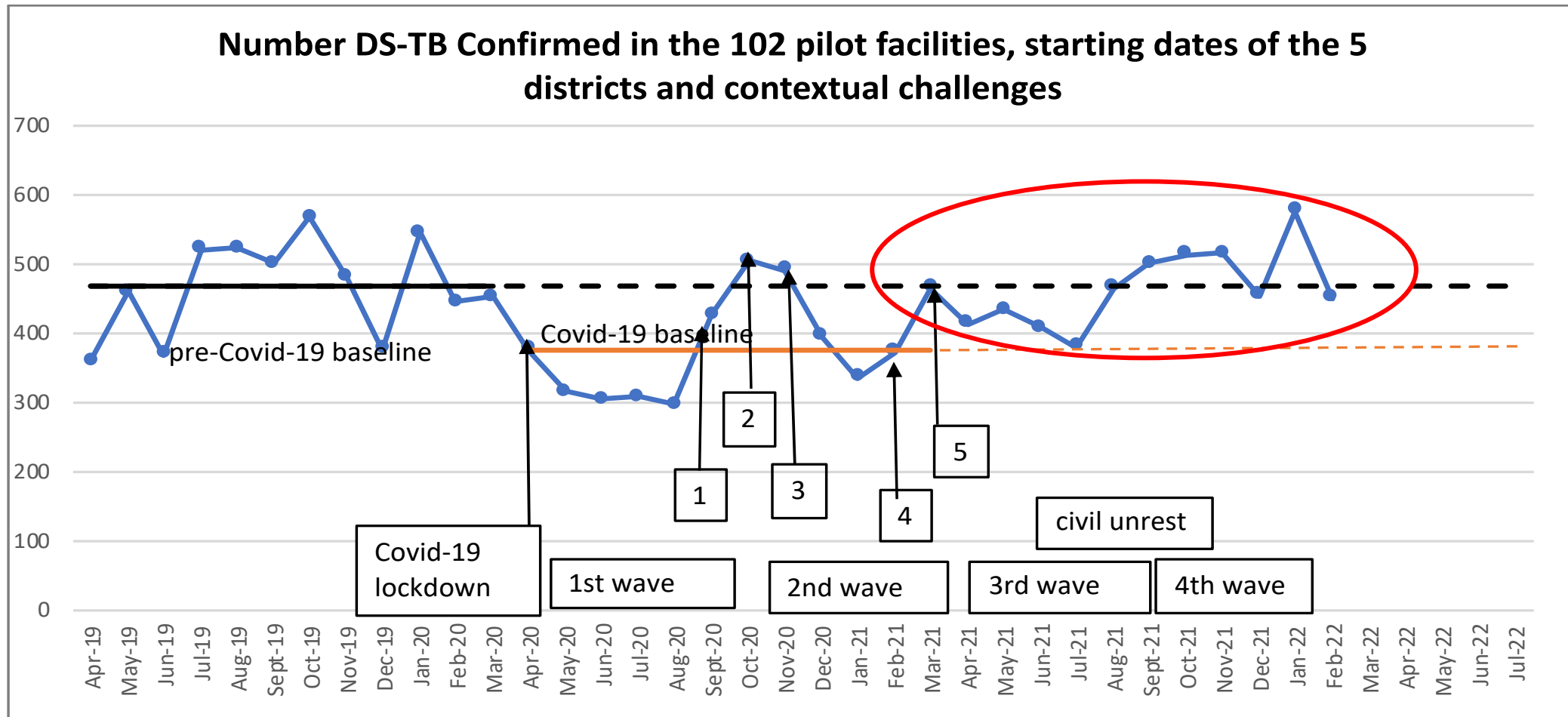
In Conclusion – The Modified QI Approach

- **'Just enough'** limited number of high-yield change ideas focused on high-risk HIV groups

- **'Just enough'** QI theory, practice
  - Specific to implementing these ideas

- **'Just right'** engagement and support
  - Series of high frequency, low content Learning Sessions
    - Streamlined, integrated QI
    - Structured content (curriculum)
    - All managers doing the same exercises during the same period
- **Blended** approach
  - Mix of in person and virtual support
  - Use of mobile app for daily coaching and mentorship

Results − DS-TB Confirmed in the pilot sites (DHIS)

Number DS-TB Confirmed in the 102 pilot facilities, starting dates of the 5 districts and contextual challenges

Learnings

A rapid **spread project** can be implemented using

- a simplified QI approach (QI implicit rather than explicit)

- a small set of high confidence change ideas

- simple, practical tools (A4 worksheets) that are easily adopted by health workers

- hybrid face-to-face/virtual learning system.

- a small skilled technical QI team working through existing DoH structures

Thank you