



Teamwork for Health Workshop:

Exploring a Collaborative Approach to Tackle Brain Health Inequality in Aging Underrepresented Communities

Date: 16th October 2023

Location: Tiger Community Hub, Lister Gate, Nottingham

Attendees

Fourteen people attended the workshop, each with diverse life experiences and various levels of disadvantage. Some had faced homelessness (one currently still facing), while others had dealt with severe mental health issues. A few had cared for family members with dementia, and all were familiar with challenges related to the benefits system.

Among the attendees, some have achieved notable successes. One individual, who had experienced homelessness and trauma, now serves as the director of their own Community Interest Company aimed at supporting others who have experienced trauma. Another workshop member assists people dealing with gambling addiction, having previously worked as an advocate for teenagers in the care system. Additionally, one member currently operates her own dementia support group.

All of these individuals have some connection to the Tiger Community Hub.

Aim of the workshop

The primary goal of ComPHAD is to redefine our approach to understanding brain health with aging, particularly concerning dementia, which is not adequately captured by routine health data. The purpose of this workshop was to adopt a systematic, critical realist approach to uncover themes that may have been overlooked in previous workshops. Specifically, we delved into the themes of "Healthcare Access" and "Research Engagement" using critical realist-informed questions that address causality, ontology, epistemology, context, social structure, and agency (see Appendix A).

Representing the workshop were Nicole Thomas and Katrina Messiha. Katrina, a PhD student from Amsterdam participating in a secondment initiative, brings a research interest in incorporating theory into participatory research. It's important to note that this workshop was part of a pilot effort to put critical realism into practice as an ideal theory for participatory research and co-development exercises, which will be detailed in a separate report.

Format

People facing challenging circumstances, such as homelessness, addiction, criminality, and mental health challenges, often find themselves in difficult situations. The Tiger Community Hub was established by Toni Jarvis, who envisioned creating a judgment-free, safe haven where individuals from all walks of life could come together in Nottingham City Centre.



To maintain continuity with previous workshop formats, Nicole initially introduced the ComPHAD project to the group, offering a Q&A session to address any project-related questions.

Subsequently, the group enjoyed a communal lunch provided by the Tiger Community Hub. The attendees were then divided into two groups, with three attendees opting to remain on the outskirts of the discussion groups, resulting in five individuals per group. There were

opportunities for those outside of the discussion groups to provide feedback via sticky notes and question prompts placed around the room.



The discussion groups were tasked with responding to specific questions related to either healthcare access (Group 1, led by Katrina) or research engagement (Group 2, led by Nicole). Visual prompts highlighting previous paraphrased statements from prior workshops were used to help facilitate the discussions.



All attendees received compensation for their time in the form of a £25 shopping voucher, with options including Tesco, Sainsbury's, or One4All.

Additionally, apart from the main workshop, drop-in sessions were organised before and after the workshop to accommodate those who might feel less comfortable in group settings but still wished to provide feedback. Insights gathered from these offshoot conversations are incorporated into the overall summaries.

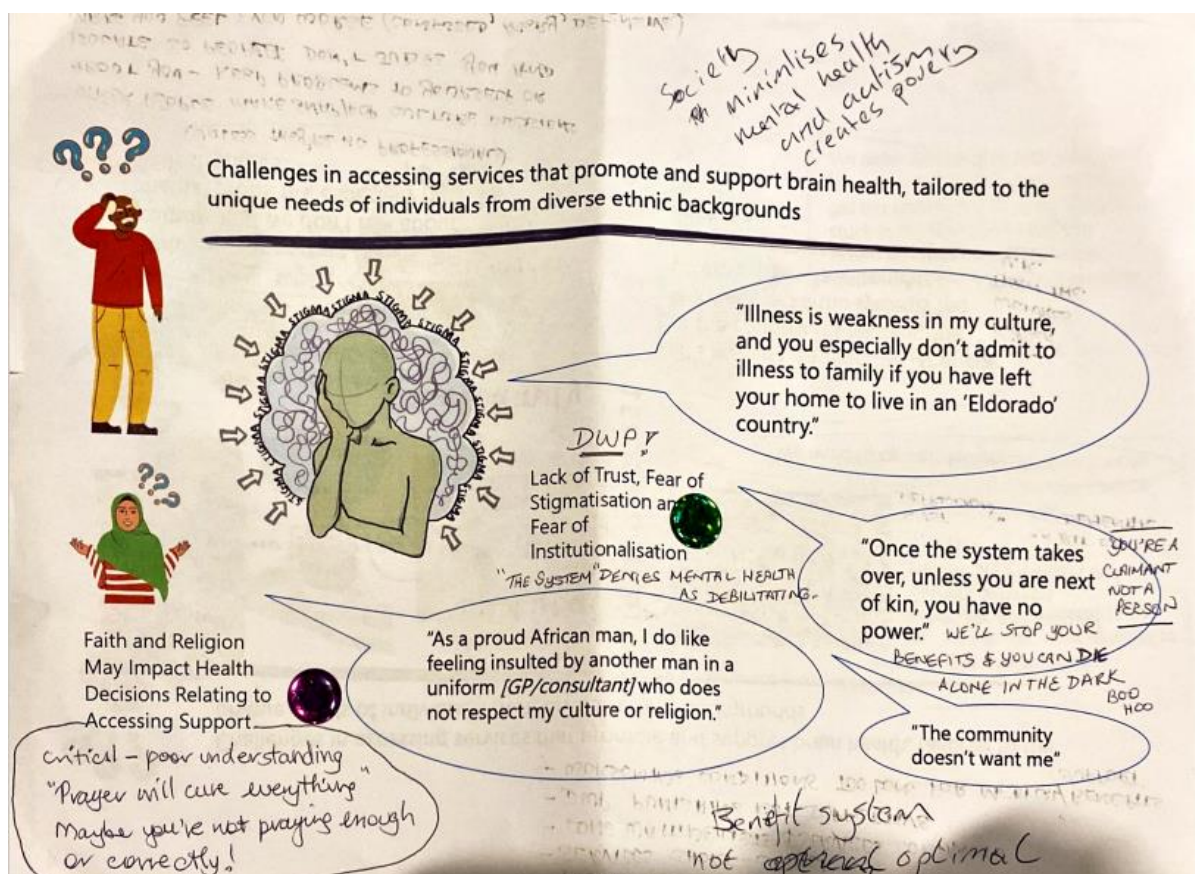
Contribution to ComPHAD Methodology Development

Group 1: Healthcare Access

This group was made up of five individuals, three who were involved in their Christian church, an individual who was a nurse who previously faced homelessness, and an individual with neurodivergence currently living in a homeless shelter. All group members shared a history of mental health struggles.

The discussion facilitated by Katrina focused on healthcare access. Katrina structured the discussions through the set of critical realism questions (Appendix A), acknowledging the multitude of higher-level factors that could potentially influence healthcare access and the decision-making processes linked to it.

Those taking part in this discussion were invited to write additional thoughts on the visual prompts and use stickers to highlight any areas which particularly resonated with them.



From these discussions, two themes emerged, “Systemic Barriers” and Stigmatisation and Trust”.

Systemic Barriers

This theme emerged from deeply personal stories shared by some of these individuals about their harsh realities of healthcare access highlighting formidable barriers they faced. For instance, one lady with lived experience of caring for a parent with dementia and her own brain health challenges shared an experience with a brain aneurysm from two decades ago. She felt that despite being in a healthcare system that was understaffed, the medical professionals at the time displayed admirable compassion and commitment. However, this individual felt the sense of security dissolve once discharged, due to the lack of appropriate information available for her. The leaflets provided for aftercare were not useful as her brain injury meant she was unable to process and retain information. Her husband became her main source of information which he sought from Google and a Facebook community group. She further reflected on how she felt that the healthcare system had not improved, and if anything had worsened in recent times, particularly continuity of care.

Shared experiences from Group 1 illuminated the shortcomings of general practitioners (GPs) when it came to addressing their brain health issues. Many individuals shared their collective frustrations at GPs who seemed ill-equipped to handle the complexity of their situation and health conditions, resulting in delayed diagnoses and exasperating encounters. The group felt services were short-staffed with long diagnostic waiting lists impacting their access to other supportive services. The lack of specialised knowledge among GPs left patients feeling unheard and their concerns dismissed. However, individuals were somewhat reliant on their GPs to provide the evidence they needed to apply for financial support through the Department for Work and Pensions (DWP) system.

It was described by two group members how there appeared to be a limited number of treatments options for their brain health issues, made worse by long waiting lists with multiple criteria to be seen and treated. Having a number of mental health conditions which overlap with issues relating to neurodivergence made accessing services a particular challenge for one individual. In addition, the criteria felt problematic, e.g., another individual described how a psychiatric assessment used a sliding scale for eligibility. Because the person scored 1 unit below the threshold, they were not able to access the support which in turn impacted eligibility for welfare.

Moreover, there were additional barriers for those who were users of homeless shelters. One individual, currently residing in a homeless shelter, explained being denied internet access by the facility. This lack of internet access further isolated them from crucial resources and opportunities for assistance.

The lack of optimal, cohesive systems including the DWP system was an observation put forward by the group who relied on the healthcare and DWP system working in unison. It was felt that the DWP is a punishing and not supportive system exacerbated by delays in a timely diagnosis, which causes their conditions to worsen as a result of waiting too long to receive medical/benefit support. Such schemes without penalisation for lack of use should be offered up as a solution to promote mental health for eventual return to work.

An idea which was shared by an individual and agreed by the group was that having “kind” volunteers in the hospital setting whilst waiting to be seen by a specialist would be key to building trust in the healthcare system. Overall, it was felt kindness was lacking across healthcare and welfare.

Stigmatisation and Trust Issues

The experiences shared revealed stark instances of stigmatisation, trust issues, and shame that accompanied the pursuit of mental health care. It was felt that mental health issues are generally not discussed with people outside of healthcare professionals possibly due to social and cultural issues when it comes to keeping things private. When it comes to brain health, and dementia specifically, identification badges to signify the person has dementia was not felt as being helpful to one individual who felt that her mother received less compassion and understanding from people when it was known.

Many individuals felt that the questions posed by both healthcare professionals and the welfare system were deliberately crafted to ensnare them, leading to a pervasive sense that they were not trusted. This erosion of trust became a two-way street – individuals didn't trust the system because they felt the system didn't trust them. This mutual distrust cultivated an overarching atmosphere of scepticism and suspicion, ultimately discouraging individuals from seeking help. An individual described that the welfare system would leave them to “die alone in the dark”, which was an opinion strongly shared amongst the group. They also felt society as a whole, minimalised brain health issues to “just depression” or “a bit of dementia.” Another group member added that the media perpetuate stereotypes about mental health causing others to make quick judgements

about their problems and how they should solve them which leaves them feeling worse. Equally, however, judgements were returned as it was suggested by the group that people tend to make the mistake of believing they have brain health issues or learning disabilities based on just a couple of symptoms, rather than considering the entire spectrum of related conditions. This misconception not only undermines accurate understanding of brain health issues or learning disabilities but can perpetuate trust issues in society.

An example provided by an individual with a background in nursing was developing what is termed 'treatment-resistant depression.' She recounted losing friends and colleagues and transitioning from being perceived as a trusted member of society to being "treated like a criminal" for needing benefits and mental health support. Conversely, she also noted that crisis nurses had been able to provide exactly what was needed and knew precisely how to offer emotional support following a suicide attempt, creating a sense of emotional safety. However, there was a sense of regret that it had needed to escalate to this point in order to be believed.

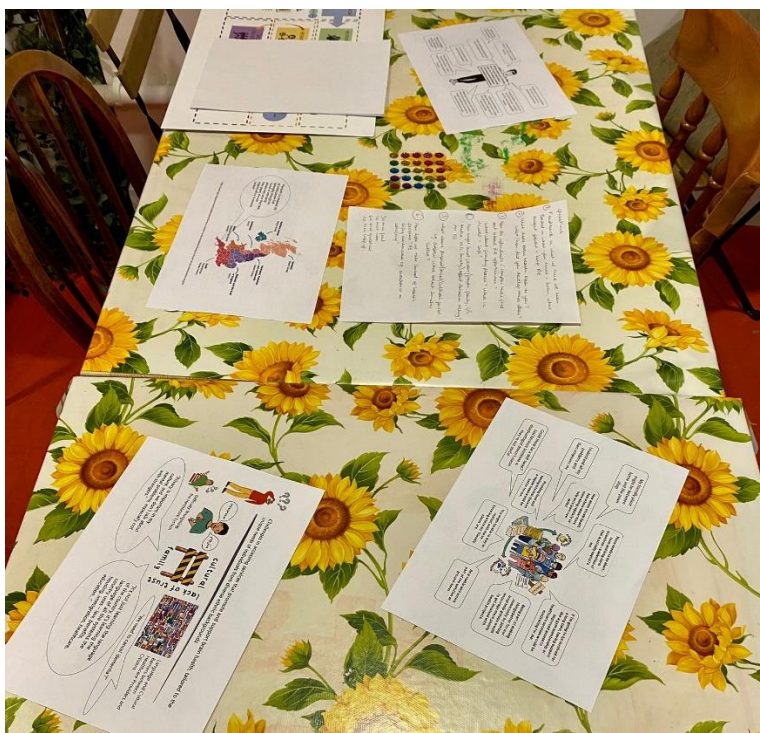
The benefit system emerged as a significant obstacle, particularly for those who relied on it for support. The fear of losing benefits due to perceived inconsistencies in mental health diagnoses became a chronic stress, as if the benefits system aimed to catch them exaggerating their conditions. This resulted in an ongoing struggle to demonstrate their worthiness and eligibility for the essential support they needed, both from the welfare system and their GPs.

Another compelling example was shared by an individual concerning a church vicar. During a church gathering, this individual encountered stigmatising beliefs when the vicar attributed their mental health challenges to 'satanic influences.' This deeply insensitive and misguided statement not only perpetuated stigma but also left the individual feeling betrayed by a trusted figure in their community. This sentiment was echoed by another group member who added there is poor understanding from the vicar at church where a belief was held that 'prayers will cure everything; maybe you're not praying enough or correctly!' Despite this, the church has also been a point of a friendly space for them and although they don't open up about their issues with the community there due to stigma, they feel that going provides a sense of community and that ability to have that friendly space to get away from any tension that they experience day to day regarding their health.

The group members felt that entering safe and friendly spaces like the community café, internet support groups like those on Facebook and religious communities could be possible avenues for support and trust building. In addition, one individual shared their idea of healthcare and welfare involving patients in shared-decision making through education and knowledge sharing was seen as a valuable solution to the barriers faced by the individuals. Overall, the group expressed feeling more comforted by the lived experience of others rather than technical information delivered by professionals, especially when it comes to the complexity of their lives. One-size fits all creates too much discrimination.

Group 2: Research Engagement

This discussion group was made up of five individuals with lived experience of trauma, homelessness, brain health conditions and dementia. All of the individuals are now part of advocacy services in some way, either to support experiences of trauma, dementia, gambling addiction or homelessness.



Using statements from previous workshops as prompts and the critical realist questions, discussions were based around whether the factors impacting other areas of their lives may translate to an ability or inability to engage with research.

There were two main themes which surfaced from the discussions, “Recognition and Support” and “Creating Emotionally Safe and Inclusive Environments”. These themes underscored the need for empathy, understanding, and support within research contexts, especially for individuals facing multiple levels of disadvantage and experience of trauma.

Recognition and Support

Recognition and support was not just discussed on an individual basis but also on a community level, especially as the Tiger Community Hub served as such as a safe place for those who used it. It was understood that this was dependant on funding and could be lost at any moment. Many were unsure how they would survive without the hub.

Community-level

In the local landscape, an initiative called HealthStreet are taking steps to bring diagnostic services to the streets. HealthStreet, initially London-based, has plans to expand its services to Nottingham and believes health is mostly driven by social, not medical factors. However, a significant challenge arises from property developers rapidly acquiring town centre buildings for student accommodation. This poses a threat to vulnerable individuals and jeopardises the existence of the vital community hub. To address this, efforts are underway to secure a larger property within the town centre, but this endeavour necessitates substantial support from various stakeholders, including the police, local universities, and the council. Due to Toni's holistic and inclusive approach, evaluating the hub with specific outcome measures to evidence value in order to procure funding (e.g., demonstrating how the hub impacts local crime rates) is not currently feasible. In addition, despite buy-in from both local universities to use the hub for research activities (arts, engineering, sustainability, and health), the sense of urgency for funding does not feel shared in the same way that Toni feels it due to universities and other stakeholders not being as embedded into the community.

For those accessing, the Tiger Community Hub stands as a symbol of warmth and inclusivity. It's not just a place; it's a safe haven where individuals find acceptance and belonging unconditionally. It offers a sense of purpose, attracting those with skills and talents they're eager to share, whether advocacy, painting, or crocheting. They have a crammed schedule of activities throughout the week, with a focus on sustainability providing reusable sanitary wear to help alleviate period poverty in the community.

Week Commencing	Tuesday	Wednesday	Thursday	Friday	Saturday
2 Oct					
9 Oct					
16 Oct					
23 Oct					
Coming for...	Monday 6 Nov XFA Arts evenings 6-8pm	Wellbeing Day 4 November 10 - 4pm Egg Recipes Burgers, etc who will supply George Williams	Art Club Family friendly	Starting local book morning Tina's class	Be much more Family friendly & open to all ages from 2000 community





While the hub has some rules in place, such as the expectation of respectful behaviour towards others, it operates on the principle of accepting everyone as they are. It also aims to not define people by characteristics or conditions.

Individual-level

An insight from one individual described how frequent interactions in the mental health system culminated in a sense of hopelessness due to professionals stating she had “exhausted all opportunities”. However, these opportunities included long waiting times and extended gaps between treatments, sometimes exceeding a year. These gaps created space for mental health deterioration leading the crisis.

During the group discussion, the relentless struggle for their needs to be recognised and supported was expressed as a perpetual struggle to be believed. For those receiving benefits-based support, this battle continued even after assistance was granted, often contingent on meeting certain conditions. It was collectively agreed that this can lead to feelings of paranoia, guilt or shame when experiencing moments of happiness or joy – as if they don't deserve to feel good

because they rely on benefits due to their mental health challenges. This sense of shame wasn't limited to society's judgements on people with complex needs; it also extended to interactions with healthcare professionals. They felt judged if their behaviour deviated from what's expected of someone with mental health issues, including those associated with dementia. This led to needing to be very guarded, with one individual discussing how those from other cultures may lean towards secrecy and not integrating with other cultures in order to safeguard themselves from shame and judgement.

Creating Emotionally Safe and Inclusive Research Environments

From a research methods perspective, there was a collective consensus that medical examinations, surveys, and interviews can potentially trigger trauma, especially physical examinations. Additionally, the extensive questioning that comes with navigating the care system can already be a source of trauma. A support worker, with experience assisting individuals dealing with gambling addiction and young people in care, shared that interviews within the care system can stretch on for hours, making any form of 'interview' an undesirable prospect. Therefore, any indication towards an interview should be avoided.

The group also acknowledged how words or images could inadvertently trigger repressed memories. One individual bravely shared their own experience, revealing how a previously buried memory resurfaced when their grandchild innocently showed them a clip of a children's program that had played in the background during a traumatic period of abuse by a neighbour. In response to these concerns, there was a call for a trauma-informed approach. Such an approach would emphasise containment, offering pre- and post-support after each interaction with the research program to create a safe and secure space for participants.

The idea of fostering a sense of safety and trust within the research process was put forth, with the proposal of implementing a peer support system. It was noted that surveys, while essential for research, can be triggering due to the frequent completion of forms required to demonstrate one's eligibility for financial or medical support. The peer support system could play a vital role in alleviating this burden by assisting individuals in completing research surveys, thereby making the process less daunting and more supportive. However, the exact structure of this peer support system, coupled with the trauma-informed approach, would require further co-development, especially so not to inadvertently create bias in the collection process.

Ultimately, it was felt by all that the specific content of the questions is less significant than the manner in which they are delivered. Furthermore, it was suggested that there should be a structured process in place to support individuals if they are triggered during their engagement with the research. This scaffolding would provide assurance that there would be no conflict, with instant belief in the participant's experience and mechanisms for addressing any potential ruptures or trauma triggers. This approach would be designed to reduce attrition rates resulting from a breach of trust.

An example from an individual who supports people with dementia highlighted the profound impact of small gestures. When visiting consultants, those who introduced themselves by saying, "My name is... I've been reading your notes," instantly cultivated trust and put the individual at ease. The individual discussed how this approach could be readily integrated into the research methodology providing a potential resolution to the continuity of research staff over the longer term. It could be made part of the process that any researcher could convey that they've reviewed previous notes or information, sparing the participant the distress of retelling their story or questioning whether they are going to be believed by the new person.

Another aspect of small gestures was the idea that friendlier badges could be used instead of official looking lanyards (or as well as) such as the one worn by an individual who supports people with dementia. This needs for friendliness was also discussed by an individual separate to the workshop who highlighted how she felt healthcare settings were unfriendly and unwelcoming.



There was a unanimous consensus that adopting a trauma-informed approach is paramount, given the collective experiences of people marginalised in various

ways. These individuals have all grappled with the same fundamental issue – not being believed or feeling diminished by family, friends, institutions, the healthcare system, and society at large. They have experienced a pervasive sense of not belonging, worthlessness, and hopelessness. Therefore, regardless of how they came to experience this form of trauma, it was felt that it would be significantly alleviated by embracing a trauma-informed approach. This approach hinges on genuine curiosity and empathy, listening without judgment or comparison, and allowing for additional time to accommodate this critical process.

While discussing the concept of community, it became evident that the traditional notion of 'community' doesn't always apply. In reality, such gatherings can inadvertently foster “toxic jealousy” and envy among individuals. People may become aware of disparities in the support received by different individuals, leading to an environment that feels unsafe for everyone involved.

When considering this within the context of research methodology, concerns arose regarding eligibility criteria. Some individuals may be included in a project and receive rewards, potentially triggering trauma for those who were excluded. This process mirrors the eligibility criteria for mental health services or benefits, where exclusion from not reaching a criterion (which may be the difference between scoring a 7 and missing out and an 8 and getting support) can trigger trauma.

The handling of eligibility criteria must therefore be done with great care. Additionally, for some, the guilt associated with receiving something that others may not be able to access can deter them from participating in the project. This is because their sense of belonging to the group may feel fragile, and the fear of potential rejection by their peers may lead them to opt out, even if it means missing out on valuable opportunities.

Informing the methodology

The shared experiences of individuals facing systemic barriers and stigmatisation offer crucial insights to enhance the methodology for ComPHAD. The project could prioritise a trauma-informed approach, recognising that interviews, surveys, and examinations can potentially trigger trauma in participants. This approach entails providing pre- and post-support mechanisms, fostering a safe and secure space, and considering the implementation of a peer support system within the research process. Additionally, researchers should be

mindful of eligibility criteria and their potential to trigger exclusion-related trauma, ensuring sensitivity in handling these criteria to create an inclusive research environment.

The BRAVING framework developed by shame researcher Brené Brown (see Appendix B) provides an existing evidence-based structure that closely aligns with the core values highlighted in the workshop discussions regarding the trauma-informed approach. By integrating the BRAVING framework into ComPHAD, the project can scaffold efforts to create emotionally safe and inclusive research environments. This alignment ensures that participants' emotional well-being, boundaries, and trust are at the forefront of the research process, ultimately leading to more meaningful and impactful research outcomes.

To potentially address the issue of "toxic jealousy" arising from research participatory rewards, an alternative approach can be considered, drawing inspiration from models used in industry whereby purchasing a product leads to a community investment. A notable example is TOMS shoes, where each purchase results in a donation to a child in poverty. This model not only incentivises individual purchases but also generates an immediate positive impact on disadvantaged communities.

In the context of ComPHAD, we could explore a similar concept. Instead of offering individual incentives, participants could be informed that their involvement in the research contributes to a communal initiative, which goes towards the support and sustainability of the community hub. This approach helps build on the ethos of the community hub by fostering a sense of collective well-being and shared goals. Importantly, this contribution would extend to the entire community without the expectation or condition of being part of the research program, ensuring that everyone benefits from the initiative. In this way, the research process not only becomes more inclusive but also aligns with the principles of community support and collaboration, enriching the overall research experience.

Researcher reflections

Using researcher reflections in critical realist research is important because it helps researchers to understand and explain their own viewpoints and how these might affect their work. This self-awareness is key to making the research process more honest and trustworthy. This transparency aids anyone reading their work to see what may have influenced their conclusions, making the process more open and credible.

Katrina Messiha

It was a privilege to listen to the group members reflecting on their personal mental health challenges and how they navigate healthcare access. The unique aspect of co-facilitating this workshop in the group's community café enabled them to converge in their safe and welcoming space, where candid sharing of their stories and frustrations was made possible.

The discussions appeared to be driven by their authentic enthusiasm to discuss matters important to the group, which led to a broad exploration of topics relating to healthcare access. Whilst there were a couple of more dominant voices in the group, a notable aspect of the group dynamic was the consensus among its members regarding key issues tied to the challenges of the benefits system, and how these perceptions can perpetuate issues in healthcare access such as stigmatisation and inadequate care.

I personally found it interesting how the issue of poverty and its connection to limited healthcare access was a key focal point - where the impact of economic status on health outcomes and how individuals with lower incomes typically seem to face poorer health prospects, was raised. It was considered that people known with more disposable income had a noticeably better ability to manage their health, whereas those with limited resources faced significant challenges. Moreover, it was reflected on that in times of extreme adversity, such as the loss of livelihood, one could be compelled to take more initiative to educate and empower themselves to overcome these obstacles which reinforces the notion of individual agency.

There also appeared to be juxtaposition between older generations' attitudes of healthcare access versus that of younger generations. For the former, there was a comment about the prevailing Victorian mindset about health which led to reluctance to seek medical attention, in turn delaying the early intervention of dementia. On the other hand, it was suggested that younger generations are

extra contentious about their brain health and are not only more proactive but insistent on having their needs met through healthcare access despite some negative experiences.

While the open discussion format facilitated flexible and spontaneous reflections, introducing a bit more structure and allowing additional time for the individuals to pause, deliberate and write down their key takeaways about healthcare access could have complemented the possibility for richer insights.

Overall, I felt these group discussions emphasised the necessity of addressing systemic problems to enhance the healthcare experience for individuals dealing with mental health challenges, especially those reliant on the benefits system. It also reinforced for me that co-development work is vital, to not only ensure that the voices of service-users are heard, but that such voices are truly incorporated within decision-making capacities for the betterment of health at the individual and population level.

Nicole Thomas

Many of the themes discussed in this workshop resonate with the experiences shared by attendees from other workshops, particularly concerning the potential trauma associated with interviews and the pervasive mistrust of GPs. Furthermore, my own experiences as a parent carer, along with conversations I've had with other parent carers, closely mirror the sentiments expressed in this workshop. In order to access essential services and financial support, parent carers often find themselves compelled to emphasise all the worst aspects of their child's character in order to be eligible for support. This process is inherently traumatic, especially for those who have already struggled to be believed and secure an autism diagnosis in the first place.

Additionally, the sentiments from this workshop echo those of another focus group I facilitated, which explored the acceptability of an online support group for new mothers dealing with perinatal mental health challenges. These mothers sought help at the earliest signs of postnatal depression, yet their concerns were frequently dismissed until their situation escalated to crisis levels. In some cases, this escalation led to potential harm to themselves or their children, which ironically, they had sought to prevent by reaching out for healthcare support initially. These parallel potentially highlight the trauma associated with eligibility and inclusion criteria across various contexts and

may underscore the need for more empathetic and proactive approaches to research methodologies with underrepresented groups.

Conclusion

In conclusion, this workshop has provided valuable insights into the challenges faced by marginalised individuals in accessing healthcare, with implications for the ComPHAD research methodology. The discussions highlighted specific issues such as stigmatisation, trust deficits, shame, and barriers to access. These insights highlight the importance of designing a research methodology that is sensitive to these challenges and emphasises empathy, understanding, and trust-building throughout the research process.

Additionally, the workshop highlighted the need for a trauma-informed approach within the research methodology, as it may inadvertently mirror the ways individuals have already been traumatised by the healthcare and welfare system. The ComPHAD methodology should consider these insights to ensure it aligns with values like compassion, inclusivity, and trauma-informed care, thereby enhancing its inclusion and retention of marginalised populations.

Acknowledgments

We extend our heartfelt gratitude to all attendees for their invaluable insights and contributions during the workshop. Special thanks go to all the “Tiger Team” for facilitating the workshop on their day off.

An extra special thank you to Toni for cultivating an environment conducive to meaningful discussions and working effortlessly for the community. All those involved will undoubtedly enrich the ComPHAD methodology.

Appendix A:

Critical realism informed topics and questions

Event: Brain health including dementia, individuals with complex lives

Ontology

From what we *think* we know about why certain experiences regarding healthcare access/research engagement might be more common among people facing similar challenges to yours, what are your thoughts and opinions?

Based on what you've seen and know, what might prevent and help some individuals who have complex lives from accessing healthcare services or engage with research?

Epistemology

What does brain health mean to you and what influenced this?

Social Structure

How do individuals with complex lives know about available opportunities for healthcare services/research engagement? Where might individuals with complex lives usually go for (trusted) help and advice? Friendly places?

Can you imagine how social factors affect people with complex lives in terms of their decisions (positively and negatively) about healthcare services/research? For example, friends, family, healthcare professionals including GPs, the public at large?

Context

From your perspective, how might the environment (physical and social/ cultural) influence individuals' decisions to access healthcare services/participate in research?

Prompts: dispersal cities, Brexit – ethnicity is weaponised, culture within Nottingham

Agency

What factors do you believe influence people's choices to seek healthcare services/participate in research, given their unique situations?

In mind of all the people and things that influence you, how do you (or not) take control and ownership of your health decisions whether related to access to services/engagement in research?

Prompts: Coping mechanisms, disengagement, avoidance or positive?

Appendix B:

<https://brenebrown.com/resources/the-braving-inventory/>



The **BRAVING INVENTORY**

BRAVING Definitions

The acronym BRAVING breaks down trust into seven elements:

BOUNDARIES, RELIABILITY, ACCOUNTABILITY, VAULT, INTEGRITY, NONJUDGMENT, AND GENEROSITY.

BOUNDARIES: Setting boundaries is making clear what's okay and what's not okay, and why.

RELIABILITY: You do what you say you'll do. At work, this means staying aware of your competencies and limitations so you don't overpromise and are able to deliver on commitments and balance competing priorities.

ACCOUNTABILITY: You own your mistakes, apologize, and make amends.

VAULT: You don't share information or experiences that are not yours to share. I need to know that my confidences are kept, and that you're not sharing with me any information about other people that should be confidential.

INTEGRITY: Choosing courage over comfort; choosing what's right over what's fun, fast, or easy; and practicing your values, not just professing them.

NONJUDGMENT: I can ask for what I need, and you can ask for what you need. We can talk about how we feel without judgment.

GENEROSITY: Extending the most generous interpretation to the intentions, words, and actions of others.

The BRAVING Inventory can be used as a rumble tool—a conversation guide to use with colleagues that walks us through the conversation from a place of curiosity, learning, and ultimately trust-building.