



Trauma- Informed Approaches

TOOLKIT



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Introduction

The application of trauma-informed approaches is growing rapidly in health care and social service settings. In this context, **trauma** is broadly defined as experiences that produce intense emotional pain, fear, or distress, often resulting in long-term physiological and psychological consequences. Experiences of trauma, especially in childhood, can change a person's brain structure, contributing to long-term physical and behavioral health problems.

Applying a trauma-informed lens is a critical tool to address the HIV epidemic in the United States. Research indicates that **people living with HIV (PLWH) have significant trauma histories when compared to the general population**. According to the **Substance Abuse and Mental Health Services Administration (SAMHSA)**, 70% of PLWH have experienced trauma, and PLWH are twenty times more likely to have experienced trauma than the general population.

In 2017, NASTAD published a policy brief, **A Health Systems Approach to Trauma-informed Care**. Subsequently, NASTAD developed this toolkit to assist health departments, specifically Ryan White HIV/AIDS Program (RWHAP) Part B and AIDS Drug Assistance Programs (ADAPs), AIDS services organizations, and HIV clinics to take action on the recommendations outlined in the initial policy brief. This toolkit equips administrators and providers at all levels of service with approaches to realize, recognize, respond to, and resist the impacts of trauma in people affected by HIV. Of note, to truly embody a trauma-informed approach, it is imperative that any person who may interact with PLWH in the healthcare setting — from receptionists, management and program administrators, security guards and facilities staff to case managers, physicians, etc. — be trauma-informed. This toolkit covers the basics of trauma, provides an overview of the impact of trauma in PLWH, describes trauma-informed approaches and strategies, and provides practical steps for RWHAP Part recipients and HIV providers (throughout this document, “provider” refers to any case manager, medical professional, etc.), and organizations to develop and operationalize a plan for delivering trauma-informed prevention and care services to PLWH.

*Terrance E. Moore, Acting Executive Director
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TRAUMA-INFORMED DEFINITION

Being trauma-informed is an approach to administering services in care and prevention that acknowledges that traumas may have occurred or may be active in clients' lives, and that those traumas can manifest physically, mentally, and/or behaviorally.

A program, organization, or system that is trauma informed:

“**REALIZES** the widespread impact of trauma and understands potential paths for recovery;
RECOGNIZES the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
RESPONDS by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively **RESIST** retraumatization.”

Source: [SAMHSA](#)

Understanding Trauma

Although the application of trauma-informed approaches in HIV services is a recent advancement, trauma has been well studied. Trauma can be a one-time event (e.g., natural disaster, loss of a loved one, or receipt of an HIV diagnosis), repeated events (e.g., abuse or neglect), or a vicarious event (e.g., witnessing trauma experienced by another). Traumas can be experienced by a single individual (e.g., domestic violence, sexual assault) or an entire population (e.g., slavery,

intergenerational trauma). While some people fully recover from trauma, others experience lifelong physical and behavioral effects. In this segment of the toolkit, we will provide an overview of four areas key to understanding trauma in PLWH – NEAR Science, intersectionality, trauma throughout the HIV continuum, and vicarious trauma.

NEAR Science

Providers are developing a more comprehensive understanding of trauma, including the concept of NEAR Science (neurobiology, epigenetics, adverse childhood experiences, and resilience). NEAR Science provides a holistic understanding of how trauma impacts health outcomes. This section will describe each of these four components.

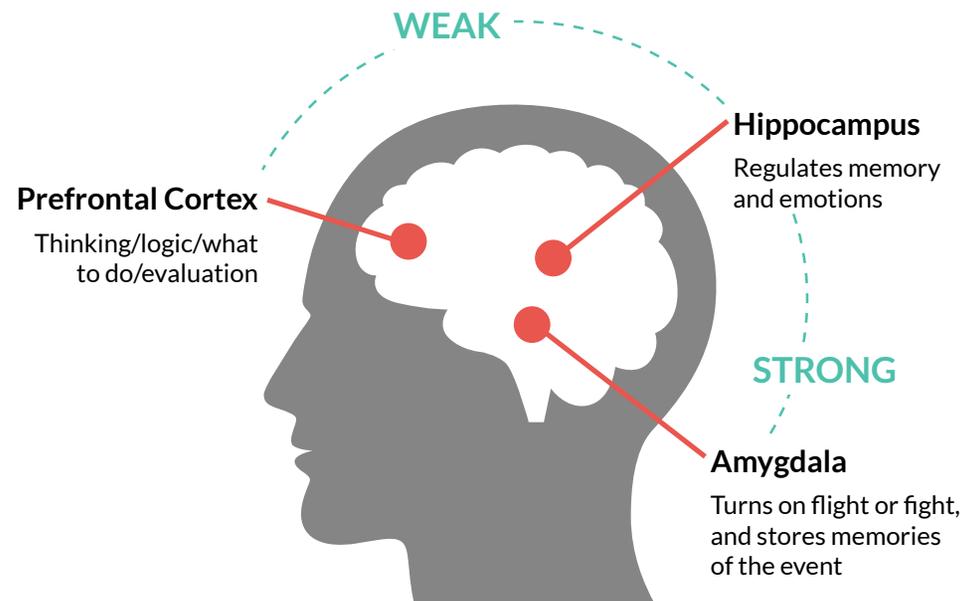
Neurobiology {NEAR Science}

Recent advancements in neuroscience are having a profound impact in understanding trauma. Three primary areas of the brain are impacted by a traumatic experience: (1) the prefrontal cortex, (2) the hippocampus, and (3) the amygdala.

- The **prefrontal cortex**, known as the “Thinking Center,” is located near the top of your head, behind your forehead. When this area of the brain is strong, we are able to think clearly, make good decisions, and be aware of ourselves and others. Research indicates that **after trauma, particularly during childhood, the prefrontal cortex experiences a loss of neuronal integrity** and is less able to communicate with other parts of the brain.
- The **hippocampus**, known as the “Emotion Regulation Center,” is located next to the prefrontal cortex, but is deeper inside the brain. When this region is strong, we are able to manage difficult thoughts and emotions and recall and recognize memories. For example, when the smell of a perfume reminds you of your grandmother, it is likely your hippocampus in action. In contrast, individuals who have experienced traumatic stress may experience vivid

memories or persistent thoughts that are reminiscent of a trauma. They may have a difficult time distinguishing between a memory and a current threat.

- The **amygdala**, known as the “Fear Center,” responds to stress and anxiety and coordinates a behavioral response that helps to ensure survival, also known as the “fight, flight, or freeze” response. For example, imagine you are walking down a hiking trail and suddenly see a snake. With lightning



speed, your amygdala reacts to that snake before you even consciously notice it. The amygdala helps you react quickly when there is a threat in the forest, but it can be a problem for someone who has experienced trauma. In the traumatized brain, the amygdala is on high alert, often leading to inappropriate, erratic, or defiant behavior as the brain is unable to access the prefrontal cortex and apply logic to a situation.

An understanding of how the brain is affected by trauma is essential for developing and implementing trauma-informed approaches and can also help providers better understand the actions and responses of clients who have experienced trauma.

TRAUMATIC STRESS RESPONSES

FIGHT — Person may appear irritable, argumentative or hostile. Loss of temper or defensiveness. Clenched fists or jaws, grinding teeth, knotted stomach, glaring, snarl in voice.

FLIGHT — Person may appear anxious, panicked, or assume worst possible outcome. Avoidance and fear. Restlessness in legs, feet or hands, fidgeting, tense shallow breathing, darting eyes.

FREEZE — Person may have difficult making decisions, miss appointments or forget documentation. Feeling detached or numb. Holding breath, sense of dread, pounding heart.

Epigenetics {NEAR Science}

In the context of trauma, epigenetics refers to the historical and multi-generational trauma based on shared experiences of a community, such as African Americans, American Indians and Alaska Native (AI/AN) people, and other communities who have experienced genocide, enslavement, displacement, forced assimilation, and language and cultural suppression. The stress of intergenerational poverty can also result in epigenetic changes.

The trauma experienced by previous generations can be etched in our epigenome, which alters the expression of certain genes that, in turn, activates a dysfunctional response to stress, and therefore, heightens the possibility of the development of trauma-related symptoms. Studies have shown that those who have experienced intense and/or repeated trauma can pass their altered genetic expression on to their children who have not experienced trauma directly in their own lives.

The study of epigenetics offers an important linkage to racial equity within a trauma lens, which is critical given the disproportionate impact that HIV has on communities of color. As illustrated by the [Racing Adverse Childhood Experiences \(ACEs\) pyramid](#), the trauma of structural racism and microaggressions contributes to the burden of HIV disease and other health outcomes experienced by people of color.

Adverse Childhood Experiences {NEAR Science}

Adverse childhood experiences refer to experiencing or witnessing abuse, neglect, and other dysfunction in a household during a person's earliest years. The original [ACEs Study](#) revealed how negative experiences in childhood can derail a child's development and lead to a lifetime of health and social challenges. Through the use of an [ACEs scale](#), the study assessed experiences such as physical, emotional or sexual abuse, or the presence of a household member experiencing substance use, domestic violence, or incarceration. Ongoing studies are also examining community violence and experiences of racism.

These studies have two major findings: (1) ACEs are very common, and (2) ACEs, especially when compounded, have a strong correlation to health outcomes later in life. For example, people who have experienced four or more ACEs are twice as likely to smoke or become dependent on alcohol, 10 times more likely to inject drugs, and 12 times more likely to attempt suicide. The ACEs study found that two-thirds of people had at least one ACE, and over one-tenth had more than four ACEs. While the original ACEs study was conducted in a primarily white, middle-class community, [a similar study conducted with a more racially diverse community in Philadelphia](#) found that ACEs were even more common; 83% had at least one ACE, and 37% had four or more ACEs.

The RWHAP Part B Program in Iowa added the ACEs scale to their client needs assessment and then compared the results to their state's Behavioral Risk Factor Surveillance System (BRFSS). Respondents from the RWHAP Part B Program were more likely to identify ACEs than the general population: 20% of PLWH reported zero ACEs (compared to 44% of BRFSS respondents), 21% reported four to five ACEs

In addition to the experience of adversity in childhood, exposure to chronic, toxic stress in adulthood also impacts the brain. Toxic stress, such as that associated with experience of racism or other structural violence, poverty, unsafe neighborhoods, chronic or terminal illness, homelessness or housing instability and food insecurity can cause a prolonged stress response in the brain.

(compared to 9% of BRFSS respondents), and 16% reported six or more ACEs (compared to 5% of BRFSS respondents). There was also a difference in the types of experiences: 49% of RWHAP Part B Program respondents reported emotional abuse (compared to 28% of BRFSS respondents), 43% reported physical abuse (compared to 16% of BRFSS respondents), and 32% reported sexual abuse as a child (compared to 10% of BRFSS respondents). Experiences of substance use, parental separation or divorce, and violence in the home were also more common. There was also an increase in viral load as the number of ACEs increased.

Children and adults often develop coping mechanisms to alleviate the pain of trauma and release of stress hormones. Negative coping mechanisms can include eating unhealthy food, use of tobacco, alcohol or other drugs, or engaging in risky sexual activities. When childhood traumatic stress goes unaddressed, coping mechanisms can contribute to anxiety, social isolation, suicidal ideation, chronic diseases like HIV, diabetes, cancer, or substance use disorders, and difficulty in school, employment, and stable relationships, among many other social determinants of health.

Resiliency {NEAR Science}

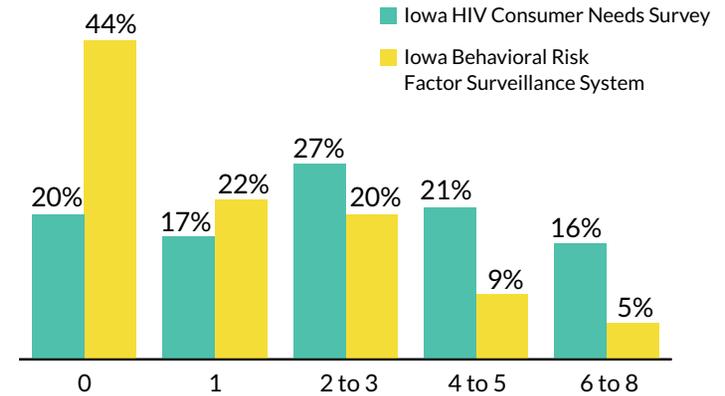
People can, and do, heal from all kinds of trauma. Resilience refers to a person's ability to recover from and adapt to difficult experiences. The most important resilience factor is the existence of a caring and supportive relationship. Other resilience factors include the capacity to make and follow through with plans, a positive self-view and confidence in one's strengths and abilities, ability to

Intersectionality

Intersectionality is a theory that the overlap of various social identities, such as race, gender, sexual identity, disability, and class, contribute to systemic oppression and discrimination experienced by an individual. As HIV disproportionately impacts marginalized communities, using an intersectional approach to understand trauma among those living with HIV is critical.

GENDER IDENTITY: Sexual abuse among women is common, affecting 15– 25% of women. According to SAMHSA, the prevalence of domestic violence among women ranges from 9–44%, depending on the definition. Among women living with HIV, one study found that **42% report physical or sexual abuse, and intimate partner violence (IPV) is experienced by 68–95%**. Among transgender people, the

Iowa's 2016 Adverse Childhood Experiences Scores



communicate and problem solve, and capacity to manage feelings and impulses. Similar to an ACEs scale, the [resilience scale](#) identifies a person's strengths and opportunities to cope with difficult experiences.

Traumatic events affect the mind, body, and spirit and as such, recovery should include all three aspects. A number of trauma-specific services and treatments are effective and include therapies like guided imagery, creative visualization, hypnosis, neurofeedback, and Eye Movement Desensitization and Reprocessing (EMDR). Self-directed activities such as [journaling, drawing and painting, meditation and mindfulness, yoga, and Tai Chi](#) are also evidence-based treatments.

“In a forthcoming study looking at deaths in our program over the past decade, only 16% were due to complications of HIV/AIDS,” states Edward L. Machtinger, MD, Director of UCSF's Women's HIV Program. “The majority of the rest of these deaths were due to the effects of trauma: directly through murder; and indirectly through substance abuse, depression, isolation, and illnesses linked to trauma like obesity, diabetes, heart, lung, and liver disease.”

Source: [Positive Women's Network](#)

experience of trauma is even higher due to hate crimes, lack of legal protection, and discrimination. Another study found that nearly 100% of trans-identified women participants have experienced trauma.

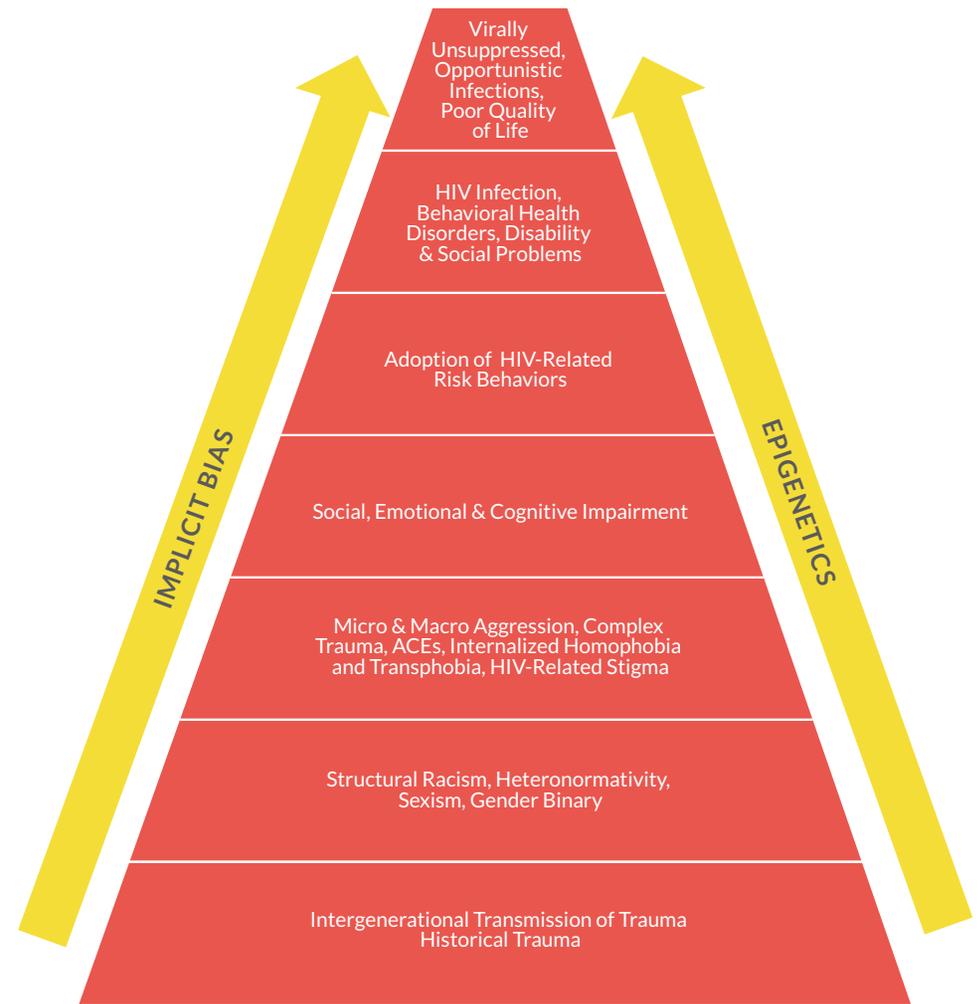
SEXUAL ORIENTATION: Individuals who identify as lesbian, gay, or bisexual are likely to experience higher rates of trauma. In addition to bullying and harassment, gay, lesbian, and bisexual identified individuals have higher ACE scores when compared to their heterosexual counterparts. They also report higher levels of IPV compared to their heterosexual counterparts.

PEOPLE OF COLOR: Communities of color are disproportionately impacted by trauma. The 2016 National Survey of Children's Health found that 61% of Black, non-Hispanic children and 51% of Hispanic children have experienced at least one ACE, compared with 40% of White, non-Hispanic children. Furthermore, communities of color are disproportionately impacted by community violence (defined as deliberate acts intended to cause physical harm against a person or persons in a community), including experiences of racism, unsafe neighborhoods, and gun violence. A RWHAP Special Project of National Significance study found that among young men of color who have sex with men, 83% had witnessed community violence, with 55% occurring in the prior three months.

ADDICTIONS AND MENTAL HEALTH: The link between trauma exposure and substance use and mental health challenges is well-established. In the National Survey of Adolescents, teens who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance use than those without a history of trauma. In surveys of adolescents receiving treatment for substance use, more than 70% had a history of trauma exposure. PLWH are disproportionately suffering from both mental health and substance use challenges. PLWH have higher rates of anxiety, depression, and alcohol and substance use than the general population.

POVERTY AND HOMELESSNESS: The experience of living with little to no income is traumatic. Many people who grow up in poverty live with chronic uncertainty of how basic needs, like shelter and food, will be met. Living in poverty increases risks for many adverse outcomes, including homelessness. Rates of trauma are high among people who are homeless (one study found 76–100% of women and 67% of men). People who have experienced homelessness report high levels of trauma preceding their homeless status, especially physical and sexual abuse. In addition, assault, rape, and other traumas frequently occur while people are homeless.

HIV ACEs Pyramid

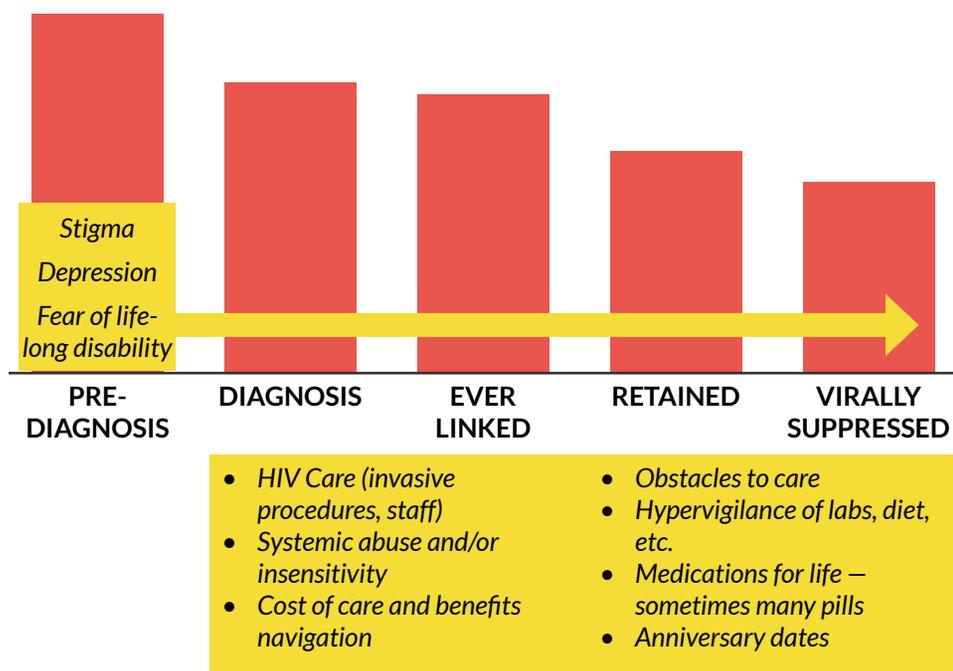


Adapted from the ACEs and Racing ACEs pyramid, the following diagram illustrates the relationship between epigenetic trauma, systems of oppression, adoption of HIV-related risk behaviors, and progression of HIV disease. The base of the diagram indicates intersectional factors that influence a person's health outcomes at the highest level (i.e., "the 30,000-foot view"). As you continue to read up the diagram, the factors listed indicate the structural, community, interpersonal and individual level influences and potential traumas that may lead to an HIV diagnosis and related negative health outcomes.

Trauma and the HIV Continuum

Past and current traumatic experiences have impacts along the HIV continuum and contribute greatly to whether or not a person contracts HIV, is diagnosed, is linked to care, is retained in care, and maintains viral suppression. When considered with comorbidities such as substance use disorders and mental health issues, addressing the effects of trauma at every stage of the continuum becomes imperative.

Trauma & the HIV Continuum



Pre-diagnosis

Past traumatic experiences can lead to engagement in increased risk behaviors for HIV transmission, such as sexual risk taking and substance use. Contraction of HIV can be particularly traumatic if acquired during a sexual assault. Preventing and responding to trauma through a public health approach is imperative to address many of our greatest health challenges, including the HIV epidemic.

Diagnosed

Although treatment is widely available, the experience of receiving an HIV diagnosis can be traumatic. The receipt of an HIV diagnosis can be exacerbated depending on the method of delivery (e.g., by letter, phone call or partner disclosure), the person delivering the diagnosis (e.g., impacts of stigma, discrimination, lack of training), the health of the person receiving the diagnosis (e.g., the person is experiencing a life-threatening illness at time of diagnosis), the timeliness of the diagnosis (e.g., lab results taking longer than expected or are inconclusive), and other related fears (e.g., threat of IPV). The [experience or threat of IPV may create a barrier for both the act of getting diagnosed, partner disclosure](#) after diagnosis has been made, and access to care. Avoidance of stressful experiences is common among people who have experienced trauma and may contribute to delayed diagnosis and subsequent unintended transmission of HIV. To reduce the trauma associated with receipt of an HIV diagnosis, share the test result immediately (i.e., avoid small talk before giving the result), use plain language, and offer plenty of time and space, even if it means sitting with long periods of silence, for the person to have time to process the result and share their questions and concerns.

Ever Linked to Care

Those who have experienced trauma are [less likely to link into care](#) after a diagnosis. The experience of linking and engaging in care can be traumatic due to invasive procedures, insensitive providers, cost of care, and/or navigation of health and medication benefits. Other obstacles to care include housing, transportation, adequate mental health and substance use treatment, literacy, and language and cultural barriers. Ensuring there is a range of funding available to provide 'low threshold services' is critical for serving people with a history of trauma to link to and engage in care. These services include warm hand-offs among providers and peer navigation services offered between diagnosis and care, allowing for walk-ins and the ability to address basic needs such as housing, food, and transportation prior to enrollment, and reducing documentation requirements. Private foundations and other grant opportunities can help fund services provided prior to RWHAP eligibility determination.

Retained in Care

People who have experienced trauma often have difficulty staying in care. While some clients are at risk for falling out of care, others may call multiple times a day. Despite the best intentions of providers, HIV medical care and support services can be re-traumatizing. Examples of this include:

- Being unaware that the client’s traumatic history significantly affects their life
- Use of overly complicated or redundant forms, procedures and policies, and unnecessary documentation requirements
- Failing to screen for trauma history prior to treatment planning
- Challenging or discounting reports of abuse or other traumatic events
- Labeling behaviors such as sex with same gendered individuals or intravenous drug use as immoral or pathological
- Failing to provide adequate security or safety and confidentiality within a program
- Failing to acknowledge the stigma of HIV
- Unreasonable case loads
- Failing to attend to the impact of vicarious trauma in the workforce
- Failing to provide linguistically and culturally responsive services
- Practicing a confrontational or conditional treatment or counseling approach

- Limiting participation of the client in treatment decisions and care planning processes
- Minimizing, discrediting, ignoring, or pathologizing client responses
- Disrupting provider-client relationships by changing schedules and assignments
- Use of language such as “non-complaint,” “no-showed,” “resistant,” or “manipulative”
- Expecting perfect adherence to medication regimens and other lifestyle changes

Often, behaviors such as taking medication erratically or not attending appointments can be linked back to patients’ history of trauma. Considering the impact of trauma may help providers empathize with their clients to better understand behaviors and enable more effective communication and relationship-building that can lead to better outcomes.

Virally Suppressed

For those PLWH engaged in care, [trauma is associated with a variety of poor health outcomes](#), including treatment adherence issues, increased viral load, and decreased CD4 counts. One study found that women living with HIV in the U.S. who had suffered recent trauma were [four times more likely to experience HIV treatment failure](#). Conversely, [those with high resilience scores are more likely to be treatment adherent and have an undetectable viral load](#).

Vicarious Trauma

Vicarious trauma can occur in providers as a result of bearing witness to the experience of trauma in others. Providers are exposed to trauma through hearing about traumatic experiences or bearing witness to symptoms of trauma in their clients (e.g., aggression or anger). Vicarious trauma can lead to various levels of burnout and compassion fatigue, impacting high rates of turnover in many organizations that serve PLWH. Furthermore, many persons in helping professions are drawn to the work based on their own personal experiences, thus increasing the risk for vicarious trauma.

Given the multiple layers of vicarious trauma that can exist within the workplace, workforce wellness and self-care among providers is central to a trauma-informed approach. This means attending to both protective factors (e.g., training,

supervision, and a manageable case load) and risk factors (e.g., personal trauma history, isolation, and length of employment) among employees. Workforce wellness strategies include wellness plans, physical and emotional spaces for self-care and celebration, and routine discussion of self-care within supervision.

Trauma-informed approaches provide opportunities to reduce and prevent trauma, both within the agency and the workforce. When organizations become trauma-informed, and intentionally support providers and staff who may experience vicarious trauma, there is a more cohesive, innovative, and creative context within which healing from psychological and social traumatic experience and adversity can be addressed – for both clients and providers.

Defining Trauma-Informed Approaches

SAMHSA is a leader in trauma-informed approaches and has outlined a series of strategies and principles for describing this important work. SAMHSA further defines [trauma-informed approaches](#) through the following six principles:

Six Principles of Trauma-Informed Approaches

Physical & Emotional Safety

- Create a safe and welcoming environment
- Be consistent and predictable
- Non-shaming, non-blaming, non-violent
- Ensure privacy and confidentiality
- Provide clear expectations about what is happening and why

Collaboration & Mutuality

- Ensure respect, connection, and hope
- Recognize that healing occurs in the context of the interpersonal relationship
- Share in decision making (i.e., doing 'with' vs. 'to' or 'for')
- Level power differences between staff and clients by creating true partnering
- Everyone has a role to play in a trauma-informed approach from reception to direct medical care

Trustworthiness & Transparency

- Build and maintain trust among staff, clients, and family members of those served
- Maintain professional boundaries
- Transparent policies and processes
- Roles are clear
- An informed consent and grievance process are present

Empowerment, Voice & Choice

- Validate strengths and resilience
- Use strengths to build and enhance healthy coping skills
- Understand past coping mechanisms and the normalcy of the response to a not normal situation
- Apply strengths-based philosophy
- Value social roles
- Increase and ensure individual control and autonomy
- Frame experiences as survivorship, not victimization

Peer Support

- Recognize that peer support and mutual self-help are key vehicles for:
 - Establishing safety and hope
 - Building trust
 - Enhancing collaboration
 - Using stories and lived experience to promote recovery and healing

Cultural, Historical & Gender Issues

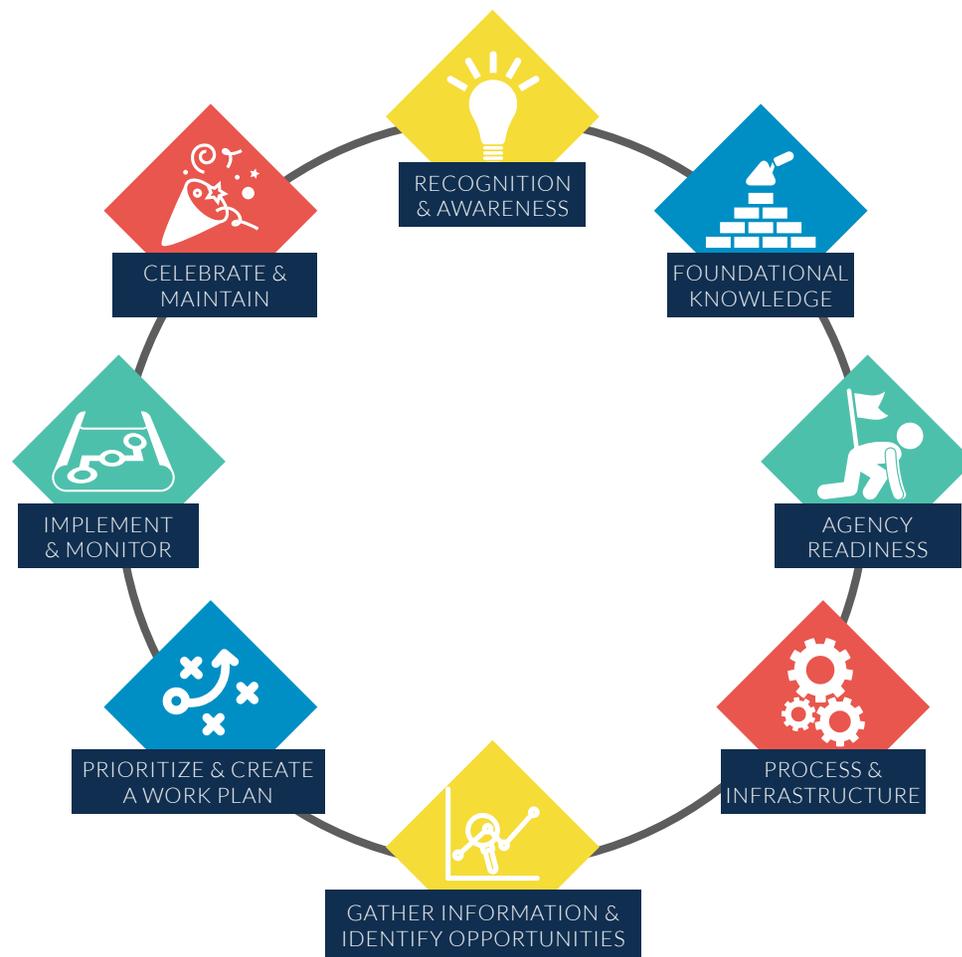
- Actively move past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, religion, gender geography, etc.)
- Provide gender responsive services
- Leverage the healing value of traditional cultural connections
- Incorporate policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served
- Recognize and address historical trauma

Trauma-Informed Approaches to HIV Services

Many health care agencies, education systems, correctional settings, and social service agencies have joined the movement to become trauma-informed. There are many actions that health departments, community-based organizations, and medical clinics can take to address trauma in the populations that they serve.

Shift the question from “What’s wrong with you?” to “What happened to you?”

The following section provides a “how-to guide” adapted from the extensive work of Trauma-Informed Oregon (TIO), a statewide collaborative aimed at preventing and ameliorating the impact of adverse experiences on children, adults, and families. The following section describes eight modules based on TIO’s road map to trauma-informed care. Within each module, considerations, actions, and examples from HIV-service entities are provided. This is neither a dependent nor a linear process. Depending on your setting or readiness level, some of the activities may not be applicable. Furthermore, becoming trauma-informed is not a fix that can be made quickly, rather, it is a slow-moving process aimed at creating sustained culture change within every person in a system. That being said, systems do not often accept change easily. It is important to attend to feelings of denial, resistance, or guilt that may arise as these approaches are implemented. Finally, give yourself credit for the work your agency is already doing to become trauma-informed.





Recognition & Awareness

Trauma is prevalent among social service recipients and those providing services. This can affect an individual's ability and willingness to engage with programs either as a service recipient or as part of the workforce. Further, the service setting has often been a source for re-traumatization. This awareness or trauma sensitivity is an important first step in becoming trauma-informed.

CONSIDERATIONS

- ⊕ Services can be re-traumatizing for both the service recipient and the workforce. Learn to recognize when and how services are triggering.
- ⊕ The prevalence of trauma within the population served by your agency.
- ⊕ The prevalence of trauma and work-related stress within the workforce.

ACTIONS

- ✓ Add trauma-related topics to agency newsletters, board meetings, trainings, conferences, and as a standing agenda item at staff meetings.
- ✓ Gather data on prevalence of ACEs. Inquire about the use of ACEs in your state's BRFSS. Consider adding the ACEs and resilience scales in consumer needs assessments or other surveillance projects (such as the Medical Monitoring Project or National HIV Behavioral Surveillance). If using an ACEs scale in surveys, provide reasoning and explanation of how information will be used and include referrals and resource information.
- ✓ Assess for burnout and vicarious trauma within the workforce, using instruments such as the Professional Quality of Life scale. Ensure supervision is trauma-informed and that self-care is regularly being discussed in staff supervision.
- ✓ Sign up to receive trauma and resilience related information and connect with local or national initiatives (see resources). Connect with other federally funded programs within your jurisdiction's health department that may be implementing trauma-informed approaches, such as Title V Maternal & Child Health Programs or the Special Supplemental Nutrition Program for Women, Infants and Children.
- ✓ Read about the impact of trauma within PLWH and HIV services in peer-reviewed journals.
- ✓ Assess client experiences with your agency through the use of a tool like this client feedback survey.

STATE EXAMPLE HAWAII

Hawaii's RWHAP Part B Program added the ACEs module to their 2018 consumer needs assessment. They plan to compare the responses they receive to the results of their state's BRFSS data and incorporate trauma-informed approaches accordingly.





Foundational Knowledge

All staff benefit from having fundamental knowledge of trauma-informed approaches. Training all staff helps form a common language within an organization and demonstrates a commitment to creating a sensitive, safe, and welcoming environment for service recipients and the workforce.

CONSIDERATIONS

- ④ Train all staff including reception, billing, management, support staff, volunteers, board members, and direct providers. The frequency and availability of foundational training and education should reflect the needs of the agency. Trainings, webinars, videos, books, and discussion groups could include the following content:
 - The ACEs study
 - The prevalence and impact of trauma among PLWH
 - A basic understanding of the neurobiology of trauma
 - Issues of power, oppression, and micro-aggression
 - Historical, collective, and intergenerational trauma
 - Guiding principles of trauma-informed care
 - Role and benefit of peer support services
 - Trauma in the HIV workforce and vicarious trauma
 - Motivational interviewing techniques

ACTIONS

- ✓ Provide a kick-off training for all staff within your continuum or agency. Especially consider providing trauma-related education to new employees as part of the hiring and onboarding process. There are many people across the country who provide trauma-related trainings — ask other agencies (via ACEs Connections) who are implementing trauma-informed approaches for recommendations.
 - Additional training might be needed for supervisors or persons in direct care positions.
- ✓ Incorporate trauma-related content into ongoing training. Consider existing webinars, videos, and Ted-Talks (see resources).
- ✓ Start a monthly lunch-time book club with staff. Consider books such as: *The Body Keeps the Score* by Bessel van der Kolk, *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* by Dr. Sandra L. Bloom, *Childhood Disrupted* by Donna Jackson Nakazawa, or *Trauma Stewardship* by Laura van Dernoot Lipsky.
- ✓ Build knowledge among clients. Distribute posters, infographics, and other client-specific information about the impact of trauma on health outcomes.

STATE EXAMPLE IOWA

Iowa's RWHAP Part B Program requires all case management providers to complete the [Trauma-informed Excellence \(TIE\) Series](#) offered by the ColdSpring Center. They incorporated this requirement into agency sub-contracts. Through use of discussion guides, and online and in-person trainings, the TIE Series gives organizations the knowledge and skills needed to fully integrate the trauma-informed approaches into day-to-day operations.





Agency Readiness

Implementing trauma-informed approaches requires a commitment from agency leaders and staff. Individuals within the organization must believe trauma-informed care is needed, appropriate, and possible given the service setting and circumstances. Readiness, in terms of psychological (attitudes, values, and beliefs), skills and knowledge, and structural factors (infrastructure, policies, and procedures), is important to consider if trauma-informed approaches are to be embraced and sustained.

CONSIDERATIONS

- ⊕ Reflect trauma-informed care principles in your mission, vision, and strategic plan.
- ⊕ Identify resources to support trauma-informed efforts.
- ⊕ Support continuing education and training.
- ⊕ Assess for organizational readiness for change.

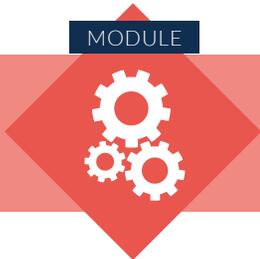
ACTIONS

- ✔ Set aside time to review your mission, vision, strategic plan, and other guiding documents, such as your jurisdiction's integrated prevention and care plan. Ensure that commitment to trauma-informed approaches is reflected.
- ✔ Review budgets to ensure adequate resources for training and technical assistance are identified.
- ✔ Use RWHAP funding, including ADAP rebates. Trauma-informed efforts can be addressed through RWHAP quality management or administration as well.
- ✔ Add trauma and resilience related expectations to position descriptions. Include trauma-related questions in interviews with new staff and invite clients to participate on interview panels.
- ✔ Research and apply for trauma-specific funding made available through the National Institutes of Health, SAMHSA, and private foundations.
- ✔ Ensure commitment to trauma-informed approaches is clearly stated within contracts with direct service providers.
- ✔ Consider creating a trauma-informed policy and procedures for direct service providers, such as these policy and procedures from Oregon's Addictions and Mental Health Division.
- ✔ Within a direct service setting, consider commitment to "universal precautions" whereby one assumes that all persons presenting for HIV-related services have experienced trauma and toxic stress. Ensure this commitment is stated within agency standards or policies.
- ✔ Assess for your agency's readiness to fully incorporate trauma-informed approaches through one of many existing tools.

STATE
EXAMPLE
OREGON

Oregon's RWHAP Part B Program includes language in their [case management standards of service](#) declaring their program's commitment to trauma-informed services.





Process & Infrastructure

Integrating trauma-informed approaches at the department, organizational, or clinic levels takes time and requires commitment and dedication. A process that supports these ongoing efforts through policy and practice is imperative.

CONSIDERATIONS

- ⊕ Support internal leadership and/or champion(s) to integrate trauma-informed approaches.
- ⊕ Sub-contractors can lead training, coaching, assessment, and ongoing monitoring and evaluation.

ACTIONS

- ✓ Identify a workgroup(s) to shepherd this effort. Consider capacity and appropriateness of existing teams, such as a quality management team, employee satisfaction or wellness committee, safety committee, consumer advisory board, or racial equity workgroup.
 - Should be representative of the organization or program
 - Consider incorporation of consumers or client voice, people with lived experience
- ✓ Ensure membership on workgroup is representative of the agency and includes staff from different levels and programs. If using an existing group, new people may need to be invited, and meeting schedules need to be adjusted to ensure everyone can regularly attend. If working in a state health department, you might consider staff from your ADAP and Housing Opportunities for Persons with AIDS (HOPWA) programs, and other RWHAP recipients around your state. Within a clinic or AIDS service organization, you might include managers, intake staff, nurses or other medical providers, case managers, and janitorial or administrative staff.
- ✓ Workgroup members should be responsible for the following:
 - Serve as trauma champions within the organization.
 - Assess the agency for current trauma-informed approaches.
 - Prioritize and recommend opportunities for trauma-informed approaches.
 - Communicate progress to the rest of the agency.
 - Create opportunities to gather feedback.
- ✓ Create or revise (if incorporating into existing workgroup) a charter that identifies:
 - Membership representation
 - Roles and responsibilities of membership
 - Purpose of group
 - How decisions are made (e.g., consensus or voting)
 - Length of commitment
 - Process for note taking, facilitation, and agenda planning

STATE EXAMPLE IOWA

In 2014, to better coordinate and share trauma-related approaches across the health department, Iowa's HIV Bureau joined the substance use, nutrition, cancer, tobacco, early childhood development, and refugee health bureaus to convene an inter-agency trauma-informed workgroup. The group meets quarterly to discuss strategies and approaches being implemented across the state health department. Additionally, utilizing a mixture of federal, state, and rebate funds, the RWHAP Part B Program hired a full time TIC Coordinator. The coordinator serves to align and facilitate their multi-prong approach to be a trauma-informed agency, including facilitating the inter-agency workgroup, supporting state-wide efforts to align trauma-informed work, and facilitating discussions for HIV bureau (prevention and care) sub-recipients around implementation of TIC.



Gather Information & Identify Opportunities

A trauma-informed assessment is critical for agencies to identify opportunities for trauma-informed approaches, to highlight current trauma-informed practices, and to measure progress in implementation.

CONSIDERATIONS

⊕ Methods to gather information:

- **External or internal:** Who will lead the process for gathering information? Someone from outside the organization (i.e., an external consultant) or internal staff?
 - External consultants can offer useful expertise and guidance. Their neutrality is a benefit when gathering information. However, there will likely be a cost associated with an external consultant.
 - Internal staff can efficiently and effectively gather information because they understand the inner workings of the agency. Lack of neutrality is a consideration as well as staff capacity. Adding this task to full workloads can be challenging.
- **Informal or formal process:** Agencies may choose to use an existing assessment instrument or conduct a more informal process.
 - Formal Process: Some instruments are tailored specifically to certain domains such as child welfare or mental health services. Using this type of instrument will help ensure considerations are specific to the field. Other tools, such as the Standards of Practice, provide categories in which to consider trauma-informed practice, more generally. While this tool isn't specific to a field, it is flexible and can be adapted for different settings.

- Informal Process: An agency can engage in an informal process to identify opportunities for trauma-informed approaches and current practices. This information can be gathered during trainings, at regular staff meetings, and using comment boxes or internal surveys

⊕ Focus areas when collecting information:

- A program within the agency (e.g., counseling or emergency assistance program)
- A location or site (e.g., courtroom, mobile unit, or housing site)
- A point in time for service recipients or staff (e.g., agencies may focus specifically on intake or new hire onboarding)
- ⊕ Be transparent about the feedback received with the entire organization on the results of this assessment and the resulting next steps.
- ⊕ Ensure perspectives of persons with lived experience or recipients of services are incorporated into the assessment.



Oregon's RWHAP Part B Program used [Trauma-informed Oregon's Standards of Practice](#) to complete an assessment. Both leadership and administrative support from a variety of programs, including ADAP, HOPWA-funded housing, and case management participated. After completion, a work plan was created and implemented. One early outcome resulted in improvements made to the ADAP lobby. While most ADAP clients receive phone-based services, for the few who come to the office, reduced clutter, framed artwork, directions to gender neutral restrooms and adjusted lighting were well received. A small work group took on the project and implemented a satisfaction survey to receive feedback from clients about the changes.



Gather Information & Identify Opportunities

ACTIONS

- ✓ Identify an assessment tool that will work best for your agency. There are many to choose from:
 - Conversation tool (pages 12 – 14) from a publication out of the National Center on Domestic Violence, Trauma, and Mental Health's.
 - TIO's Standards of Practice (general use) or Standards of Practice (for health care settings)
 - Agencies providing services to persons who are homeless might consider this trauma-informed assessment for homeless services.
 - Trauma-informed Care Project's Agency Self-Assessment
 - ACE's list of assessments
 - Start with something small like this environmental scan of your agency's physical environment.
 - Direct service providers might appreciate participating in a trauma lens exercise where trauma-informed approaches for challenging client behaviors are identified.
- ✓ Schedule time to complete the assessment. Decide whether a workgroup will complete the assessment, or if all staff will be involved.
- ✓ After the assessment has been completed, communicate the results back to all staff.



Prioritize & Create a Work Plan

The application of trauma-informed approaches will vary from setting to setting. Because it becomes part of an organization's culture and approach to service delivery, agencies will prioritize opportunities reflecting their own circumstances and environments. Identifying a method for prioritizing these opportunities and developing a work plan will help an agency move forward without becoming overwhelmed by the possibilities. Whether these are micro-level changes that involve individual practice, or meso- and macro-level changes that target policy and practice of an organization or community, it is important to build support. It's not uncommon for change to be met with resistance, however, the following considerations can help ensure that trauma-informed changes are adopted and sustained.

CONSIDERATIONS

Methods for prioritization include:

- ☉ Choose one of the TIC Principles for initial efforts. For example, many agencies prioritize issues of safety as the concrete aspects of physical safety in a service setting can be an easy place to start.
- Pick the “low hanging fruit” — starting with what is easiest to change or will make the biggest difference for service recipients and staff.
- Identify efforts that are high impact and low cost.
- Identify current practices that will have a negative impact, if not addressed.
- Use data from an assessment for guidance.

ACTIONS

- ✓ Set aside time to review results from your assessment. Discuss areas where you are doing well and areas where you would like to improve.
- ✓ Identify a few areas where you'd like to improve. Brainstorm strategies and activities needed to achieve improvement.
- ✓ Create a work plan. Organizing the areas for opportunity in a spreadsheet provides an easy method for keeping track of possible solutions, next steps, responsible party(ies), and measures for change.
- ✓ When appropriate, integrate strategies and activities into your integrated HIV prevention and care plans.
- ✓ Consider changes to policy and practice through the lens of TIC Principles.



New Jersey's RWHAP Part B Program hired external consultants to facilitate the implementation of their trauma-informed approach. Through this avenue, they engaged health department staff, sub-recipient agency leadership, as well as HIV-service providers to develop a plan over the course of two regional meetings and subsequent web conferences. The plans and preparations included the following: vision and plan for integration; development of policies and procedures; establishment of performance measures and data collection processes and systems; documentation and clinical quality improvement; plan for staff roles, responsibilities and skills training; intervention selection and training plan; financial considerations and reimbursement; referral and tracking between HIV provider and CBO sites; preparing the service environment; and, preparing for and managing change.



Implement & Monitor

After an organization has gathered information and prioritized needs, the next step is to implement the work plan (new or modified strategy, policy, or practice) while simultaneously monitoring the impact. Although the lack of validated evaluation tools is a limitation of trauma-informed approaches, assessments provide process-based measures for consideration. The following can help an organization define this process to fit their mission and population.

CONSIDERATIONS

- ⊕ Pilot ideas
 - Trauma-informed approaches result from small adjustments and large changes, so be encouraged to attempt any opportunity for improvement.
 - Solicit feedback about how it worked.
 - Be transparent with implementation plans and be willing to modify or toss ideas that don't work.
 - Set a reasonable timeframe outlining when you will decide to modify, keep, or toss a new strategy.
- ⊕ Promote innovation
 - Encourage proposals for trauma-informed practices from all staff.
 - Create an environment where all ideas are welcome.
- ⊕ Consider options for outside expertise when it comes to both implementing and monitoring the activity.
 - Weigh the pros and cons of various options and consider the amount of technical assistance needed with the time commitment and cost.

ACTIONS

- ✓ Keep trauma and trauma-informed approaches on the minds of staff.
 - Report out at meetings about new practices or happenings.
 - Ask staff for examples of trauma-informed approaches they've witnessed during meetings or staff supervision.
 - Ask about situations that could have been more trauma-informed.
 - Ask staff to reflect on something they have learned about trauma since the last meeting or supervision.
- Conduct a photo voice activity, asking staff or clients to take pictures of examples of trauma-informed communications or environments.
- In advance of need, create formal partnerships with wrap-around services in your community and create a process to support warm referrals (e.g., shelter, domestic violence advocacy organizations).
- ✓ Consider adding trauma-informed happenings to newsletters or bulletin boards.
 - Share successes (e.g., some organizations do 'shout outs' to each other either anonymously, or directly during meetings).



New Jersey's RWHAP Part B Program contracted with external consultants to support implementation of TIC at sub-recipient agencies. This includes the development of a monitoring and evaluation plan that will measure reaction, satisfaction, and assess changes in organizational characteristics and knowledge, skills, and attitudes of HIV providers and supportive service staff in implementing a TIC approach. Additionally, at the start and end of the 12-month training period for sub-recipients, participants will be asked to complete pre/post surveys that assess changes in knowledge, skills, and attitude. The findings from these evaluations will be used to improve and adjust New Jersey's trauma-informed approaches.



Implement & Monitor

- ✓ Find multiple ways staff and community can provide feedback or offer innovative ideas, such as use of suggestion boxes in lobbies.
- ✓ Identify outcomes you'll monitor to measure progress, such as provider satisfaction, burnout and turn-over, or client satisfaction, linkage, and engagement. Include these measures in your agency or statewide quality management or integrated HIV prevention and care plans.
- ✓ Monitor success and solicit feedback.



Celebrate & Maintain

As agencies pilot and implement trauma-informed changes, it is important to maintain commitment and momentum towards this cultural change through communication and celebration.

CONSIDERATIONS

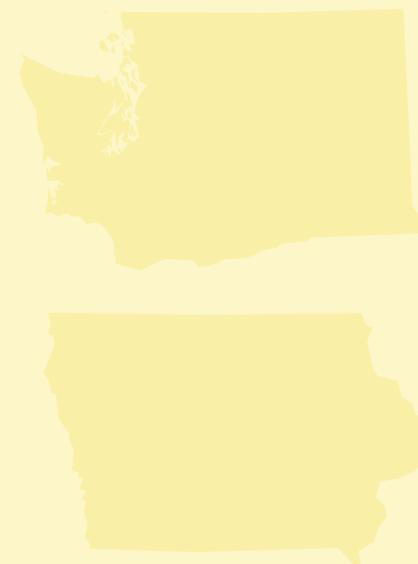
- ⊕ Promote change
- ⊕ Be trauma-informed when changes warrant staff training and skill-building
- ⊕ Be bold – but know when to discontinue an effort
 - Courage is needed in both your commitment to try things out and your commitment to stop doing what is not working. Continuing ineffective or costly change efforts erodes staff trust and commitment, thereby defeating the purpose of trauma-informed approaches.

ACTIONS

- ✓ Host a kick-off event for big changes.
- ✓ Introduce smaller changes in all-staff meetings or newsletters.
- ✓ Keep all staff in the loop (even those not directly affected), as this will promote trust and buy-in. Be transparent about who is involved in the change, how they will be affected, and the timeline for adoption.
- ✓ Balance new training with current workload and staffing levels.
- ✓ Allocate resources to ensure change is sustained. When a change has been abandoned, be transparent and explain the “why” to staff and others.
- ✓ Collaborate with other RWHAP Parts in your state. Share this toolkit and invite them to a learning collaborative.

STATE EXAMPLE WASHINGTON & IOWA

In 2018, Washington and Iowa’s RWHAP Part B Programs organized an in-person retreat to learn from one another’s trauma-informed approaches. While Iowa has facilitated extensive trauma-related training for HIV providers, Washington has a strong peer-based delivery service, both of which are demonstrations of trauma-informed principles.



Conclusion

In an era when ending the HIV epidemic is possible and state health departments have been challenged with taking the lead of this charge, embracing trauma-informed approaches as a framework is critical. The impact of trauma on the lives of those living with HIV has been demonstrated through evidence of the ACEs study and subsequent studies. In addition, the intersectionality of trauma and other oppression speaks to the disproportionality of some populations affected by HIV. **RWHAP recipients are encouraged to explore and utilize all allowable funding mechanisms available to them to fund trauma-informed approaches, including the following: RWHAP administrative and quality management funds; ADAP rebates; and, program income.**

TRAUMA-INFORMED APPROACH “ELEVATOR PITCH”

To reach the end of the HIV epidemic, we know that all PLWH need to be diagnosed, brought into care, and achieve sustained viral suppression. Applying a trauma-informed lens is a critical tool to end the HIV epidemic in the United States. Research indicates that PLWH have significant trauma histories when compared to the general population. According to SAMHSA, **70% of PLWH have experienced trauma, and PLWH are twenty times more likely to have experienced trauma than the general population.** These traumatic experiences have social, behavioral, economic, and health consequences which are disproportionately experienced by PLWH. A trauma-informed approach is not simply another intervention or activity for a health department or HIV services organization to conduct; it is a necessary strategy to our everyday work in HIV care and prevention. By **realizing, recognizing and responding** to the impacts of trauma, and actively working to reduce traumatization of both PLWH and HIV providers, we will move closer to **our vision of a world free of HIV.**

For more information on the Trauma-Informed Approaches Toolkit, please contact [Mahelet Kebede](#).

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Resources

ACEs Connection: a social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences to help heal and develop resilience rather than to traumatize already traumatized people.

Campaign for Trauma-informed Policy & Practice

Center for Integrated Health Solutions: identifies emerging evidence on [trauma](#), [suicide prevention](#), and [IPV](#), which are often interrelated.

IPV Health Partners Toolkit: a toolkit including partnership models, training curricula, and other resources.

National Council for Behavioral Health

National Center for Trauma-informed Care (NCTIC): supports interest in developing approaches to eliminate the use of seclusion, restraints, and other coercive practices and to further advance the knowledge-base related to implementation of trauma-informed approaches.

National Resource Center on Domestic Violence: provides free, evidence-based resources for clinical settings.

Project Catalyst: Statewide Transformation on Health and IPV: provides culturally specific training to prevent and end human trafficking and IPV. Community Health Centers, dually funded by Ryan White, are engaged in this initiative.

State Domestic Violence Coalitions: coordinate local IPV and domestic violence advocacy programs and provide technical support.

Ted Talks: There are a number of excellent Ted talks about impact of ACEs and trauma.

[John Rigg](#) (2015), The effect of trauma on the brain and how it affects behaviors.

[Liz Mullinar](#) (2011), Treating the core problem of childhood trauma.

[Laura van Dernoot Lipsky](#) (2015), Beyond the cliff.

[Madhumita Murgia](#) (2015), How stress affects your brain.

[Nadine Burke Harris](#) (2014), How childhood trauma affects health across a lifetime.

[Vicky Kelly](#) (2014), The paradox of trauma-informed care.

Trauma-informed Care: Perspectives and Resources: a comprehensive web-based, video-enhanced resource tool.

Trauma-informed Oregon: resources for a variety of fields of practice, organizations, training and individuals and families.

Trauma & HIV, HAB Division of Policy and Data Consultation Overview: executive summary of the December 2015 meeting convened by HHS HAB, in partnership with the National Institutes of Health, National Institute of Mental Health and the National Institutes of Health, National Institute of Allergy and Infectious Diseases.

Webinar

Evidence-based “CUES intervention” to Address IPV/Human Trafficking in Primary Care Settings, and tools for Ryan White-funded HIV Programs: this webinar will discuss the limits of disclosure-driven screening practices for IPV and offer an evidenced-based “CUES intervention” to addressing and responding to IPV in health centers. In addition, this webinar will offer specific tools for Ryan White-funded HIV programs.

Documentaries

Paper Tigers

Resilience: The biology of stress and the science of hope.

Consumer Resources

LGBT National Help Center provides peer support and local resources

Love Is Respect: a hotline that aids young people who have questions or concerns about their dating relationships.

National Domestic Violence Hotline: a 24/7 hotline that offers confidential safety and support 24/7 for anyone affected by domestic and dating violence.

Rape, Abuse & Incest National Network’s: a hotline in which local sexual assault service providers offer confidential support to survivors.

StrongHearts Native Helpline is a service for Native Americans affected by IPV