TRAUMA INFORMED CARE

IMPROVING SERVICES, SAVING LIVES

NOVEMBER 2017

PRESENTED BY

AIDS United

Christie's Place

Transforming lives since 1996

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AIDS United's mission is to end the AIDS epidemic in the United States. We fulfill our mission through strategic grantmaking, capacity building, policy/advocacy, technical assistance, and formative research. Learn more at www.aidsunited.org

Christie's Place is a nonprofit social service organization in San Diego County that provides HIV/AIDS education, support, and advocacy. Its mission is to empower women, children, families, and individuals whose lives have been impacted by HIV to take charge of their health and wellness.

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Introduction

"Trauma-informed service provision allows us to be human first; employing compassion, logic, and exquisite empathy simultaneously."

—Dawn-Marie Tol, Medical Case Manager

Despite widespread availability of effective HIV medications in the United States, most people living with HIV are not retained in medical care or accessing life-saving treatment. People living with HIV are disproportionately affected by trauma due to high rates of lifetime sexual and physical abuse, violence, and the ongoing effects of posttraumatic stress disorder (PTSD).[1] Trauma results in adverse effects on an individual's functioning and mental, physical, social, emotional, and/or spiritual wellbeing. Trauma and PTSD are known to predict poorer HIV-related health outcomes, including inferior health-related quality of life, lower rates of medication adherence, and higher mortality rates, as well as decreased likelihood of condom use.[1] Innovative, culturally relevant, and comprehensive approaches and interventions that effectively address the effects of violence and abuse on the lives of people living with HIV must be considered an integral component of HIV health care and social service provision.

People who have histories of violence and abuse are often very sensitive to people, places, or things that remind them of the traumatic event(s). These reminders may cause a person to relive components of the traumatic event(s), which may result in them experiencing a health care or social service setting as distressing rather than as a place of healing and wellness. Trauma survivors often rely on coping strategies when accessing care and services and may experience symptoms of PTSD, anxiety, and depression.[2] When these symptoms are not treated, people with histories of trauma are less likely to seek help and less able to stay engaged in treatment.[3] In addition, re-traumatization can occur when accessing services because of inherent hierarchies, gender-based historical trauma, and emotional and physical vulnerabilities. Programs designed to address trauma and PTSD may

[1] Machtinger, E. L., Wilson, T. C., Haberer, J. E., & Weiss, D. S. (2012). Psychological trauma and PTSD in HIV-positive women: A meta-analysis. *AIDS Behavior,* 16, 2091–2100.

[2] Elliot, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., Glover Reed, B. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology,* 33(4), 461–477.

[3] Elliot 2005.

increase positive sexual health, improve mental health,[4] and reduce disparities in care and service access for people with trauma histories.

Trauma-informed care is a resilience-focused and strength-based approach to service provision that involves understanding, recognizing, and responding to the effects of trauma.[5] Trauma-informed service delivery necessarily involves a partnership between service recipient and service provider in which both bring knowledge and experience to the table. Goals must be mutual and established collaboratively. Additionally, the overall aim of trauma-informed care should be an increase in the client's access to choice, options, and sense of control over life decisions, including decisions regarding the treatment process.[6]

- Staff in trauma-informed service settings demonstrate a commitment to attend to issues of power and hierarchy in ways that minimize potential for re-traumatization;
- There must be a commitment to trauma-informed service provision on all levels of the organization, particularly from those in leadership positions; and
- Trauma-informed service environments include meaningful participation by those who access services in service development, implementation, and evaluation.

Situating Trauma-Informed Care Within an Intersectional Framework

The development and maintenance of a trauma-informed care setting is an ongoing and dynamic endeavor. It is a process that grows and evolves over time through the shared commitment of stakeholders of physical, emotional, behavioral, relational, and spiritual health and wellness, including those who access and provide services and the community in which these services are provided. When addressing the effects of violence and abuse on the lives of people living with HIV, the contexts of their lives and the intersections of their identities must be considered. Structural issues of poverty, housing and food insecurity, and inadequate access to resources exacerbate circumstances, making decisions about leaving violent situations more complex. People living with HIV live day-to-day with multiple experiences of marginalization along the intersections of gender, gender identity, race, ethnicity, immigration status, sexual orientation, and ability. Experiences of violence and abuse should be considered across the lifespan including childhood physical, emotional, and sexual abuse; dating violence; intimate partner violence; increased risk of violence that can occur during pregnancy; and types of abuse facing people as they age such as elder and financial abuse.

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[4] Machtinger, E. L., Haberer, J. E., Wilson, T. C., & Weiss, D. S. (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. *AIDS Behavior,* 16, 2160-2170.
[5] Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (HHS Publication No. SMA 14-4884). Rockville, MD: Substance Abuse and Mental Health Services Administration.
[6] Elliot 2005.

The Christie's Place Model

Christie's Place began integrating trauma-informed care into their program after realizing the high degree of need among their clients. Developed as a guiding philosophy, the ongoing and dynamic structure of the Christie's Place model of trauma-informed service provision was influenced by training and technical assistance from the Office on Women's Health, literature on trauma-informed care and service provision, and 20 years of experience and lessons learned via the provision of HIV social services focused on the needs and experiences of women living with HIV. Christie's Place's efforts to better recognize and address the intersection between HIV and violence among women and girls were undertaken in conjunction with the needs of the organization, staff, and consumers. The core components described in this resource have come to comprise the philosophy through which trauma-informed service provision has developed at Christie's Place.

About AIDS United's Access to Care Initiative

The AIDS United **Access to Care (A2C)** initiative supported innovative, evidence-based, collaborative programs that connected thousands of low-income and marginalized people living with HIV to supportive services and health care. All funded projects within the A2C portfolio developed a team of organizations that collaborated to reduce barriers along the HIV care continuum, provided innovative solutions to longstanding access problems, and changed the way that systems operate in their communities. Over the past five years, AIDS United has supported three initiatives working to improve access to care for people living with HIV, and all three fall under the overarching work of A2C. Christie's Place was directly funded by two of these programs, the Social Innovation Fund and the Retention in Care initiative.

The Social Innovation Fund was inspired by the first ever U.S. National HIV/AIDS Strategy, which emphasized the necessity of public-private partnerships to help end the HIV epidemic.

The AIDS United **Social Innovation Fund** was inspired by the first ever United States National HIV/AIDS Strategy, which emphasized the necessity of public-private partnerships to help end the HIV epidemic. The Social Innovation Fund, a program of the Corporation for National and Community Service and 14 national private funders, supported 12 innovative, evidence-based, collaborative programs working in communities across the country to connect thousands of low-income and marginalized individuals living with HIV to care and support services.

Supported by the M·A·C AIDS Fund, the AIDS United **Retention in Care** initiative supported seven organizations working with populations that experience some of the worst HIV-related health outcomes in the United States. With the goal of addressing one of the largest drop-off points along the HIV care continuum, these organizations implemented innovative and emerging program models rooted in collaboration.

These initiatives were supported by a rigorous national evaluation conducted by Johns Hopkins University. Grantees informed one another as well as other initiatives across the country, and their successes put them at the forefront of the innovative, evidence-based, collaborative care necessary to end the HIV epidemic in the United States. Learn more at: www.aidsunited.org.

About Christie's Place

Christie's Place is a women-led, community-based nonprofit organization in San Diego, California, that delivers education, advocacy, behavioral health, and supportive services in a safe, home-like environment for women, children, and families impacted by HIV/AIDS. What started in 1996 as a small grassroots organization has grown into a comprehensive support center guided by its mission. Its nationally recognized model of coordination and integration of services successfully brings women and families out of isolation, provides mutual support, and ensures access to and participation in the full continuum of HIV care and treatment.

Christie's Place develops and implements innovative gender-responsive and trauma-informed approaches to ensuring access to and consistent engagement in HIV medical care, focusing on individual-level solutions to barriers to care, as well as systemic change. Our wrap-around integrated model of care is grounded in an understanding of social and structural-level factors that profoundly affect the ability of women, children, and families impacted by HIV/AIDS to access and sustain medical care. Our multidisciplinary care team provides client-centered clinical and supportive services tailored to each client's individual needs.

Christie's Place's integrity, expertise, and longstanding foundation in the community, along with the delivery of family-centered and comprehensive social services, cultivates hope and empowers women, children, and families impacted by HIV/AIDS. The strength and values behind Christie's Place represent the long-term commitment to supporting people affected by HIV and the ability to respond effectively and directly to the evolving needs of our community.

What is Trauma?

Individual trauma results from: an event, series of events, or a set of circumstances that are experienced by an individual as physically and/or emotionally harmful or threatening. It has lasting adverse effects on the individual's functioning and mental, physical, social, emotional and/or spiritual wellbeing.[7]

Trauma can affect a person's:

- Identity, purpose, hopes, dreams, and goals;
- Relationships including intimate, work, friendships, and family relationships;
- Ideas about how close or distant relationships should be, as well as decisions about what relationships to engage in;
- Expectations of self and of others;
- Ability to regulate emotions and respond to situations or stressors;
- Worldview and perceptions of safety; and
- Health outcomes.

Potentially Traumatic Life Experiences:

- Physical, sexual, or emotional abuse;
- Childhood neglect (basic needs are not met for food or shelter);
- Death of a parent;
- Violent loss of a loved one (suicide/homicide);
- Rape;
- Children living in homes with drug addiction, alcoholism, incarceration, and/or violence;
- Serious medical conditions;
- Combat/war; and
- Bias-related crimes and social discrimination.

[7] Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (HHS Publication No. SMA 14-4884). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Components of service settings that may be distressing for women with lived experiences of trauma:

- The power dynamics of the relationship, including perceptions about sense of agency to provide input or ask questions about treatment decisions;
- Loss of and lack of privacy—providers often ask invasive questions in the absence of an established, trusting relationship or in spaces where others are present;
- Changes in service providers can occur with little or no notice; and
- Models of care and reimbursement are often based on medical necessity, which often requires a focus on diagnosis and pathology rather than strengths and resiliencies.

What is PTSD?

Posttraumatic stress disorder or PTSD is a mental health diagnosis in which people experience the following types of symptoms that impact their day-to-day lives:

- Re-experiencing of traumatic event(s) through intrusive memories, nightmares, flashbacks, and reactivity to trauma-related cues;
- Persistent avoidance of reminders of the trauma such as avoiding people, places, and activities associated with the trauma;
- Changes in mood or cognition such as difficulty experiencing a full range of emotions; negative feelings such as fear, horror, guilt, or shame; and loss of interest in once pleasurable activities; and
- Changes in arousal such as sleep trouble, increased irritability and anger, difficulty concentrating, hypervigilance, and self-destructive or reckless behavior.[8]

[8] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Implementing Trauma-Informed Care

Introduction

The development and maintenance of a trauma-informed care setting is an ongoing and dynamic endeavor. There is no one-size-fits-all model of trauma-informed care. As such, an organization must tailor its efforts to develop a model of trauma-informed care that is mission driven and effective. It is imperative that organizations institutionalize trauma-informed principles and practices through a process that involves:

1. Identifying and understanding organizational and community stakeholder foundation for trauma-informed care;
2. A thoughtful and informed planning process;
3. The implementation of intentional practices rooted in trauma-informed principles;
4. Purposeful evaluation activities; and
5. An expectation and allowance for model augmentation based upon lessons learned from both implementation and evaluation activities.

TRAUMA-INFORMED CARE AT WORK: CHERYL

Cheryl was found sleeping on a park bench by a Christie's Place peer navigator. At the time, that bench was the only way that she could be reached. Cheryl has multiple diagnoses including cancer, hepatitis C, and posttraumatic stress disorder (PTSD) that have severely affected her ability to accomplish day-to-day tasks. Carrying the brunt of years of stigma, Cheryl does not disclose her status to anyone. This is one of the reasons she finds connection and hope at Christie's Place. Working with her peer navigator, she was soon connected to medical care and was undetectable within six months.

Without trauma-informed services, Cheryl would not have been able to navigate the myriad obstacles in her way. Cheryl now has stable housing, improved medical care, and PTSD treatment. This marks a milestone in Cheryl's recovery as she had declined treatment for her PTSD symptoms for years. Cheryl's case reflects the most important component of trauma-informed service provision, the ability to foster the integrity, respect, and dignity of clients throughout the many hardships that they confront.

Further, every aspect of this process must meaningfully involve people living with and affected by HIV who also have experienced trauma. Learn more about the meaningful involvement of people with HIV/AIDS (MIPA) on our website: www.aidsunited.org/resources.

This section of the manual outlines essential objectives for the early, mid, and late/maintenance phases of trauma-informed care implementation that can be tailored to fit your organizational goals. Examples of challenges, successes, and lessons learned that Christie's Place experienced will be described along with illustrative case studies and accounts from Christie's Place staff.

Early Implementation Phase of Trauma-Informed Care: Getting Started

Identification of the Need for Trauma-Informed Care

The first step in implementing trauma-informed care is identifying the need or foundation for its implementation in your care environment. As previously described, people living with HIV are disproportionally affected by trauma, making trauma-informed service provision an essential element across the HIV care continuum. It is imperative that you can clearly articulate the effects of trauma on the lives and health outcomes of your community. This should be inclusive of your staff who may have lived histories of trauma and are affected on a day-to-day basis by working with clients who have experienced trauma. This process should be informed by key stakeholders both within and outside of your organization. Implementation strategies may include:

- Review of existing organization and community data on safety, trauma history, mental health, and substance use;
- Key informant interviews; and
- Client, provider, and community focus group interviews.

To provide an initial rationale for garnering feedback, it is helpful to briefly situate key informant interviews and focus groups in available data—such as local data on safety, trauma history, mental health, and substance use—and emphasize the importance of the meaningful involvement of people living with HIV. Interview questions should engage participants to share their experiences of how barriers such as domestic violence, trauma, mental health, and/or substance use have affected their (or their client/patient) engagement in HIV care or other support services. Some participants may experience these discussions as distressing. It is critical to inform participants in advance about the topics you will be exploring. Ensure that participants understand that they can choose their participation level at all times.

Prior to engaging in key informant and/or focus group interviews, it is important to identify onsite or offsite behavioral health resources and referrals to provide to participants, if needed. If your organization does not have these resources now, it is recommended that key informant interviews and focus groups take place at a later stage of implementation when these resources are available.

2 *Resource Identification and Procurement*

Identifying the need for trauma-informed care, as described above, will guide you in the initial conceptualization of how and why your organization will benefit from developing a model of trauma-informed care. Next, you will want to determine what resources will be needed to start implementing trauma-informed care. It is helpful to start this process by evaluating what resources your organization currently has that can be leveraged as you begin the implementation process. For example, you may evaluate:

> "I have learned to recognize that people have many different types of trauma in their lives and re-traumatization can exist in our everyday interaction with clients."
>
> —Betty Uribe
> Medical Case Manager

- To what extent is your organizational mission and vision situated within fostering agency and empowerment? What practices do you engage in that reflect this?
- To what extent does your organization meaningfully engage people living with HIV in programmatic design, implementation, and evaluation? Do you place importance on recruiting people living with HIV for staff, board, and volunteer positions?
- Does your organization currently have staff members who are knowledgeable about trauma? Do you have processes in place for ongoing staff development inclusive of staff at all levels of the organization? Do you have existing relationships with providers of trauma-related services in your community?
- Does your organization's staff recognize the prevalence and impact of trauma on the lives of the people you serve? Does your organization's staff see the value of moving toward a trauma-informed care model? Does leadership support resource allocation needed to implement trauma-informed care?
- Do you have support from stakeholders in your community to implement trauma-informed care? Do the people served understand the impact of violence and abuse on the lives and health outcomes of people living with HIV?
- What aspects of your physical space and organizational atmosphere promote safety, healing, and wellness for clients and staff?
- To what extent has your organization institutionalized practices that attend to hierarchy, promote informed consent, and ensure confidentiality? Do you have processes in place to assess for trauma and current safety? Do you offer trauma-specific behavioral health services and support groups or have access to community resources that provide trauma-specific services?

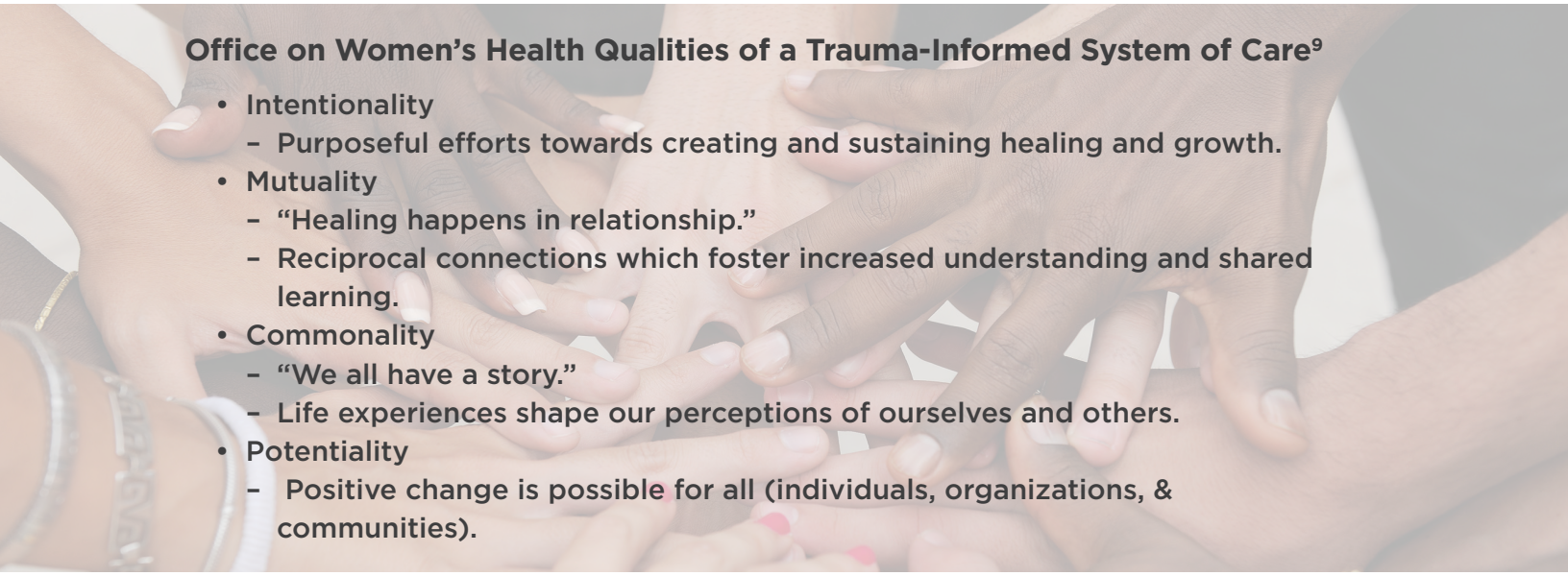
The answers to these questions can help you to determine your baseline level of preparedness for implementing trauma-informed care as well as what resources are needed to start implementation.

3 *Champions of Trauma-Informed Care*

Given that stakeholder investment is such a critical component of the successful implementation of trauma-informed care, it is imperative to establish champions for trauma-informed care at your organization. These champions should include members of the organization's leadership, staff, and clients. Organizational champions will engage stakeholders in developing their ongoing investment in trauma-informed care to ensure their continuous involvement in the process. These champions can also identify resources for ongoing staff support such as clinical supervision and wellness activities that promote team self-care. At Christie's Place, the Cultural Competency/Trauma-Informed Service Provision Committee (CCTIC) was developed to fill this role (more information about the CCTIC is provided further on in this resource).

4 *Guiding Principles*

There are several fantastic resources that describe trauma-informed principles and philosophies (see the appendix for examples). It is important to create a solid foundation for your work by identifying and agreeing upon principles that will guide trauma-informed care at your organization. These guiding principles should be congruent with your organizational mission and easily articulated to stakeholders both within and outside of your organization. These guiding principles may shift and evolve as you implement trauma-informed care at your organization. For now, they will guide your planning, practice implementation, and evaluation activities and may be augmented as you reflect upon and learn from the overall implementation process.



Office on Women's Health Qualities of a Trauma-Informed System of Care[9]

- Intentionality
  - Purposeful efforts towards creating and sustaining healing and growth.
- Mutuality
  - "Healing happens in relationship."
  - Reciprocal connections which foster increased understanding and shared learning.
- Commonality
  - "We all have a story."
  - Life experiences shape our perceptions of ourselves and others.
- Potentiality
  - Positive change is possible for all (individuals, organizations, & communities).

[9] Adapted from the HHSA Office on Women's Health trauma-informed training curriculum "A Public Health Response to Trauma: Creating Conditions, Connection, and Community for Women and Their Children."

EARLY IMPLEMENTATION AT CHRISTIE'S PLACE

Successes

- Christie's Place had a strong foundation for trauma-informed care in existence due to a long history of providing gender-responsive and family-centered services.
- Christie's Place's leadership had a solid investment in shifting to trauma-informed care and effectively engaged stakeholders to ensure their investment.
- Invaluable funding was secured through the Retention in Care initiative and existing internal resources were leveraged for staff to commence implementation.
- Training from the Office on Women's Health provided initial guiding principles.

Challenges

- It was difficult to procure resources to implement a trauma-informed care model.
- Creating investment with team members who perceived trauma-informed care as a new trend in service delivery required additional support and guidance. The team was reassured that their investment would be rewarding and fostered in an ongoing manner rather than a passing movement in service provision.

Lessons Learned

- Because a strong foundation for trauma-informed care already existed at Christie's Place, there was a need for staff to re-conceptualize existing service provision using new trauma-informed care terminology. This required staff to embrace the importance of learning and utilizing new terms for the work at Christie's Place.
- Ensuring staff investment required continuous conversation with the team regarding the benefits of trauma-informed care for clients.

Mid-Implementation Phase

The initiation of the mid-implementation phase of trauma-informed care is dependent on the amount of time and resources directed during the early implementation phase. Once the four objectives from early implementation have been achieved, it is time to move on to the middle phase.

1 *Conduct Baseline Organizational Assessments*

Based upon your previously identified guiding principles, the assessment should encompass two domains, environmental and staff competency.

- **Environmental:** The baseline environmental assessment establishes an understanding of strengths and areas for potential growth of your physical space and organizational atmosphere with regard to the promotion of safety, healing, and wellness for people who access and provide services. The environmental assessment should be completed by all staff as well as other identified stakeholders, including the clients who access your organization's services. Example assessment domains include:
  - *Physical space attributes* such as confidentiality and privacy, accessibility, appearance, and climate;
  - *Atmospheric attributes* including transparency, consistency, predictability, resource availability, gender specific and cultural competence; and
  - *Relational attributes* including boundary maintenance and authenticity.
- **Staff Competency:** Ask all staff to assess their competencies in the following areas:
  - *Knowledge:* Staff self-assess their understanding of key trauma-informed concepts and their ability to describe important fundamentals related to trauma;
  - *Skills:* Staff rate their ability to create a trauma-informed environment and to engage with others in trauma-informed ways as well as their willingness to accept influence from others; and
  - *Values:* Ask staff about their beliefs on notions that are central to trauma-informed care, such as the belief that healing from trauma is transformative, that recovery from trauma is possible for all, and that healing happens in relationship.

"The trauma-informed education that I received allowed me to be more understanding, compassionate, and patient with the people that I work with. It has allowed me to be a better professional."

—Jean Saito
Linkage to Care Coordinator

Examples of these two types of assessments, adopted from training and technical assistance from the Office on Women's Health, are included in the appendix for your reference. At Christie's Place, these assessments were translated into Spanish so stakeholders could complete them in their preferred language.

These baseline assessments allow organizations to identify areas of greatest need for staff training and environmental transformation. SMART (specific, measurable, attainable, realistic, and timely) goals should be developed based upon the data gleaned from these evaluations. Assessment data and corresponding SMART goals should be presented to identified stakeholders for additional input. Repeat these assessments at regular intervals with a mechanism for comparing results and measuring progress.

Training Implementation

Proficiency in trauma-informed care is essential at all levels of an organization. To accomplish this, all staff and management should participate in ongoing training. A thoughtful training curriculum should be developed that covers the essential elements of trauma-informed care and topics specific to the effects of violence and abuse.

Trainings may be developed and facilitated by existing staff or outside experts. Christie's Place found it useful for these trainings to be developed and provided by staff members to ensure continuity of the training from year to year, congruency with agency mission, and incorporation of the agency's mission-driven model of trauma-informed care. The Christie's Place curriculum includes the following modules:

- Trauma-Informed Service Provision/Christie's Place Model of Trauma-Informed Care,
- Trauma-Informed Agency Orientation and Client Assessment,
- Understanding and Utilizing Trauma-Informed Language,
- The Physiology of Trauma,
- Historical and Cultural Trauma,
- Adverse Childhood Experiences and Complex Childhood Trauma,
- Impact of Vicarious Experiences on Helping Professionals, and
- Healing from Trauma: Forming Relationships.

"When someone displays unusual or even hostile behaviors, the question I ask has changed from 'What's wrong with you?' to 'What happened to you?' recognizing that the behavior is perhaps a coping behavior in reaction to a traumatic event. This has really helped change my view of how we, as emotional beings, function and cope in life."

—Amanda Darlington
Development Associate

The curriculum is reviewed annually based upon identified training needs and new developments in the field.

Trainings should be delivered in a manner that is accessible to staff of varying educational and experience levels. At Christie's Place, a 45- to 60-minute training module is presented at our monthly staff in-service. The modules are repeated annually to ensure ongoing competency for existing staff members and training for new staff members. An introduction to trauma-informed care is provided to each new staff member as a part of their onboarding, making it possible for a new staff member to join the training at any point in the curriculum. The introduction to trauma-informed care is also provided to new volunteers and the remaining curriculum components can be provided to volunteers, if necessary.

Additionally, it is important to provide training on related topics that may be discipline or context specific. Resources should be identified to support these training opportunities both on- and offsite.

3 *Piloting Interventions*

During the mid-phase of implementation, augmentations of existing services and interventions aimed at meeting the SMART goals should be piloted. Examples of piloted interventions that were employed and/or augmented by Christie's Place include:

- **Trauma-Informed Client Orientation:** Client service delivery begins with an orientation to Christie's Place where the collaborative, strength-based treatment philosophy is introduced. This is an interactive process to encourage clients to develop an understanding of our services and philosophy. The orientation fosters hope, informed consent, and investment in program participation. It also ensures clients understand their role as an active collaborator in the treatment process and their ability to make choices regarding treatment and services—a critical outcome of a strength-based, trauma-informed, social justice-oriented model of care.
- **Trauma Assessment:** At client intake and annual re-enrollment, Christie's Place provides comprehensive assessment and assisted referral to appropriate resources and services, such as food assistance, case management, or behavioral health services.

  In conjunction with intake or annual re-enrollment, clients complete a strength-based, trauma-informed mental health, substance use, and support system assessment conducted by a Christie's Place peer navigator or family caseworker. This assessment ascertains the client's current level of functioning; how the intersections of past or current trauma(s), substance use, and mental health conditions create barriers to optimal engagement in care; and the level of social support currently available to the client.

Based upon the assessment results, an interdisciplinary treatment plan is developed by the team members who provide services to the client. The client then meets with their peer navigator or family caseworker to discuss the assessment results and the treatment team's recommendations. The client's feedback is solicited and revisions to the treatment plan are made when needed. In accordance with the client's treatment plan, the client is linked to indicated medical and support services at Christie's Place and other appropriate agencies.

- **Facilitative Supportive Services:** Facilitative, wrap-around, supportive services are essential to trauma-informed service provision. These services may include basic needs assistance (food, hygiene products, diapers, etc.), transportation resources and assistance, childcare, legal services and assistance, education and treatment adherence support, and system navigation assistance. Christie's Place already had these services in place at the time of trauma-informed care implementation, so the main task for staff was to integrate their understanding of gender-responsive care and family-centered care as aspects of trauma-informed service provision.

> "Shifting into trauma-informed service provision has turned out to be an eye-opening experience. I have become much more aware of how I interact with others and how much impact subtleties have."
>
> —Edna Burgos
> Medical Case Manager

- **Peer-Based Patient Navigation:** Christie's Place's nationally recognized best practice Coordinated HIV Assistance and Navigation for Growth and Empowerment (CHANGE) model utilizes the skills and talents of women living with HIV as providers of peer-based patient navigation services. This trauma-informed model, which addresses the intersection of violence and HIV and is aligned with the National HIV/AIDS Strategy for the United States, has been shown to be effective in improving engagement in care for people living with HIV and other chronic illnesses.

Since 2010, the CHANGE for Women program's peer navigators have played a pivotal role in the program's multidisciplinary treatment team. CHANGE for Women peer navigators are women living well with HIV who have personal and professional experience in navigating health care and support systems. Like so many women living with HIV, they have a history of trauma, which amplifies their ability to successfully gain the trust of clients that is needed for acceptance of services. Peer navigators identify potential clients through both in-reach and a wide variety of outreach strategies, including direct outreach to community-based organizations, community health centers, substance use treatment programs, and housing assistance programs.

Peer navigators provide needs assessment, referrals, linkage to HIV medical care providers, health and medication education, guidance, and motivation. They are trusted guides who provide easily understandable information that assists women in determining how best to get what they need from highly-fragmented service delivery systems. They serve as

role models, enhancing and supporting the professional assistance provided by primary care providers, case managers, behavioral health providers, and other service providers. Lastly, through their guidance and shared lived experiences, they help to foster agency—building a woman's confidence and determination to stay in care and on treatment. For a detailed account on the integration of peers into care systems, AIDS United has developed a tool kit, which can be accessed at www.aidsunited.org/peers.

- **Strength-Based Medical Case Management:** Medical case management is provided for clients with high acuity needs who are out of care or at risk of falling out of care—many of whom are reporting trauma-related barriers. In conjunction with the treatment team, medical case managers work with clients to increase treatment adherence by providing skills-building, education, and continuous assessment of a client's barriers to achieving viral suppression. Medical case managers provide assessment, care coordination, and advocacy and link clients to HIV medical care providers and resources, such as housing assistance and transportation, to reduce barriers to care. Additionally, they help clients obtain resources to meet their need for emergency food assistance, safe shelter, and childcare and provide vital linkages to legal services to pursue child support or escape a violent partner.

- **Trauma-Specific Behavioral Health Services:** Clients with significant scores on trauma, substance use, and/or mental health measures are referred to Christie's Place's on-site mental health services for individual and/or family therapy. The mental health counselor collaborates with clients to create a preliminary assessment of how these factors intersect to affect their health and wellness, including how they contribute to the client's ability to be optimally engaged in and retained in care. This process is essential for the client to feel empowered in their ability to make choices about health care. This assessment provides a baseline from which individualized treatment goals are constructed and progress can be measured. In collaboration with the treatment team,

For a detailed account on the integration of peers into care systems, AIDS United has developed a tool kit, which can be accessed at **www.aidsunited.org/peers**.

"At the beginning of our shift to trauma-informed care, I was confronted with some unresolved trauma issues. I had to begin my own healing process, to better serve my clients with compassion."

—Jay Blount
Peer Navigator

the mental health counselor and client formulate a tailored treatment plan. Components of this treatment plan may include:

- Gender-responsive, trauma-informed, social justice-oriented counseling services (individual, family, and/or group) that address mental health, substance use, and family/support barriers;
- Referral to a psychiatrist for medication evaluation and management; and
- Release of information and collaboration with existing treatment providers, including psychiatrist, substance abuse counselors, and/or therapist.

The client and treatment team regularly communicate about and assess progress toward stated goals. The client's voice remains at the center of this dialogue to ensure investment in the process and that the services do not replicate oppressive relational, social, and institutional power structures. Counseling services are relationally focused from the outset with the explicit aim of expanding upon current support systems. Therefore, counseling consultations may regularly include family members, friends, or other sources of support that will enhance the client's ability to remain optimally engaged and retained in care.

TRAUMA-INFORMED CARE AT WORK: DEBRA

At the time of Debra's diagnosis, she was hospitalized and near death. Debra had a history of addiction and was the primary caretaker for multiple aging family members, with little support. Her living situation was toxic, endangering her sobriety by putting her at high risk for relapse. A social worker connected her to Christie's Place specifically for its unique gender-responsive care.

Through accessing trauma-informed services at Christie's Place, Debra has evolved into an empowered woman with a healthy relationship with her family and herself. Debra has remained sober for three years and is now enrolled in school to further her education. Using skills she gained at Christie's Place's peer advocate training, she has also become active in the HIV community, volunteering and participating in local and national advocacy. She is adherent to her medications and has an undetectable viral load. Additionally, she has become an inspiration to many women through her dedication and positive encouragement.

4 *Staff Support*

All staff require ongoing support to ensure their own self-care and reduce the possibility of vicarious trauma and burnout. Elements of staff support can include:

- Regular clinical supervision (individual and group) for staff members providing clinical and supportive services;
- Ongoing training on secondary traumatization and vicarious trauma inclusive of training on vicarious resilience, the process of provider empowerment and positive development through learning about overcoming adversity from trauma survivors;[10]
- Diversity of roles and balance of workload as possible within agency mission; and
- An emphasis placed on supporting staff health and wellbeing (Wellness Committee activities, time off for therapy, or other needed supports).

TRAUMA-INFORMED CARE AT WORK: SANDRA

Sandra had a very traumatic life filled with abuse since childhood. She was separated from her mother and was passed from family member to family member, never really finding a safe place. She married at a young age and the abuse continued from her husband as well as from her children. Sandra was connected to Christie's Place during a time of extreme addiction. After spiraling deeper into her addiction, Sandra endured over a month of psychiatric care under close supervision where she was told that she would never be able to live alone again as she was no longer able to care for her basic needs. She was eventually placed in a rehabilitation home until suitable assisted living could be found. Sandra's first phone call was to Christie's Place.

Reunited with her case manager and peer navigator, Sandra immediately felt empowered. Together, they began to stabilize her situation and found permanent housing that fostered Sandra's integrity, respect, and dignity; met her medical needs; and supported her sobriety. Sandra continued her engagement in Christie's Place programming focused on the understanding of trauma and its impact on the health and wellness of women. She had regular contact with her case manager and peer navigator, attended several Christie's Place events, and participated in treatment education adherence sessions and recovery support meetings.

While her body had weathered many traumatic life experiences, Sandra's spirit was still full of life. She loved coming to the warm and welcoming comfort of Christie's Place to hear others' stories; she felt she still had something to offer. With a belief in her ability to heal and recover, Sandra made her health and wellness a priority. Sandra began therapy and was hopeful that she could put to rest some of her demons she'd been living with for so long. Sandra passed away in 2016. Her last years of life were lived with purpose and meaningful goals.

[10] Hernandez, P., Gangsei, D., & Engstrom, D. (2007) Vicarious Resilience: A New Concept in Work With Those Who Survive Trauma.

Additionally, the normalization of vicarious trauma, vulnerability to impairment/trauma, vicarious resiliency, reactions to client/community trauma, and support of staff's development of realistic self-expectations at work should be incorporated into the organizational culture.

Because self-care is different for each person, it is essential to determine how an agency can provide time or resources to support staff. Management and staff must recognize the importance of each person's own definition of self-care. It is critical to create an environment in which people can participate in agency-coordinated self-care activities if and as the activity provides for their own self-care.

5 *Cultural Competency/Trauma-Informed Service Provision Committee*

To ensure success, Christie's Place staff members were identified to take on major tasks of implementing and carrying forward trauma-informed service provision. This resulted in the creation of the Cultural Competency/Trauma-Informed Service Provision Committee (CCTIC). The CCTIC was established to advance the understanding of the impact of trauma and to incorporate policies, procedures, and practices that were situated within this knowledge. Through the work of the committee, its trainings, and the dedication of staff resources, the Christie's Place model of trauma-informed care was developed and implemented and is continually assessed for improvement. CCTIC is further tasked with ensuring the maintenance of the Christie's Place trauma-informed care model within organizational policies and procedures, institutionalizing trauma-informed practices, and providing staff training on trauma-informed program application.

COMMITTEE WORK

Christie's Place formalized the implementation of trauma-informed service provision through the solidification of the Christie's Place Cultural Competency/Trauma-Informed Service Provision Committee (CCTIC). The CCTIC ensures the maintenance of the Christie's Place trauma-informed care model through institutionalizing trauma-informed practices and providing staff training on trauma-informed program application. Christie's Place recognizes the need for community, local, regional, and national investment in the importance of trauma-informed service provision. As such, advocating for trauma-informed and trauma-responsive practices and services is also part of the work that is accomplished through the committee.

The formation of the CCTIC was important to continue the work of implementing trauma-informed care. However, the committee experienced challenges related to work distribution and staff commitment. To address these concerns, annual retreats have become essential in renewing CCTIC member commitments, refreshing ideas, and forging a greater partnership among committee members.

MID-PHASE IMPLEMENTATION AT CHRISTIE'S PLACE

Successes

- Several practices were adopted to ensure that Christie's Place was meeting the needs of women with histories of trauma and abuse, including piloting an assessment of current and past safety and behavioral health concerns that often result from histories of violence and abuse. This pilot cohort, which occurred under the CHANGE for Women Retention in Care program, was supported by a multidisciplinary treatment team including bilingual retention in care peer navigators, a retention in care specialist at University of California, San Diego (UCSD) Owen Clinic, a MSW-level medical case manager, and mental health clinicians. The treatment team engaged in ongoing discipline-specific clinical training on the intersections of trauma, mental health, and substance use. Through this collaborative team, training needs within the staff, community, and partners were identified.
- Treatment adherence activities were made available, such as monthly Afternoon TEA (Treatment Education and Adherence) workshops, which integrated a treatment adherence focus in domestic violence and substance use support groups.
- Christie's Place created validated assessment questionnaires for clients.
- Christie's Place began identifying the training needs of staff, the community, and partners.

Challenges

- It was often difficult to train staff who had differing organizational roles, educational backgrounds, and experience levels simultaneously on trauma and the principles of trauma-informed care.
- Christie's Place soon discovered that a large number of clients had histories of trauma, current safety concerns, or issues with substance use. This required Christie's Place staff to develop partnerships with organizations that were better equipped to meet the needs of higher acuity clients, while shoring up the support systems in place to address these complex issues internally.
- It became evident that there were gaps in service provider knowledge related to trauma and trauma-informed care, including key trauma-informed terminology. To address this issue, Christie's Place developed language- and terminology-related training supplements.

Lessons Learned

- Ongoing training and support is vital to foster this type of intentional agency environment. It is important to pay attention to emergent training needs in addition to basic foundational knowledge and skills.
- Staff required ongoing training and support on the assessment protocol (largely due to their perceptions that they were unprepared, despite years of experience handling sensitive conversations).
- As Christie's Place recognized the pervasiveness of lived experiences of violence and abuse in women's lives, the definition of "peer" expanded. The largely female Christie's Place staff were also functioning as peers, as many had lived experiences of violence. As team members at Christie's Place were faced with personal realizations, regular supervision became a vital resource to ensure support for team members.
- Many elements of trauma-informed service delivery are similar to and support cultural competency. Christie's Place's commitment to cultural competency is strengthened through the commitment to trauma-informed care.

Late Implementation and Maintenance

The initiation of the late implementation phase of trauma-informed care commences once the five objectives from mid-implementation have been achieved. The late implementation phase largely consists of evaluation and refinement of strategies piloted during the mid-phase, and sets the stage for successful long-term maintenance of trauma-informed care at your organization.

1 *Evaluation*

While informal evaluation activities should occur regularly throughout implementation, during the late implementation phase significant efforts should be directed at formally evaluating your organization's overall progress. A helpful starting point is to review data gleaned from previous evaluation activities, including those substantiating the organizational decision to implement trauma-informed care in the early phase and the baseline assessment data from the mid-phase. The formal evaluation process should be informed by key stakeholders both within and outside of your organization. Evaluation strategies may include:

- Review of quantitative data collected via piloted interventions such as data on safety, trauma history, mental health, and substance use;
- Key informant interviews;
- Client, provider, and community focus group interviews;
- Environmental and staff competency organizational assessments; and
- Review of progress towards SMART goals.

The evaluation process will assist your organization in identifying strengths and growth areas, defining the challenges and barriers to implementation, and allowing for course correction where feasible. Successful strategies should be identified and less successful strategies should be augmented or discontinued. Resources needed, including new partnerships, additional staff time, areas of further training, and funding, should be explored. Remaining unmet SMART goals should be evaluated and new SMART goals should be identified. Lastly, ongoing informal and formal evaluation strategies should be defined and scheduled at regular intervals with mechanisms for comparing results and measuring progress.

2 *Model Definition*

Data from the above-described evaluation activities are a useful starting point for model definition. Model definition encompasses the key principles and core components that guide your model of trauma-informed care, as well as the strategies your model includes. Once defined, the model should be formally integrated into your organizational culture. Specifically, a trauma-informed approach should be reflected in organizational mission, team commitments, and policies and procedures.

At Christie's Place, the Cultural Competency/Trauma-Informed Service Provision Committee (CCTIC) held a retreat to review evaluation data and identify proposed core components. Once identified, CCTIC brought the proposed core components to the entire staff and solicited their feedback and input. Six core components of trauma-informed care were then identified:

- Agency and empowerment;
- Meaningful inclusion of women living with HIV;
- Education and support;
- Stakeholder involvement;
- Trauma-informed environment; and
- Intentional practice.

It was agreed that these components—coupled with the four Office on Women's Health guiding principles (intentionality, mutuality, commonality and potentiality)—encompassed Christie's Place's model of trauma-informed care. (See appendix for more information.)

3 *Innovation*

The opportunity for innovation stems from evaluation activities and model definition. For example, based upon lessons learned from trauma-informed care implementation, Christie's Place partnered with the University of California, San Diego's (UCSD) School of Global Public Health in 2015 and was awarded funding to design and implement the EmPower Women intervention. This intervention specifically builds upon the existing peer-based patient navigation services by integrating components of an evidence-based mental health intervention successfully utilized by Christie's Place mental health counselors.

Guided by the Theory of Triadic Influence and Social Cognitive Theory, EmPower Women employs a six-month peer navigation model to improve linkage to and retention in care among out-of-care women living with HIV who face syndemic-related barriers (two or more conditions that

interact synergistically to contribute to both increased vulnerability to HIV and poorer treatment outcomes). This model is culturally tailored to:

- Build skills to cope with syndemic-related affective distress;
- Facilitate linkages with both HIV treatment and relevant ancillary service providers (e.g., domestic violence, mental health, and substance use counselors); and
- Teach women interpersonal skills to activate social support networks (e.g., service providers, peers, friends, family) when faced with new or ongoing barriers.

By targeting underlying syndemic factors in the context of HIV care, women living with HIV will be empowered with the skills, resources, and support needed to maintain their engagement in the HIV care continuum post intervention. Concurrently, these gender- and syndemic-responsive efforts will begin to bridge the persistent disparities observed along the HIV care continuum among women living with HIV in San Diego County.

Partnership

Evaluation activities will assist your organization in identifying partnerships needed to develop, strengthen, and successfully maintain trauma-informed care. These partnerships may include providers of off-site behavioral health care, legal services, and domestic violence shelters and services. As was the case with Christie's Place, your organization may also partner with academic or research institutions to further your efforts.

These partnerships also allow for the expansion of trauma-informed care in your community as they provide opportunities for your organization to expand your community referral base and offer training and technical assistance. This is a fantastic opportunity to educate providers that do not traditionally offer HIV-related services. This ensures that staff can make appropriate referrals to other trauma-informed providers and that clients feel supported in accessing services with trusted providers in a network of care throughout the community.

Sustainability

The ongoing sustainability of trauma-informed care depends on your organization's intentional efforts and resource allocation to your model. It is vital to justify the importance of this work to funders and grant makers. This involves engaging existing and new stakeholders locally and nationally to ensure continued resources for implementation. Without funding, dedicating significant efforts to implement trauma-informed activities becomes difficult to maintain. Just as vital to sustainability is that staff, clients, and volunteers renew their commitment to ensure trauma-informed services are provided at all levels of care and treatment.

Maintenance

Staff must be designated to oversee the maintenance of trauma-informed care at your organization. This should include at least one staff member in a leadership or management position who has the capacity to significantly affect decisions at your organization.

At Christie's Place, the Cultural Competency/Trauma-Informed Service Provision Committee (CCTIC) continues to oversee the work of implementing and maintaining trauma-informed service provision. The committee reviews policies and procedures, develops language, and reviews assessment tools to ensure that they remain relevant and updated to the most appropriate standards. As the agency continues to grow and expand, and through staff turnover, it is important to continue to identify champions for the work as well as to continue to set out a minimum level of understanding for new staff and volunteers. In addition, the education component of our model encourages furthering trauma-informed care in the community with partners, other community-based organizations, and beyond.

Conclusion

Creating and implementing a successful trauma-informed program is a deliberate and ongoing process. This work takes careful planning, resources, and dedication from staff and clients. The Christie's Place model is a prime example showing that, when done well, the investment is worth it. A program grounded in trauma-informed service provision improves the health and wellness of your clients, your staff, and your organization.

LATE IMPLEMENTATION AND MAINTENANCE AT CHRISTIE'S PLACE

Successes

- The CCTIC created a year-long, cycling training plan. This included producing and facilitating trainings for staff members. To achieve this, staff from the committee were tasked with researching trauma-related topics and exploring new and relevant studies.
- Christie's Place identified a primary staff member who was charged with ensuring that all new staff, interns, and volunteers had been given a Trauma-Informed Care 101 training during onboarding.
- Christie's Place has been nationally recognized for its trauma-informed service provision model, which has helped to advance the work and justify the importance of continuing to direct resources toward maintaining the model.

Challenges

- Determining how to distribute the large workload of implementing trauma-informed care among several staff members was a major challenge. This resulted in conversations around dedication and commitments for CCTIC members.
- Christie's Place found it difficult to secure continued funding for program administration. As a result, leveraging stakeholder commitments became even more important in ensuring continued success.

Lessons Learned

- CCTIC leadership recognized the need for additional support for committee members who were tasked with this large endeavor. As such, an annual retreat was instituted in order to renew team commitments, plan for the year ahead, and forge a greater partnership among members.
- A continuous refreshing of team commitment and an assessment of internal implementation are needed to maintain team momentum for the transformation.
- It is imperative that ongoing training is provided in order to secure community stakeholder investment. This not only helps to further understanding of the importance of trauma-informed care but also garners support for trauma-informed service providers, including Christie's Place.
- Continuing progress and maintaining forward movement requires commitment and dedication in the face of external and internal pressures including a lack of funding and additional workload concerns.

Appendix

Core Components of Christie's Place Trauma-Informed Service Provision

I. Agency and Empowerment

With a mission statement that is empowerment-focused, Christie's Place encourages a woman's choice and voice in her care and treatment.

- Fosters the integrity, respect, and dignity of service recipients and providers.
- Supports a belief in one's capability to heal and recover.
- Responds to trauma in ways that are characterized by choice, voice, and agency.

II. Meaningful Inclusion of Women Living With HIV

Christie's Place is a proponent of the meaningful inclusion of women living with HIV in all aspects of HIV health care and social service provision. The voices and experiences of women living with HIV are integral to our model of trauma-informed care.

- Emphasizes recruiting people living with HIV for staff, volunteer, and board positions.
- Encourages and supports representation in the community planning process as well as in local and national advocacy roles.
- Values the meaningful inclusion of women living with HIV and their family members in all aspects of service design, delivery, and evaluation such as focus groups, surveys that inform service provision, and support groups facilitated by peers.

III. Education and Support

Christie's Place believes that ongoing education and support must occur at all levels of agency involvement.

- Provides ongoing training for service providers and recipients (including partner agencies) on topics relevant to trauma-informed service provision.
- Provides leadership training and leadership opportunities for women living with HIV.
- Creates a supportive agency culture that includes consistent staff/clinical supervision, case consult and treatment team meetings, support among staff, support among clients, and emphasis on self-care and fostering resilience.

IV. Stakeholder Investment

Christie's Place believes that active investment from the community, clients, staff, and board members is vital to establishing and maintaining our trauma-informed model of care.

- Management, staff, clients, and board commit to trauma-informed care at Christie's Place.
- Internal committee of dedicated staff ensures the progress of trauma-informed care that is inclusive of the voices of all invested stakeholders, including the community, clients, staff, and board members.
- Staff champions lead significant efforts to motivate and move forward trauma-informed care internally.
- Stakeholder champions promote trauma-informed care and develop local and national investment.

V. Trauma-Informed Environment

Christie's Place's trauma-informed environment promotes access to services that are founded upon an understanding of the impact of trauma, violence, abuse, stigma, and discrimination.

- Gender-responsive, culturally competent, accessible location, and intentionally non-identifiable locale create a family-centered space for women, children, and families affected by HIV to visit and access services safely.
- Ambience is warm and welcoming:
  - » Child-friendly with carved out spaces for child play.
  - » Inclusive setting for meaningful involvement and respectful interactions.
  - » Attention to hierarchy diminishes the potential for re-traumatization.
  - » Accessible services utilize language of comfort and choice.
- Staff is reflective of the people accessing services with relation to gender, culture, and ethnicity.

VI. Intentional Practice

Intentional practices at Christie's Place are based upon an understanding of how the effects of violence and abuse exist within the context of women's lives and the intersections of their identities across the lifespan.

- Collaborative and strength-based trauma-informed client orientation is completed to foster hope, meaningful informed consent, and investment in program participation.
- Trauma-informed mental health, substance use, and support system comprehensive assessments are conducted during intake and re-enrollment, resulting in appropriate referrals, if necessary.
- Strength-based medical case management is provided for clients with high acuity needs who are out of care or at risk of falling out of care.
- Trauma-specific behavioral health services are provided by the on-site mental health counselors during individual and/or family therapy.
- Community-building social activities and events are hosted throughout the year with the intention of diminishing isolation and the impact of stigma and discrimination on women, children, and their families affected by HIV.
- Facilitative, wrap-around, and supportive services including basic needs assistance such as food, hygiene products, diapers, and formula; transportation resources and assistance; childcare; legal services and assistance; education and treatment adherence support; and system navigation assistance.
- Formalized partnerships with immigration rights and other social justice organizations.

Stories from Christie's Place Peer Navigators

Martha's Story

Martha is a peer navigator for Christie's Place. Her story illustrates the pervasive nature of violence and abuse in the lives of many women living with HIV. It also exemplifies the way in which Christie's Place seeks meaningful inclusion through the recruitment of people living with HIV for staff, volunteers, and board positions. Stories like Martha's can motivate stakeholders in recognizing and validating the importance of trauma-informed care at your organization.

Photo: Louis Kengi Carr

My name is Martha Robles. I'm a Latina woman living with HIV from Ensenada, Baja California, Mexico. My life has been characterized by many challenges and struggles, as well as strength, resilience, and triumph.

I was 6 when my mother passed away and I moved in with my father. He used drugs and sexually abused me from the ages of 6 to 12. I ran away at age 13. I found a new home with a man over eight years my senior and the abuse continued. At 17, I picked up again and fled. I began drinking, using drugs, and sex work to cope and survive. I moved to the United States with my sister; however, without the tools to cope with my addiction and abusive past, my problems continued to follow me.

After living in the United States for one year, I got married. Not even one year into our marriage my husband was going out with other women, drinking heavily, and being physically abusive. I wanted to be a mother, but after many years of trying, I believed that I could not have children. I adopted my niece's newborn son as she was not able to care for him.

My life took a sharp turn when I learned that I was five months pregnant and HIV positive. I stopped using drugs and started my HIV meds. My daughter was born HIV negative, but positive for crystal meth. Child Protective Services put my children in a foster home. After completing parenting classes, domestic violence classes, and the Narcotics Anonymous 12-step program, I got my children back, but I started using again.

Five years later, I decided to stop using and start in recovery—for real this time. It was hard at the beginning, but I rejoined support groups for HIV-positive women and began doing volunteer peer advocacy. Through helping others, I began to have hope for my own life as well.

I've worked at Christie's Place as a peer navigator since 2010, helping women find hope as well as access and stay in their health care. I love working with our Christie's Place team because we care so much for women and our community. This year, I will be drug free for 11 years. I'm living well with my HIV and am undetectable. But most importantly, I am a happy single mother who is proud of herself.

Jay's Story

Jay is a peer navigator for Christie's Place. Not only does her story exhibit how trauma permeates the lives of women living with HIV, it demonstrates the importance of supporting those with lived histories of trauma in their journeys to empowerment. Jay's story demonstrates the impact of social support in the lives of women living with HIV.

My name is Jay Blount and I am a Black woman living with HIV. I grew up in a violent home. My mother had a lot of boyfriends and husbands she would fight with. My father was a huge part of my life until his death when I was 12 years old. Later that year, I started using drugs to fill my loneliness, to fit in, and to kill the pain of losing my dad. My stepbrother molested me and my drug use got even worse after that.

After high school, I was using crystal meth and crack. In every intimate relationship I had, there was domestic violence. I started sex work for money, drugs, and places to stay. I had two daughters who died before they were 6 months old.

HIV was very visible in our gay and bi-sexual communities. Friends were getting sick and even dying. I did not think I would acquire HIV because I am a heterosexual woman. I began to get sick and was finally diagnosed with AIDS a year later. I was told I only had one year or less to live and to get my affairs in order. It was so final. My mom was devastated. Me—not so much. I needed to be out of my terrible life. I stayed sober for about nine months. I wasn't getting better so I started smoking marijuana to gain weight. It worked, but it also rekindled my addiction to crack and I spent the next 11 years in the streets.

During this time, I got married to a man who loved me for me and we adopted his 9-year-old nephew. My husband and I would get drunk and fight and my adopted son would witness the violence. In 2006, my husband died and I went off the deep end. Child Protective Services took my son from me because I wouldn't stop using drugs. I lost everything and didn't care. The only person who truly loved me was gone, and I thought my life was over too. I became homeless, but still got high every day. A year later, my life changed when I moved to San Diego to live with my brother. My brother helped me find a recovery home which I completed.

From the beginning of my diagnosis, I knew I needed to educate people about HIV. Working as a peer navigator at Christie's Place was just what I needed. I could work with women just like me. Women living with HIV, and with the same issues I had worked through. Today I am doing the same job, six years later. I have been rewarded with the many women I have met along the way.

Priscilla's Story

Priscilla is a peer navigator for Christie's Place and her story illustrates the pervasive nature of violence and abuse in the lives of many women living with HIV. It also illustrates how trauma can create or exacerbate barriers to getting into and staying in care. Stories like Priscilla's can motivate stakeholders in recognizing and validating the importance of trauma-informed care at your organization.

Photo: Louis Kengi Carr

My name is Priscilla Mahannah and I am a woman living with HIV. My life, like the lives of so many women living with HIV, has been significantly impacted by violence and abuse.

As a girl, I lived with my mother, younger sister, and stepdad. Violence was a regular occurrence in our household; my mother got beat almost every night for eight years. My stepdad was also sexually abusive towards me. I was afraid of him. When I was 9, my mom tried to commit suicide. After that, I spent a lot of time with my grandparents. They were my safety net and their home was the only place I could sleep soundly. However, my grandparents passed away shortly after. I felt like I had lost everything.

By the age of 13, I was drinking, using drugs, ditching school, and involved with gangs. I thought that I had met the man of my dreams. He was 27 years old and emotionally abusive. The next year, I was diagnosed with HIV. I stopped taking my HIV meds when my boyfriend and I separated. The pattern of abuse didn't stop within my relationships. I got into another abusive relationship and had a daughter by this man when I was 19. I started taking my HIV meds again when I found out I was pregnant. But after I had my daughter, I stopped taking my meds and fell out of care.

Shortly after, I started utilizing services at Christie's Place. I got a vision of hope there and started to learn about how my life could be different. Finally, a sense of normality! I wanted help but was not quite ready. From 2003 to 2005, I was locked up and this afforded me a lot of time to think things through. When I was released I went to a recovery program where I graduated and stayed sober with the help of aftercare and Narcotics Anonymous.

HIV has significantly shaped my life, but it does not define me. In many ways it has been a blessing. As a peer navigator, I get to help women like me every day. My journey and everything I have been through was tough but I have no regrets. I am the person I am because of it and I am forever grateful for the life I am creating every day.

Creating Conditions for Safety: Elements of a Trauma-Informed Environment

Office on Women's Health 'A Public Health Response to Trauma' training

Your assessment is anonymous and will be analyzed in conjunction with the responses of all staff. This is an assessment into our current (6 month) environment and the information garnered from this assessment will be used to inform focus groups and next-step action plans.

Thank you for your time, participation, and honesty.

Physical Environment						
Confidentiality and Privacy	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Space is available for private conversations for program participants and staff						
Staff do not talk about program participants in common areas						
The agency informs program participants about what information is gathered, where it is kept, and who has access to it, and when and what the agency has to report and to whom						
Staff supervision is made available in a private confidential space						
Accessibillity	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
All doors have automatic openers and all furnishings set up for ease of movement of wheelchairs and walkers						
All materials available in audio versions as well as big print						
Interpreters available for the deaf and hard of hearing when requested						
Appearance	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Space kept clean and neat						
Space is well lit						
Parking area is well lit at all times						
Furnishings comfortable						

Physical Environment						
Climate	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Layout of space promotes interactions between program participants and staff						
Posted signs have "person-centered" language						
Someone always available to welcome anyone walking into space						
Space reviewed and assessed by program participants	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Space reviewed and assessed by former and/or current program participants						

Supportive Environment						
Transparency	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Policies and procedures reviewed with client						
Program participants informed why they are asked to fill out certain forms and who has access to them						
Program participants informed of program protocols on how staff respond to participants experiencing a crisis						
Policies and procedures reviewed with staff						
Consistency and Predictability	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Hours of operation posted and adhered to						
Change in hours provided to program participants with advance notice						
Change in staff provided to program participants with advance notice						
Staff respond to participants' inquiries for services/support within 48 hours						
Staff meetings and supervision on a consistent and predictable schedule						

Supportive Environment						
Resource Availability	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Culturally sensitive staff are culturally responsive to women						
Resources compiled, updated, and made available to program participants and staff						
Staff serve as a resource to program participants and are responsive to needs of program participants						
Clear Expectations	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Code of ethics developed with program participants						
Code of ethics developed with staff						
Code of ethics posted in common areas						
Code of ethics reviewed regularly with program participants and staff						
Common group agreements developed and followed for all meetings						
Agency mission, vision, and/or guiding principles posted in common areas						
Staff and participants' actions guided by the agency mission, vision, and/or guiding principles						
Gender Specific	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Programs offered for women only in private and confidential spaces						
Program elements designed by and for women						
Opportunities provided for women to come together in informal settings to share their experience, strength, hopes, and dreams						
Cultural Sensitivity	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Signs posted in different languages to meet needs of community						
Images and language on posters and artwork represent the demographics of the community						
Staff represent the demographics of the community						

Inclusive Environment						
Voice	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Former and/or current program participants involved in program development						
Former and/or current program participants involved in program implementation						
Former and/or current program participants involved in program evaluation						
Women self-identify their own goals						
Women evaluate whether their self-identified goals have been met						
Different perspectives are included						
Choice	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Information and resources shared with program participants so they can make informed choices						
All program functions and regulations clearly described so program participants make informed choices						
Language	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
All written and verbal communication uses "person centered" language						
Language does not limit what a person can do (people are not viewed or talked about as a diagnosis or "label")						
Materials available in the primary languages of community members						

Relational Environment						
Boundaries	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
All staff and volunteers have clear job descriptions						
The role of staff made clear to program participants						
Staff do not do for one person what they would not do for all						
When ready and appropriate, staff share their own life experiences						

Relational Environment						
Balanced	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Mutuality demonstrated between staff and program participants						
Whenever and wherever appropriate, decisions made collaboratively between program participants and staff						
Staff seek ways to share power with program participants						
Supervisors seek ways to share power with staff						
Authentic	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unknown**	**N/A**
Staff able to relate and empathize with program participants in response to the very human experience of woundedness and recovery						
Staff are able to engage with program participants and notice what each brings to the interaction						
Staff meet people (participants, other staff, etc.) where they are at in their healing and recovery journey and offer support and guidance without judgment						
Agency recognizes that the staff person's lived experience affects her/his response to women's narratives/stories						

Core Competencies for Trauma-Informed Staff

Office of Women's Health "A Public Health Response to Trauma" training

NOTE: These are the values that the Office on Women's Health have identified for a trauma-informed organization. Review your organization's values and see how and if they align with these values.

Demonstrates KNOWLEDGE in the Following Areas	Demonstrates Competency	Needs Further Development	Uninformed
Summarizes the findings of the Adverse Childhood Experience Study (ACES)			
Describes interconnection of violence, trauma, and social issues			
Describes impact of trauma on the body, spirit, mind			
Understands impact of trauma over the lifespan			
Understands "symptoms" are considered adaptive strategies/coping mechanisms from trauma			
Understands the complex needs of trauma survivors			
Understands the prevalence and impact of gender disparity (especially regarding women)			
Describes the impact of cultural trauma			
Understands re-traumatization			
Understands cultural differences in how people understand, respond to, and treat trauma			
Understands universal precautions			
Understands the impact of natural disasters and war and its link to earlier traumatic experiences for trauma survivors			
Understands impact of trauma on LGBTQI individuals and community			
Understands healthy boundaries within trauma-informed contexts			
Understands the intergenerational cycle of violence			
Understands the importance of self-care			
Understands the building blocks of establishing a trusting relationship			
Understands collaborative decision-making processes and need to seek common ground			
Understands the role of staff self-disclosure in trauma-informed settings			
Understands the need to know peers/participants beyond their label, disability, and/or affect			
Understands why gender specific options are available			

Demonstrates SKILLS in the Following Areas	Demonstrates Competency	Needs Further Development	Unskilled
Articulates a working definition of trauma			
Articulates difference between trauma-informed and trauma-specific			
Ability to establish and maintain healthy boundaries			
Ability to create a safe and welcoming physical environment			
Ability to create a safe, welcoming, supportive environment			
Ability to create a safe, welcoming, inclusive environment			
Ability to create a safe, welcoming, relational environment			
Ability to provide gender specific supports and services			
Supports peer skill development by sharing power			
Supports peer/participant involvement by providing opportunities for program participants to facilitate, organize, and/or coordinate activities			
Ability to establish and maintain transparency in actions and interactions			
Establishes means for sharing information in an ongoing, consistent manner			
Ability to establish trusting relationships with colleagues			
Ability to establish trusting relationships with peers/ participants			
Ability to make appropriate referrals with timely follow-up			
Ability to communicate and collaborate with peers/ participants in a respectful, inclusive manner			
Ability to make decisions in collaboration with peers/ participants			
Ability to engage peers/participants with empathy, warmth, and sincerity			
Ability to practice self-care in an intentional, consistent manner			
Ability to maintain confidentiality			
Ability to identify and use relevant existing community programs and resources and alternative peer/participant operated supports/programs			

Demonstrates SKILLS in the Following Areas	Demonstrates Competency	Needs Further Development	Unskilled
Willingness to ask for help from supervisor, peers/ participant, colleagues			
Willingness to learn from peers/participants			
Ability to offer true choice to peers/participants and to honor their choice			
Ability to coach peers/participants to know their strengths and talents			
Demonstrates culturally appropriate respect			
Ability to tailor staff person approach to individual peer's/participant's unique goals and needs			
Demonstrates the Following VALUES in their Work	**Reflected in Actions**	**Needs Further Development**	**Not Adopted**
Values the lives experience of peers/participants			
Peers and program participants are the experts in their own recovery			
Healing from trauma is transformative			
Connections between staff and participants are reciprocal and offer opportunities for shared learning			
Women heal in relationship with self, others, and/or a source outside of themselves			
Pathways to recovery are diverse and vary from individual to individual			
Recovery is a spiral path, not direct, not linear			
Healing builds strength in the "broken places"			
Recovery from trauma is possible for all			
Informed choice is central to trauma recovery			
Healing happens in relationship			

Additional Resources

This list is not an exhaustive list of resources, but instead is intended to be a short list of valuable resources for any organization beginning its trauma-informed journey.

AIDS United Resources

- Best Practices: Integrating Peers into HIV Models of Care http://bit.ly/2vYX7XC
- Meaningful Involvement of People with HIV/AIDS (MIPA) http://bit.ly/2vg2KxN
- Securing the Link: A Guide to Support Individuals Transitioning Back Into the Community from Jail http://bit.ly/2xt4Mev
- AIDS United Technical Summit on Women, HIV, and Violence http://bit.ly/2v5XmkV

Download these and other free resources at **aidsunited.org!**

Other Reports and Documents

- "Addressing the intersection of HIV/AIDS violence against women and girls & gender-related health disparities" Interagency Federal Working Group Report http://bit.ly/2uzBWev
- "Update on efforts to address the intersection of HIV/AIDS, violence against women and girls, and gender-related health disparities" Office of National AIDS Policy, White House Advisor on Violence Against Women, White House Council of Women and Girls http://bit.ly/2u5mGn0
- "Engaging Women in Trauma-Informed Peer Support: A Guidebook" http://bit.ly/2tllsDC
- "SAMHSA's concept of trauma and guidance for a trauma-informed approach" SAMHSA's Trauma and Justice Strategic Initiative http://bit.ly/1aB4k1D
- "A treatment improvement protocol: Trauma-informed care in behavioral health services" SAMHSA http://bit.ly/1PFcSUx

Organizations and Programs

- Institute on Violence, Abuse, and Trauma (IVAT) http://www.ivatcenters.org/
- Futures without Violence https://www.futureswithoutviolence.org/
- National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV) http://www.npeiv.org/
- National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) https://www.samhsa.gov/nctic
- Justice Resource Institute http://jri.org/

Getting to zero

The AIDS United Getting to Zero Initiative

The AIDS United Getting to Zero initiative provides no-cost capacity building assistance to CBOs across the country as they implement trauma-informed care models of service into their programs. Email **cba@aidsunited.org** to find out more!