WELCOME!

Please fill out the pre-training survey found in your folder!

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Intimate Partner Violence, Health, and HIV

Intersections and and Evidence-Based Intervention

Thank you to our contributors:

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

whp Women's HIV Program

Christie's Place
Transforming lives since 1996™

Workshop Agreements

- Take breaks and take care of yourself
- Share your expertise!
- Ongoing process
- Stories stay, lessons leave

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What are we talking about today?

Agenda:

- Intro
- We always start with taking care of ourselves
- Gender based violence and health outcomes
- Violence as a barrier to HIV care
- Evidence based intervention CUES
- Trauma informed care systems change

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Grounding To Promote Resiliency

Bring yourself into your body:

- Stand (or sit) as you are able
- Reach your hands up
- Stretch and breathe

(Levine & Mate, 2010; Levine 1997)

MODULE 1

It Starts With Us: Understanding of How Our Work Can Affect Us

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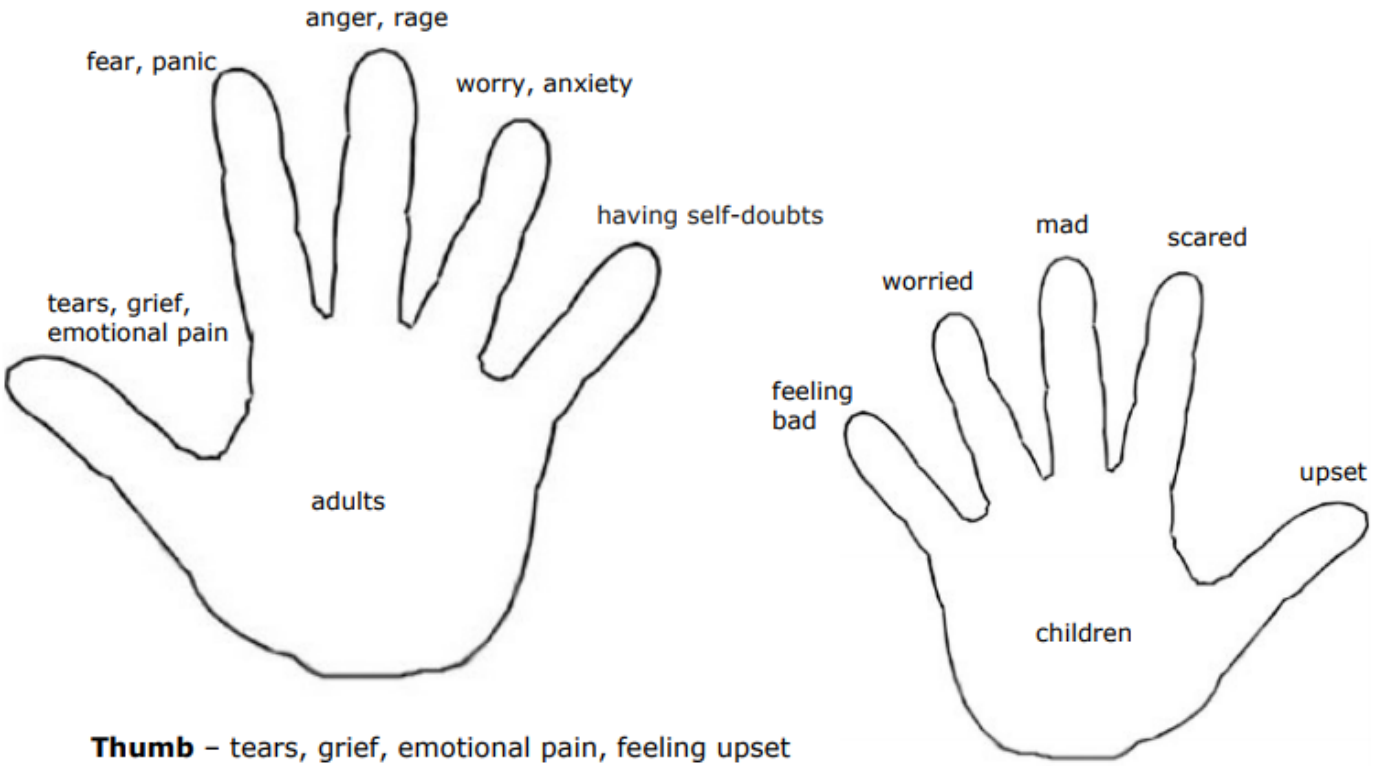
Learning Objectives

After this training, participants will be better able to:

- Describe trauma-informed programming
- Name two common reactions when caring for survivors of trauma
- Name two strategies for promoting self-care related to trauma-informed workplace practice

Grounding To Promote Resiliency: Finger Holds



Thumb – tears, grief, emotional pain, feeling upset
Pointer/Index finger – fear, panic, feeling scared
Middle finger – anger, rage, resentment, feeling mad
Ring finger – worry, anxiety
Little finger – having self-doubts, not feeling good about ourselves or feeling bad

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Working Definition of 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 and*
- *Has lasting adverse effects on the individual's functioning and mental, physical, social, emotional and/or spiritual wellbeing.*

SAMHSA, 2013

Looks different for everyone, but what are common effects for care givers, healers, and providers?

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Activity: Reflecting on Historical, Intergenerational and Systems Trauma

Discuss an example and how it may affect your clients and/or you as a care giver

- Cultural trauma: an attack on the fabric of a collectivity, affecting the essence and identity of the community
- Historical trauma: cumulative exposure of traumatic events that affect an individual and continue to affect subsequent generations
- Intergenerational trauma: when trauma is not resolved, subsequently internalized, and passed from one generation to the next

(D.S. BigFoot, 2007)

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Vicarious Trauma and Resilience

Vicarious trauma is a change in one's thinking [world view] due to exposure to other people's traumatic stories.

Secondary traumatic stress, also referred to as vicarious trauma, burnout, and compassion fatigue, describes how caring for trauma survivors can have a negative impact on providers. This is not a judgment but a reality of the job.

(Dr. David Berceli, 2005)

There can also be strengths that come from working with clients who have experienced trauma

- witnessing others overcome adversity
- recognizing people's capacity to heal
- reaffirming the value of the work you do

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Common Reactions to Vicarious Trauma

- Fear
- Helplessness
- Sleep disruptions
- Depressive symptoms
- Feeling ineffective with clients
- Recurrent thoughts of threatening situations
- Reacting negatively to clients
- Thinking of quitting clinical [contact with clients] work
- Chronic suspicion of others

Grounding To Promote Resiliency

Resiliency Skills – bring yourself back into your body:

- Stand with your back against the wall
  - helps you stay connected to your body
- Wrap your arms around yourself, squeeze and rub the outside of your arms

(Levine & Mate, 2010; Levine 1997)

a) Does the practice of taking care of yourself align with your values and support your identities (as a healer, provider, activist, parent, etc.)?

b) For you, does taking care of your impact how you show up (to work, in your community, in your family)? Provide an example.

c) What is a practice that works for you?

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Support for Taking Care

What are ways that your workplace:

- supports you in taking care of your self?
- **could better** support you in taking care of your self?

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MODULE 2

Making the Connection: Intimate Partner Violence and HIV

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Learning Objectives

As a result of this activity, learners will be better able to:

- Define intimate partner violence (IPV) in the context of lifetime experiences of trauma.
- Identify three ways (IPV) and trauma affects health for people living with HIV
- Describe the intersection between gender based violence and STIs/HIV and how IPV affects HIV health outcomes and access to care

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Intimate Partner Violence

When one person in a relationship is using a **pattern** of harmful methods and tactics to gain and maintain **power and control** over the other person

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Experiences of violence across the lifespan

IPV is a part of a continuum of Gender Based Violence

Gender-based violence includes:

- domestic violence, sexual harassment, rape, sexual violence
- female genital mutilation, forced marriages
- sex trafficking
- rape as a tool of war
- forced sterilization, forced abortion, coercive use of contraceptives, female infanticide and prenatal sex selection.
- Sexual abuse
- Elder abuse
- homophobia and transphobia
- police and state violence

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Who are Victims/Survivors?

- Cuts across all lines
- Develop coping strategies
- Have love for their partner
- Expert of their own situation
- Blame themselves for the violence
- Multiple traumas

Who are Abusive Partners?

- Cuts across all lines
- Often jealous and controlling
- Tend to not take responsibility and blame survivor
- Can be loving
- Not anger management problem
- Multiple traumas

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Why do people stay in abusive relationships?

- Violence happens in a cycle
- Risk of leaving vs. Risk of staying
- Violence is not always a person's priority

We need to move away from asking:

"Why hasn't the survivor left?" to asking:

"What can I do to support this person so that they can make their own decisions?"

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Child Sexual Abuse

- **So common:** In the United States, over 63,000 children are victims of sexual abuse every year
- **Children at risk:** The risk of CSA is higher for children who are isolated, living in communities that have been marginalized by systems of oppression, and have been witnesses to other forms of violence and harm
- **Health outcomes:** Results in higher rates of substance dependency, mental health problems like PTSD and severe depression, disordered eating, rapid repeat pregnancy, STIs.

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Connected traumas

- Those who experience childhood trauma (child abuse, child sexual abuse, neglect, etc) are at higher risk for both experiencing and committing intimate partner violence and sexual violence later in life.
- People who are exposed to violence within their communities (school violence, shootings, violent and discriminatory social control, etc.) are more likely to use violence to hurt or control their dating partners.

Widespread and Pervasive

- More than **1 in 4** women and **1 in 9** men in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- **61%-72%** of bisexual women and **37%** of bisexual men experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- **44%** of lesbian women and **26%** of gay men experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- Of transgender individuals, **34.6%** reported lifetime physical abuse by a partner and between **50% and 64%** reported experiencing sexual assault.

(Breiding et al, 2011; Landers & Gilsanz, 2009; The TaskForce; FORGE)

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Racial Disparities?

Black, American Indian/Alaska Native and Multiracial women and men experience higher rates of intimate partner violence

- **43.7% of Black women, 46.0% American Indian or Alaska Native women, and 53.8% of multiracial non-Hispanic** women have been the victim of rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- By race/ethnicity, **non-Hispanic Black women had the highest rate of dying by homicide** (4.4 per 100,000 compared to 1.5 per 100,000 white women), **at least 51.3% of which were IPV-related**.
- Reproductive coercion (RC) was strongly associated with race, where **37.1% of Black women and 29% of multiracial women had experienced RC compared to 18% of White women**.

(Black, 2010) (Petrosky, 2017) (Holliday, 2017)

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People Living with HIV: Experiences of IPV

A study done in a HIV primary care clinic found that:

- **(73%) of the sample reported lifetime IPV** and 20% reported current abuse.
- Physical IPV (85%) was cited the most by abused participants. IPV rates were highest among African Americans and men who have sex with men (MSM).
- More than one fourth (29%) of those abused felt the **abuse was related to their HIV status**.

(Ramachandran, 2010)

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Nationally, over half of women living with HIV have experienced partner violence, considerably higher than the national prevalence among women overall (55% vs. 36%). (Machtinger, 2012; Black, 2011)

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HIV and partner violence

Heterosexual women and homosexual men who are living with HIV experience more severe violence and more frequent abuse compared to people who are not living with HIV.

(Gielen et al, 2007), (Ramachandran, 2012)

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Clarifications

There is a lack of literature on Queer and Trans peoples' experiences of IPV.

Intimate Partner Sexual Violence

51% of rape survivors were raped by an intimate partner.

(Basile, et al. 2010)

Group Discussion

What are some health consequences associated with gender based violence and/or intimate partner violence?

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Health Consequences of Abusive Relationships

(Breiding et al, 2011; Bailey, 2010; Black & Breiding, 2008; Elsberg et al, 2008; Bonomi et al, 2007; Lesserman et al, 2007; Kaysen et al, 2007; Sato-DiLorenzo & Sharps, 2007; Weinsheimer et al, 2005; Kendall-Tackett et al, 2003; Ackard et al, 2003; Campbell et al, 2002; Coker et al, 2002; Lemon et al, 2002; Coker et al, 2000; Constantino et al, 2000; Dienemann et al, 2000; Kernic et al, 2000; Letourneau et al, 1999; Campbell & Lewandowski, 1997; Plichta, 1996; Cohen et al, 1995; Drossman et al, 1995; Stark & Flitcraft, 1995; Wagner et al, 1995; Talley et al, 1994; Conway et al, 1993; Cacardi et al,1992; Bergman & Brismar, 1991; Follingstad, 1991; Bergman & Brismar, 1991; Drossman et al, 1990; Plichta, 1992; Campbell & Alford, 1989; Chapman JD, 1989; Miller et al, 1989; Domino & Haber, 1987)

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Traumatic Brain Injury and Strangulation

- **Traumatic Brain Injury (TBI):** 71% of women experiencing IPV have incurred TBI due to a physical assault

- More than **two-thirds** of IPV victims are **strangled** at least once
- Strangulation in LGBTQ relationships is prevalent but underreported .

{ the average is **5.3** times per victim }

(Chrisler & Ferguson, 2006; Abbott et al, 1995; Coker et al, 2002; Frye et al, 2001; Goldberg et al, 1984; Golding et al, 1999; McLeer et al, 1989; Stark et al, 1979; Stark & Flitcraft, 1995)

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Understanding Strangulation and Traumatic Brain Injuries

- Common form of physical violence that is often repeated
- Not always immediate physical repercussions
- Even if it is not painful, can leave marks, make voice raspy, or break blood vessels in eyes, it is still cutting off oxygen to the brain.
- Victims can die from TBI hours or days after the assault

Pointer - Google "HELPS screening tool for traumatic brain injury"

(Training Institute on Strangulation Prevention, 2017)

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IPV and Behavioral Health

- **Anxiety and/or depression**
- **Post-traumatic stress disorder (PTSD)**
- **Suicidal behavior**
- **Low self-esteem**
- **Emotional detachment**
- **Sleep disturbances**
- **Substance dependency**

(Tjaden P, 2000; Coker AL, 2002; Mazeda 2010; Zimmerman 2011;)

Research suggests that women may also be more likely than men to use prescription opioids to self-medicate for other problems including anxiety or stress. (McHugh 2013)

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IPV and Substance Use Coercion

Substance use is another way abusive partners exert power and control

3,380 Hotline callers reported:

- **27%** were **pressured or forced to use** alcohol or other drugs by their partner
- **60.1% had partners who tried to prevent or discourage them from getting help**
- **37.5% of partners threatened to report** alcohol or other drug use to someone in authority to keep them from getting something they wanted or needed

(Warshaw, NCDVTMH/NDVH 2014)

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Substance use, survival and HIV

Survivors of IPV who are living with HIV

- Experience high rates of substance coercion
- Are using at higher rates
- Are more likely to be engaging in risk behaviors

(Meyer, 2011)

"Research shows us that violence is both a significant cause and a significant consequence of HIV infection."

American Foundation for AIDS Research (AmfAR)

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IPV and HIV Status Disclosure

24% of female patients experienced physical abuse after disclosing their HIV status and 45% feared such a reaction.


News › Crime

Crime

Man who admitted killing HIV-positive girlfriend: 'I wanted to make her pay'

By JENNIFER EMILY

Staff Writer

Published: 29 October 2013 10:18 PM

Updated: 30 October 2013 02:49 PM

In addition to structural oppression of people living with HIV, they are also targets of interpersonal violence related to stigma

(Rothenberg K.H. et al, 1995)

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IPV Increases Risk for HIV

- Sexual coercion/forced sex with an positive partner
- Limited or compromised negotiation of safer sex practices
- Increased sexual risk-taking behaviors, including survival and transactional sex
- Increased risk of mother-to-child HIV transmission among abused pregnant women
- Increased risk of unsafe injecting practices and coerced drug use

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Sexual Coercion

What is Sexual Coercion?

- Creating a feeling, situation or atmosphere where emotional and physical control lead to sexual abuse or rape, or the person feeling that they have no choice but to submit to sexual activity.

Compromised Negotiation of Safer Sex

People who have experienced IPV have compromised sexual & condom negotiation opportunity

- Inability to refuse sex or certain kinds of sex
- Lack of control over condom negotiation
- Perpetrator condom refusal and condom removal
- As a result they have limited ability to protect themselves from STIs.

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How does GBV affect HIV outcomes and access to care?

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Access to Care

GBV is an

UNDER-RECOGNIZED BARRIER

to survivors's ability to obtain regular medical care for HIV/AIDS.

Lichtenstein, 2006

IPV + Engagement in care

In one study looking at IPV and engagement in care:

- The average 'no show rate' was significantly higher for people threatened by their partners in the last 12 months of their most recent relationship.
- **Partner threat emerged as the only statistically significant predictor of having a high no show rate.**

(Schafer, 2012)

IPV as a Barrier to Care

Brainstorm: Get in groups of three

- What are some of the strengths and resiliency characteristics of your clients?
- How might experiencing IPV be a barrier to engagement in care, wellness, and viral suppression for your patients?
- How might experiencing IPV compromise patients self-efficacy around their health?

How could IPV be a Barrier to Care?

Brainstorm

- Abusive partners often control access to food, money, health care and medication (including insurance coverage), support systems, and transportation
- Use of HIV status as means of control particularly for immigrant and LGBT populations
- Lowered standard of wellness due to extreme circumstances
- Those experiencing violence often suffer a wide range of health-related problems caused or exacerbated by the abuse

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Violence and Trauma: Barriers to Viral Suppression

- Violence can compromise anti-retroviral therapy (ART) uptake and adherence, and is linked to poor treatment response
- Violence, trauma and related stresses can accelerate HIV disease progression, likely due to compromising the immune system

(Hatcher, et al 2015)

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IPV/HIV Interface

Characteristics of people living with HIV long term

- Sense of self-efficacy for their health
- Perceive their physician as collaborator
- Can communicate about their illness and concerns

Dynamics of Intimate Partner Violence

- Lack power and control - access to health insurance and care
- The vast majority of victims do not tell their providers

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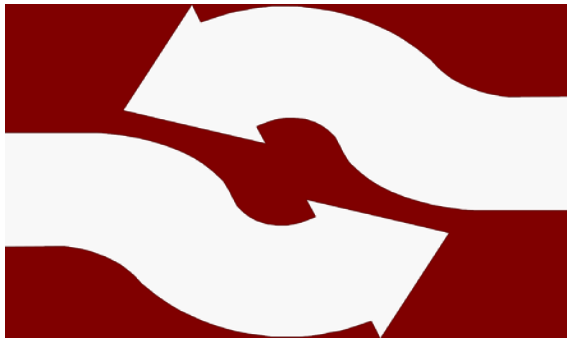
IPV/HIV Interface

Characteristics of people living with HIV long term

- Are sensitive to their bodies and physical/ psychological needs
- Are assertive and have the ability to say “no”
- Are not alone



Dynamics of Intimate Partner Violence

- Victims experience significantly higher rates of somatic and psychological disorders
- Resisting demands of abusive partner is correlated with increased violence
- Increasing levels of isolation is a key tactic used to establish control

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MODULE 3

Practice Implications for HIV Care Services

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Learning Objectives

As a result of this activity, learners will be better able to:

- Identify strategies to assess for relationship abuse and trauma and respond appropriately to disclosures
- List harm reduction strategies
  - Partner notification
  - Health access
  - Health promotion

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Strategies for HIV Programs

Universal education on how relationships affect health provides an opportunity for clients to make the connection between violence, health problems, and risk behaviors

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SURVIVORS WHO TALKED TO THEIR HEALTH CARE PROVIDER ABOUT THE ABUSE WERE:

4 times more likely

to use an intervention

McCloskey et al, 2006

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Your Role is Important - DOABLE

- Providers do not have to be GBV experts to recognize and help patients experiencing GBV
- Ability to partner with local domestic and sexual violence agencies to support your work
- HIV testing and counseling offers a confidential, private and unique opportunity for education, early identification, risk reduction and intervention

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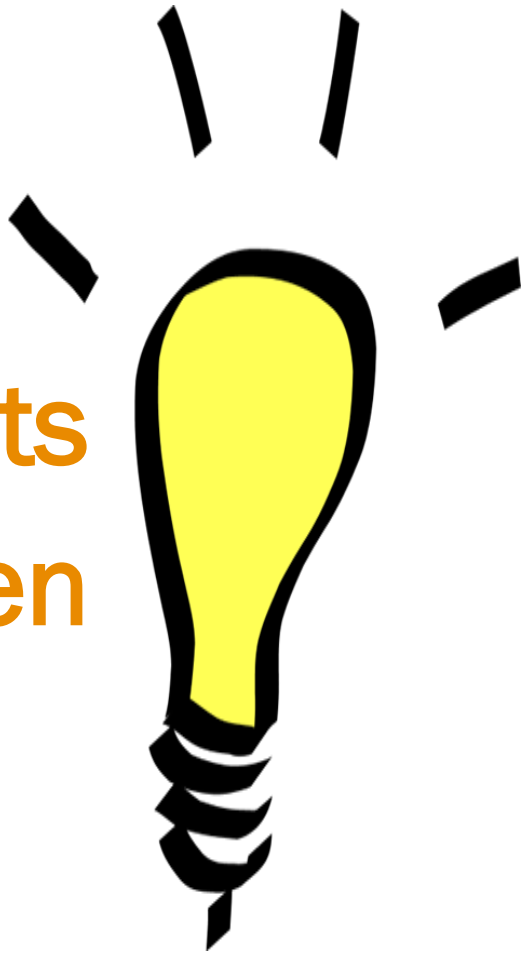
Moving Beyond Screening

What if we challenge the limits of disclosure driven practice?

(Miller, 2017)



A Trauma Informed Intervention

- NOT a checklist, something that gets filled out and goes in the chart
- IS a conversation
- IS how a clinic is set up
- IS how providers are trained

Move away from screening questions to universal education, assessment and brief counseling.

Patient-Centered Approach

- Patients want providers to talk to them about GBV
- Patients may have concerns about how information will be shared (health records, reporting, etc)
- Empower patients with information, regardless of disclosure
- Be aware of the mistrust of health care that people may have because of legacy of discrimination and inequitable care.

The "perfect" screening question will not necessarily increase disclosure rates

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CUES Universal Education Approach

C: Confidentiality

Disclose limits of confidentiality & see patient alone

UE: Universal Education + Empowerment

Normalize activity: *"I've started giving info on D/SV to all of my patients"*

Make the connection: Open the card and do a quick review: *"They talk about relationships and how they affect our health. Take a look, and here is another one for a friend or family member. On the back of the card there are 24/7 text and hotlines and you can always talk to me about how you think your relationships are affecting your health. Is any of this a part of your story?"*

S: Support

Warm referral

Follow up at next appointment

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C: Confidentiality

- Always talk with patients about relationships alone and not within earshot of a partner or family member
- Always disclose the limits of confidentiality before beginning any assessment
- Never use a family member or friend as an interpreter—use professional interpreters
- You violate HIPAA reporting laws if you report something not mandated by law

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C: Video: We Always See Patients Alone

- The following video clip introduces strategy for ensuring that providers are able to have confidential conversations with their patients.

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C: Sample Script limits of confidentiality

Sample script to disclose your state's limits of confidentiality before asking about GBV:

"Before I get started, I want you to know that I cannot share anything we talk about today outside of the care team, unless you were to tell me you were going to hurt yourself."

Simple intervention tool and conversation starter: The Safety Card

Safety cards can be ordered for a nominal shipping fee at: **http://ipvhealth.org/resources/**

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This safety card is an evidence-based simple intervention tool and can take seconds to share with a patient.

- A conversation starter/guide and patient education resource
- Help survivors of violence and sexual coercion learn about safety planning, harm reduction strategies and support services.
- Plant seeds for those who are experiencing abuse but not yet ready to disclose.
- Provide primary prevention for patients who have not been in this kind of relationship—so they can identify signs of an unhealthy relationship and ideally avoid them.
- Who at your clinic will be responsible for ordering them?

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UE: Universal Education

- **Connect to the Visit:** “Because violence in relationships is so common, and can impact health, I talk to every patient about experiences they might have had.”
- **Introduce Safety Card:** (Unfold card and show it) "It's kind of like a quiz. It talks about relationships, boundaries and health”
- **Make the Connection:** “Unhealthy relationships can affect people’s health. There are options and resources in our community for people who need them”
- **Always Give Two Cards** “This resource may not be useful for you right now, but I am going to give you two cards in case you want to look at in the future or have a friend or family member who would find the information useful”

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UE: Universal Education: Connecting to the visit

You deserve kindness

Do your partner(s) support you:

- ✔ by respecting your choices?
- ✔ in spending time with friends or family?
- ✔ in staying healthy and taking care of yourself?

Do you:

- ✔ give your partner(s) the same respect and space?
- ✔ feel safe talking about sex and protection with your partner(s)

Supportive, caring relationships are good for your health. You deserve to be treated with kindess.

Universal education: Practical Application

- Divide into groups of three. One person is the provider, one person is the client, and one person is the observer.
- Practice introducing the Health, Healing and Relationships. Your goal is to introduce the card and make the connection between relationships and health.
- “We have started giving this out to all our patients in case they need this information for themselves or to help a friend…”
- Discuss as a group– what worked, what would you change.

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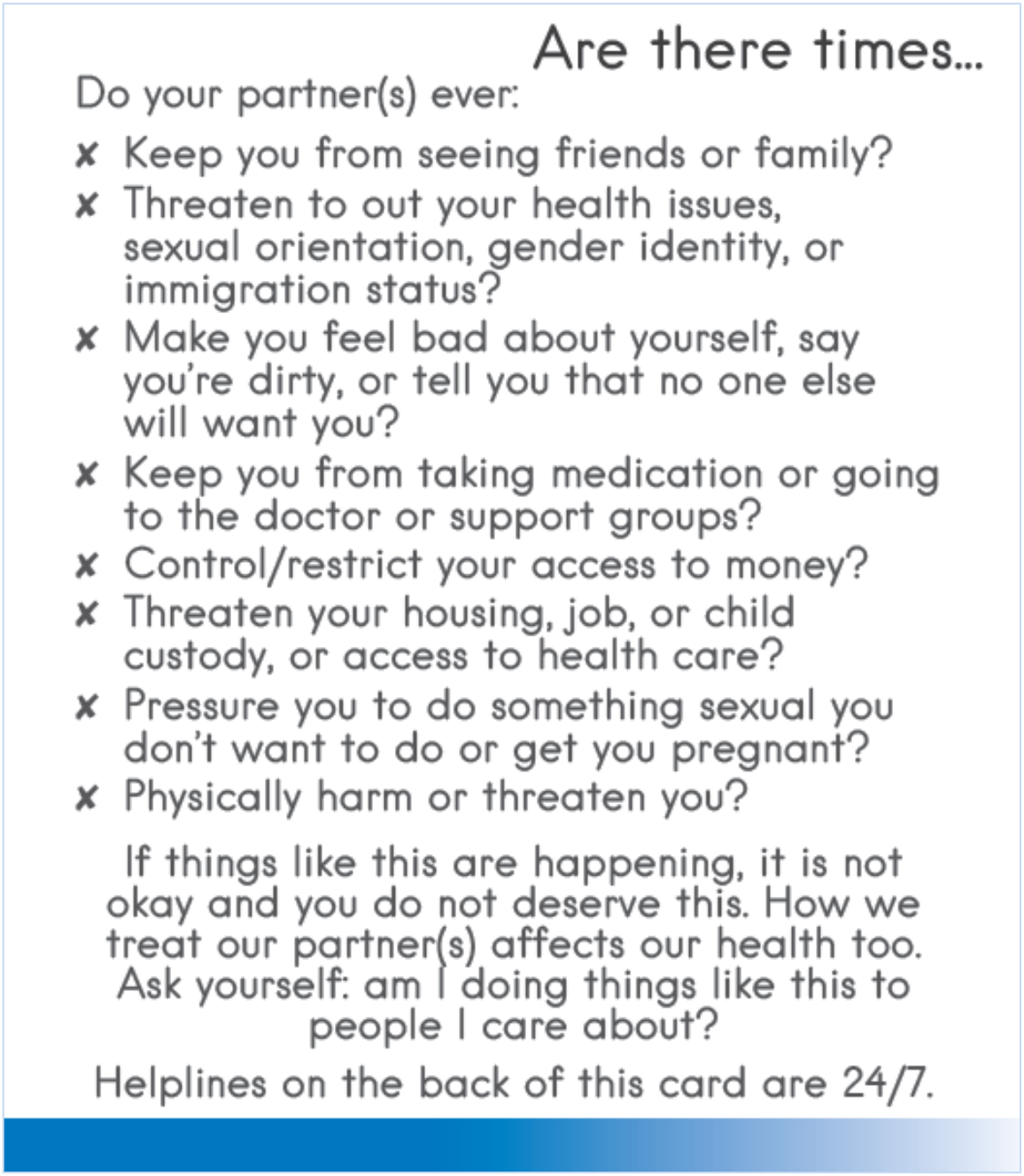
UE: How is Your Relationship?

Ask simple questions to assess for violence and sexual coercion, such as:

- "Is any of this a part of your story?"
- "Has anything like what the card is talking about every happened to you?"

UE: Direct Assessment



Direct Assessment: Health and Coping

Using to cope

- ✘ Are you drinking or using drugs more in order to cope?
- ✘ Has your partner(s) used your drug/alcohol use to control, manipulate, or shame you?
- ✘ Has your partner(s) ever pressured to use or share works?

Talk to your provider or a trusted friend about what you have been experienceing, ways to stay safer while using, and treatment options if that is something you are interested in.

You are not alone

- ✔ Do you often feel depressed or anxious?
- ✔ Has taking your medication and staying healthy been more difficult than usual?
- ✔ Do you ever think about hurting yourself?

Reactions like these are common for folks who have experienced physical/ emotional abuse, sexual violence, or discrimination.

Opportunities for Discussion of Relationships and IPV:

- At intake/pre-test counseling
- Risk assessment
- Partner notification
- Safer sex discussions
- Primary care visits
- Case management visits
- Reproductive health visits
- Behavioral health visits
- Peer health education
- Harm reduction support

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Practical Application of Direct Assessment

Jackson is a 33 year-old man living with HIV. This is the 3rd time you have seen him for care in the last year.

Use the "You Deserve Kindness" panel of the card to guide your conversation to offer universal education and provider direct assessment

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REMEMBER:

Disclosure is Not the Goal, **and**, Disclosures Happen!

S: Supporting Survivors: Listen and Validate

When a patient discloses that they are experiencing GBV, sexual coercion, or is afraid to ask their partner to use condoms, first validate their experience.

What do you survivors say they want from their health provider?

- Be nonjudgmental
- Listen
- Offer information and support
- Don't push for disclosure

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S: Validating Statements:

- "Thank you for sharing this with me. I'm so sorry this is happening. No one deserves this."
- "You're not alone."
- "Help is available."
- "I'm concerned for your safety."

Your recognition and validation of the situation are invaluable.

S: What NOT to Say

- "You should call the police and make a report"
- "You are definitely in an abusive relationship"
- "That does not sound like rape to me…"
- "Your partner is crazy, you need to break up with them"
- "So what happened after that, and what happened after that?"

S: Supporting Survivors: You are not alone

Dealing with what happened to you can feel isolating, but you are not alone.

It can be helpful to:

- ✔ Talk to a trusted health care provider, friend, or domestic violence advocate (see info on the back of this card) about what is going on.
- ✔ Work with someone you trust to develop a self-care plan to take your medications as prescribed, connect with others, get a good night's sleep, and more.
- ✔ Share this card with your friends and others in your community who might need help.

Video: “Visit for Asthma”

The following video clip demonstrates how providers can integrate direct response for DV into discussion of health symptoms.

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Video Debrief

- What worked well?
- What would you change?
- Are there considerations or questions specific to your setting?

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S: Providing a "Warm" Referral

When you can connect to a local program it makes all the difference.

"A lot of my patients experience things like this. There are resources that can help. [Share name, phone and a little about your local DV program] I would be happy to connect you today if that interests you?"

Role of the Domestic Violence Advocate

DV advocates received specialized training to be able to support survivors. Can work with survivors to achieve their priorities

- Housing
- Legal advocacy
- Safety planning
- Survivor support groups/counseling

Advocates are an important complement to in house services

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- 24/7 Helpline **216-391-HELP (4357)**
- **Support, safety planning, legal support, shelter**
- **Training & community education**

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Building Partnerships with DV advocates

Partnering with advocates can make your job easier and survivors safer!

- Connect with your local DV agency
- Host cross-trainings with the DV agency to promote shared knowledge between your staff
- Develop a survivor referral procedure between health providers and advocates
- Outline and agree to an MOU to define your partnership
- What are other opportunities?

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S: Providing a "Warm" Referral

Review the Resources Panel

"On the back of the card are some phone numbers and websites, in case you or a friend ever needs information or support."

Support
Practical Application

- After you ask Jackson about his relationship, you find out that he does not get to make decisions about sex and that his partner is very controlling. Using the safety card, respond to Jackson's disclosure. You will want to:
  - Offer validating and supporting statements
  - Make a warm referral

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Violence is a barrier to health care planning, and providers must become more creative in how they help patients manage risk, safety, and treatment plans

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Harm Reduction and Health

Eating well, sleeping well, taking daily medicine, and getting exercise can be particularly difficult for people who have survived trauma and/or are currently in violent relationships.

Brainstorm: How can HIV testing, treatment/care providers support survivor health even when trauma and violence are present?

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S: Harm Reduction

Deferral of HIV Partner Notification

Partner notification should be deferred if there is risk of behavior toward the HIV+ individual which may affect their physical health and safety, his/her children, or someone who is close to them or to a partner/contact.

Practical Application

Groups of two: One person is the health worker, the other is the patient who has experienced IPV. Health worker provide CUES intervention using CUES handout:

1. **Confidentiality**
2. **Universal Education + Empowerment**
3. **Support**

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Group Discussion

Based on what we have discussed so far,

What do you need to implement in your clinic in order to implement the CUES intervention?

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MODULE 4

Trauma-Informed HIV Treatment and Care: A Systems Approach

Thank you to our partners at Christie's Place for their contributions to this module

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Learning Objectives

As a result of this activity, learners will be better able to:

- Name three implications for HIV treatment and care services
- How to build partnerships with local support organizations/working with community partners/building partnerships.
- Describe trauma-informed care

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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.

SAMHSA, 2014

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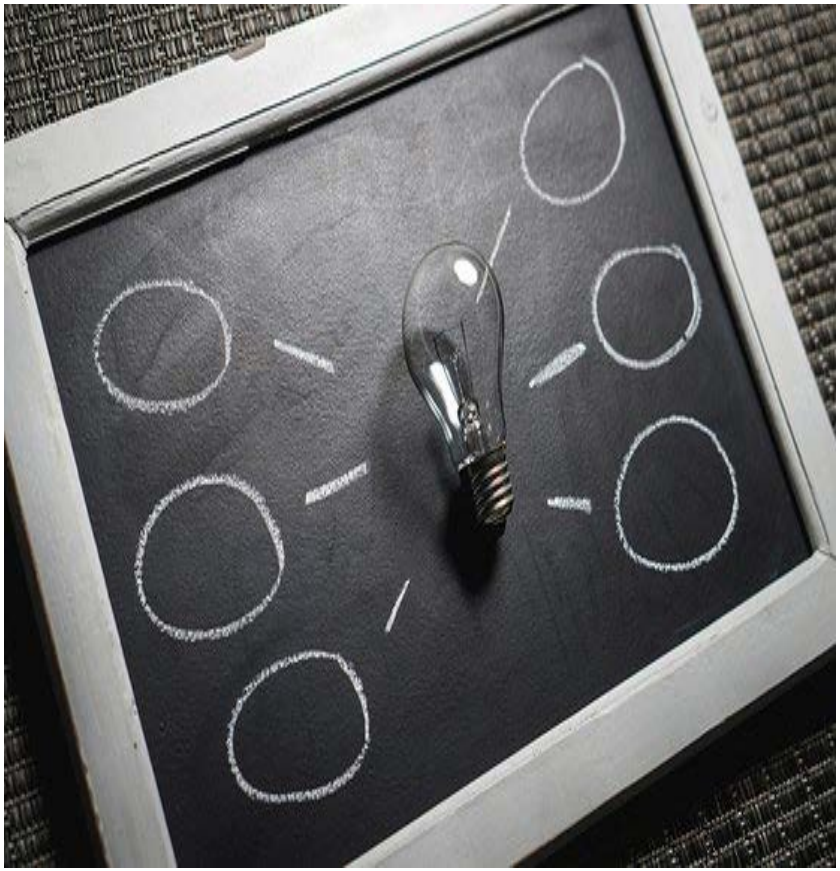
Let's Make it Real: Pair and Share

- Think of specific things within a health setting that might be triggering for your patients
- Write down three potential triggering things and possible ways to help address them.
- Report back



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Triggers and power dynamics

- Invasive procedures, removal of clothing, physical touch, vulnerable physical position
- Personal questions that may be embarrassing/distressing
- Power dynamics of the relationship
- Loss of and lack of privacy
- Negative past health care experiences
- Personal questions asked in absence of trusting relationship
- Racist/sexist history of health care intuitions
- Changes in service providers can occur with little or no notice
- Models of care are often based on medical necessity which focuses on diagnosis/pathology rather than strengths and resiliencies
- Deficit based language; eg “infected” v “person living with HIV”
- Patient’s voice not reflected in goal setting or treatment planning
- Processes not fully explained to patient

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Discussion

What are some examples of how you have experienced your healthcare/social services environment as trauma-informed?

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SAMHSA's Concept: Trauma Informed Practice

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

(1) realizes the prevalence of trauma and taking a universal precautions position;

(2) recognizes how trauma affects all individuals involved with the program, organization, or system, including its own workforce;

(3) responds by putting this knowledge into practice; and

(4) resists retraumatization.

Activity: Examples of Key Principles in practice:

- **Safety**
- **Trustworthiness and transparency**
- **Peer support**
- **Collaboration and mutuality**
- **Empowerment, voice and choice**
- **Cultural, historical, and gender lens**

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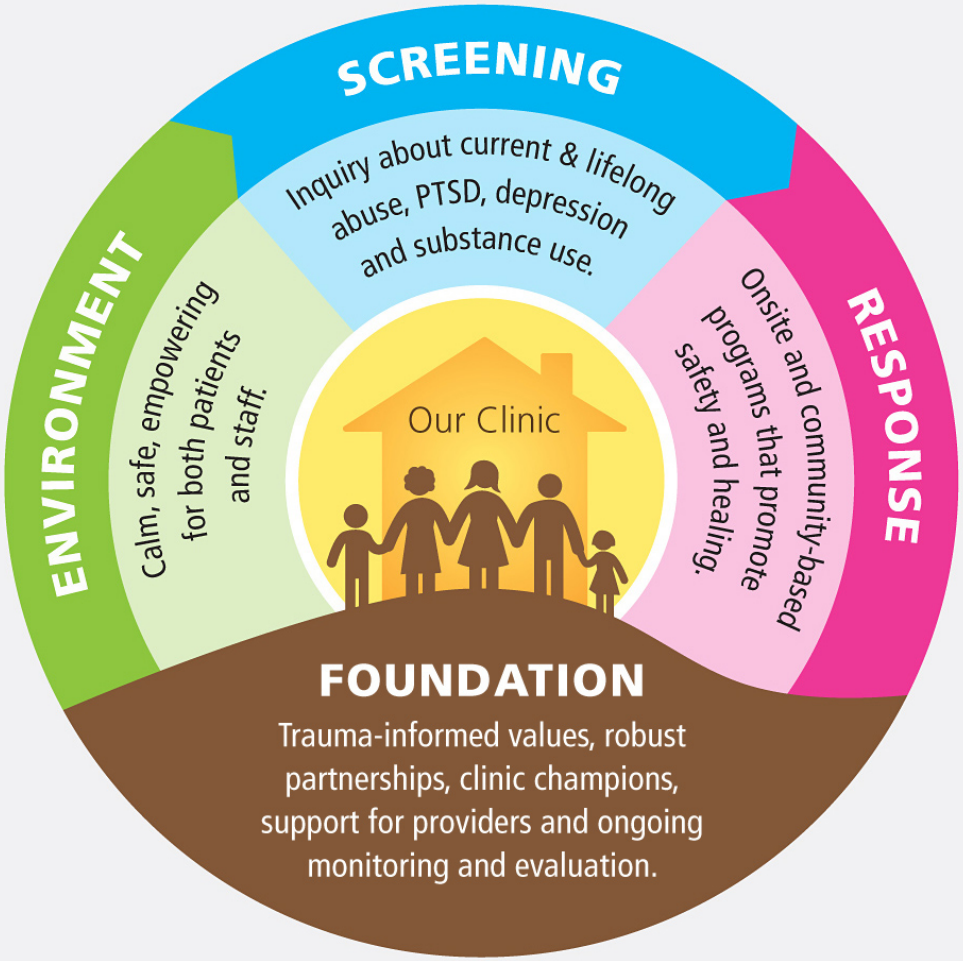
But what does it look like?

Service Delivery Examples:

- Safe, welcoming, environment: not clinical?
- Based on a strength-based, empowerment model that fosters growth and resiliency
- Influenced by understanding of the impact of violence and harm
- Shifts on all levels of the health organization
- Health goals are mutual and established collaboratively
- Attends to issues of power and hierarchy
- Meaningful participation of patients in program design, evaluation and delivery of services
- Understands that behaviors traditionally viewed through a pathological lens are often attempts at coping that may (or may not) result in the outcomes that an individual desires.



A conceptual model developed by Women and HIV Program (UCSF) and Positive Women's Network

Machtinger, E, Khanna, N, Cuca, Y, Kimberg, L, et al. A Conceptual Model of Trauma-informed Primary Care for Women Living with HIV. 4th International Workshop on HIV & Women, Jan 13-14, 2014. Manuscript in review.

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A Trauma-Informed Workplace is Essential

Trauma informed supervision is:

- Safe, non-judgmental, and supports staff growth and self awareness
- Provides positive regard and caring
- Is regular and reliable
- Uses a strength-based approach
- Provides space for reflection

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Reflective Supervision

- Reflection means stepping back from the immediate, intense experience of hands-on work and taking the time to wonder what the experience really means.
- When meeting with staff, supervisors can help staff assess: What does it tell us about ourselves? How does it make us feel? How does it affect our work?

(Parlakian R, 2001)

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Simple Steps to Organizational Self Care

- Weekly (if possible) staff check in
- Staff check in that begins with ALL staff writing down three positive things about a client or colleague
- Share a few positives before debrief of difficult cases
- Share a few more positives after the difficult cases

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Trauma-Informed Practice: Model Program

- Meaningful inclusion of women living with HIV in all aspects of service design, delivery, and evaluation
- Leadership training and opportunities for women living with HIV
- Ongoing training on the principles and practices of trauma-informed service provision
- Discipline specific training on trauma and the effects of violence and abuse
- Trauma-Informed Service Provision Committee
- Education of partner agencies
- Expanded definition of "Peer"
- Support for staff

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What is a Peer Navigator at Christie's Place?

- Integral members of the treatment team
- Women living with HIV who are trained to work with HIV healthcare and social service settings
- Have personal experience and training with substance abuse and trauma recovery
- Help other women living with HIV take control of their health and well-being through self empowerment.
- Women helping other women who share similar experiences or backgrounds. Peer Navigators are role models that offer hope to others who are HIV+.

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Next Steps: Furthering Trauma-Informed Care in Your Community

- What steps could be taken within your work context/community to shift towards a more trauma-informed environment?
- What opportunities for new partnerships or collaborations do you see?
- What types of resources do you need?

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Next Steps: Places to start

- Ensure spaces to provide Universal Education and the CUES approach with patients alone
- **Practice CUES! Pilot CUES!**
- Provide visuals that indicate this is a safe space to discuss trauma and relationships (rainbow stickers, healthy relationship posters, etc)
- Support staff in addressing their own experiences of violence and trauma
- Document your progress with Quality Improvement tools

Get more info here: http://ipvhealth.org/health-professionals/

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www.ipvhealth.org

Resources for HIV care settings

- Safety Card for use in
  - HIV/STI testing
  - HIV treatment and primary care
- Training PowerPoint deck for HIV testing and care health settings
- Available at: ipvhealth.org
- Contact health@futureswithoutviolence.org

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Please fill out the Post Training Evaluations!

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