CALIFORNIA HIV / AIDS POLICY RESEARCH CENTERS

Evaluating Trauma-Informed Care Practices Among HIV Care Providers in California

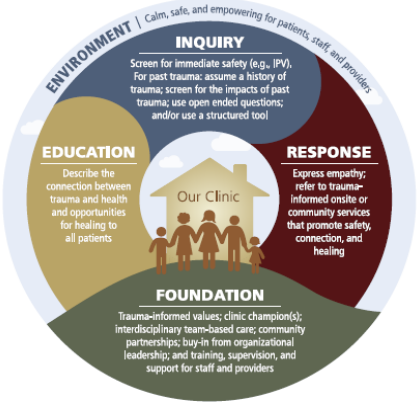
Background

People living with HIV (PLWH) experience a disproportionate rate of trauma compared to the general population and trauma's association with poorer treatment adherence, health outcomes and increased risk behavior has long been known (Chartier et al., 2010; Kamen et al. 2013; Machtinger, Haberer, Wilson, & Weiss, 2012). Current literature examines sources and experiences of trauma among PLWH, including intimate partner violence, gender violence, experiencing and witnessing violence, child abuse, sexual abuse, and racism (LeGrand et al., 2015). Aligning with a sexual health framework that attends to complex elements that influence sexual behavior, utilization of services, and adherence, trauma-informed care is an area for innovation in HIV prevention and treatment (Sales, Swartzendruber, & Phillips, 2016).

After convening national experts with wide experience on the subject, including trauma survivors who had received care from various service systems, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed a concept of trauma-informed care, also known as the trauma-informed approach, as follows:

> a program, organization, or system that … **realizes** the widespread impact of trauma and understand potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization** [emphasis in the original] (SAMHSA, 2014, p. 9).

SAMHSA adds adherence to the following six principles as essential to trauma-informed care: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; concern for cultural, historical, and gender issues (SAMHSA, 2014). Machtinger and colleagues advance a conceptual framework for implementing trauma-informed primary care that may be applied to care for PLWH. They provide a graphic identifying foundational principles and clinical practices essential to trauma-informed care (Machtinger et al., 2019, p. 98):



The integration of trauma-informed care in agencies providing services for PLWH is often influenced by clinical and organizational elements, such as a lack of evidence-based behavioral interventions, practice guidelines, and inadequate

provider training (Brezing, Ferrara, & Freudenreich, 2015; LeGrand et al., 2015). Still, various studies indicate how a trauma-informed approach may inform HIV testing services and care for PLWH. These include promoting a practice environment in which patients feel safe; screening for trauma, its mediators, and consequences; making appropriate referrals and including them in HIV prevention and treatment efforts; educating patients about the association between trauma and their health; and training all staff who engage with patients (Aaron et al., 2013; Brezing et al., 2015).

Purpose and Methods

The purpose of this study is to explore whether trauma-informed care is systemically integrated in HIV care settings in California. It examines how different health care and social service providers define trauma-informed care and how they translate existing knowledge into practice. It compares these practices and notions with models of trauma-informed care emerging from our literature review. The research team partnered with Christie's Place, a nonprofit social service organization engaged in HIV/AIDS education, support, and advocacy that is nationally recognized as a model for trauma-informed care service provision. Together with AIDS United, they have published a report explaining the stages of implementing trauma-informed care in a service setting (AIDS United & Christie's Place, 2017).

In 2019, the study team identified all Ryan White-funded HIV service providers in California and selected a sample of providers that represented diverse geographic locations and organizational sizes. To be eligible for the study, respondents were required to be age 18 and over, work for an identified agency serving PLWH in California, be familiar with trauma-informed care and with their agency's policies and practices as they relate to providing care to PLWH, and hold either a managerial, administrative, or frontline staff position.

For the study, 21 individuals were screened and deemed eligible and 20 completed the interview. Of these, 11 respondents were from Southern California, 6 were from Northern California, and 3 were from Central California. Participants were offered a $50 e-gift card for their participation. Of those interviewed, 15 held managerial or administrative titles and 5 held direct service positions as identified during the screening process. Eligible respondents that provided consent completed a study interview through an online platform, Zoom. Each interview was conducted by research staff and a content matter expert from Christie's Place. Interview topics covered participants' knowledge and experiences of implementing trauma-informed care within their organizations.

The study team transcribed all interviews and summarized them according to a common template containing relevant provider information and conceptual domains derived from the interview guide, namely notions and practices of trauma-informed care, TIC training, and integration barriers and facilitators. Based on a model of rapid qualitative analysis in health services research (Hamilton, 2013), the summary data were combined into a single, comprehensive matrix for analysis. The team conducted matrix analysis using a set of reduced data tables jointly with experts from Christie's Place and arrived at a consensus about the findings.

Results

The HIV service providers interviewed were aware of the basic elements of trauma-informed care and its underpinning values and principles. They identified different practices and processes that show how trauma-informed approaches are implemented within their organizations, despite the lack of a formal policy integrating trauma-informed care into their operations. Participants also outlined

facilitators and barriers to implementing trauma-informed care. A common facilitator identified was invested leadership to promote trauma-informed care practices. A common barrier identified were the competing interests faced by HIV service organizations. Funding and training were identified as facilitators of implementing trauma-informed care. Conversely, the disparity of these elements among HIV service organizations was identified as a barrier to implementing trauma-informed care.

Definitions of Trauma-Informed Care

Participants understand trauma-informed care as a framework for engaging in HIV service provision in a manner that acknowledges trauma as common among their clients, but who may experience trauma differently from one another. They recognize the deleterious effects of trauma on clients' daily functioning and behavior, their interactions with the health care system, health outcomes, and overall well-being. Participants understand that trauma-informed care focuses on the trauma motivating behaviors rather than attributing actions simply to bad behavior. Several participants mentioned dealing with clients not from the standpoint of "What's wrong with you?", but rather "What happened to you?".

As a licensed social worker and Ryan White program manager stated,

"[Trauma-informed care is the] recognition that … folks' trauma histories have a profound impact on [their] health and the relationship with health care providers, their relationships … with their peer and family networks and that certain experiences, especially around engaging with healthcare … can be very triggering."

Indeed, about a third of the service providers interviewed also stated that trauma-informed care seeks to prevent re-traumatization. At one organization providing comprehensive support services, the staff were trained to understand non-verbal cues which suggest when a person has been triggered. This training was important for them because they serve a large client population of monolingual Spanish speakers. Participants identified the various ways their agencies respond to clients' traumatic experiences. They make referrals and exercise flexibility in their procedures when appropriate, for instance. Only one-fifth cited using specific and validated screening instruments, such as the Adverse Childhood Experiences (ACEs) tool, though several participants reported that their behavioral health staff assess clients for signs of trauma more generally.

HIV service organizations identified competing interests along with the lack of funding and training as barriers to implementing trauma-informed care.

Of all participating HIV service provider agencies, 60 percent lacked a formal policy to integrate trauma-informed care throughout their systems of care and at least one-fourth did not have an organizational definition at the time of the interviews. Instead, some participants said that principles of trauma-informed care are organically integrated into their work. One participant observed that trauma-informed approaches have become woven into their organization's identity. There are drawbacks to not institutionalizing trauma-informed care, however. An example provided by a participant is that their organization's policies included a long, uncomfortable list of rules a client must obey, which may work to counter efforts to implement trauma-informed care. Another drawback identified by a participant was that though their division applies a trauma-informed care model, there has been less dialogue about it in other areas of their organization. Another participant similarly noted that though a smaller unit may be observing trauma-informed processes, without a formal policy, such

practices are not integrated with the rest of the organization. This was demonstrated by a participant that reported initiating trauma-informed care in their agency less than a year ago.

Though the majority of participants' organizations lacked formal policies to implement trauma-informed care, over half of those interviewed explicitly recognize that trauma-informed care requires a commitment at the organizational level. Fittingly, a participant in senior management noted,

"It's not just a particular service or intervention, but a structure that provides [an] environment sensitive to their [the patients'] specific needs."

This participant further explained that structural interventions have a larger impact than individual or group-level efforts. Overall, participants maintained that the commitment to implementing trauma-informed care extends to all levels of personnel. A participant mentioned that at the stage of interviewing potential hires, they emphasize safety, welcoming people without judgment, and entering into a mutually respectful partnership with clients. Some evidence of organizational commitment is that almost 60 percent of participants mentioned that staff undergo or conduct training to varying degrees with their agency's remit, as opposed to training on their individual, professional initiative.

Of all participating HIV service provider agencies, 60% lacked a formal policy to integrate trauma-informed care

Because mental or behavioral health personnel tend to be associated with TIC in daily clinical practice, organizations also face the temptation to reduce trauma-informed care to being in the sole purview of behavioral health. As one participant indicated, the behavioral health department has been the biggest facilitator of trauma-informed care within their organization. There is also a risk of identifying it solely with "a prescribed set of practices or procedures" or as a "checklist" (SAMHSA, 2014, p. 10).

Facilitators and Barriers

The capacity to become a trauma-informed organization requires this approach be a continuous priority for both leadership and frontline staff. Half of the participants discussed the importance of well-invested leadership in their respective organizations as a facilitator to trauma-informed care or the lack of such support as a barrier. A participant cited commitment from the leadership of the organization, with the active involvement of all staff, as a facilitator to implementing trauma-informed care practices. For this participant, trauma-informed care is a value recognized not just within their organization but within the field. In contrast, a different provider, who primarily focuses on direct service, explained that a lack of understanding of TIC from upper management was a barrier to implementing trauma-informed care. The same service provider, however, added that this possible disconnect between administrative leadership and front-line staff is changing. For example, they indicated that their management has made more requests for information regarding trauma-informed care. One provider described a process whereby staff were designated to champion trauma-informed care practices by training other staff. These champions facilitate trainings which get

Half of the participants discussed the importance of well-invested leadership as a facilitator to trauma-informed care

"sent down to each site, for there to be more conversation to be looking at ways that our work environments … could be improved … to alleviate stress or trauma."

Half of the participants mentioned competing interests as a fundamental barrier to implementing trauma-informed care, including being understaffed, experiencing time constraints, institutional barriers such as silos within agencies, and the trauma experiences of the staff themselves. One provider stated,

A majority of participants indicated that trainings, or a lack thereof, were a central theme in integrating trauma-informed care.

"Everyone is spread so thin that there's people doing multiple jobs. So we might not be meeting the client's needs like we should. There's a possibility that happens in a lot of nonprofit social services places."

A direct service provider illuminated the competing interests involved by explaining that a trauma-informed approach

"asks that we spend more time with our patients," yet primary care providers are "so used to seeing patients within a certain amount of time, there has been push back up from administration, from taking the extra time that is necessary to fully develop the trauma-informed model of care."

A majority of participants indicated that trainings, or a lack thereof, were a central theme in integrating trauma-informed care. One service provider located in a rural area of Northern California described their in-house efforts to disseminate know-how among staff but expressed concern about the lack of access to expert training. On the other hand, a participant who described having broader access to trainings identified a formal training program as a facilitator to implementation.

Funding also appeared to be an important theme for participants. Half of those interviewed mentioned funding as either a facilitator or barrier to the implementation of trauma-informed care. One participant's concern relates to the lack of prioritization for trauma-informed care. They indicated,

"the money is there, but then the [administration] don't want to allocate it [to trauma-informed care]."

Half of those interviewed mentioned funding as either a facilitator or barrier to the implementation of trauma-informed care

Another participant asserted that funding was available because their organization serves a

"critical mass of older adults with HIV." As a result, they have "rolled out some interventions and activities that address trauma."

Similarly, another participant alluded to the twin facilitators of mandates and funding. Trauma-informed care has become a priority, because the grants they receive mandate practices that are trauma-informed.

Policy Recommendations

Summary data from the qualitative interviews indicate three clear pathways to shift policy toward the successful implementation of trauma-informed care in Ryan White-funded clinics in California. According to participants, systemic integration requires significant investments, which many claimed was not the current state. These include:

1. A champion within the organization with clear authority to act.

   The distinct difference between organizations that reported successful integration of trauma-informed care and those that did not report such was the presence or absence of a leader who serves to champion the approach. While almost all providers interviewed indicated their own knowledge of trauma-informed principles and practices, the degree to which that knowledge and the associated practices were spread throughout the agency, bottom-up or top-down, depended upon leadership within the organization.

2. Process-oriented training and continued education across the organization.

   Participants had a clear sense of the definition of trauma-informed care and the potential role of trauma and its specific impact on the lives of their clients and patients. Training and education as described by participants, however, did not appear to include a formal review of the agencies' own policies and practices, which may serve as a barrier to systemic implementation. Training and education opportunities were not individualized, targeting the specific needs and challenges to implementing trauma-informed care within the agency. Additionally, a significant number of participants indicated that information sharing, training, and education efforts tended to occur in a siloed manner, making integration of trauma-informed care across departments non-existent. This appears to be driven by misperceptions within organizations that trauma-informed care is synonymous with treating clients and patients' trauma and, thus, was a job primarily for those practicing in behavioral health.

3. Funder support to facilitate systemic integration of trauma-informed care.

   While placing additional program requirements on grant-funded agencies appears onerous, participants that reported successful implementation of TIC practices were from organizations that either a) undertook training of staff at different levels and committed resources to such training or b) were encouraged by funders to do so. One participant described an example of successful execution through the provision of technical assistance and focusing attention on trauma-informed care as a measure of quality. Improvement, with funding and programmatic support from the funder, may be ensured by explicitly coupling any requirements around systemic integration of trauma-informed care with needed resources to do so. Should funders consider including integration of trauma-informed strategies as a measure of quality, the first step could be to target simple, low-barrier changes. This can include conducting a review of the physical space and organizational policies, acknowledging existing practices which support integration of trauma-informed care, crafting intake procedures to eliminate the need for clients to repeat their stories and cases to staff they encounter at different points of care, disseminating web training and other easily accessible resources among colleagues, and communicating staff roles and responsibilities to clients in clear ways such as posters displayed at their sites

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