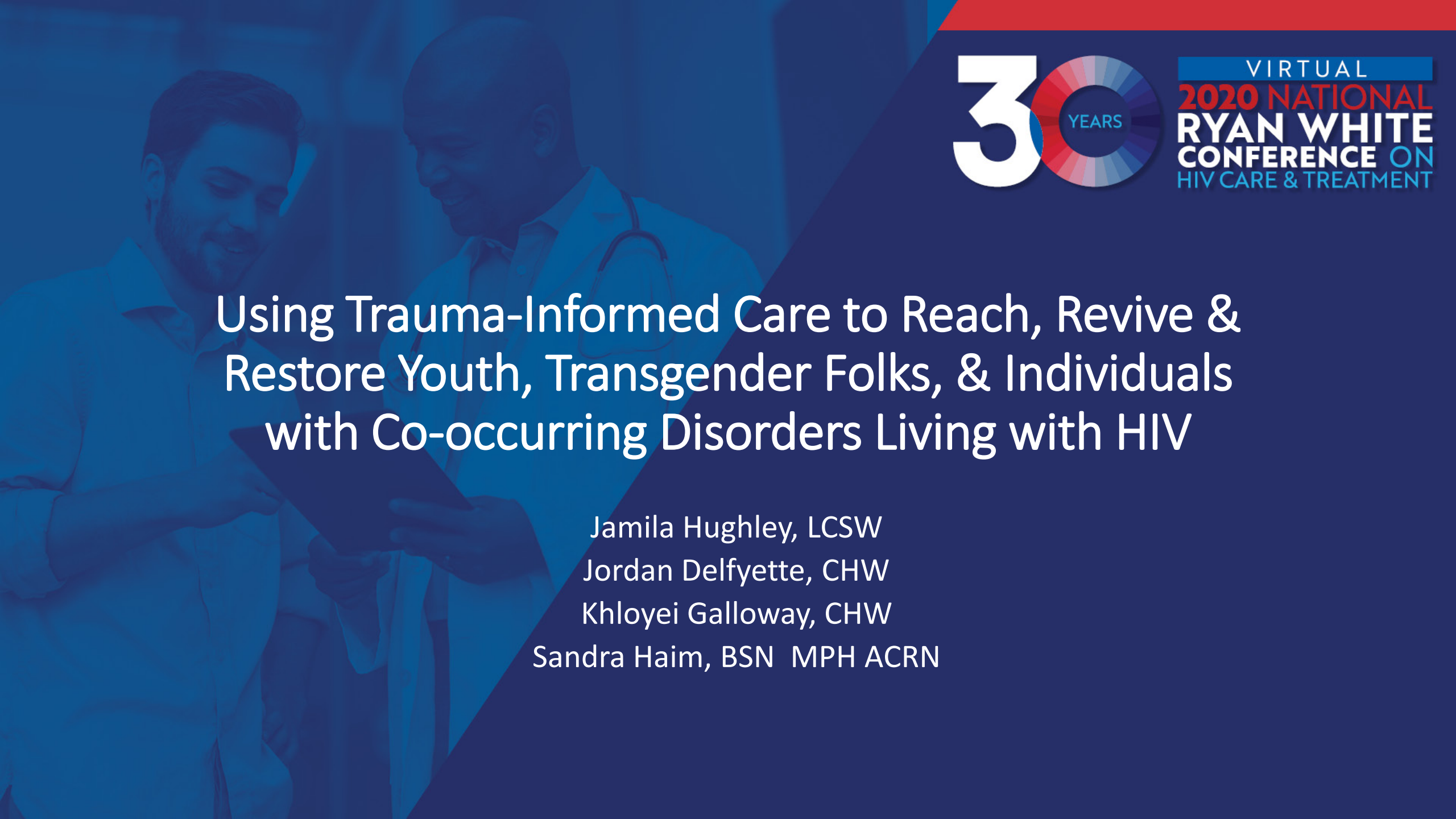

VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Using Trauma-Informed Care to Reach, Revive & Restore Youth, Transgender Folks, & Individuals with Co-occurring Disorders Living with HIV

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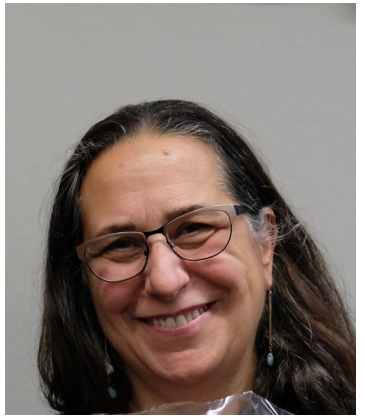
Jordan Delfyette, CHW
Khloyei Galloway, CHW
Sandra Haim, BSN MPH ACRN

About us

Jamila
Clinical Supervisor of Community Outreach Program
LCSW



Sandra
Assistant Manager,
Department of Health Programs

Jordan
Community Health Worker,
Youth “Reach Revive & Restore” Specialist

Khloyei
Community Health Worker,
Transgender Advocate,
& Social Support Specialist

About us (2)

- Rutgers New Jersey Medical School Infectious Diseases Practice
  - Newark, NJ
  - Ryan-White funded for multidisciplinary HIV primary care, 1600+ patients living with HIV
    - **80% Black/African American**
    - **15% Hispanic**
    - **43% Women**
    - **1% Transgender**
  - "One stop shop" offering on site psychiatry, suboxone, dental, women's health, gender affirming health care.
  - NJDOH funded program for intensive medical case management, community health workers and transgender health.

Workshop Overview

- Ice Breaker (5 minutes)
- Learning Objectives
- Presentation (30 minutes)
- Discussion (15 minutes)
- Wrap Up (5 minutes)

Ice Breaker

https://www.youtube.com/watch?v=jkLRith2wcc
https://www.healthyplace.com/

Learning Objectives

- Define trauma-informed care and identify practical approaches to implementation in clinical programs
- Identify internal resources to develop and implement support groups for youth, transgender women, and those with co-occurring disorders who experience HIV.
- Describe how working from a trauma-informed lens can empower youth, transgender women, and those with co-occurring disorders in HIV prevention and treatment

Definition of Trauma

The NJ Division of Mental Health & Addiction Services (DMHAS) defines trauma as:

- Trauma refers to extreme stress that overwhelms an individual's ability to cope. Individual trauma can result from an event, a series of events, or circumstances that an individual experiences as physically or emotionally harmful or threatening. It is not the objective facts of an event that determines whether that event is traumatic; it is the way in which each individual internalizes the emotional experience of the event. Traumatic events or circumstances often have lasting adverse effects on an individual's basic sense of self, trust in others, physical, social, emotional, or spiritual well-being.

www.nj.gov/humanservices/dmhas/initiatives/trauma/index.html

Prevalence of Trauma

2011-2012 National Survey of Children's Health-nearly 35 million children in US have experienced one or more adverse childhood experiences (50%)

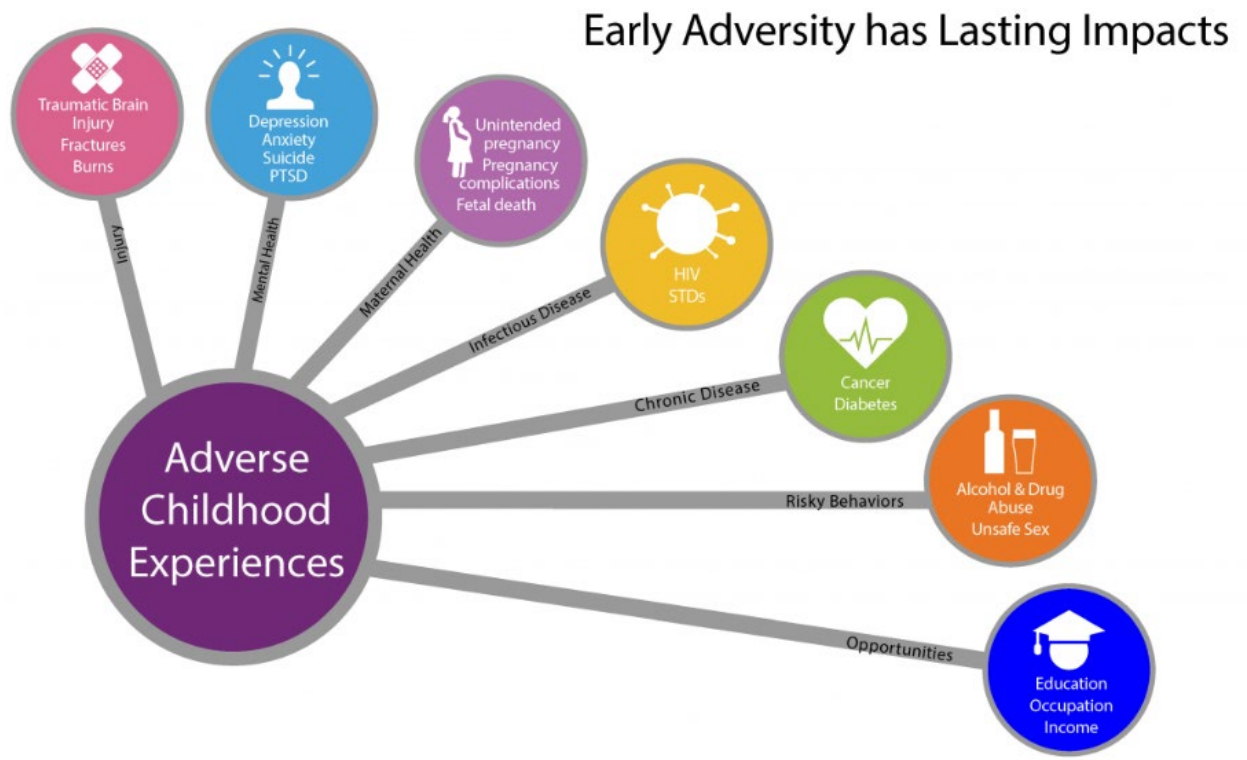
People living with HIV (PLWH) have higher rates of trauma, post-traumatic stress disorder (PTSD) and depression compared to those without HIV and those with other chronic conditions

https://www.childhealthdata.org/

https://hiv.rutgers.edu/wp-content/uploads/2018/06/New-Jersey_Ending-the-Epidemic-Update_Revised-26Apr18.pdf

Prevalence of Trauma (2)

People with 4 or more Adverse Childhood Experiences are at a higher risk for depression, suicide alcoholism, drug abuse smoking, heart disease, cancer, lung disease and liver disease.



https://www.cdc.gov/violenceprevention/acestudy/about.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fchildabuseandneglect%2Facestudy%2Findex.html

Trauma Informed Care

The NJ Division of Mental Health & Addiction Services (DMHAS) defines trauma informed care as:

"In a trauma informed system, trauma is viewed not as a single discrete event, but rather as a defining and organizing experience that forms the core of an individual's identity. The far reaching impact and the attempts to cope with the aftermath of the traumatic experience come to define who the trauma survivor is." (Harris and Fallot, 2001)

www.nj.gov/humanservices/dmhas/initiatives/trauma/index.html

Trauma informed care (2)

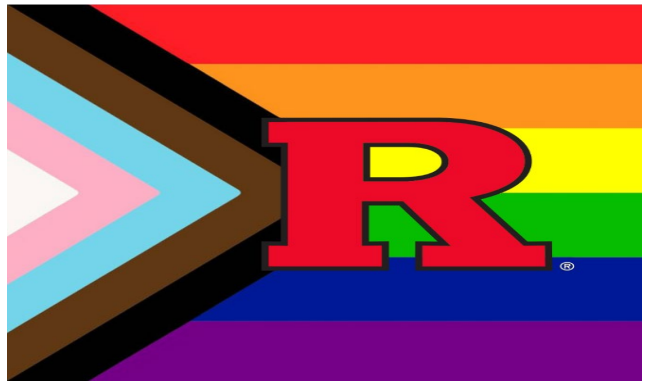
Trauma Informed Practice uses a strengths-based framework which is founded on five core values:

1. Emotional and physical safety for all – staff and service recipients.
2. Trustworthiness: Clear and consistent policies, honest service delivery with program appropriate boundaries.
3. Choice: Activities offer service users choices and control
4. Collaboration: Inclusive approach instead of a top-down hierarchical model.
5. Empowerment: Self-esteem and skill building.

www.nj.gov/humanservices/dmhas/initiatives/trauma/index.html

Universal Precautions

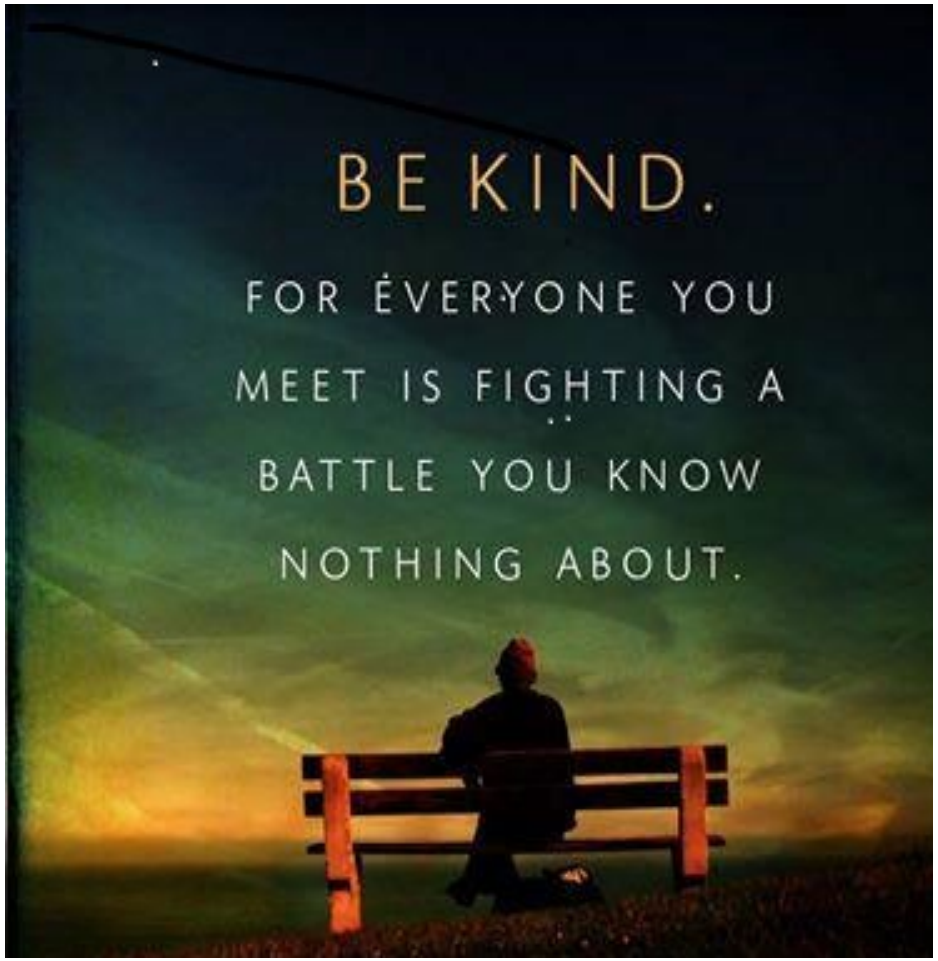
We need to presume that the clients we serve have a history of traumatic stress and exercise "**universal precautions**" by creating systems of care that are trauma informed—Hodas, 2005.



www.nj.gov/humanservices/dmhas/initiatives/trauma/index.html

Universal Precautions (2)

- Assume everyone has a history of trauma
- Treat all clients with respect and empathy.
- Listen first. Be collaborative, accept that a client would do more if they could.
- Symptoms of trauma may mask depression, hopelessness, distrust, lack of control, anxiety and fear
- Recognize the culture and practices which are traumatizing
- Communication is key. Certain clinic practices may be retraumatizing.
- Maintain confidentiality



IDP Programming

CORE Coordinated Outreach Retention & Engagement (intensive medical case management)

R.U.T.H Rutgers University Transgender Health (Medical care and treatment, CHW and MCM services)

CHW Community Health Worker (collaboration with CBO counterparts)

RESTORE Resources, Education, Support, Treatment, with Opportunities to Renew and Evolve

Dialogue is Healing A support group for both men and women ages 18-90 living with or affected by HIV in need of additional support.

Memoirs of a Butterfly A support group for people living with or affected by HIV, who identify as transgender.

Core Value #1
Emotional and Physical Safety

Staff/clinical space needs assessment

https://transequality.org/health-care-action-center

- Staff had very little prior experience with transgender patients and had high anxiety around mis-gendering
- No system in place for pronouns/names
- Forms not inclusive
- No policies for pronouns/names
- EMR not set up to capture chosen names and pronouns, alerts for screening inappropriate
- Unclear which insurance companies cover which treatments and the requirements that needed to be met
- Patients would feel comfortable in our space, but not in spaces to which we referred (internal and external)

Core Value #1
Emotional and Physical Safety cont

- Extensive staff training on gender identity and the disproportionate affect of violence on the transgender community.
- Affirming signage was added around the clinic “what’s your preferred pronoun”?
- Staff of transgender experience were hired.
- A support group and dedicated MCM were added to the program.
- Gender and sexual history taking training provided
- Intake forms that include preferred name, pronoun and sexual identity
- Unisex bathrooms signage replaced MEN/WOMEN

Core Value #2 Trustworthiness:

Case Study

History

- Patient is a 57 year old single heterosexual African American male of Christian faith. He was gainfully employed prior to becoming extremely ill in February of 2017 due to poor adherence to HIV care and treatment. He had multiple comorbidities which caused him to become newly blind. He had limited social support with minimal resources, which resulted in him being isolated to his home.
- He presented to our clinic in February of 2017 as detached, distant, and difficult to engage and retain in care. He became increasingly depressed with suicidal thoughts and was referred to the CHW April of 2019 for additional support.

Core Value #2 Trustworthiness: (2)

Interventions and outcomes

- CHW made weekly visits to client and provided compassionate listening and spiritual motivation.
- Food, referrals to food pantry by nutritionist and “engagement facilitators” provided.
- Daily coordination with MCM and client’s family to ensure patient has services in place.
- Linkage to Commission for the Blind and Visually Impaired
- **Patient is now actively engaged in care and treatment. He is now undetectable ☺**

Core Value #3 Choice

Case Study

History

- Patient is a 57 year old single heterosexual African American male of Christian faith. Patient has significant history of Schizoaffective Disorder Bipolar Type and Cocaine Use Disorder. The CHW and Outreach Worker met with patient in the emergency room of University Hospital and engaged the patient in to care.
- Patient was homeless with an extremely high viral load. Due to mental illness and substance use and the loss of his mother, patient became estranged from his family who live in New Jersey. Due to his untreated mental illness and substance abuse, he was very unpredictable and disruptive when he came to clinic which was almost daily.

Core Value #3 Choice (2)

Interventions

- CHW made regular outreach visits to client and provided compassionate listening, spiritual empowerment and motivational interviewing.
- CHW provided “engagement facilitators” to engage the patient into treatment and care, as well as to assist the patient who was experiencing food insecurity.
- CHW coordinated daily with MCM and accompanied the patient to his medical appointments to help manage the patient’s mood swings.
- CHW worked with the MCM to navigate the patient to shelter placement, psychiatric treatment, clothing resources, co-occurring mental health and substance use counseling, and facilitated communication with the patient’s family in NJ and Florida.
- CHW advocated with the patient’s siblings to be more involved with the patient’s treatment and helped the ID providers to educate patient about his medical conditions and regimen in order to increase the patient’s health literacy.

Core Value #3 Choice (3)

Interventions continued and outcomes

- CHW was the designated staff person to interact with patient each time patient came to the practice in order to de-escalate and prevent patient from disrupting the environment or becoming threatening to staff or other patients.
- On several occasions the IDP staff, including provider, administrator, mental health clinician MCM and CHW all educated the patient about acceptable behavior while in the clinic. The ID policy about disruptive and threatening behavior was also reviewed with the patient.
- Patient was encouraged to follow up with outpatient psychiatric treatment to increase his ability to maintain relationships and to be able to obtain and keep necessary resources. **Patient had an honest and trusting relationship with the CHW** but repeatedly made the choice not to follow up with outpatient mental health services despite encouragement, motivational interviewing and incentives. **Patient was able to reach and maintain an undetectable viral load with the support of the entire treatment team**.

Core Value #4 Collaboration

Case Study

History

- Patient is a 37 year old single bisexual African American female with significant history of traumatic experiences. Her two young children were removed from her care. She was frequently incarcerated for assault and controlled dangerous substance possession. She was in and out of care due to the multiple events of incarceration. She would present for treatment once released from Essex County Correctional Facility. On several occasions she presented under the influence of PCP, disorganized, loud and aggressive towards staff and other patients while in the waiting room.
- Patient presented for an appointment and aggressively cornered a medical tech in the triage area after being triggered from having to wait for what she considered to be some time.

Core Value #4 Collaboration (2)

Interventions and outcomes

- Management of a disruptive patient policy was revisited and revised.
- A de-escalation training session was offered to all clinic staff
- Staff were trained on TIC and provided with guidelines for how to handle an angry or aggressive patient.
- A case conference was held with the client to discuss guidelines and expectations
- The patient was accompanied by her MCM when in potentially triggering situations.
- The CHW accompanied her to social service appointments and other medical appointments. The CHW encouraged her on weekly check in calls.
- She did not have any further problems in clinic.

Core Value #5 Empowerment

Helping clients learn to self manage triggers that sometimes prevent engagement and retention:

- CHW Outreach “meet clients where they are”
- Support groups designed to provide a safe space and real-life tools to help navigate through life’s challenges
- Literacy level and language used are considered when reviewing plans of care

Core Value #5 Empowerment (2)

Integrating TIC in Community Outreach and Support Groups

Core Value #5 Empowerment (3)

Dialogue is Healing Support Group

- Using the arts to cover topics such as grief, mental illness and substance abuse by incorporating and teaching essential tools such as forgiveness, self care, motivation, strength, purpose and healing.
- Implemented Poetry, meditation, painting, ice breakers, writing for reflection and healing

Core Value #5 Empowerment (4)

"To breathe life when it rains seems harder, then to breathe life when its sunny"

This workshop is a place where participates will share, release, and grow.

While the facilitators work to **"reach, revive, and restore"** those individuals in need.

Trauma Informed Care Checklist

Trauma Informed Services should

- Include individuals and supporters in planning design and implementation and monitoring of TIC practices
- Train staff to ask about trauma respectfully and to be prepared to listen
- Utilize language that is patient centered
- Include all types of trauma
- Incorporate knowledge about trauma in all aspects of service delivery
- Ensure environments are welcoming hospitable and engaging
- Ensure that service delivery minimizes re: victimization and facilitates wellness recovery and resilience

DMHAS

Trauma Informed Care Checklist (2)

Checklist

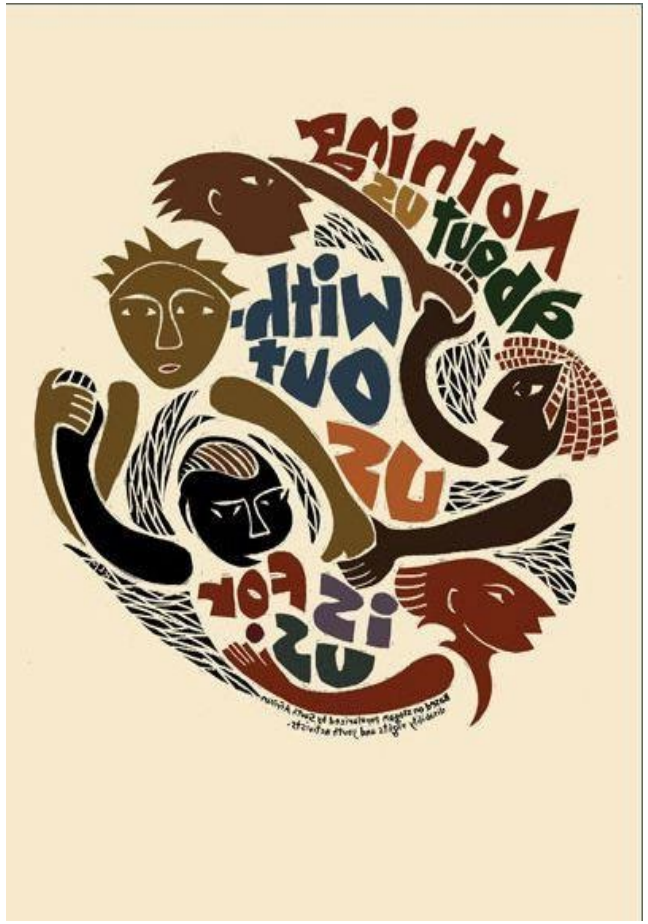
- ❑ Buy-in from administrators, consumer advisory board, all levels of staff senior leadership and work groups
- ❑ Staff training that includes any staff that may come in contact with the patient from front desk, security, maintenance.
- ❑ A screening tool that screens for all types of trauma
- ❑ Clear information is provided to patients such as an after-visit summary, interpreters, written information in primary language, support groups
- ❑ Staff have skills and knowledge needed to manage or deescalate clients/consumers whose reaction to trauma triggers may be jeopardizing the physical or emotional safety of other patients or staff
- ❑ Policies are in place to ensure staff and patient safety
- ❑ Staff treat patients with respect, using “universal precautions”
- ❑ Staff have an awareness of the importance of self care and boundaries and have opportunities to review their own wellness.
- ❑ The environment promotes a sense of safety and avoids being re-traumatizing

DMHAS

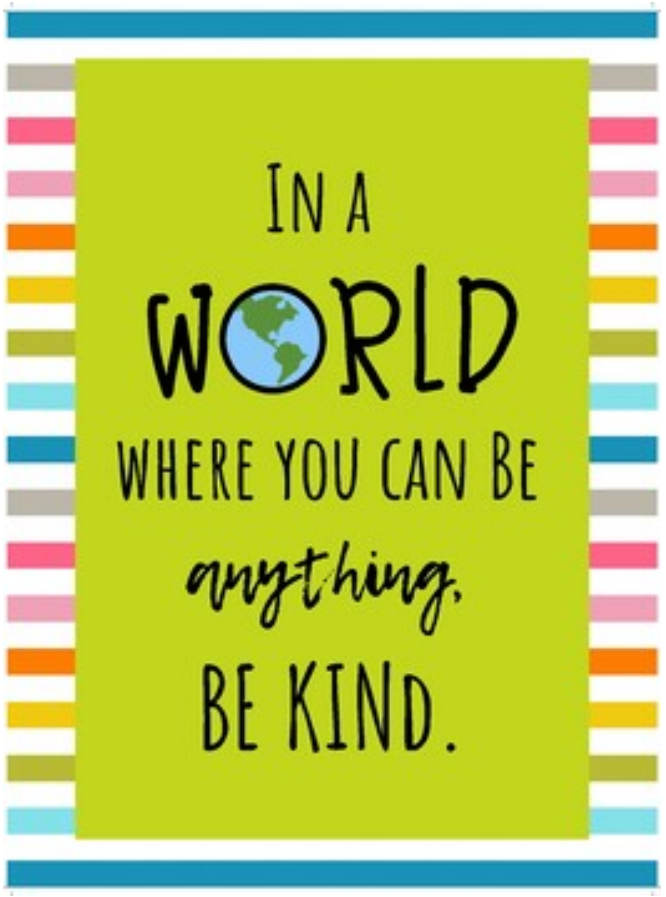
Challenges and Lessons Learned

- Nothing about us, without us!

  Staff wellness is also a part of TIC
- Cultural and physical needs assessment are important to acknowledge gaps in service
- Continual and ongoing Training, Training, Training
- Leverage existing internal resources and search for external resources to be able to provide tangible resources for clients



Thank You



Additional Resources

- https://nj.gov/humanservices/dmhas/initiatives/trauma/
- https://www.cdc.gov/injury/
- https://www.healthyplace.com/
- https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp#obtain http://www.odmhsas.org/picis/ACE.pdf
- https://www.counseling.org/docs/trauma-disaster/fact-sheet-9---vicarious-trauma.pdf?sfvrsn=f0f03a27_2

Discussion