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Dear Dr. Cheever and Mr. Macrae:

Thank you very much for your ongoing attention to the urgent matter of trauma's impact on women and other individuals living with HIV. In preparation for the release of federal action plans outlining specific steps agencies will take to implement components of the updated National HIV/AIDS Strategy (NHAS), we urge the Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) to seize this opportunity to ensure that steps toward trauma-informed approaches in HIV care and service delivery are a top priority in its NHAS implementation plan for the coming five years.

We were glad to have the opportunity in January to present to you key findings regarding the link between past and current trauma and poor health outcomes for women living with HIV. Here, we:

- Briefly summarize the findings and conclusions reached from the data presented;
- Survey encouraging new developments in this area; and
- Make six specific requests for your consideration in developing HRSA's implementation strategy to actualize NHAS objective 2.C.2: *"Improve outcomes for women in HIV care by addressing violence and trauma, and factors that increase risk of violence for women and girls living with HIV."* Many of these recommendations also apply to other objectives referenced on p. 13 of the Strategy.

Prevalence and Impact of Trauma, Violence and Abuse

- **A crisis of unaddressed trauma among women living with HIV is resulting in exceptionally high rates of preventable deaths** in Ryan White-funded programs from substance use, overdose, suicide,

murder, and illnesses such as obesity, diabetes, heart, lung and liver disease. **All of these illnesses and conditions are known to be associated, directly or indirectly, with childhood and adult trauma.**[1,2]

- Thirty percent of women living with HIV are **currently living with post-traumatic stress disorder (PTSD)**. Rates of intimate partner violence (IPV) and lifetime abuse are between two and six times greater than the general population of women.[3]
- **Recent and past abuse are directly associated with poor outcomes at every stage of the HIV care continuum** for both women and men, including lower rates of linkage to and retention in care, poor medication adherence and lower rates of viral suppression,[4] as well as with other HIV-specific outcomes, including disease progression,[5, 6, 7] hospitalizations,[5] and risk of death.[4] In fact, trauma has a larger impact on medication adherence than other conditions such as depression, substance use, stigma, financial constraints or pill burden.[8]
- For example, women living with HIV who report recent trauma, including IPV, are **3 times more likely not to be linked to care within 90 days**,[9] have twice the rate of being lost to follow-up,[10] and are half as likely to be on HIV medications.[10, 11] They are also 2-3 times more likely to experience nonadherence to HIV medications[12,13] and 2-4 times more likely to experience virologic failure.[10, 14]
- **Recent and past abuse, as well as PTSD, are associated with most of the other non-biological (i.e., social and economic) determinants of poor outcomes on the care continuum**. In particular, depression, substance abuse, stigma, lack of social support, and homelessness are strongly linked with the lifetime effects of trauma.[1, 15, 16, 17]
- **According to published data from the Women's Interagency HIV Study (WIHS), recent and past trauma and their effects are killing women living with HIV far more often than disease progression itself.** Recent (unpublished) data from WIHS suggest that AIDS accounted for only approximately 17% of deaths among WLHIV in 2013.

A growing number of providers, policymakers, and community members in sectors ranging from education to criminal justice to health care recognize the need to move toward trauma-informed practice in a variety of service settings. The recognition of the devastating impact of unaddressed trauma is now coupled with a body of literature demonstrating that PTSD and IPV, and their many consequences (e.g., substance use, depression, disengagement from care, medication non-adherence), can be effectively treated with an increasing number of evidence-based interventions that have already been successfully integrated into primary care settings.

<u>Interventions and Outcomes</u>

- **Effective, prospectively evaluated interventions exist** for IPV that lead to reduced IPV, as well as improved self-efficacy, improved social support, reduced depression, reduced pregnancy coercion, and improved pregnancy outcomes.
- **At least 17 effective, prospectively evaluated interventions exist for lifetime trauma, and 10 for PTSD**. These interventions demonstrate improved PTSD symptoms, reduced substance use, reduced alcohol abuse, reduced depression, reduced suicidal ideations, improved "global mental health functioning," and, among women with HIV, a decrease in the frequency of unprotected sex with partners who are HIV-negative or of unknown serostatus. These interventions can easily be integrated into Ryan White-funded settings through partnerships with local community-based

organizations, funding new services, and/or refocusing existing resources. Treatments for depression and substance abuse disorder are clearly improved when co-occurring trauma and/or PTSD are treated.[18, 19]

- Screening and treatment for IPV and/or PTSD have successfully been integrated into large-scale multi-site primary care programs. Prominent examples include successful PTSD screening programs at every Kaiser Permanente hospital in Northern California; use of trauma-informed care by providers at the US Department of Veterans Affairs; and PTSD treatment programs at military-base primary care clinics (RESPECT-Mil).

The inclusion of a call for development and evaluation of trauma-informed primary care practices in the updated NHAS – specifically, NHAS objectives 1.B.2, 2.C.2, and 3.B.2 – lends powerful support to the imperative for HRSA to create a bold action plan to address this issue, with measurable goals and outcomes. We are excited by this opportunity, and look forward to working with you to ensure that HRSA HAB, through the Ryan White HIV/AIDS Program, plays a key role in this burgeoning movement.

<u>Existing and Emerging Guidance</u>

- In July 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a guide for implementing trauma-informed care: "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach." They also recently released tools to guide implementation of trauma-informed approaches, screening and response for recent and past trauma in behavioral health settings.[20, 21]
- In May 2015, an interdisciplinary team of researchers from The Women's HIV Program (WHP) at UCSF and Positive Women's Network-USA (PWN-USA) published "From Treatment to Healing: The Promise of Trauma-Informed Primary Care," in the peer-reviewed journal *Women's Health Issues.*[22] The conceptual model featured in the publication provides a practical guide to aid providers in incorporating trauma-informed care into clinical practice.
    - This publication codifies the work of a national expert working group, co-convened by PWN-USA and UCSF's WHP in August 2013, which developed a practical framework for trauma-informed primary care to inform implementation and evaluation studies. The framework is composed of evidence-based building blocks and the flexibility to implement interventions on-site or through linkages to community organizations.
- In July 2015 the updated version of the NHAS, applicable through 2020, was released; all five of the 2013 recommendations of the Federal Interagency Working Group on the Intersection of HIV/AIDS, Violence Against Women and Girls, and Gender-Related Health Disparities were integrated into the updated Strategy (see p. 13 of the Strategy for the fully integrated recommendations).
- In September 2015 the *Building a Trauma-Informed Nation Summit,* convened at the US Department of Labor by the Federal Partners Committee on Women and Trauma, brought together leaders from the health care, education, and criminal justice sectors to discuss strategies for making trauma-informed practice a more widespread reality.
- Multiple national private foundations (e.g., Robert Wood Johnson) have recently taken up the charge to advance this field and have released calls for proposals that will fund integration of trauma-informed services in primary care settings.

Conclusions

Sufficient evidence exists to justify implementation and evaluation of trauma-informed primary care practices for women living with HIV, including transgender women, and possibly for other populations experiencing high rates of trauma (i.e., young gay black men). Multiple interventions addressing trauma have demonstrated improvements in known causes of poor outcomes at each stage of the care continuum and in the leading causes of death for women living with HIV. Examples and guidance are available to help clinics integrate these evidence-based interventions into primary care. *Trauma-informed primary care appears to be the most promising opportunity to address the leading social determinants of health in a clinic-based setting. To achieve this, Ryan White clinics need to become educated and resourced to integrate these interventions into care, and held accountable for reducing preventable trauma-related deaths.*

Many years ago, the Ryan White care system successfully innovated a highly effective framework for the multi-disciplinary care of low-income people living with HIV. Today, although HIV has become a chronic manageable condition, there remains a literal crisis of trauma-related suffering and death among women living with HIV. There is also ample room for improvement on the care continuum. Responding to trauma in the Ryan White care system is a practical and ethical imperative. Doing so would add significantly to the legacy of Ryan White as a model of innovative, effective and compassionate health care and a beacon for others to follow. Now is the moment for HRSA to assert this role by including the six recommendations below in its upcoming federal implementation plan:

Requests

1. Use established mechanisms for delivering education and training to build HIV workforce capacity – among case managers, social workers, nurses, administrative staff, and other clinic professionals, in addition to doctors – around trauma-informed approaches with clients and with fellow providers and staff members at Ryan White service delivery sites.
2. Require Ryan White programs to collect and report data about rates of IPV and PTSD symptoms, using standardized measures, alongside existing quality of life indicators – as well as more accurate data about rates of substance use, depression, stigma, and social isolation. This will serve to raise awareness about this issue and provide baseline data for the eventual broad implementation and evaluation of trauma-informed care in the Ryan White system, while building trauma competency and response.
3. Facilitate implementation and evaluation projects of trauma-informed primary care in at least 6 primary clinics serving women, including transgender women, living with HIV, that incorporate clear guidance about the core components of interventions, common nomenclature and variables, and centralized oversight, evaluation, and technical assistance.
4. Integrate evidence-based responses to PTSD into existing funded clinical services including therapy, psychiatry, medication adherence and substance abuse treatment.
5. Encourage collaborations between community-based IPV organizations and trauma recovery centers, and HIV and primary care clinics and AIDS service organizations, to leverage and integrate effective responses to IPV and PTSD into HIV service delivery.
6. Consider, and facilitate, the following components when assessing grantee applications: commitment to, and competency in delivering, trauma-informed services; demonstrated community relationships to facilitate addressing trauma and violence, including partnerships and collaborations with

antiviolence and/or trauma healing organizations to advance trauma-informed practice goals; and implementation of evidence-based interventions to reduce PTSD symptoms and promote healing.

In the words of the first Federal Implementation Plan, from 2010: "The National HIV/AIDS Strategy is just a collection of words on paper, unless it provides a strategic vision for the country that leads to action." HRSA is at the helm of a life-expanding source of high-quality care for communities living with HIV. HRSA is in a unique position to ensure that that system of care becomes ever stronger and more responsive to the complex needs of people living with HIV through the implementation of trauma-informed practices everywhere that women with HIV receive care. We urge you to make trauma-informed care the next legacy of the Ryan White program. We can think of no better way to improve the lives of people living with HIV, and no better health system to fully realize the healing potential of treating trauma and PTSD.

Thank you both again for your vision and leadership. We remain available to you in any way that would be helpful to facilitate this endeavor.

Sincerely,

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