Published in final edited form as:

AIDS Care. 2021 March ; 33(3): 316–325. doi:10.1080/09540121.2020.1764473.

Barriers and Facilitators to Implementation of Trauma Support Services at a Large HIV Treatment Center in the Southern United States

Kaitlin N. Piper[a], **Julia Schiff**[b,c], **Clara Riddick**[b], **Betelihem Getachew**[a], **Eugene W. Farber**[d], **Ameeta Kalokhe**[b,e], **Jessica M. Sales**[a,*]

[a]Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, Atlanta, GA, USA

[b]Department of Global Health, Rollins School of Public Health, Emory University, Atlanta, GA, USA

[c]Emory University School of Medicine, Atlanta, GA, USA

[d]Department of Psychiatry and Behavioral Sciences, Atlanta, GA, USA

[e]Division of Infectious Diseases, Emory University School of Medicine, Atlanta, GA, USA

Abstract

The high prevalence of trauma among people living with HIV underscore the need for tailored, integrated trauma management ("trauma-informed care" or TIC) to improve retention, adherence to care, and overall well-being. Although TIC has been identified as a priority area for HIV care, uptake has been limited. To investigate barriers and facilitators to integrating trauma support services within HIV primary care, surveys (n=94) and interviews (n=44) were administered to providers, staff, and patients at a large HIV treatment center. Results highlighted the availability of several trauma services, including psychotherapy and support groups, but also revealed the absence of provider training on how to respond to patient trauma needs. Identified gaps in TIC services included written safety and crisis prevention plans, patient education on traumatic stressors, and opportunities for creative expression. Providers and staff supported implementation of trauma support services and employee trainings, but expressed a number of concerns including resource and skill deficiencies. Patient-reported barriers to TIC services included lack of awareness of services and difficulties navigating the healthcare system. This assessment revealed support and methods for strengthening integration of trauma support services within HIV primary care, which future TIC implementation efforts should address.

Keywords

Trauma-informed care; HIV/AIDS; Trauma support services; implementation

[*]Corresponding Author: Jessica Sales, PhD, Emory University, Rollins School of Public Health, 1518 Clifton Road NE, GCR 570, Atlanta, GA 30322, Phone: 404-727-6598, jmcderm@emory.edu.

Declaration of Interest: The authors have no conflict of interest to disclose.

Introduction

Trauma is highly prevalent among people living with HIV (PLWH), with up to 90% of PLWH reporting physically, emotionally, or sexually traumatic experiences (Brezing, Ferrara, & Freudenreich, 2015). Trauma adversely affects HIV treatment outcomes and is associated with fewer clinic appointments and decreased adherence to medications such as antiretroviral therapy (ART) (Cohen et al., 2004; Colasanti, Stahl, Farber, del Rio, & Armstrong, 2017; Hatcher, Smout, Turan, Christofides, & Stöckl, 2015). Poor adherence to care can lead to higher HIV viral loads, lower CD4 counts, increased ART resistance, more opportunistic infections, and higher rates of AIDS-related morbidity and mortality (Jewkes, Dunkle, Jama-Shai, & Gray, 2015; Kalokhe et al., 2012; Machtinger, Haberer, Wilson, & Weiss, 2012; Mugavero et al., 2007; Schafer et al., 2012). Additionally, a history of trauma and abuse is associated with higher HIV risk behaviors such as unprotected sexual intercourse (Machtinger, Haberer, et al., 2012), increasing the risk of HIV transmission.

Despite the potential for significant adverse impacts of trauma on health and health-promoting behaviors among PLWH, there is a paucity of research on strategies for the clinical management of trauma-related complications in the provision of HIV primary care. Specifically, there is a need to understand the feasibility and capacity to integrate trauma-informed care (TIC) approaches in HIV primary care settings to improve retention, adherence to therapy, and overall well-being. According to SAMHSA, TIC is an evidence-based, organizational treatment framework, which is guided by an appreciation for the prevalence and impact of trauma and concomitant clinical practices that ensure a meaningful response to trauma in the health care setting (SAMHSA, 2014).

Currently, it is unclear the extent to which trauma needs among PLWH are being met through provision of trauma-informed support services, such as mental health and substance abuse services, legal and educational advocacy, and housing and employment support. It is also unclear what barriers and facilitators might exist to strengthening the provision of trauma services in HIV primary care. Therefore, the aims of this study were to: (1) assess the current availability of trauma services at an HIV primary care center, (2) investigate medical provider, clinical staff, and patient perceptions regarding integration of trauma support services into HIV care, and (3) identify barriers/facilitators to enhancing trauma support.

Methods

We conducted a comprehensive needs assessment employing a mixed-methods convergent parallel design from March 2017-January 2018. For a complete description of the methods and procedures used in this study, see Kalokhe et al. (2019). The study was conducted at an urban, Ryan White-funded HIV primary care center in the Southeastern United States (hereafter referred to as “the Center”) that serves over 6,000 PLWH, who are primarily low-income and medically underserved (Colasanti et al., 2015). Surveys and in-depth interviews were conducted with HIV care providers and staff as well as patients receiving primary HIV health care. Surveys were utilized to assess which trauma services were currently being provided at the Center, and qualitative interviews were utilized to gain in-depth

information on barriers and facilitators to implementation of trauma-informed services. The study was approved by the university-affiliated Institutional Review Board and the health system Research Oversight Committee. All participants provided written informed consent prior to engaging in study activities.

All providers and staff at the Center were invited to participate in the survey. Providers included physicians and advanced practice providers; staff included social workers, case managers, patient navigators, health educators, peer counselors, nurses, interpreters, patient access representatives, pastoral and palliative care providers. Purposive sampling was utilized to sample providers and staff for the in-depth interviews to ensure adequate representation across different services within the Center and staff roles. Purposive sampling was also utilized to recruit patients at the Center to ensure adequate representation of patients with varying levels of service utilization.

After providing informed consent, staff, providers, and patients completed an electronic self-administered survey. Individuals who participated in the survey were also invited to participate in the in-depth interviews, which were conducted in-person by study team members at a private area in the Center and audio recorded. Participants received $25 for completing the survey and $50 for completing an in-depth interview.

The survey was adapted from the National Center on Family Homelessness “Trauma-informed Organizational Toolkit,” which was designed to help programs evaluate their current TIC practices (Guarino, Soares, Konnath, Clervil, & Bassuk, 2009). Eight closed-ended items in the provider/staff survey, and 14 items in the patient survey assessed Center practices regarding trauma support services. Example survey items included, “when mental health services are needed, the Center refers patients to counseling”. Response choices included, “strongly disagree,” “disagree,” “agree,” and “strongly agree.” Descriptive statistics were calculated for all survey items, by participant type (i.e., provider, staff, or patient).

The interview guide was adapted from the “Creating Cultures of Trauma-informed Care” materials (Fallot & Harris, 2009) and was guided by implementation-focused constructs from the Consolidated Framework for Implementation Research (CFIR). Questions explored current Center trauma support service offerings, capacity to provide trauma services, and barriers to implementing trauma services at the Center (see appendix for complete provider/staff and patient interview guides). In-depth interviews were analyzed using thematic analysis (Hennink, Hutter, & Bailey, 2011) using NVivo version 11 qualitative software (QSR International Pty Ltd, 2015). Three analysts coded the transcripts, and the full study team met bi-weekly to review themes as they evolved. Themes were then consolidated into a narrative and analyzed separately by participant type (i.e., providers/staff or patients).

Results

Participant Characteristics

Fourteen providers, 17 staff, and 63 patients completed the survey, and 9 providers, 10 staff, and 25 patients completed in-depth interviews. Patient demographic characteristics are

presented in Table 1. Providers and staff from all four medical clinics within the Center (e.g., those serving men and transgender men, women and transgender women, children and adolescents, and patients with mental health needs) participated. Additional demographic information on providers and staff was not collected to preserve confidentiality of Center employees.

Surveys

The results of the survey are presented in Tables 2 and 3, which highlight participant-perceived strengths and gaps in trauma support services. Across all items, provider scores suggested they perceived lower availability of trauma-specific services compared to staff and patients. Overall, identified gaps in current trauma services included patient trauma education, written safety plans, written crisis prevention plans, and opportunities for creative expression.

Qualitative Interviews with Providers and Staff

Providers and staff identified facilitators to implementation of trauma support services including, (1) strong organizational support of TIC and (2) utilization of an integrated service delivery model; and they identified barriers to implementation including, (1) lack of services dedicated to TIC, (2) unclear procedures for linking patients to external trauma support, (3) lack of training and skills in TIC, and (4) Center resource constraints (Table 4).

Organizational Support of TIC Implementation—All interviewed staff and providers supported implementation of organization-wide TIC procedures to improve the delivery of support services to patients with trauma histories. They believed implementation of trauma-informed services would ultimately improve patient outcomes:

> "I think [TIC] would definitely improve outcomes for our patients. I personally think it might actually improve outcomes in terms of retention and engagement in care, because of the amount of understanding that our providers can show towards the patients." (Provider)

Integrated Service Delivery Model—The Center currently utilizes an integrated service delivery model where HIV care, mental health, and social services are provided on-site, allowing for enhanced care coordination for patients with complex needs. Providers and staff believed they can build upon this existing structure to enhance the provision of services for patients with trauma histories. They emphasized the importance of providing services on-site, because it facilitated effective and timely linkages to support services and mental health providers:

> "I think that's where we benefit from having mental health in the same building and having an on call mental health provider. And personally, I've experienced it where the mental health provider takes care of [trauma] and addresses issues immediately with a patient." (Provider)

Lack of Services Dedicated to TIC—Although some support services were available, participants were unclear if these services were specifically dedicated to trauma:

> "I don't think there's any specific service that's dedicated to trauma-informed care or trauma-related services. It seems like if we alert the [Mental Health Department] staff when we refer them for mental health services, if we mention trauma specifically, then they have maybe a certain set of individuals who are trained in trauma related mental health services that are assigned to the case. But I'm not even really sure to be honest with you." (Provider)

Unclear Procedures for Linking Patients to External Trauma Support—In addition to on-site support, the Center also had connections to external social service and medical organizations, including shelters, legal aid, and behavioral health providers; however, many providers at the Center were generally unsure how to link patients to external organizations:

> "In terms of the referral for services, I don't think all providers know what the services available are…I would do better for my patients if I personally knew more about the available services for referral that are local and that could be tailored to each person's specific circumstance." (Provider)

Lack of Training on TIC—Participants were also concerned that providers and staff at the Center were untrained in effective methods to recognize and manage patient trauma:

> "Each provider does the best they can with it. I don't know if any provider has actually gotten any certification or anything in trauma." (Provider)

Resource Constraints—Furthermore, providers and staff discussed structural barriers to the adoption of additional trauma support services and procedures, including the lack of personnel and resources necessary to accommodate the large proportion of patients who experienced trauma:

> "I think that there are time constraints for providers…that limit providers from being able to sometimes ask with the level of detail that may be required if [patients] have all types of conditions that may require a referral." (Provider)

Qualitative Interviews with Patients

Patients identified facilitators to implementation of trauma support services including (1) satisfaction with current on-site support and (2) strong relationships with their providers. However, they identified barriers to implementation including: (1) a need for a broader range of trauma support services, (2) lack of awareness of available services, (3) difficulties navigating the healthcare system, and (4) access barriers (Table 4).

Satisfaction with Current On-Site Support—Patients appreciated that support services were offered on-site at the Center, including therapy and support groups. They believed the services helped improve their quality of life and engagement in care:

> "There was a time that I didn't even wanna leave the house because I was afraid that something would happen to me. Once the people in the [Mental Health Department] really engaged with me, they brought me out of that, and I was able to come up here, take my medicine, speak to the psychiatrist, and start feeling better."

Strong Patient-Provider Relationships—Patients described the strong, trusting relationships they built with providers at the Center, which promoted open conversations about traumatic experiences:

> "I feel so connected with [my doctors] because they've seen me from the beginning and they were able to really calm me down and get me into a place to where I would take the medicine and take it correctly. And they listened to me."

Need for Broader Range of Trauma Services—Although many patients were satisfied with the support services, some patients thought that the Center should provide more services to help patients dealing with trauma:

> "[I would feel more emotionally supported with] more group meetings and like peer counseling, and people who are living with the virus or have been living with the virus for the longest to interact with the people who are just now finding out about their diagnosis."

Lack of Awareness of Available Services—One barrier to patients' engagement in trauma services included their lack of awareness of available services at the Center:

> "As far as letting us know other things that's coming up, sometimes we can pass by the signs, the fliers, and miss them. But if we heard it verbally, that would help."

Difficulties Navigating the Healthcare System—Patients also described how they faced difficulties navigating the healthcare system and were unsure how to gain access to trauma services:

> "They do offer [therapy], but it's not so clear what the process is to go through to get these services and help in general, so it's hard to find out."

Access Barriers—Other patient barriers to engaging in trauma services included a lack of transportation as well as services that conflicted with their work schedules:

> "I think it's more an issue of distance. It's not hard to [access services] if I can get out here."

Discussion

The importance of addressing trauma needs in HIV care has received national attention (Aberg et al., 2014; UNAIDS, 2014; White House Interagency Federal Working Group, 2013), however, strategies to effectively deliver trauma-specific services within these contexts has yet to be delineated (US Department of Health & Human Services, 2006). In this study, we collected critical insight from providers, staff, and patients at an urban safety-net HIV primary care center to inform adoption of trauma support services in this setting. Although the study was conducted at a single site, findings are likely generalizable, as many HIV primary care centers have similar structures and follow similar service standards/guidelines (e.g., Ryan White) (HSRA, 2018). For instance, Ryan white-funded clinics typically utilize integrated care models, have multidisciplinary staff/providers with

longstanding relationships with patients, serve patients with complex trauma histories, and operate under resource and staffing constraints.

Based on surveys, the Center currently provides several trauma support services on-site or via facilitated referral, however, gaps in current services included the lack of written crisis prevention and safety plans. Written plans are necessary to identify strategies to prevent future crisis, and have been have been shown to decrease emergency visits and admissions (Gudde et al., 2013; Hootz, Mykota, & Fauchoux, 2016; Tetterton & Farnsworth, 2011). It is recommended that crisis plans be developed during the first point of contact with care (i.e., during intake appointments) and shared with the patients' care team (Tetterton & Farnsworth, 2011). Other gaps included the lack of patient education on trauma. Patients not only need education and awareness of trauma and its' health impacts, but they also need skills to recognize and respond to traumatic stressors (SAMHSA, 2014). Patient trauma education can be integrated into already existing HIV education within in the clinic. Additionally, patients reported the lack of opportunities to express themselves in creative non-verbal ways. Creative expression has been linked to improved mental health (Leckey, 2011), however, if events such as dance and theater can feasibly be integrated into the HIV care setting has yet to be explored.

Results also revealed that staff and providers have different perceptions of current trauma service availability. These differences may suggest that providers and staff have differing levels of scrutiny and expectations of the program, but may also be the result of varying levels of experience with trauma services due to differences in clinical roles: the contributors of provider/staff differences can be explored in future studies. Due to a lack of trauma training, providers reported that their knowledge of trauma support services was limited, and many providers were unsure what services to provide or where to send patients if a trauma need was identified. These results indicate that all employees, including providers and staff, need awareness of trauma and training on how to link patients to support services. This is in line with a central tenant for organizations transitioning to a TIC organization framework, that specifies the importance of agency-wide training familiarizing providers and staff with the multitude of forms, causes, and effects of trauma, as well as education on treatment and referral practices (SAMHSA, 2014). Because trainings are a cornerstone of medical education and a component of continuing education within HIV care, there is infrastructure available for TIC trainings, even within resource constrained settings such as safety-net HIV clinics.

Other barriers to the delivery of trauma services, included time and resource constraints, which are commonly cited TIC implementation challenges across healthcare settings (Blakey & Bowers, 2014; Bruce et al., 2018). To overcome these constraints, clinics can leverage partnerships with social service organizations and link patients to external trauma support services, without having to provide all services on-site. In addition, patient-reported barriers to engaging in trauma services included lack of awareness of services and difficulties navigating the healthcare system. Ensuring care coordinators and navigators are aware of patient trauma needs can increase patients' receipt of necessary support services, both internally and externally to the clinic (McBrien et al., 2018; Sarango, de Groot, Hirschi, Umeh, & Rajabiun, 2017). Not only do patients need education on trauma, but they need

education on the support services available within the clinic and broader community, which should be offered on a routine basis as services may change or patients may not be in a position to consider engaging in certain services when newly diagnosed (Martinez, Lemos, Hosek, & the Adolescent Medicine Trials Network, 2012; Nightingale, Sher, & Hansen, 2010).

Limitations of this study include the focus on a single clinic drawn from one region of the country, self-reported data, and lack of a random sampling procedure. Despite limitations, the findings from this research may be useful for informing the implementation of TIC in HIV primary care settings. Adoption of organization-wide service delivery models, like TIC, in healthcare settings serving patients with complex needs (e.g. trauma histories) may ultimately lead to improved patient health outcomes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgements:

This study was funded by a developmental grant from the NIH Center for AIDS Research (P30AI050409). We also thank the treatment center for their dedication and continued support, as well as staff, providers, and administrators for their participation in the study.

Funding Source:

This study was funded by a developmental grant from the NIH Center for AIDS Research (P30AI050409).

References

Aberg JA, Gallant JE, Ghanem KG, Emmanuel P, Zingman BS, Horberg MA, & Infectious Diseases Society of, A. (2014). Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV Medicine Association of the Infectious Diseases Society of America. Clin Infect Dis, 58(1), 1–10. [PubMed: 24343580]

Blakey JM, & Bowers PH (2014). Barriers to integrated treatment of substance abuse and trauma among women. Journal of Social Work Practice in the Addictions, 14(3), 250–272.

Brezing C, Ferrara M, & Freudenreich O (2015). The syndemic illness of HIV and trauma: implications for a trauma-informed model of care. Psychosomatics, 56(2), 107–118. [PubMed: 25597836]

Bruce MM, Kassam-Adams N, Rogers M, Anderson KM, Sluys KP, & Richmond TS (2018). Trauma Providers' Knowledge, Views, and Practice of Trauma-Informed Care. Journal of trauma nursing: the official journal of the Society of Trauma Nurses, 25(2), 131–138. [PubMed: 29521782]

Cohen M, Cook JA, Grey D, Young M, Hanau LH, Tien P, … Wilson TE. (2004). Medically eligible women who do not use HAART: the importance of abuse, drug use, and race. American journal of public health, 94(7), 1147–1151. [PubMed: 15226135]

Colasanti J, Kelly J, Pennisi E, Hu Y-J, Root C, Hughes D, … Armstrong WS. (2015). Continuous retention and viral suppression provide further insights into the HIV care continuum compared to the cross-sectional HIV care cascade. Clinical Infectious Diseases, 62(5), 648–654. [PubMed: 26567263]

Colasanti J, Stahl N, Farber EW, del Rio C, & Armstrong WS (2017). An exploratory study to assess individual and structural level barriers associated with poor retention and re-engagement in care among persons living with HIV/AIDS. JAIDS Journal of Acquired Immune Deficiency Syndromes, 74, S113–S120. [PubMed: 28079721]

Del Rio C (2018, March 2018). The Evolving HIV Epidemic in the United States. Paper presented at the Conference on Retroviruses and Opportunistic Infections, Boston.

Fallot RD, & Harris M (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Community Connections, 2(2), 1–18.

Guarino K, Soares P, Konnath K, Clervil R, & Bassuk E (2009). Trauma-informed Organizational Toolkit. Retrieved from www.homeless.samsha.gov

Gudde CB, Olsø TM, Antonsen DØ, Rø M, Eriksen L, & Vatne S (2013). Experiences and preferences of users with major mental disorders regarding helpful care in situations of mental crisis. Scandinavian journal of public health, 41(2), 185–190. [PubMed: 23296158]

Hatcher AM, Smout EM, Turan JM, Christofides N, & Stöckl H (2015). Intimate partner violence and engagement in HIV care and treatment among women: a systematic review and meta-analysis. Aids, 29(16), 2183–2194. [PubMed: 26353027]

Hennink M, Hutter I, & Bailey A (2011). Qualitative Research Methods: SAGE Publishers.

Hootz T, Mykota DB, & Fauchoux L (2016). Strength-based crisis programming: Evaluating the process of care. Evaluation and program planning, 54, 50–62. [PubMed: 26512431]

HSRA. (2018). Ryan White HIV/AIDS Program Fact Sheet. Retrieved from https://hab.hrsa.gov/sites/default/files/hab/Publications/factsheets/program-factsheet-program-overview.pdf

Jewkes R, Dunkle K, Jama-Shai N, & Gray G (2015). Impact of exposure to intimate partner violence on CD4+ and CD8+ T cell decay in HIV infected women: longitudinal study. PLoS One, 10(3), e0122001. [PubMed: 25816336]

Kalokhe AS, Paranjape A, Bell CE, Cardenas GA, Kuper T, Metsch LR, & del Rio C (2012). Intimate partner violence among HIV-infected crack cocaine users. AIDS patient care and STDs, 26(4), 234–240. [PubMed: 22364209]

Kalokhe AS, Riddick C, Piper K, Schiff J, Getachew B, del Rio C, & Sales JM (2019). Integrating program-tailored universal trauma screening into HIV care: an evidence-based participatory approach. AIDS care, 1–8.

Leckey J (2011). The therapeutic effectiveness of creative activities on mental well-being: a systematic review of the literature. Journal of psychiatric and mental health nursing, 18(6), 501–509. [PubMed: 21749556]

Machtinger E, Haberer J, Wilson T, & Weiss D (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. AIDS and Behavior, 16(8), 2160–2170. [PubMed: 22426597]

Machtinger E, Wilson T, Haberer JE, & Weiss D (2012). Psychological trauma and PTSD in HIV-positive women: a meta-analysis. AIDS and Behavior, 16(8), 2091–2100. [PubMed: 22249954]

Martinez J, Lemos D, Hosek, & the Adolescent Medicine Trials Network, S. (2012). Stressors and sources of support: The perceptions and experiences of newly diagnosed Latino youth living with HIV. AIDS patient care and STDs, 26(5), 281–290. [PubMed: 22536931]

McBrien KA, Ivers N, Barnieh L, Bailey JJ, Lorenzetti DL, Nicholas D, … Edwards A. (2018). Patient navigators for people with chronic disease: a systematic review. PLoS One, 13(2), e0191980. [PubMed: 29462179]

Mugavero MJ, Pence BW, Whetten K, Leserman J, Swartz M, Stangl D, & Thielman NM (2007). Predictors of AIDS-related morbidity and mortality in a southern US Cohort. AIDS patient care and STDs, 21(9), 681–690. [PubMed: 17919095]

Nightingale VR, Sher TG, & Hansen NB (2010). The impact of receiving an HIV diagnosis and cognitive processing on psychological distress and posttraumatic growth. Journal of Traumatic Stress, 23(4), 452–460. [PubMed: 20648562]

QSR International Pty Ltd. (2015). NVivo qualitative data analysis Software (Version 11.).

SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Retrieved from https://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

Sarango M, de Groot A, Hirschi M, Umeh CA, & Rajabiun S (2017). The role of patient navigators in building a medical home for multiply diagnosed HIV-positive homeless populations. Journal of Public Health Management and Practice, 23(3), 276. [PubMed: 28079645]

Schafer KR, Brant J, Gupta S, Thorpe J, Winstead-Derlega C, Pinkerton R, … Dillingham R. (2012). Intimate partner violence: a predictor of worse HIV outcomes and engagement in care. AIDS patient care and STDs, 26(6), 356–365. [PubMed: 22612519]

Tetterton S, & Farnsworth E (2011). Older women and intimate partner violence: Effective interventions. Journal of Interpersonal Violence, 26(14), 2929–2942. [PubMed: 21156690]

UNAIDS. (2014). 90-90-90 An Ambitious Treatment Target to Help End the AIDS Epidemic. Retrieved from

US Department of Health & Human Services. (2006). Model trauma system planning and evaluation. US Department of Health and Human Services, Washington, DC.

White House Interagency Federal Working Group. (2013). Addressing the Interection of HIV/AIDS, Violence against Women and Girls, & Gender-related Health Disparities.

Table 1.

Patient Characteristics (n= 63).

	Mean (*SD*)/ N (%)
Age (*SD*)	39.8 (12)
Gender (%)	
Female	19 (30)
Male	40 (64)
Transgender Female	4 (6)
Race (%)	
Black/African American	51 (81)
White	5 (8)
Multiracial	7 (11)
Sexual Orientation (%)	
Heterosexual/Straight	31 (49)
Gay or Lesbian	28 (44)
Bi-Sexual	4 (6)
Center Department (%)	
Women's Clinic	11 (18)
Main Clinic	32 (51)
Pediatric/Adolescent Clinic	13 (21)
Other	7 (11)
Resource Utilization (%) [a]	
High	25 (40)
Low	38 (60)

[a]High resource utilization was defined as receiving two or more Center support services in the prior year.

Table 2.

Staff and provider responses regarding trauma-specific services (n=31).

Trauma-Specific Services	Number of Participants				Average [a,b]		
	Strongly Disagree	Disagree	Agree	Strongly Agree	Providers and Staff (N=31)	Providers (N=14)	Staff (N=17)
The Center provides opportunities for care coordination for services not provided within that organization.	2	1	16	8	2.1	1.7	2.5
The Center educates patients about traumatic stress and triggers.	2	5	9	5	1.8	0.9	2.3
The Center has access to a clinician (medical caregiver) with expertise in trauma and trauma support services (on staff or available for regular consultation).	2	2	9	9	2.1	1.7	2.5
The Center provides opportunities for patients to receive a variety of services (e.g., housing, employment, legal and educational advocacy, mental health and substance abuse services).	0	0	15	15	2.5	2.4	2.6
When mental health services are needed (i.e. individual therapy, group therapy and/or family therapy), the Center refers patients to counseling.	0	0	15	16	2.5	2.4	2.6
The Center provides opportunities for patients to express themselves in creative nonverbal ways (i.e. art, theater, dance, movement, music).	0	2	14	17	2.2	2.1	2.3
Written safety plans (i.e. what a patient and staff * members will do if the patient feels threatened by another person outside of the Center) are incorporated into patients' individual goals and plans.	2	8	6	6	1.7	0.9	2.3
Each patient has an individualized written crisis prevention plan (i.e. for how to help manage stress and feel supported) which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons the patient can go to for support.	4	8	6	4	1.5	0.8	2.1

* The term "staff" in the quantitative assessments was defined as inclusive of both center providers and staff. Participants were provided this definition as part of the introduction to the assessment.

[a] Answer options ranged from 0=strongly disagree to 3=strongly agree

[b] Shading indicates the mean is ≥2, suggesting availability of TIC services

Table 3.

Patient responses regarding trauma-specific services (n=63).

Trauma-Specific Services	Number of Participants				Average *a,b*
	Strongly Disagree	Disagree	Agree	Strongly Agree	Patient (n=63)
The Center helps me find care for services not provided within the center.	2	4	34	18	2.2
The Center educates patients about traumatic stress and triggers.	2	7	33	19	2.1
The Center has access to a clinician (medical caregiver) with expertise in trauma and trauma support services (on staff or available for regular consultation).	2	2	28	21	2.3
The Center gives me a chance to express myself in creative nonverbal ways (i.e. art, theater, dance, movement, music).	5	13	17	17	1.9
When I had a need, I could get linked to Center-based mental health services (i.e. therapy, counseling) without difficulty.	0	2	32	25	2.4
When I had a need, I could get linked to Center-based substance abuse/ addiction services without difficulty.	2	3	30	20	2.2
When I had a need, I could get linked to Center-based legal services without difficulty.	1	2	31	19	2.3
When I had a need, I could get linked to Center-based social work and case management services without difficulty.	1	2	30	30	2.4
When I had a need, I could get linked to Center-based organizations that provide housing and shelter without difficulty.	1	1	30	26	2.4
When I had a need, I could get linked to Center-based spiritual services without difficulty.	2	3	26	13	2.1
When I had a need, I could get linked with community-based domestic violence organizations and shelters outside of the Center	2	1	28	15	2.2
When I had a need, I could get linked with community-based organizations that provide support for children who have experienced trauma without difficulty.	1	15	11	29	2.2
Written safety plans (i.e. what a staff * member and I would do if I feel threatened by another person outside of the Center) are included in my individual goals and plans.	3	15	32	7	1.8
At the Center, I have an individualized written crisis prevention plan (i.e. for how to help manage stress and feel supported) which includes a list of triggers, strategies and responses which are helpful and those that are not helpful and a list of persons I can go to for support.	3	17	29	12	1.8

* The term “staff” in the quantitative assessments was defined as inclusive of both center providers and staff. Participants were provided this definition as part of the introduction to the assessment.

a Answer options ranged from 0=strongly disagree to 3=strongly agree

b Shading indicates the mean is ≥2, suggesting availability of TIC services.

Table 4.

Qualitative Interviews: Barriers and Facilitators to Implementation of Trauma Support Services

	Barrier/Facilitator	Example Quote
Providers and Staff	Organizational Support of TIC Implementation	"You never know who is going to come through that door and if you're trained and have the knowledge to help that patient, I think that would really benefit the clinic and that patient as well." (Staff)
	Integrated Service Delivery Model	"We have programs and support groups and tools in place so that when clients identify trauma needs or violence or what have you, we have tools in place. We have peer counselors, we have mental health that can address those needs. We have our case management team that can support and help identify places where people can get the assistance they need." (Staff)
	Lack of Services Dedicated to TIC	"I think that we probably have some very good therapists who help with that. I don't know that we have a trauma-specific group." (Provider)
	Unclear Procedures for Linking Patients to External Trauma Support	"If I do ask about [trauma], then I'm still at a loss of where to send people, which informs if I asked or not, because…you don't wanna ask a question you don't know the answer to." (Provider).
	Lack of Training on TIC	"If you are not a skilled and trained counselor or provider, then it's almost a disservice. Like you say, 'where you raped recently?' then you check a box and move on." (Provider)
	Resource Constraints	"There are so many people that are coming through with HIV. There are far more beyond than our resources- than what we can do." (Provider)
Patients	Satisfaction with Current On-Site Support	"I speak to the psychiatrist and working on my previous traumas and issues, I'm able to talk about it more openly and freely, and sometimes we'll sit and talk for an hour. And it's a release, 'cause it's not bottled up anymore."
	Strong Patient-Provider Relationship	"I do feel comfortable communicating 'cause [my doctors] seem very nonjudgmental, very helpful…they do seem like they have a concern about helping you."
	Need for a Broader Range of Trauma Services	"I feel like they could be more useful in the simple fact of more therapy offers or something like that. I feel like a lot of people really need somebody to talk to in here."
	Lack of Awareness of Available Services	"[I wish] you could go to a site or something that lists different support groups that's going on and what you could take advantage of, 'cause I would like to do something like that."
	Difficulties Navigating the Healthcare System	"Some people come in with pre-existing barriers, and not only just learning about their diagnosis. They have other issues that they may need addressed, but they don't know whom to ask or which direction to be pointed in."
	Access Barriers	"I attend group every other Wednesday of the month…I just typically take off of work for those Wednesdays."