Violence and PTSD screening in HIV care settings in the Southeastern United States: A qualitative study to understand current practices and identify strategies to improve adoption and implementation in HIV care

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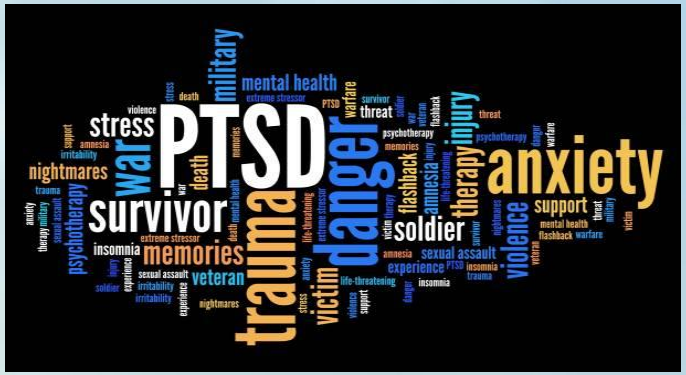
Violence is a Public Health Problem

- Spectrum of types of violence is vast
  - Adverse childhood experiences (ACEs)
  - Intimate partner violence (IPV)
  - Community-based violence (non-partner physical and sexual assault, hate crimes, gang violence)



- Violence and PTSD are commonly experienced among people with HIV (PWH) and associated with poor HIV outcomes, making violence screening within HIV care potentially critical for providing support to improve health outcomes.

- Unfortunately, little is known about current violence/PTSD screening practices in HIV care settings and factors impacting violence/PTSD screening adoption and implementation in these settings are poorly understood.

Study Objective

As part of a larger mixed-methods study, we purposively key informant interviews among administrators, providers, and staff working in unique Ryan White Clinics (RWCs) across the Southeastern US to understand influences on adoption and implementation of violence/PTSD screening in RWCs.

https://special-learning.com/screening-tools-used-during-a-developmental-behavioral-screening/

Methods

- Between January-November 2024, we purposively recruited for and conducted 31 key informant interviews among administrators, providers, and staff working in Ryan White Clinics (RWCs) across the Southeastern US (GA, SC, NC, FL, TN, KY, MS, AL)

- **Eligibility**: Participants needed to be age ≥18 years, work in a RWC in the Southeastern US, and speak either English or Spanish fluently

- Interview guides were informed by the Consolidated Framework for Implementation Research

- Interviews were conducted/recorded via Zoom; transcripts were analyzed using a rapid analysis approach to generate inductive and deductive themes.

Description of Study Sample (N=31)

RWC location	n
Georgia	9
Florida	5
South Carolina	3
North Carolina	6
Tennessee	3
Kentucky	2
Alabama	2
Mississippi	1

Role at RWC	n
Administrator/manager/coordinator	8
Clinical provider	3
Mental health provider	4
Nurse/medical assistant	3
Social worker/case manager	10
Linkage coordinator	2
Peer navigator	1

https://www.istockphoto.com/photos/healthcare-provider

Results

Existing Screening Practices

- Two-thirds of participants indicated their clinic conducted some type of violence screening. Of those, half reported screening only for specific forms of violence (e.g., intimate partner violence) and most noted screening was conditional rather than universal.

- PTSD screening was less common (n=10), though those who conducted PTSD screening, most reported it being done for all new patients (n=4) or being done largely “as needed”(n=5).

Screening Implementation

- Among participants not conducting PTSD screening/or only on “as needed”, participants were split regarding ease of adopting/implementing.

- Those who said it would be difficult to implement cited:
  - Need for trainings or cost/time for training (n=5), the existing heavy workload for staff and providers (n=3), time availability (n=2), administrative buy-in and inadequate resources to help those who screen positive (n=2 each), and budget and patient acceptability (n=1 each).

Results

Screening Acceptability

- Respondents largely felt that universal PTSD screening would be acceptable to providers/staff, though some felt acceptability would be contingent upon training (n=4), adequate protocols (n=1), an administrative/organizational buy-in (n=1).

- By comparison, participants were split on whether violence screening would be acceptable to providers/staff, noting concerns about the potential burden on nurses that screening would cause and heavy workloads.

- Clinic culture and general understanding of the importance of violence/PTSD screening were cited as reasons for acceptability of both types of screening.

Screening Feasibility

- Approximately half of participants believed it would be “difficult” to implement universal PTSD screening due to time and staffing constraints.

- Many were concerned about staffing and time constraints, and some believed screening implementation would require significant cultural “shift” and “buy-in.” Others noted that a “short and quick” screener would be “easy” to implement “with training.”

Results

Barriers and Facilitators to Screening

- For both types of screening, two-thirds cited time availability as the most widely cited barrier to implementation of screening.
- The next most frequent concerns were lack of resources to respond to a positive PTSD or violence screen, noted by a quarter of participants, as well as administrative approval, prioritization, or buy-in.
- Other barriers: screening burden/emotional burden of screening for patients, and patient honesty.
- The availability of a simple, short tool was the most cited facilitator for PTSD screening (n=9).
- Training was also a significant facilitator (n=6 PTSD, n=2 violence) as well as having resources and/or protocols to respond to positive screens (n=4 PTSD, n=1 violence).
- For PTSD screening, availability of information about the prevalence of PTSD to increase provider/staff buy-in, longer appointment times, and collaboration on screening between nurses and providers.
- Increased staffing, self-administration of screeners, and restructuring of visits were mentioned as a potential facilitator of both types of screening.

Discussion

- Experiences of violence and PTSD are concerningly high among PWH, and without identification and appropriate services/care, individuals physical and mental wellness are in jeopardy.

- Violence and PTSD screening are occurring non-systematically among many RWCs, or not at all in others, creating missed opportunities for many patients to get comprehensive care.

- The majority of RWCs report universal screening, especially for PTSD, as acceptable and generally feasible.

- Clinic-level strategies such as provision of training, integration of simple screening tools, and protocols for responding to positive screens are potential ways to support violence/PTSD screening adoption and implementation.

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Individual characteristics		n (%)
Race*	Black / African American	15 (48)
	White	13 (42)
	Multiracial	2 (6)
Ethnicity*	Latinx	2 (6)
Gender*	Cis woman	23 (74)
	Cis man	5 (16)
	Genderqueer / gender nonconforming	2 (6)
Primary role	Social worker, case manager, service plan coordinator	10 (32)
	Manager, administrator, center coordinator	8 (26)
	Mental health counselor, psychiatrist, therapist	4 (13)
	Clinical provider (NP, CNM, PA, MD, DO)	3 (10)
	Nurse, medical assistant	3 (10)
	Linkage coordinator, retention specialist	2 (6)
	Patient navigator, peer counselor, community health worker	1 (3)
Has ever tested positive for HIV*		5 (16)
Type of organization	Ryan White-funded clinic (20 unique clinics)	21 (68)
	Ryan White-funded CBO (9 unique organizations)	10 (32)
State	AL – Alabama	2 (6)
	FL – Florida	5 (16)
	GA – Georgia	9 (29)
	KY – Kentucky	2 (6)
	MS – Mississippi	1 (3)
	NC – North Carolina	6 (19)
	SC – South Carolina	3 (10)
	TN – Tennessee	3 (10)
Number of clients served by the organization	Less than 500 clients	7 (23)
	500 – 2000 clients	15 (48)
	More than 2000 clients	9 (29)