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Jakarra Jenkins

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Considerations for Standardizing Safety Planning, Crisis Prevention, and Crisis Response in Ryan White Funded Clinics: Lessons Learned from Current Practices in Ryan White Clinics, Mental Health Clinics, and Domestic Violence Shelters

By

Jakarra Jenkins
MPH

Hubert Department of Global Health

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Ameeta Kalokhe, MD
Committee Chair

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Jakarra Jenkins
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Thesis Committee Chair: Ameeta Kalokhe, MD

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

Considerations for Standardizing Safety Planning, Crisis Prevention, and Crisis Response in Ryan White Funded Clinics: Lessons Learned from Current Practices in Ryan White Clinics, Mental Health Clinics, and Domestic Violence Shelters

By Jakarra Jenkins

In making considerations for the standardization of safety planning, crisis prevention, and crisis response in Ryan White-Funded Clinics (RWCs), it is important to highlight its significance as a pillar to providing Trauma Informed Care (TIC). The data that was used in this thesis was nested within a study that focused on TIC in RWCs. For this thesis, qualitative interview data from participants in various clinical roles were used to assess their level of awareness of site safety and crisis protocols and the extent to which they are regularly implemented. Participants discussed methods used to standardize safety and crisis planning protocols, such as: collecting information through the patient intake process, peer navigators, using social workers as mediators, addressing environmental factors, and leveraging community advocacy boards. Crisis response strategies discussed the need for consistent clear policies and protocols, police officers, and creating safety plans based on patient or healthcare professional needs. Safety planning tactics included monitoring potential conflicting schedules for involved parties, creating safety contracts, installing panic buttons, having protocols for domestic violence affairs, and room placement for staff. These methods provide an effective approach to creating and maintaining safe environments in such clinics while reducing the risk of harm. RWCs can consider providing education and resources on coping skills, having regular mental health screenings, partnering with domestic violence shelters, and offering support groups.

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Literature Review

History of the HIV Epidemic

When analyzing the current state of the HIV/AIDS epidemic, it is important to understand its history and evolution. AIDS was first recognized in 1981 and was initially referred to as Gay-Related Immune Deficiency (GRID) (Landers et al., 2021). Gay men in New York City and San Francisco began showing heightened symptoms of an illness and dying of infections that their immune systems were not able to fight off (Miller, 1995). Symptoms included frailness and the development of dark purple lesions on the arms and faces of the infected. The lesions were caused by a form of cancer called Kaposi's sarcoma (Mehta et al., 2011). Men were shown to have aged appearances although they were relatively young. After the initial recognition of AIDS, the first test to detect HIV was licensed in the United States two years later when there was a documented heterosexual spread of AIDS (Henny et al., 2019). However, over 9,000 men had been diagnosed and there had been a substantial number of deaths within those 2 years (Landers et al., 2021). In 1987, azidothymidine (AZT), an antiretroviral medication was introduced as the first anti-HIV medication (Broder, 2010). AZT prohibits an enzyme called reverse transcriptase (RT) from allowing HIV-infected cells to make new copies of the virus (Chiu & Duesberg, 1995).

Although there has been a progression in medication, benefits, and healthcare, women are still disproportionately affected by the lack of research on their experiences with HIV (Lemly et al., 2021). Some women living with HIV/AIDS in the early years of the epidemic had backgrounds of low income, employment through sex work, were people who injected drugs, or were racial and ethnic minorities. These factors contributed to them being overlooked for care due to their unconventional roles in society (Liu and Mager, 2016). There were delays in research which caused limited testing, limited women-responsive care, and exacerbated stigmatization surrounding HIV (Liu and Mager 2016). Women's HIV symptoms were often unrecognized until they reached an advanced stage of the disease which led to the short life expectancy of women with AIDS (Chu et al., 1990). The symptoms of AIDS in women were generally attributed to pneumonia, cervical cancer, or other illnesses that their immunocompromised systems could not fight off (Pellowski et al., 2014). However, it was in this era that the grassroots development of women's HIV advocacy organizations like Women Organized to Respond to Life-Threatening Diseases (WORLD) emerged to connect women to appropriate care (WORLD, 2019).

Overall, AIDS activist organizations such as AIDS Coalition to Unleash Power (ACT UP) and the Treatment Action Group (TAG) (Rabkin et al., 2018) advocated for awareness, prevention, and treatment of HIV/AIDS. These organizations along with the World Health Organization (WHO) collaborated to institute the first World AIDS Day in 1988. HIV activism has impacted the trajectory of care since 1990 and has provided those living with HIV with an extended life expectancy through medical advancement and care considerations. In 2008, Congress passed the Americans with Disabilities Amendments Act (ADAAA) that enabled those PLWHA to meet the definition of disability under federal antidiscrimination laws and receive corresponding benefits (DeLisa et al., 2011).

HIV Care Continuum

The HIV care continuum is a public health model that outlines clinical steps that PLWHA goes through from diagnosis to maintaining viral suppression through care such as antiretroviral therapy or ART (Broder, 2010). These steps include the diagnosis of HIV infection, linkage to HIV medical care, receipt of care, retention in care, and the achievement and maintenance of viral suppression. Viral suppression is signified by having less than 200 detectable copies of HIV per milliliter of blood (Allorant et al., 2020). Although the HIV treatment cascade is represented as a linear and one-directional framework, PLWHA tends to experience the care continuum in a less continuous process. It is known for PWLHA to skip steps or even exit the continuum for a while which causes status regression to an earlier stage in their treatment (Chen et al., 2019). The proportion of PLWHA has been shown to decrease at each successive step of the care continuum (Kay et al., 2016). In the Southeastern states of the United States, barriers such as isolation, lack of transportation, limited healthcare access, the conservative climate of nonurban communities, religion, stigma, and confidentiality concerns broaden the gap for PLWHA who are out of care (Kay et al., 2016). When PLWHA who are undiagnosed attend general sexual health clinics, they risk not receiving appropriate care due to missed opportunities for specific testing (Korthuis & Edelman, 2018). Improved outcomes could be facilitated by real-time assessment of HIV status and HIV care (Chen et al., 2019).

Although there have been developments in HIV prevention and treatment medication, there are social and structural factors that are prevalent in the United States, specifically the Southeast, that contribute to the lack of testing, prevention methods, and care retention (Korthuis & Edelman, 2018). Income, social inequality, poverty, and poor overall health are examples of systemic challenges that impact increased HIV risk and related negative health outcomes among vulnerable populations in the Southeast (Chen et al., 2019). Of the social factors, homophobia, racism, and HIV stigma are contributing barriers to care that are prevalent (Korthuis & Edelman, 2018). The various expressions of stigma can impede the most at-risk individuals from accessing adequate HIV care (Allorant et al., 2020). To mitigate these challenges, the HIV care continuum serves to guide health workers as they monitor and aid patients in care retention (Korthuis & Edelman, 2018).

The implications of each step are integral to understanding why the continuum is utilized for monitoring care outcomes for PLWHA (Tymejczyk et al., 2018). HIV diagnosis allows those in need of care to be identified and assessed for ART eligibility. Previously, HIV patients with CD4 counts ≤350 and ≤500 cells/µL were recommended to begin ART immediately after testing (Tymejczyk et al., 2018). In 2015, the WHO updated its guidelines for ART for HIV-positive adults, adolescents, and children. These guidelines recommend that all HIV-positive adults and adolescents should start ART as soon as possible after diagnosis, regardless of their CD4 count or clinical stage (DHHS, 2018). For children, the guidelines recommend that ART start as soon as possible after diagnosis, when the child is at least two months old, and has a CD4 percentage of 25% or less (DHHS, 2018). The updated guidelines also recommend that all people living with HIV should be offered viral load testing every six months and that those who are virally suppressed should continue to receive ART for life (DHHS, 2016).

Support and connection to resources at diagnosis lead to readily available linkage to care. Although it is the suggested next step in the continuum, lifestyle factors can challenge care retention for PLWHA. Low health literacy and stigma associated with receiving HIV care are two common factors that are known barriers to linkage to care (Li et al., 2017). Limited care engagement is a contributor to healthcare disparities and plays a role in HIV transmission by reducing the chances of changing risk behaviors. It can also limit opportunities to reduce transmission via effective antiretroviral therapy and the accompanying reduction in HIV viral load (Mugavero, 2016).

Subgroups that were found to be out-of-care at the time of their clinic visits, experienced significantly poorer outcomes of re-linkage to care and viral suppression (Kay et al., 2016). Actionable information about these gaps can inform and drive the development of scalable interventions for assessing and improving HIV care continuum outcomes during encounters at front-line, public-sector service delivery settings such as sexual health clinics (Ridgway et al., 2020). Patients diagnosed in a clinic and those who self-report being out-of-care can be immediately linked to treatment through the instant provision of ART at the clinic, and efficiently linked to care through patient navigation services that offer risk-reduction counseling, behavioral and psychosocial services, insurance benefits navigation, referral to a partnering HIV care provider, and follow-up efforts to ensure that patients are connected with referred providers (Korthuis & Edelman, 2018). These services are expected to impact linkage rates and downstream outcomes such as retention in care and viral suppression. To further support strengthening the HIV care continuum, providing patients and providers structural access to real-time information on care status could enhance the effectiveness of the previously mentioned services to improve both individual and public health outcomes (Hogg, 2018).

Significance of Ryan White-Funded Clinics

To ensure the efficacy of the HIV care continuum, patients must have access to services through funded coverage of health costs. RWCs take care of more than fifty percent of PLWHA living in the United States and provides wraparound services to fulfill the needs of patients. These services include case management, peer counseling, dental care, housing connection, and mental healthcare services (Griffin et al., 2020). -The Affordable Care Act (ACA) enabled thousands of people living with HIV who have benefitted from the Ryan White HIV/AIDS Program to have additional options for insurance coverage and access to general clinics

(Ginossar et al., 2019). However, ACA was not expanded in all states across the United States. RWCs are still needed and provide full coverage care for PLWHA who might be ineligible for Medicaid or subsidized insurance (Cahill et al., 2015). In 1990, Ryan White died from complications of AIDS (HRSA, 2022). While alive he was diagnosed with hemophilia. This disorder prevented his body's ability to make blood clots (Cahill et al., 2015). To treat his ailment, he received Factor VIII medication to supplement his body's clotting factors (Institute of Medicine, 2004). Through these treatments, he was infected with HIV and subsequently barred from school due to his diagnosis. Ryan White became an advocate for raising HIV/AIDS awareness (Cahill et al., 2015). Consequently, the Ryan White CARE Act is enacted to provide healthcare to those living with HIV/AIDS in his honor (Ginossar et al., 2019). The law strengthens the protection against insurance discrimination based on pre-existing conditions (Ginossar et al., 2019). By doing this, ACA increased healthcare access for many, but this does not mean that the Ryan White Program is no longer needed. Services essential to improving outcomes on the continuum of HIV care are not supported by any other source and are specific to the Ryan White program. It is still needed in areas that have not progressed with ACA. The uneven implementation of healthcare reform in the South due to the refusal of Medicaid expansion and eligibility criteria exacerbates racial and regional disparities in healthcare access and outcomes. Having support from RWCs is integral for PLWHA given the social stigma that still exists that may prohibit them from seeking care in other healthcare settings that are not equipped with trauma-informed care tailored to their needs.

Trauma among PLWHA

According to a 2020 report by the Centers for Disease Control and Prevention (CDC), nearly one in four people living with HIV in the United States has experienced trauma (CDC, 2020). This suggests that the percentage of people living with HIV who have experienced trauma in the southeast region could be similar or higher. Some examples of trauma that are commonly experienced by PLWHA are childhood abuse, intimate partner violence, and sexual abuse.

Childhood abuse can have a profound impact on people living with HIV. Abuse can increase the likelihood of risky behaviors such as substance use, which can increase the risk of HIV infection, as well as put people living with HIV at greater risk for developing mental health issues such as depression, anxiety, and post-traumatic stress disorder. These mental health issues can interfere with medication adherence, leading to poorer physical health outcomes. Abuse can also lead to feelings of isolation and stigma, which can make it difficult to access the care and resources needed to manage HIV.

The rates of intimate partner violence among people living with HIV vary depending on the population. In general, studies have found that people living with HIV are more likely to experience intimate partner violence than those without the virus. Studies have also found that rates of intimate partner violence are higher among women living with HIV and that the risk for intimate partner violence is even higher for women who are not receiving HIV treatment. Women who are not receiving HIV treatment may be more likely to experience intimate partner violence due to the stigma and discrimination associated with having the virus, which can make them more vulnerable to abuse. In addition, women who are not receiving HIV treatment may be more likely to engage in risky behaviors, such as drug use or unprotected sex, which can increase the risk of violence. Finally, women who are not receiving HIV treatment may be less likely to seek help or support if they are experiencing violence, which can make it more difficult to escape the situation.

People living with HIV who have experienced sexual trauma may experience a range of mental health issues, such as depression, anxiety, post-traumatic stress disorder (PTSD), emotional distress, and difficulty forming trusting relationships. They may be at higher risk of HIV transmission due to risky behaviors, such as engaging in unprotected sex or substance use. They may also be more likely to experience stigma and discrimination related to their HIV status. Additionally, survivors of sexual trauma may have difficulty accessing appropriate HIV care and treatment due to stigma, fear of disclosure, and lack of resources. Survivors of sexual trauma must receive trauma-informed care and support that is tailored to their specific needs. Trauma-informed care is important for people living with HIV because it can help address the psychological, social, and physical impacts of trauma. Trauma-informed care considers the history of trauma, which can include sexual trauma, and provides appropriate support that is tailored to the individual's needs. This type of care can help individuals to build trust in healthcare providers and to access necessary treatments, including HIV medications and mental healthcare. Additionally, trauma-informed care can help to reduce the risk of HIV transmission by addressing the factors that may lead to risky behaviors.

Defining Crisis:

Through understanding the history of HIV and its associated stigma, it is important to define the crisis and how it impacts access to care for PWLH. A crisis is generally defined as a time of intense difficulty, trouble, or danger that can be overwhelming. These events can include divorce, displacement, violence, the death of a loved one, or the discovery of a serious illness (Wang & Gupta, 2022). In the context of HIV, these events of crisis can occur or be magnified by triggers people experience while accessing care. In general, higher levels of both psychosocial and physiological stress among PLWHA have been associated with poorer immune status, increased viral load over time, faster disease progression, and higher rates of mortality (Felker-Kantor et al., 2019).

According to the National Alliance of Mental Illness (NAMI), a mental health crisis is any situation in which a person's behavior puts them at risk of hurting themselves or others, prevents them from being able to care for themselves or function effectively in their social community (NAMI, 2022). Several factors can lead to a mental health crisis. Some examples of situations that can lead to or contribute to a crisis include psychosocial and physiological stress, adverse childhood experiences (ACEs), education level, socioeconomic status, and intimate partner violence (IPV). In the context of the Southeast region of the United States, these examples of trauma are common in the lives of many PLWHA. They are documented in various research studies (LeGrand et al., 2015). When a crisis happens, healthcare workers need to identify, understand, and manage the outcomes through systematic approaches (Rinker, 2019).

In addition to social crises, there are natural disasters that lead to crises. Some of these include tornadoes, hurricanes, tropical storms, floods, wildfires, earthquakes, drought, and others. According to The Substance Abuse and Mental Health Services Administration (SAMHSA), natural disasters are defined as large-scale geological or meteorological events that have the potential to cause death or property loss (SAMHSA, 2022). Natural disasters may affect things like air and water quality which can cause challenges for PLWHA by making them susceptible to infections. PLWHA might lose or run out of medications during a disaster which can result in a possible interruption in treatment (DHS, 2012).

Crisis and Safety Planning

While the terms may seem interchangeable, there are distinct differences between crisis and safety planning. Crisis planning is a plan of action to be taken in the case of an emergency or unexpected event that requires immediate action (Needleman, 2020). It is a proactive approach focused on preventing, mitigating, and responding to an imminent crisis. Safety planning, on the other hand, is a proactive approach to reducing the risk of harm to an individual, either physically or emotionally (NAMI, 2020). It is focused on identifying and managing risk factors, as well as providing resources and support to the individual to keep them safe.

Crisis Planning

To mitigate the effects of crises, some processes can be implemented to support PWLH. Crisis intervention is a short-term management technique designed to reduce potential permanent damage to an individual affected by a crisis (Wang and Gupta, 2022). An effective intervention like SAFER-R is a common intervention model that is used. It consists of stabilization, acknowledgment, facilitation of understanding, encouragement, recovery, and referral to resources (Wang & Gupta, 2022). Considering the variety of crises that PLWHA might experience, exploring multiple crises and safety planning protocols might aid in providing clinical staff with a centralized model to reference in times of need.

Clinician training starts with acknowledging the Pre-Crisis Phase which involves prevention measures seeking to reduce known risks that could lead to a crisis. These preventative measures include the internal organizational preparedness of clinics (Bundy et al., 2017). Protocols are set by the clinical manager or committee boards depending on the administrative format of the clinic. They consider previous incidents, the social dynamics of patients, crisis prevention standards, and the values of their respective organizations. If crisis prevention is ineffective, there is a crisis management model that the staff is familiarized with (Patt, 2020). The procedures used in these safety plans can be transferrable to create crisis planning tools in

RWCs. There will have to be adaptations made that consider the specific needs and behaviors of the related population.

Safety Planning

According to the National Domestic Violence Hotline, a safety plan is comprised of organized actions that can help to decrease the risk of being hurt by partners. It includes information specific to the person's life that will increase their safety at school, home, and other places they visit daily (National Domestic Violence Hotline, 2020). Actions can include making an escape bag, planning a route for a specific destination, creating code words within a trusted support network, and sustaining reliable forms of communication. Alternatively, NAMI defines crisis planning as a Wellness Recovery Action Plan (NAMI, 2023). It is utilized to help patients plan their overall care and how to avoid a crisis. These plans typically include phone numbers for all healthcare providers, contact information for supportive family members or friends, the local crisis line number, locations of walk-in crisis centers or emergency rooms, previous diagnosis, medications, and history of drug usage.

Three tenets are generally the guiding tools of each safety plan which include clinician training, comfort, and safety plan utilization (Moscardini, Hill, et al. 2020). The Suicide Prevention Resource Center and the Joint Commission recommend safety planning as a standard of care for individuals identified as at risk for suicide-related behaviors (Suicide Prevention Resource Center and the Joint Commission, 2018). Safety planning is a brief intervention to help individuals survive suicidal crises by having them develop a set of steps to reduce the likelihood of engaging in suicidal behavior (Gould & Davidson, 2007).

In addition to safety and crisis planning, mandatory reporting is an important factor that can be used as a supportive catalyst in crisis management (Geiderman &Marco, 2020).

Mandatory reporting laws establish a legally enforced duty for professionals who have contact with vulnerable populations to report suspected or confirmed mistreatment and abuse to state and local authorities (Thomas & Reeves, 2022). These laws vary by state and typically cover neglect, physical, sexual, emotional, and financial abuse. Reporters include childcare providers, clergy, coaches, counselors, healthcare providers, law enforcement, principals, and teachers (Liu and Vaughn, 2019). In some cases, mandatory reporting may conflict with ethical duties such as patient autonomy considerations or confidentiality protection (Geiderman & Marco, 2020). RWCs should be aware of mandatory reporting laws for their state to ensure that they follow all applicable laws and regulations. These laws may require the clinic to report certain types of incidents and/or health information to the proper authorities. Knowing and adhering to mandatory reporting laws can help protect the clinic, its staff, and its patients from potential legal and financial issues (CDC, 2018).

Potential Challenges with Implementation of Safety and Crisis Planning

Although defining crisis and outlining safety plans help providers to identify signs to aid during conflicts, barriers exist that can challenge their ability to fully support patients experiencing a crisis. A lack of resources such as funding or specific staff may prevent healthcare organizations from implementing policies to protect individuals from implementing safety and crisis plans. Lack of privacy, visit time constraints, fear of child custody loss, feelings of shame, guilt, and powerlessness are other factors that contribute to patients' reluctance to express that they are in crisis (Shaheen et al., 2020).

Existing Safety Protocols and Procedures in Clinical Settings

The World Health Organization's guidance around safety precautions in clinics and healthcare settings has traditionally focused on environmental and pathogen-related safety. For example, safety protocols in clinical settings have been centered on transmission prevention such as hand washing, the use of clean needles, and sterile environments (WHO, 2019).

While the WHO outlined protocols for patient safety and fidelity of information, it did not encompass crisis potential, prevention, or intervention. SAMHSA created its National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit that includes tools to identify crises, implement best practices, tools for the continuum to evaluate crisis systems, and methods to integrate law enforcement if necessary (SAMHSA, 2020). De-escalating aggression and violence in the mental health setting is another practice that has been explored for universal use in clinical settings for crisis intervention (Spears & McNeely, 2019). The objective is to prevent aggression and behavioral problems when a crisis is not occurring and to respond quickly and effectively when it does happen. There has yet to be a proven effective method that can be streamlined for other organizations. Another study explores prepping nurses with knowledge and tactics to maneuver a crisis. Researchers established a final de-escalation kit that includes a large poster, a nursing staff survey, an in-service education session, and a literature-based discussion paper for reference (Cowin et al., 2003). It is not clear how useful this kit is in practice but the combination of the three tools listed in this paragraph can be used as a foundation for a comprehensive approach to crisis prevention and management.

Gaps in Literature

There is limited research and evidence on the effectiveness of safety planning and crisis planning to support people with histories of trauma in Ryan White-funded clinics. While there is some information available on the importance of providing trauma-informed care, there is still much to learn about how best to provide safety planning and crisis planning services to people with histories of trauma. Various factors contribute to the limited information on safety planning and crisis planning to support people with histories of trauma in RWCs. These include an acknowledgment that these services are relatively new, and there has not been sufficient time or resources to adequately evaluate their effectiveness. There may be limited resources for providing trauma-informed care due to budget constraints and a lack of communication and collaboration between organizations providing services to people living with HIV/AIDS. Additionally, there may be barriers to accessing services due to stigma or discrimination related to HIV/AIDS. Ideally, effective implementations of trauma-informed crisis planning in RWCs could include providing evidence-based interventions such as cognitive behavioral therapy, trauma-focused therapy, and other evidence-based treatments. By providing crisis response services, such as on-call clinicians and peer-support services, they can help to ensure that people living with HIV/AIDS have access to immediate and appropriate care when they are in crisis. Other components that could be included in a trauma-informed crisis plan could include creating safe spaces for people to access services, a clear system for reporting incidents of violence or abuse, and training for staff on how to provide trauma-informed care. Acknowledging each of these factors lead to inquiries regarding the current needs of clinicians, administrative staff, and other personnel to create regulated, safe, and functioning healthcare settings within RWCs.

Introduction

The HIV/AIDS epidemic has had a great impact on the United States and the world. As of 2016, 1.1 million people were living with HIV in the United States, with approximately 40,000 new infections each year (CDC, 2016). RWCs are essential in providing treatment and support for those living with HIV/AIDS, however, the safety of those utilizing these services is of great importance. The safety of the clinic, the staff, and the patients is paramount.

In making considerations for standardization of safety planning, crisis prevention, and crisis response in RWCs, it is important to highlight its significance as a pillar to providing Trauma Informed Care (TIC). The data that was used in this thesis was extracted from a study that focused on TIC in RWCs. It is an organizational treatment framework promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) as a means of recognizing and addressing the consequences of trauma. Per SAMHSA guidelines, trauma-informed (TI) systems and programs: realize the widespread impact of trauma and potential paths for recovery while also recognizing symptoms of trauma in clients, staff, and others involved with the system; respond through integrating knowledge into policies, procedures, and practices; and explore ways to actively minimize re-traumatization.

This research explores considerations for standardizing safety planning, crisis prevention, and crisis response in RWCs through the lens of current practices in the clinic, mental health clinics, and domestic violence shelters. RWCs are essential and provide vital services for those with HIV/AIDS, however, the safety of those utilizing these services is paramount. The research will explore the current safety practices in RWCs, mental health clinics, and domestic violence shelters to determine the best practices for RWCs.

Methods

Recruitment and Data Collection

For this study, participants were recruited from RWCs within the Department of Health and Human Services (DHHS) Southeast Region IV. This region covers Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. From December 2019 to April 2021, selected participants were invited to partake in a mixed methods study. The study's focus prioritized trauma-informed care (TIC) implementation, current TIC approaches used by clinics, facilitators of TIC, and the associated barriers. To be eligible for the study, participants had to meet the following eligibility criteria: an administrator, clinician, or other staff members from at least one of the 136 RWCs in DHHS Region IV. In the original study, 321 participants from 46 RWCs, completed a quantitative survey. Of those participants, 200 provided consent to be contacted for a follow-up qualitative interview. Interview prospects were selectively sampled (i.e., by role, clinic region, and type) and completed interviews which lasted 60 minutes. In total, 38 interviews total were conducted with participants from 19 clinics. All participants provided consent to participate. One participant declined to consent to be audio recorded which resulted in their exclusion from analysis. As an incentive for participating in the study, participants were given $50 in compensation for their time upon completion of the interview. Qualitative interviews were audio recorded using Zoom videoconferencing features. These recordings were directly transcribed by a professional transcription agency. All procedures were approved by the Emory University Institutional Review Board.

Data Collection Tools

Unique interview guides were developed for interviews with administrators, clinical providers, and staff at RWCs using the SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. The SAMHSA domains explored included: governance and leadership, policy, physical environment, and engagement. The five domains of the Consolidated Framework for Implementation Research (CFIR) were also used to inform the guides' structure. These domains include Intervention Characteristics, Outer Setting, Inner Setting, Characteristics of Individuals, and Process. Throughout the guides, some questions probed for information about participants' experience with institutional support, prioritization for Trauma Informed Care (TIC) implementation, resources available for implementation, implementation facilitators, barriers, and current implementation practices of TIC. Questions specifically used for my thesis question included: inquiring about the clinical response when someone discloses that he, she, or they have experienced violence, changes that have been made to create safer, either physical or emotional, environments for patients, and what facilitated those changes, and how patient safety complaints are handled within the clinics.

Analysis

Abstracting specific data from the transcripts required the development of a codebook that used deductive codes based on the interview guide. These codes were then supplemented with inductive codes derived from themes identified in the transcript review conducted by the research team. To ensure the quality of the codebook, transcripts were deductively coded based on each SAMHSA domain and CFIR principles. MAXQDA software was utilized to facilitate the coding of the data. Two team members with doctoral-level training in qualitative research and experience with CFIR coding were responsible for creating the codebook. Each transcript was independently coded by team members. They met regularly to conduct inter-coder agreements. A third team member was present to resolve disputes and ensure the integrity of coding usage. Complete agreement based on discussions between coders was needed before the final approval of the coded transcripts. After coding, analyses were performed to identify CFIR constructs most applicable to the implementation of each SAMHSA TIC domain. For this thesis, I utilized data that was coded with codes "safety issues and crisis response" and "safety issues and crisis response" in RWCs.

Results

When addressing the need for standardizing safety and crisis planning protocols in Ryan White-funded clinics, exploring crisis prevention, crisis response, safety planning, and safety response methods are key to understanding how to handle systematically the scope of potential traumatic occurrences experienced by patients and clinic staff. Through the collection of data found in this study, participants shared current approaches and ideal ones they are interested in having implemented to facilitate effective crisis prevention, response, and safety.

Crisis Prevention

One provider discussed how the medical record can be used as a tool in crisis prevention. By utilizing the information collected through the intake, providers can check for traumatic experiences through patient's electronic medical records to assess how to engage with them for crisis prevention:

> *"Yes. We try to when they first get here there, of course, is a questionnaire that they answer and that is generated before they see a provider and when we open up their electronic medical record one of the first things we see is their questionnaire and their responses to past trauma. And so, when we go to see the patient we are prompted before we see them as to some of the trauma they've experienced. So you know, we try to do our best not to corner them in the room, not to stand over them, you know, to sit down speak with them and to use the type of language – ... it is to talk with them in calming, you know, motivational interviewing to where we're not going to cause any trauma to be brought up in their memory."*
>
> *Provider*

The role of peer navigators in crisis prevention was also discussed. Peer navigators are those who have accepted their HIV diagnosis and have learned to live well with HIV. Peer navigators are role models who provide reliable and relevant information to help patients overcome barriers that may prevent engagement, retention, or re-engagement in treatment, and can help with mitigating crises:

> *"Sure. So for those who are uncomfortable being in the general population. So for example, if someone is uncomfortable walking into our lobby, the medical peer navigator will meet them in the parking lot and escort them through a different entrance. And in some cases will completely bypass the front desk altogether and complete any necessary pre-appointment documents and will remain in the room with that individual. So that does happen oftentimes with, one, the population of executives who we serve."*
>
> *Peer Navigator*

Other participants mentioned the role of social workers, their well-versed knowledge of patients' experiences, and their ability to operate as mediators:

> *"The social workers are very good with finding out what those needs are, or what those emotional triggers are, and then working with all of the staff, whether it be clinic staff, whether it be grant staff, social workers, providers, or office managers, to make sure that the patient's fully comfortable."*
>
> *Clinical staff*

> *“The social worker also wrote an e-mail to the provider, the clinic staff, or the office manager, letting them know that this patient was coming in, and these things could arise”.*
>
> *Clinical staff*

Participants also mentioned strategies to navigate around and avoid environmental factors of the clinic that could contribute to a crisis:

> *“We've had an African patient who, just for example, had a lot of trauma before she came to the States, so every time she walks into that clinic, she's reminded of that trauma. So the provider, the office manager, and I, and the social worker kinda set it all up to where she can be seen in one of our mental health rooms that is set up like a nice office with a couch. With non-HIV all over the walls so that – and then walk her into where she doesn't have to walk straight through the waiting room so everybody sees her, or afraid that somebody's gonna know her.”*
>
> *Clinical staff*

Clinical staff discussed the role the Community Advisory Boards could also play in crisis prevention through a review of clinic policies to ensure practices were not retraumatizing or triggering for patients:

> *“So, you know, forming a community advisory board within [clinic] with patients so they can voice their concerns, their feedback, in a, you know, confidential and anonymous way. And then maybe a document with the feedback, the general feedback, from all members of the board can be then delivered to the [clinic] leadership, and then [clinic] leadership can take those into account to either develop training, change in policies, or*

> *things like that. So I think that we should focus on preventing those reliving – causing patients to relive their traumatic experiences rather than just be reactive when they have already happened."*
>
> *Clinical staff*

Crisis Response

Participants also share their experiences with crisis response, how their positions within the clinic affected their ability to respond, and their levels of engagement based on violent or non-violent escalation. Crisis response refers to all the planning and actions taken to address natural and man-made disasters, critical incidents, and traumatic events like suicidal ideations. These events can happen in clinical settings and can have external factors that contribute to their severity.

Clinical staff recounts their limited capability and training clearances to respond to suicidal ideations:

> *"…if a patient gets you on the phone and they start, like, having suicidal ideation, or you feel like they're gonna harm themselves or somebody else***,** *we're not trained to take those calls. We're not trained to walk them through that. That is not something that we need to be a part of. What we need to do at that point is keep ourselves on the phone with a patient and have somebody nearby go get a social worker, or a mental health counselor, or a psychiatrist to walk them through that process, because again, we're not trained…if someone's actively suicidal in the clinic. And we do have protocols in place for that, and we have, like I said, an on-site mental health team that can help if we need 6404, et cetera. And then occasionally people will come in actively intoxicated, and again, similar*

> *types of situations…Aside from that very acute stuff, I would say I probably am not very well trained to do all that.”*

Clinical staff

Providers share their reporting practices to contact case managers during moments of suicidal or homicidal crisis but are not aware of protocols for domestic abuse:

> *“So if it’s like a safety issue, you know, we’re all mandated reporters for abuse. So, you know, if we are concerned about like suicidal or homicidal ideations and things like that, you know, we would then reach out to the case managers, and have the patient walked over to the crisis intake. If it’s like any other kind of trauma, like domestic abuse, and things like that, too, or we would then – so I don’t know the exact protocol… it would be reaching out to the case management and social workers.”*

Provider

Other clinical staff mentioned the use of police officers as a means of crisis response:

> *“Yeah, and we also have a full-time police officer for individuals who tend to get out of hand, because unfortunately, we have individuals who have psychiatric conditions, so when that happens, it sometimes can trigger someone else's condition, you know what I'm saying?...So, that person might be having an episode, and it triggers, so he's there to shut that down immediately so it doesn't do the cascade thing. A domino effect…And that has worked well.”*

Clinical staff

Other participants mentioned the role of social workers, their well-versed knowledge of patients' experiences, and their ability to operate as mediators:

> *"Well, we staff the clinic with two to three social workers at all times. So there are trained staff available to meet with patients if there is a sort of crisis like that. We have referral options and mental health resources that we would leverage if we needed to, so if somebody was in an unsafe environment we would search for a safe place for them to stay first and try to make sure that their basic needs were being met. That all kind of runs through the social workers and clinic. If it was an immediate crisis like suicidal or homicidal ideation, something like that, then you get flagged pretty quickly by the providers so that we can if we need to get the patient admitted to the behavioral health unit at one of the [state university] hospitals or to a safety contract or something like that."*

Clinical staff

Community advocacy boards were mentioned as a catalyst for change and a collaborative initiative to respond to crises when prompted about an issue of safety in the clinical environment is identified or raised by patients, providers, or staff, how is this issue handled by the clinic?:

> *"Ok, well, a couple of things – one, if it is an issue that a staff member faces, you know, they would go to their supervisor and then that would assume – we have a group called Community Bridge. And, we have consumers in this group, as well as at least one person from every job function in our clinic. And we get together, and we talk about a lot of issues, how we can improve things…"*

Clinical staff

Participants acknowledged the nuances in responding to violent- versus non-violent crises. The crisis response varied from calling 911 to referring patients to grievance reporting procedures so they feel heard:

> *"Yeah. I mean, if it's out-of-control violence, there are directives where you immediately get the supervisor that's on site. You know, if it's extreme, you're calling 911. There is an alarm system, all that. But when it's clients that are just struggling, they're having a hard time with homelessness or frustrated, they've been waiting, there is a policy about the best way to address it, about the ability for a client to say file a grievance or a complaint. The integrity policy, basically all of our staff sign it. And within that policy, they're essentially agreeing to the fact that as an [organization] employee they'll always act within integrity, they'll always act ethically, in the best interest of the organization and of the clients. You know, being honest. I mean, it's essentially documentation that all of our employees will adhere to those principals that integrity as a whole is made up of."*
>
> *Administrator*

> *"So it could be. Yeah, some things will just go directly to our director and he will address them very clearly. But usually, they'll go through the grievance policy and procedure, and [name], he's our grievance officer/chaplain, will – he's very good at kind of collecting the story and listening to someone. And a lot of times that – just that process alone helps the patient be heard, and we know that's such an important thing.*
>
> *And when it can be rectified through that process that's good. And then sometimes when it needs to go to the director, or like some clear action, we have like – like in very rare instances we've had to fire patients from the clinic if you will. And that was because of a really direct threat to usually a staff member."*

Clinical staff

One participant shared their experience of handling romantic advances and feeling threatened by patients and the process to address them through clinical protocol:

> *"I notify the administration, the clinic kind of manager. I don't know what their actual title is. I don't know what happens after that. I do know that there are policies around patient behavior. And most of this is around providers feeling threatened especially around not prescribing narcotics and things. I think this might be dealt with similarly to that. I don't know exactly what the policy is. You get a warning. I don't know. It's more of a policy of when you can fire a patient for acting inappropriately.*
>
> *Usually, that goes to our Client Director and he is very hands-on. I mean if somebody were to go to him right now and say hey there's an issue in the waiting room with you know, x, y, and z and it may be dangerous. He would get up immediately and go out there and take a look at it and if it could be corrected by you know, me moving something or him asking someone to leave then it would be taken care of right then."*

Nurse

Safety Planning and Response

Safety planning ensures secure environments that help reduce the risk of future harm. It can include planning for a future crisis, considering options to optimize safety, and making decisions about relatively supportive protocols. In this study, participants discussed methods they used to implement safety planning. Methods were rooted in tactics used in domestic violence shelters and the respective resource partnership:

> *"I know some referrals can go out to our domestic violence shelters, safe words on charts, you know?... Um, So the social worker works with the hospital staff and another – we refer out to the domestic violence shelters. We have resources for the patients, and our social workers do help get them through that."*
>
> *Social worker*

A clinical therapist shares how their team addresses safety issues and incidents by creating future safety plans:

> *"It is a safety issue identified by staff with a patient, they would likely come to me or the other therapist. And if we need to develop a safety plan or a safety contract, we would do that and I would be the one to sit down with the patient to kind of, you know discuss this is what we're seeing, this is what we need to happen, where can we go from there, what are your thoughts on this. ...."*
>
> Clinical therapist

Safety response is an organized, strategic approach to identifying and managing incidents in ways that minimize damage, recovery time, and overall harm to the clinical environment. One provider mentioned cases of domestic violence and strategies to ensure a patient was not scheduled for their appointments on the same day as another patient who perpetrated violence against them:

> *"We've had partners who are both patients and then you know, all of a sudden domestic violence came up and we would make it a point to not share – at one point the partner- the patient was okay with the partner getting information about them over the phone, then we would shut that down if they want. Or we would stop scheduling them together on the same*

> *day."*
>
> *Provider*

Other participants mentioned the role of social workers, their well-versed knowledge of patients' experiences, and their ability to operate as mediators:

> *"Typically it's [a safety issue is] directed to the social worker or the attending. So if there's a specific complaint we would either like say the person at check-in used an improper pronoun, we would – that information would come to me and the lead patient navigator or it would go to our clinic attending. And so we would take the time to address that with a staff member. If a patient has– is currently experiencing trauma or has identified past trauma that information is then filtered through to the social worker."*
>
> *Clinic administrator*

A clinical staff shares the implementation of panic buttons to encourage systematic safety responses and room placement to ensure the safety of clinical staff:

> *"The only other change that I am aware of is that they put panic buttons in the in– we had these interview rooms for social workers and their clients. [I: mhm] And um, the rooms are set up where the door opens, and the client sits closest to the door and the social worker sits on the inside at the desk. [I: mhm] There's-there's no exit, and it's a very small area. [I: ok] So the social workers, for their safety, I honestly do not know if there was an actual incident[I: mhm] that happened or if someone just said, "I don't feel like this is a good arrangement."*
>
> *Clinical staff*

Discussion

In this study, participants within various clinical roles shared their understanding of crisis prevention, crisis response, safety planning, and safety response protocols in their respective Ryan White-funded clinics. Each of them discussed their level of awareness of these protocols and the extent to which they are regularly implemented. Additionally, participants discussed methods used to standardize safety and crisis planning protocols in RWCs. These methods included exploring crisis prevention methods, such as utilizing information collected through the intake, utilizing peer navigators, using social workers as mediators, addressing environmental factors, and leveraging community advocacy boards. There was also emphasis placed on partnering with domestic violence shelters to pipeline referrals and adopting some of their standard practices to identify safe words for crisis prevention. For crisis response, participants discussed the need for having consistent clear policies and protocols. These include utilizing police officers and creating safety plans based on the patient's or healthcare professional's needs in case of crises. For safety planning, participants discussed tactics such as monitoring potential conflicting schedules for involved parties, creating safety contracts within care plans, the impact of installing panic buttons, having protocols for domestic violence affairs, and room placement for staff while tending to patients' needs. These methods demonstrate an effective approach to creating and maintaining safe environments in such clinics while reducing the risk of harm.

The topic of standardizing safety and crisis planning protocols in RWCs is not well-researched. To support the findings in this study, related hospitals, mental health clinics, and domestic violence shelter protocols needed to be explored for reference. They were utilized to better understand how RWCs can approach their systems to improve their protocols. An example of this would be a study that assessed the management of alarm systems for quality and safety in the hospital setting (Bach et al., 2018). The study researched how alarming medical devices are designed to generate alarm signals that indicate unsatisfactory physiological patient states and unsatisfactory functional states of medical electrical equipment within the electrical system. Although this study did not directly correlate with conflict crisis, it highlighted measures to consider like alarm training, multidisciplinary teamwork, alarm safety culture, alarm configuration, alarm design, and alarm assessment when ensuring the effectiveness of alarm systems and alert response management. This is helpful when considering the usage of panic buttons that were mentioned in RWCs and how they should connect to a central source for immediate response.

Additionally, another study magnified how the implementation of Behavioral Emergency Response Teams (BERT) improves patient safety, staff safety, and staff collaboration (Zicko et al., 2017). BERT are specialized teams of mental health professionals who respond to crises involving individuals with mental health or behavioral issues. Zicko's research included an evidence-based practice process improvement project to determine how the implementation of a BERT affects staff and patient safety. It also examined the nursing staff’s level of knowledge, confidence, and support in caring for mental health patients and patients exhibiting behavioral emergencies. The results of this study indicated that “the number of assaults decreased from 10 (pre) to 1 (post); security intervention decreased from 14 to 1; and restraint use decreased from 8 to 1” (Zicko et al., 2017). The staff's level of BERT knowledge and rating of support between mental health staff and their medical staff increased. The initiative was deemed effective for the respective clinical setting. This is relevant for usage in RWCs because it could allow specialized teams to handle crisis response instead of adding to the workload of social workers and care providers.

Lastly, Dr. Carole Warshaw (the director of the National Center on Domestic Violence, Trauma & Mental Health) explained the importance of establishing a collaborative working group as a key aspect of developing an appropriate response to women who have experienced domestic violence is the initial collaboration between healthcare providers and domestic violence advocacy communities. She acknowledged the impact of incorporating multidisciplinary involvement within clinical settings to standardize identification and intervention so that all staff is trained to recognize domestic violence and offer appropriate responses. Dr. Warshaw also described how to adopt and implement policies by tailoring them to the needs of the setting. She mentioned how the process of protocol development can utilize a team that involves administrators and staff in designating roles, allocating time, preparing materials, developing, and revising intervention and training strategies, and assuring that patients will be seen in a safe and timely manner can begin to reinforce the establishment of official policy. The resources provided in Dr. Warshaw's manual could be useful for RWCs when approaching safety response or crisis prevention for people experiencing domestic violence while in care (Futures Without Violence, 2013).

Although these supplemental studies can be useful and tailored to meet the needs of this study, it is wise to consider the niche focus needs and how they might impact the implementation of proposed practices. This study is unique in its focus on RWCs, which often serve vulnerable populations and require additional safety measures. The methods discussed in this study, such as the utilization of peer navigators, safety contracts, and panic buttons, are not typically seen in other studies and are specific to the needs of RWCs. The culmination of each of these sources can aid the study's purpose to provide valuable insight into the best practices for creating safe environments in these clinics and how to effectively respond to crisis and safety situations.

One of the gaps to consider is the lack of a standardized system for tracking patient safety data across all RWCs. Without a standardized system, it is difficult to monitor the effectiveness of safety protocols and identify any potential gaps in safety implementation. Additionally, there is a need to better understand the needs of the patients and staff to create tailored safety protocols that are specific to their needs. Additionally, there is a need to provide better resources and training for staff to ensure that they are aware of and can effectively implement safety protocols. Finally, there is a need to foster partnerships with local domestic violence shelters to better address the needs of patients and families affected by such violence.

Some strengths of this study included the provision of a thorough exploration of methods used by various RWCs for safety and crisis planning. It included a wide range of participants with different expertise, which provided a more holistic understanding of the challenges and solutions in this area. Additionally, the study provided the inclusion of some protocols and policies for crisis response and safety response. On the other hand, the study did not explore the effectiveness of the protocols, policies, and practices in their clinics. Although all studies do not require this, the study did not provide quantitative data to support the findings that could be used to measure responses or factors discussed. Additionally, the study did not explore the potential costs associated with implementing the protocols and policies discussed.

Conclusion

In addition to exploring crisis prevention methods such as utilizing information collected through the intake, utilizing peer navigators, using social workers as mediators, addressing environmental factors, and leveraging community advocacy boards, RWCs can consider other crisis prevention methods, such as providing education and resources on coping skills, having regular mental health screenings, and offering support groups. For crisis response, they can explore methods such as utilizing onsite counselors, providing psychological first aid, and establishing a crisis hotline. For safety planning, they can consider tactics such as implementing additional security measures, developing tools to assess the risk of harm, and training staff on safety protocols. Additionally, they can partner with local domestic violence shelters to provide resources such as access to safe housing, legal assistance, and counseling.

Public Health Implications

The standardization of safety and crisis prevention and response at RWCs has the potential to significantly improve public health outcomes. Standardization of safety protocols and procedures can reduce the risk of violence, abuse, and neglect at these clinics, which can increase patient access to healthcare services and improve overall health outcomes. Additionally, standardizing safety and crisis prevention and response at Ryan White-funded clinics can also help to identify and address underlying health issues and social determinants of health that may be contributing to the risk of violence, abuse, and neglect. Finally, standardizing safety and crisis prevention and response at Ryan White-funded clinics can help to ensure that patients receive appropriate, timely, and comprehensive care that is tailored to their individual needs.

Using domestic violence shelter protocols as an example for standardizing safety and crisis prevention and response at Ryan White-funded clinics can provide several benefits to the public health outcomes of these clinics. Women domestic violence shelters typically have protocols and procedures in place to ensure the safety of the individuals staying there. Standardizing these protocols and procedures at Ryan White-funded clinics could help to reduce the risk of violence, abuse, and neglect and ensure that patients receive appropriate, timely, and comprehensive care. Additionally, using domestic violence shelter protocols as an example could help to identify and address underlying health issues and social determinants of health that may be contributing to the risk of violence, abuse, and neglect. This could help to improve overall patient health outcomes and increase access to healthcare services.

Examples of standardized safety and crisis prevention protocols in domestic violence shelters include but are not limited to establishing a 24-hour crisis line and crisis response team, providing safety planning and safety education for those affected by domestic violence, developing protocols for responding to incidents of violence, establishing secure access points and restricted areas in the shelter, and providing training to staff on how to respond to incidents of violence.

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