



TRAUMA-INFORMED INTEGRATED CARE

**NH Behavioral Health Integration
Learning Collaborative**

May 1, 2019



WELCOME

JEANNE RYER, MSc, EdD

Director, NH Citizens Health Initiative

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Jeanne Ryer, MSc, EdD**, Director, NH Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire

New Staff



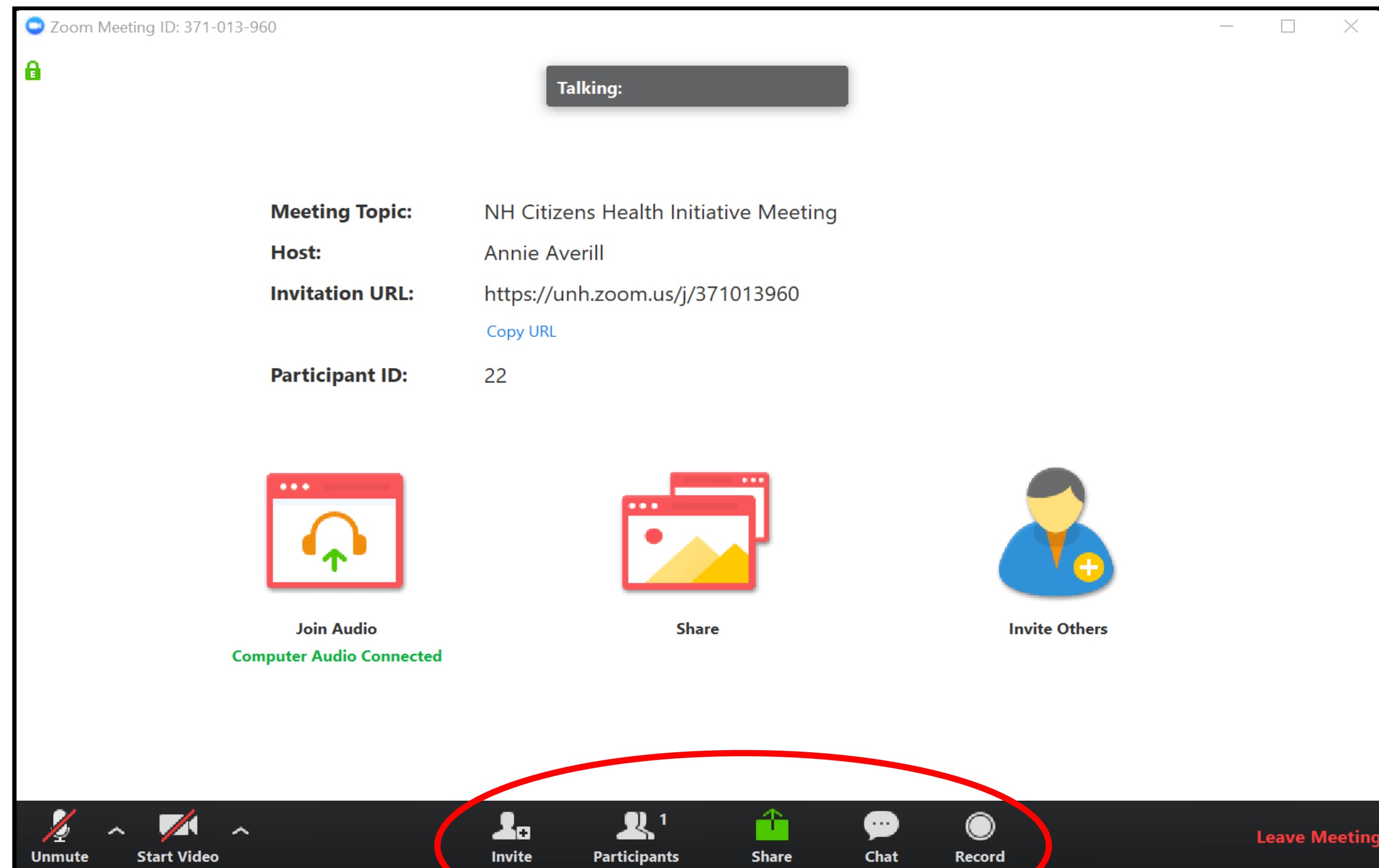
Corina Chao, BA
Research Associate
Corina.Chao@unh.edu



Devan Quinn, MPP
Project Director
Devan.Quinn@unh.edu

ZOOM REMINDER

Use the chat box if you have any questions





AGENDA

Welcome

Jeanne Ryer, MSc, EdD, NH Citizens Health Initiative

Introduction to Trauma-Informed Integrated Care

Felicity Bernard, LCMHC, MA, NH Citizens Health Initiative

Brain Break

Felicity Bernard & Michael Skinner

Evidence-Based Practices for Children Who Have Experienced Trauma

Becky Parton, MSW, LICSW, Dartmouth Trauma Interventions Research Center

Networking Break

Personal Perspective on Trauma and the Impact on Receiving Health Care

Michael Skinner, The Surviving Spirit and the National Center for Trauma Informed Care

Brain Break

Felicity Bernard & Michael Skinner

Panel: Trauma-Informed Care in Practice

Moderator: Jan Thomas, ADRN, NH Citizens Health Initiative

Lisa DiBrigida, MS, MD, Manchester Community Health Center

Peter Fifield, Ed.D, MLADC, LCMHC, Behavioral Health Department

Veronica Triaca, MD, Concord Hospital Center for Urologic Care

Closing Remarks & Next Steps

Jeanne Ryer, MSc, EdD, NH Citizens Health Initiative

PLANNING DISCLOSURES

The following individuals have responded that they have nothing to disclose:

- **Planner: Kelsi West, BS, Research Associate**, NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Frederick Kelsey, MD, FACP, Interim Medical Director**, Mid State Health Center
- **Planner: Marcy Doyle, DNP, MS, MHS, CNL, RN**, *Quality and Clinical Improvement Director*, NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Annie Averill, BA, Research Associate**, NH Citizens Health Initiative at the Institute for Health Policy and Practice, UNH
- **Planner: Laura Remick, MEd, CHES, Education and Workforce Coordinator**, North Country Health Consortium
- **Planner: Jill Gregoire, RN, MSN, Lead Nurse Reviewer**, North Country Health Consortium

LEARNING OBJECTIVES

After participating in this activity,
learners will be able to:



Describe the epidemiology of trauma.



Review the biologic pathways by which trauma compromises physical & mental health.



Discuss available trauma screens and evidence-based interventions.



Identify key considerations to prepare clinic staff for responding to trauma.



Introduction to Trauma-Informed Integrated Care

FELICITY BERNARD, LCMHC, MA

Project Director, NH Citizens Health Initiative

PRESENTER DISCLOSURE

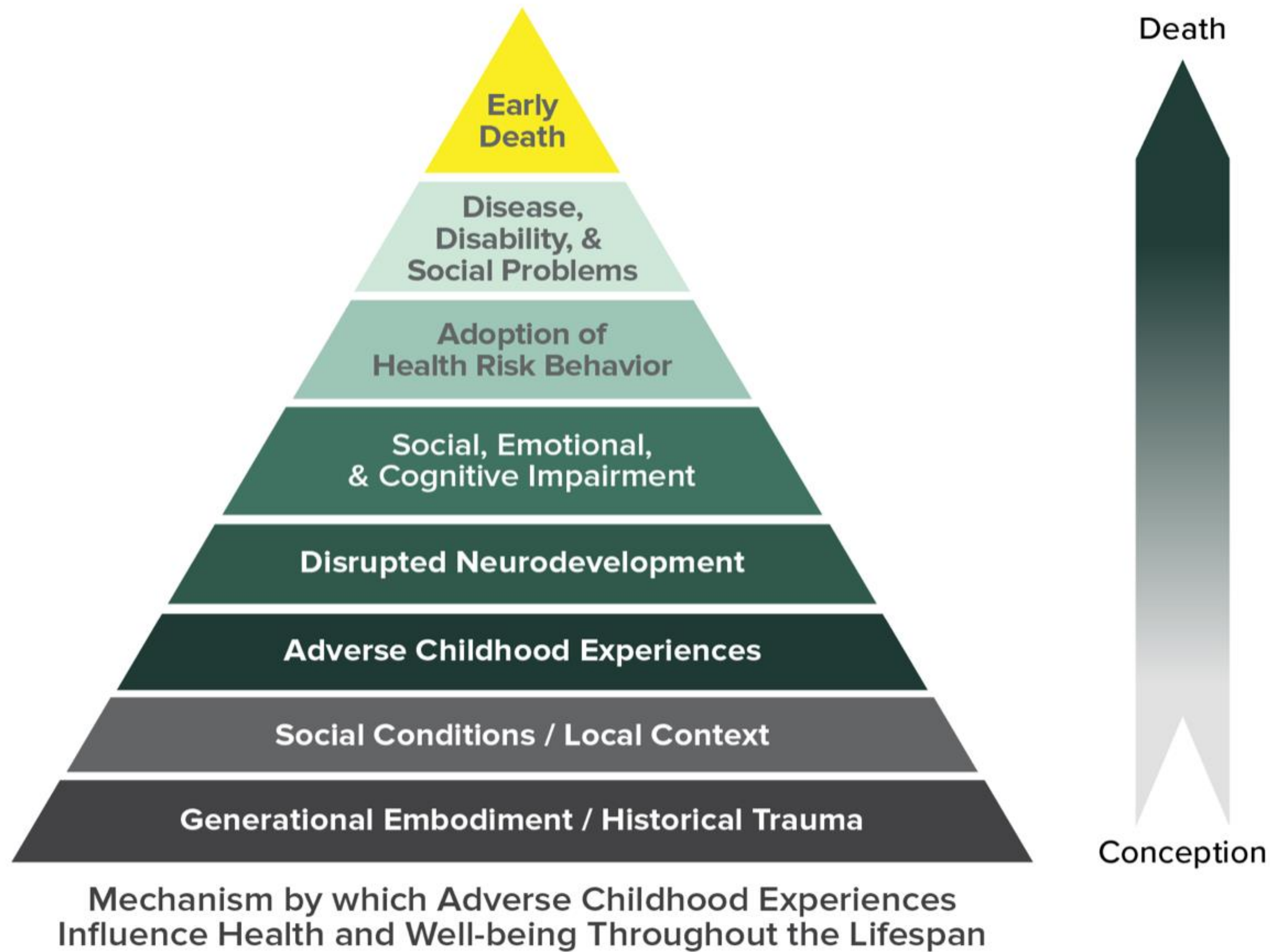
The following individuals have responded that they have nothing to disclose:

- **Planner & Presenter: Felicity Bernard, LCMHC, MA** Project Director, NH Citizens Health Initiative at the Institute for Health Policy and Practice at the University of New Hampshire



Creating a Safe Space

Trauma-Informed Integrated care



Adverse Childhood Experiences

(Source: Centers for Disease Control (CDC) ACEs Pyramid)

ACES can have lasting effects on....



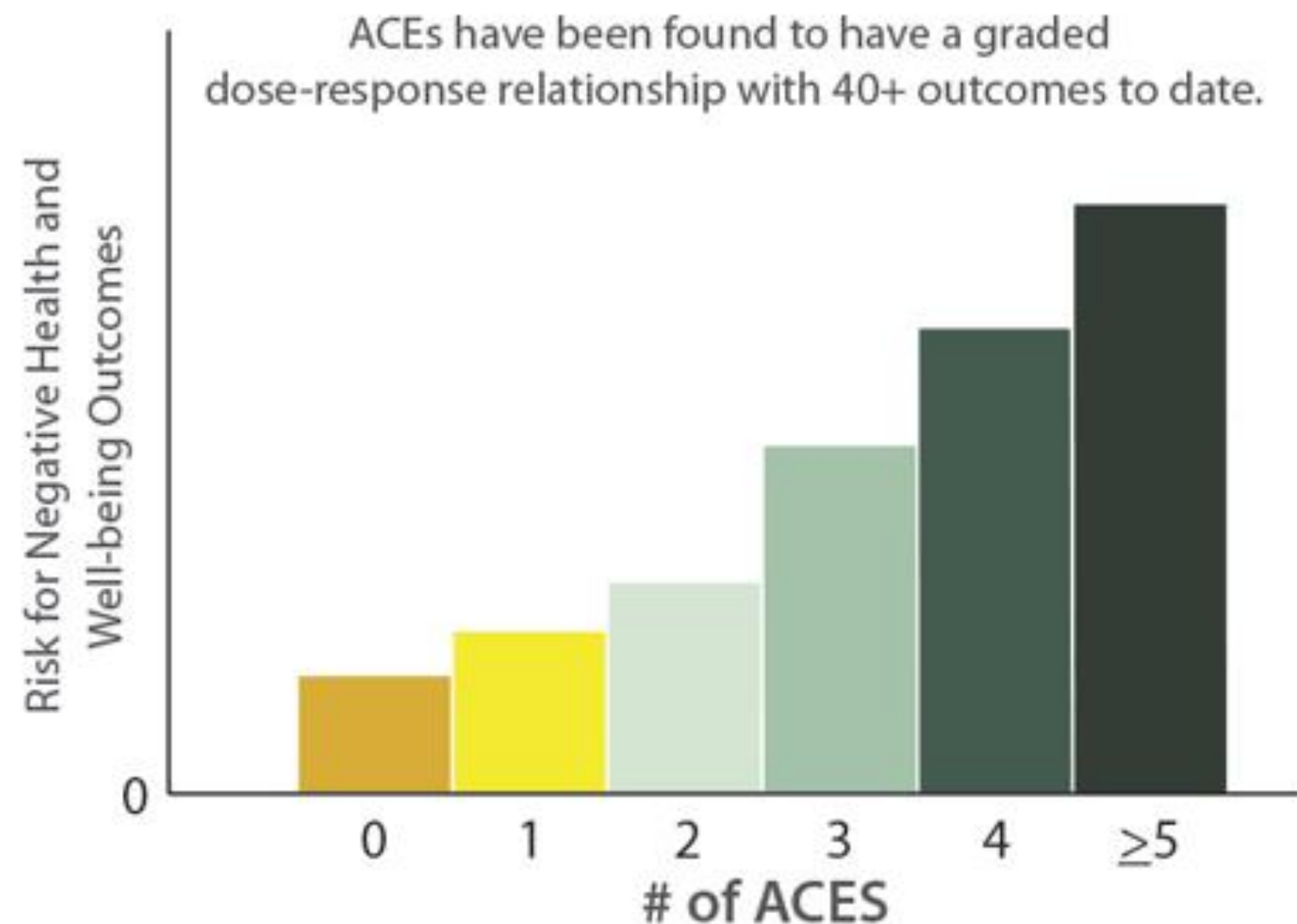
Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)



Behaviors (smoking, alcoholism, drug use)



Life Potential (graduation rates, academic achievement, lost time from work)



*This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.

Source: Centers for Disease Control (CDC)

Examples of Increased Risk

ACE Score Of **4** or
More

Suicide **1,220%**

Depression **460%**

Chronic pulmonary lung
disease **390%**

Hepatitis **240%**

Significantly higher rates
of heart disease and
diabetes

ACE Score Of **6** or
More

Likelihood of becoming an
IV drug user **4,600%**

Die, on average,
20 years earlier
than those with
low scores

Source: Felitti, V. J., et al, 1998

Trauma on the Brain

Amygdala

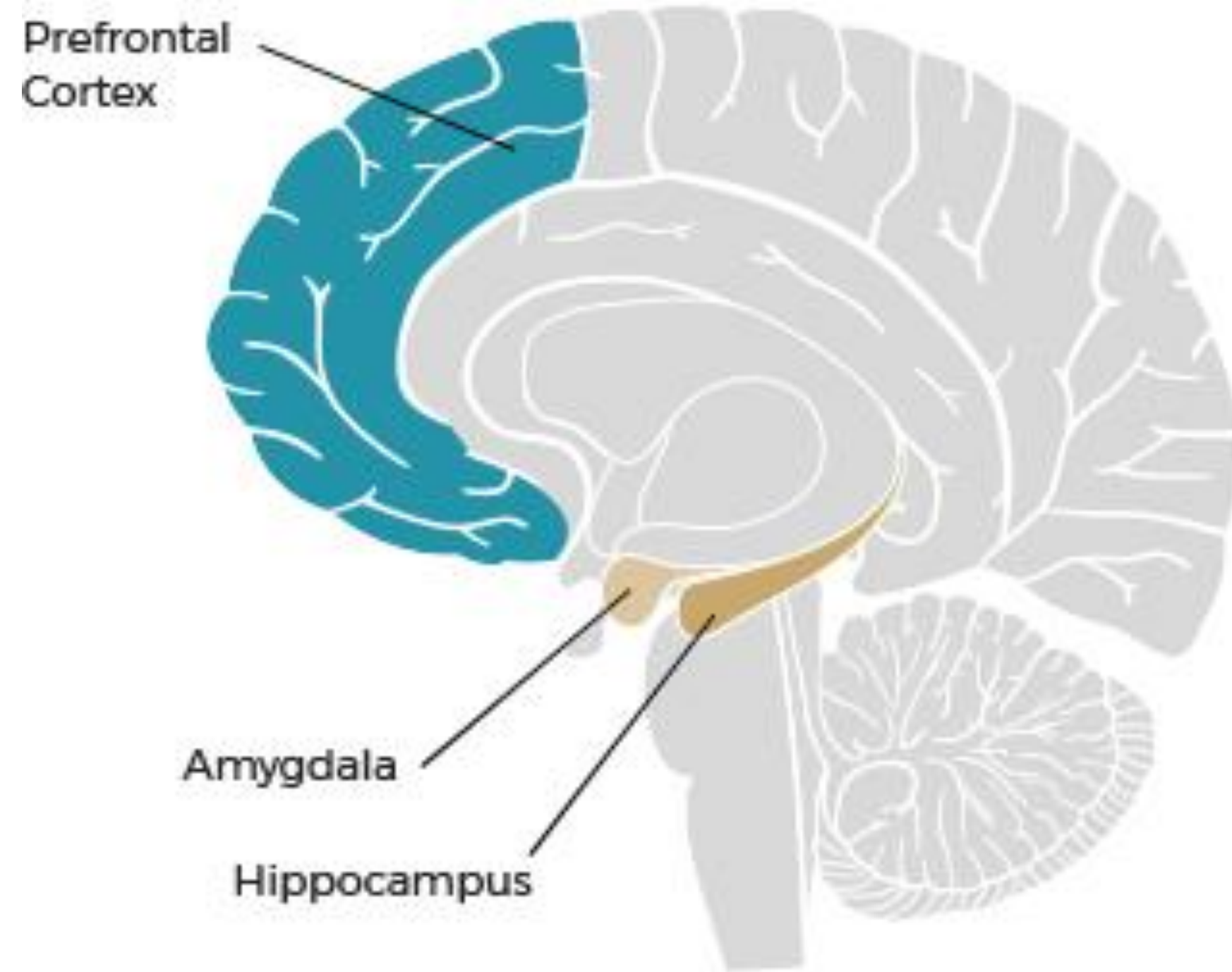
- Acute stress response: Flight/Fight/Freeze
- Promotes survival by quickly acting when danger is perceived

Hippocampus

- “Time stamp” function
- Necessary to put danger in a spatial context
- Involved in emotions, learning and memory formation
- Cortisol receptors – size decreased associated with anxiety, depression and impaired learning and memory

Prefrontal Cortex

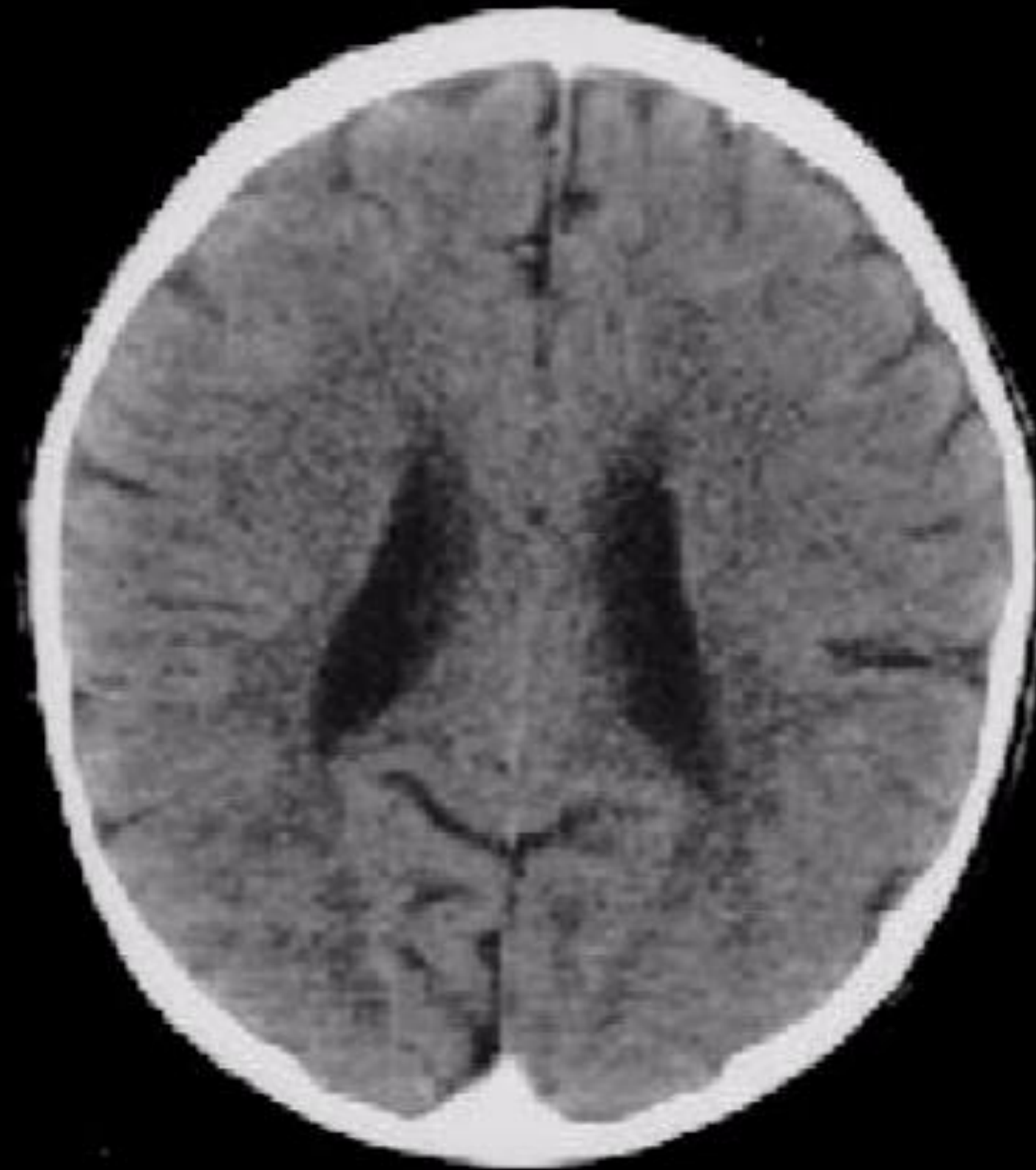
- Asks “Have I ever experienced this before? What is the best thing to do? What might the consequences be?”
- Connected with the amygdala and exerts inhibitory control over stress responses and emotional reactivity



3 Year Old Children



Normal



Extreme Neglect

Source: Perry, B. D. (2002).

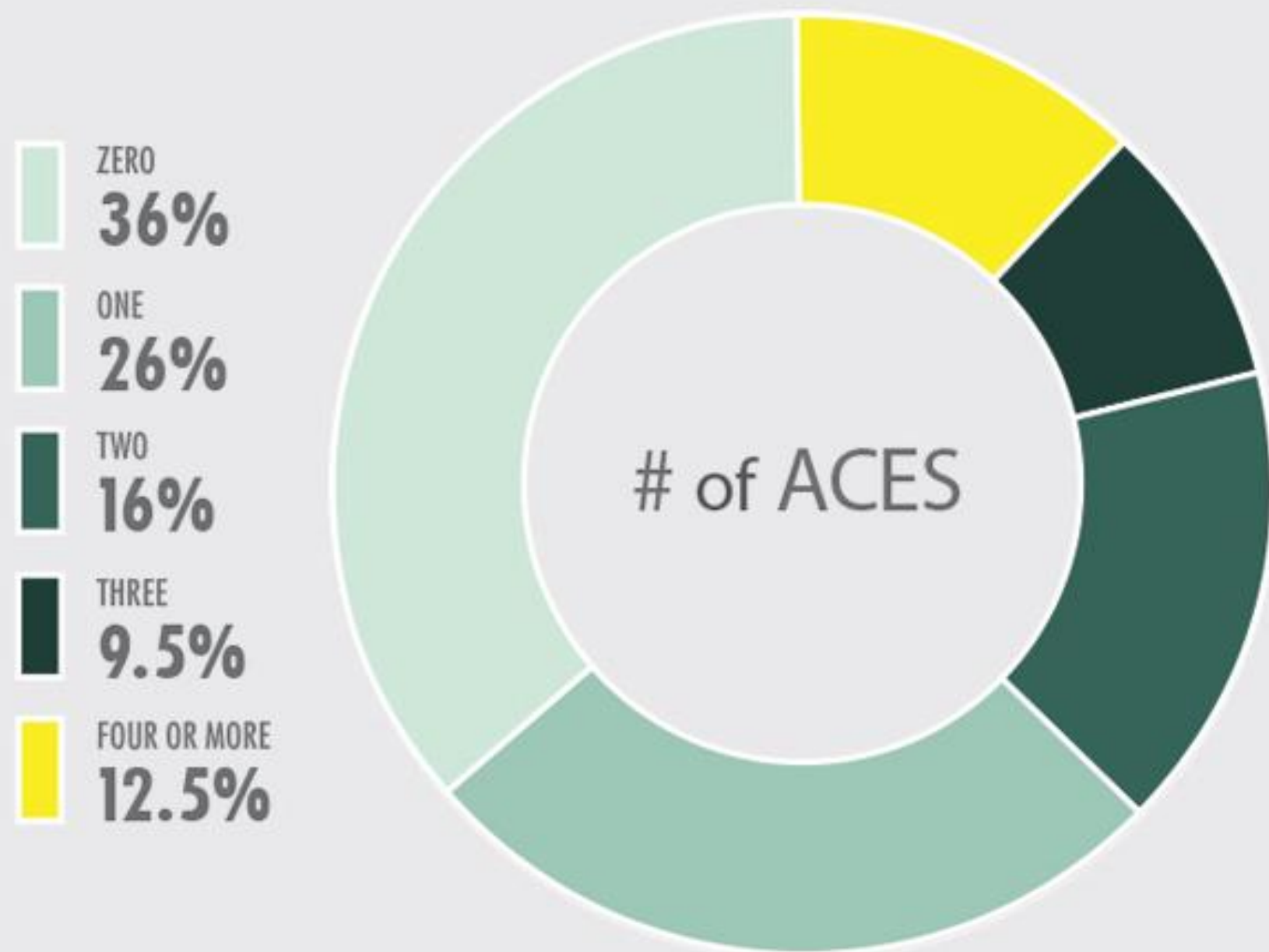


SCOPE

Prevalence

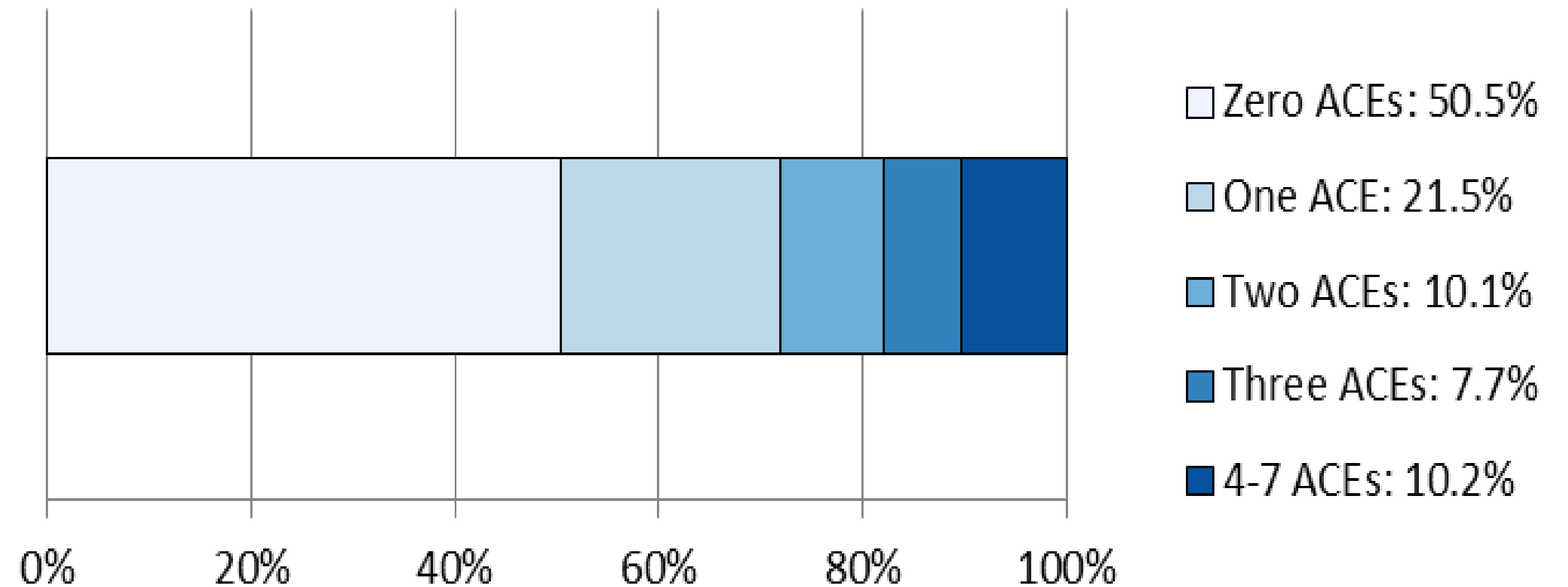
How Common are ACEs?

ACE Study



Percentage of NH population reporting ACEs

NH BRFSS 2016

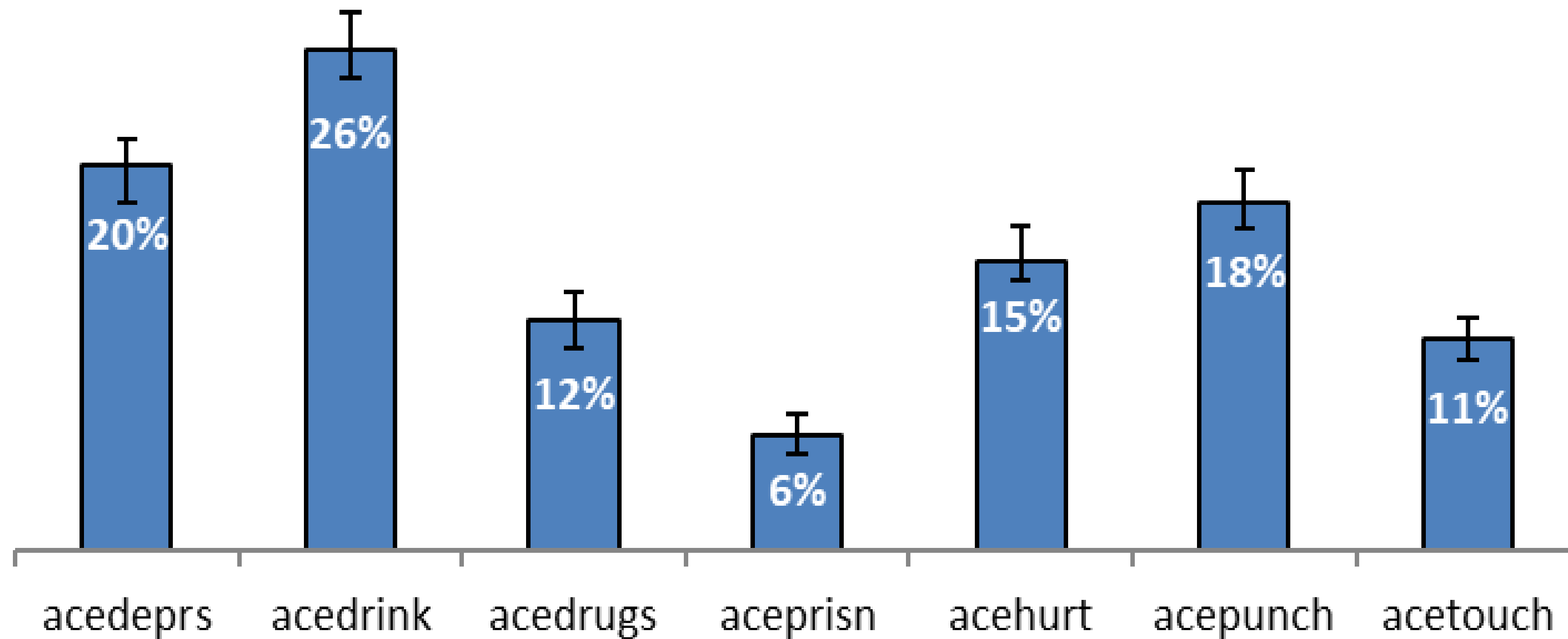


Source: NH Behavioral Risk Factor Surveillance System (BRFSS)

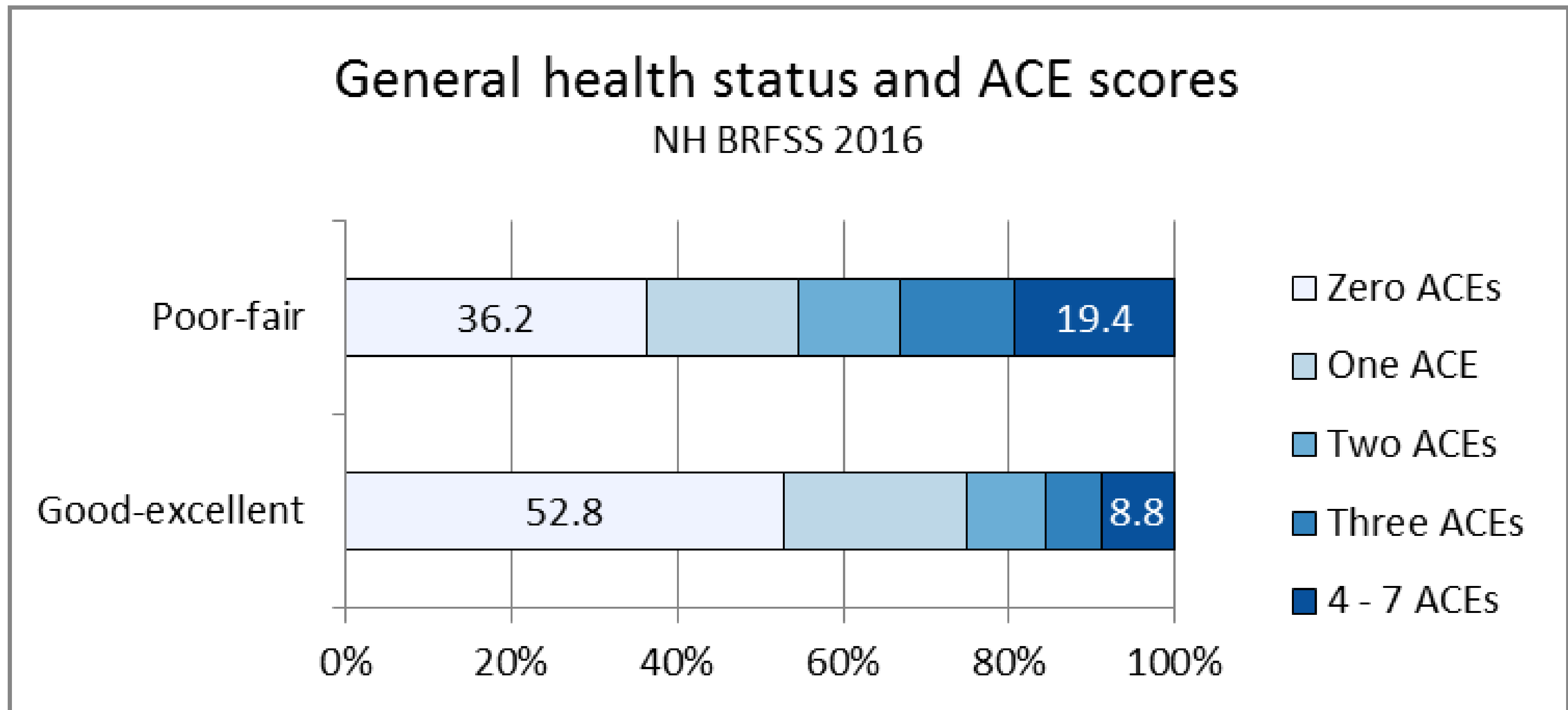
Source: Centers for Disease Control and Prevention, Kaiser Permanente, 2016.

Prevalence of ACEs: total percentage reporting each ACE

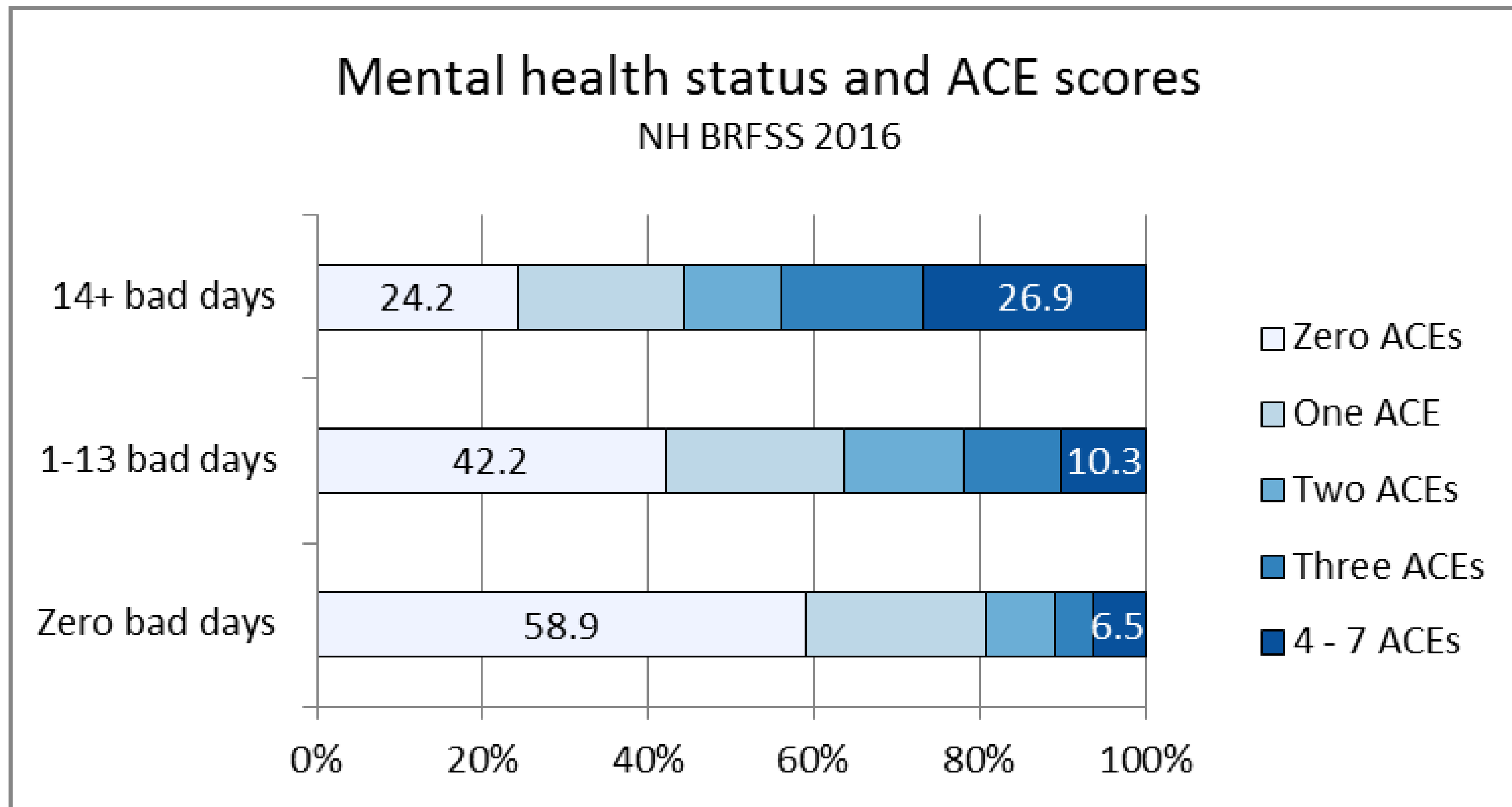
NH BRFS 2016



General Health

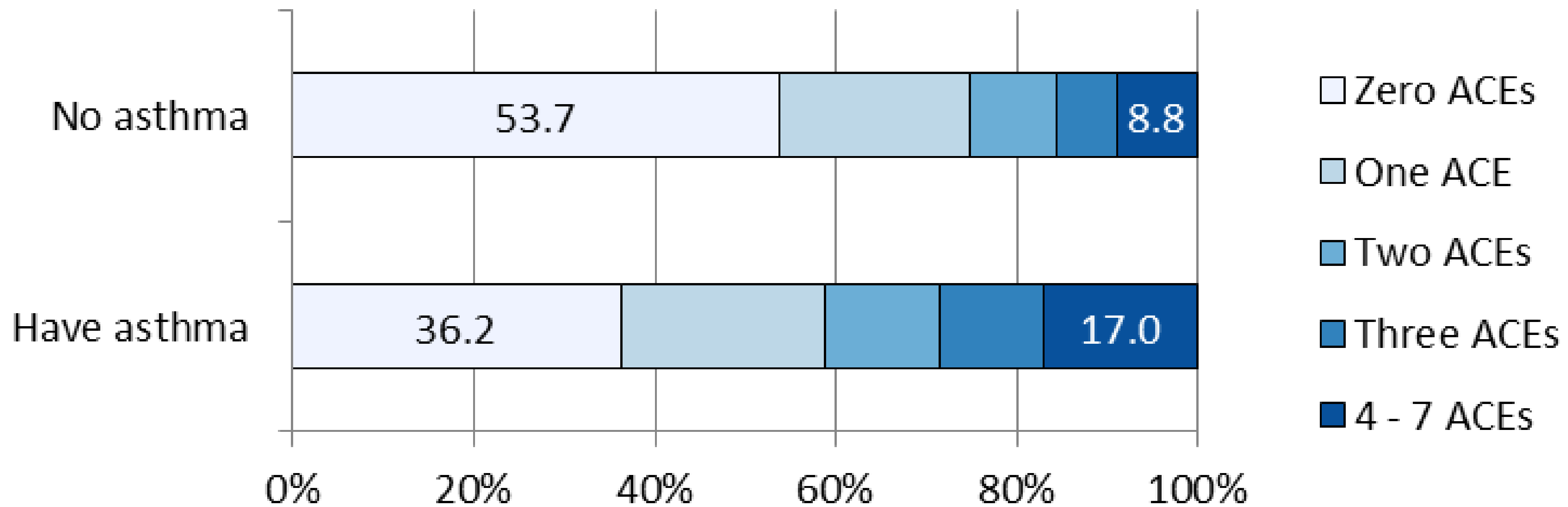


Mental Health

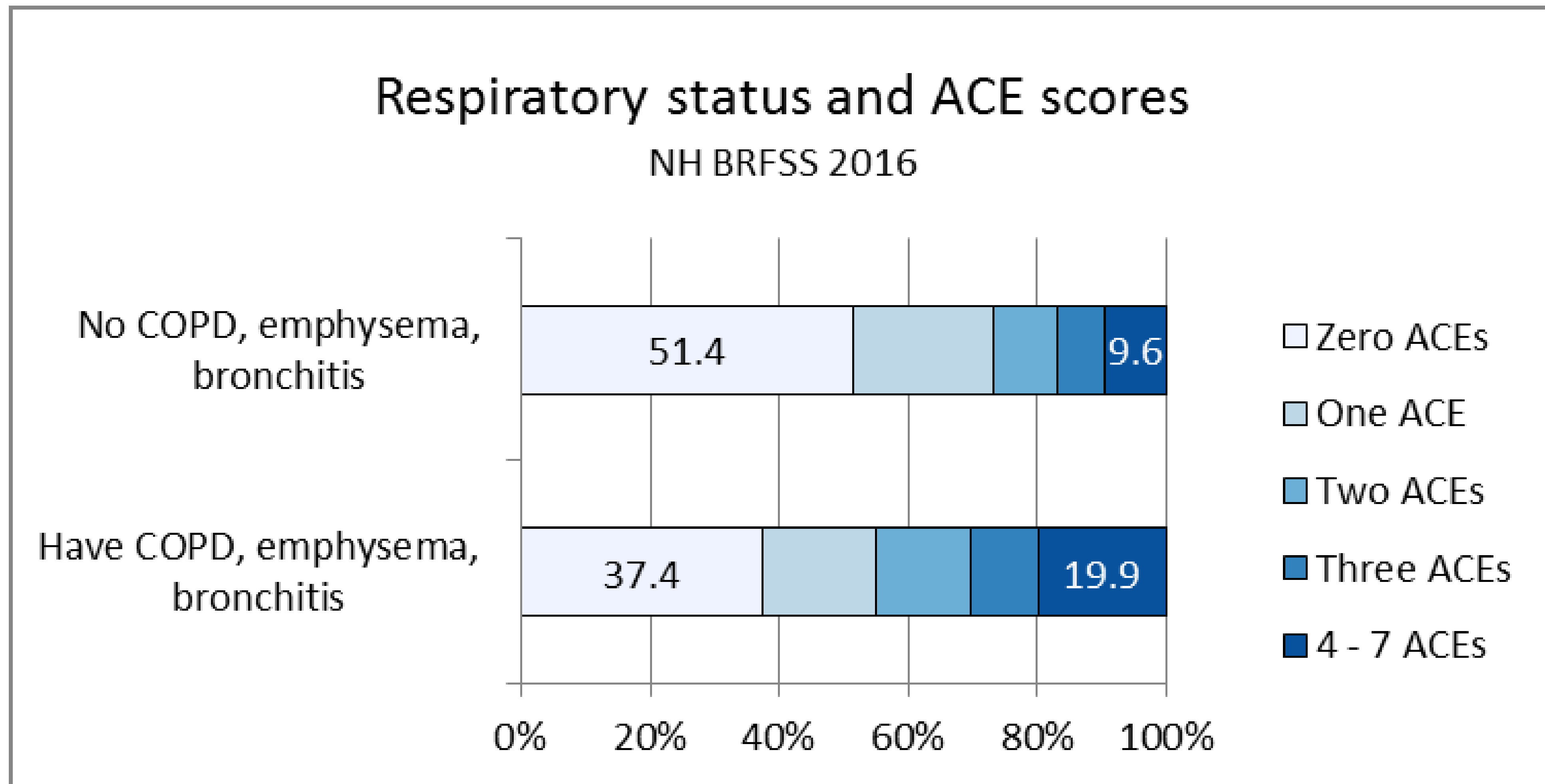


Asthma

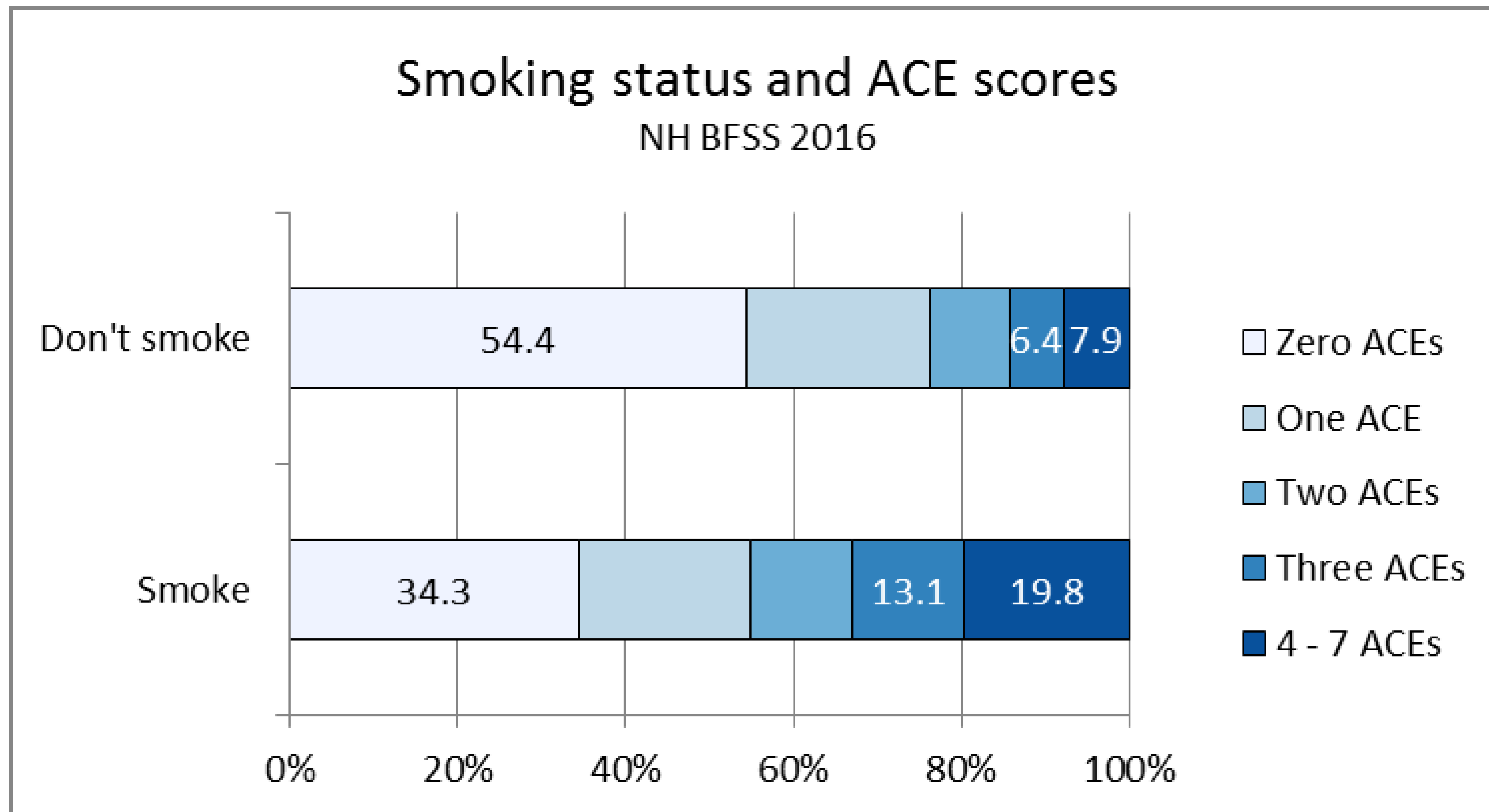
Asthma status and ACE scores
NH BRFSS 2016



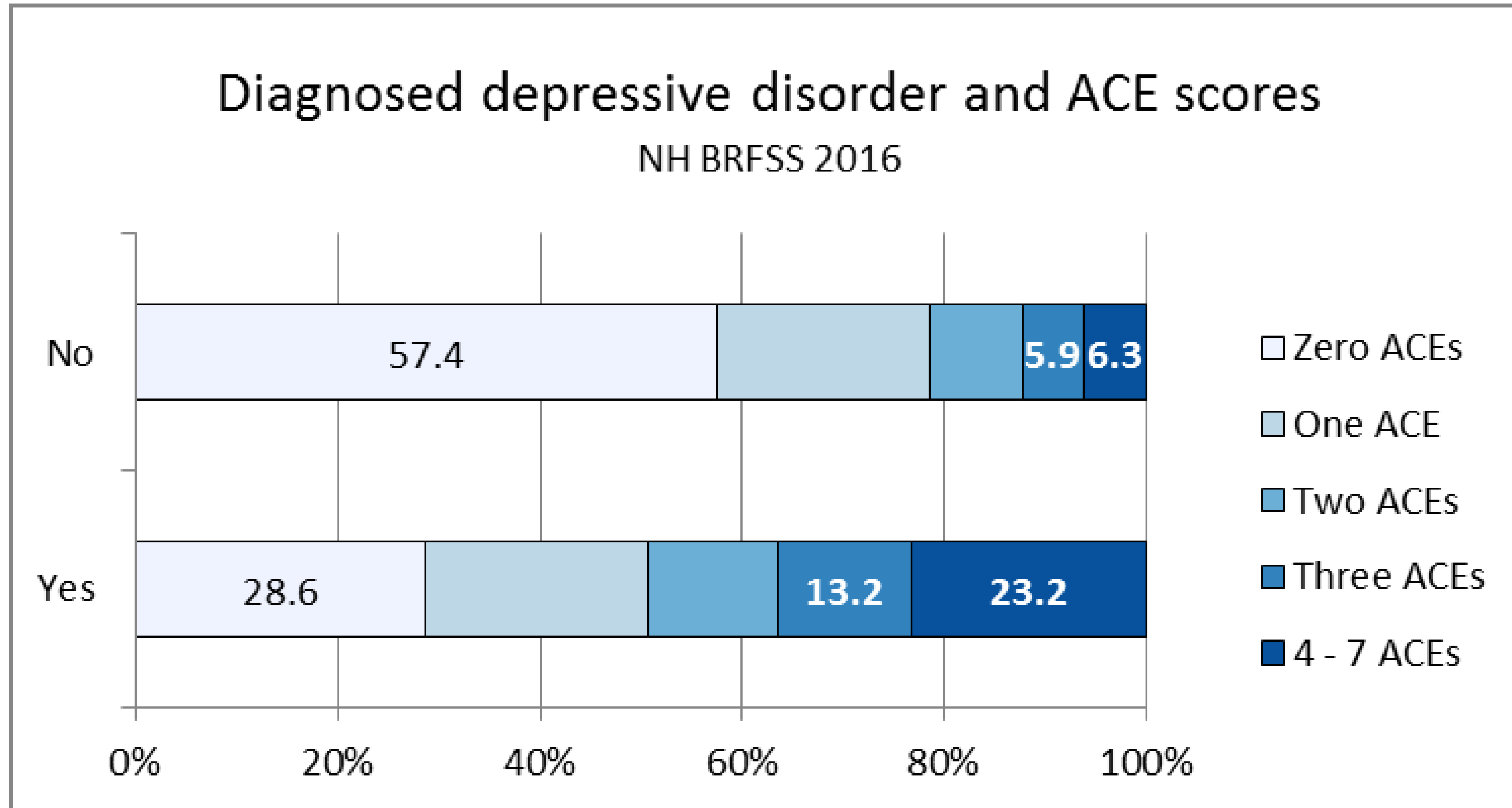
COPD, Emphysema, Bronchitis



Smoking



Depressive Disorder





Resilience

adapt

coping

**Protective
factors**

**Post
traumatic
growth**

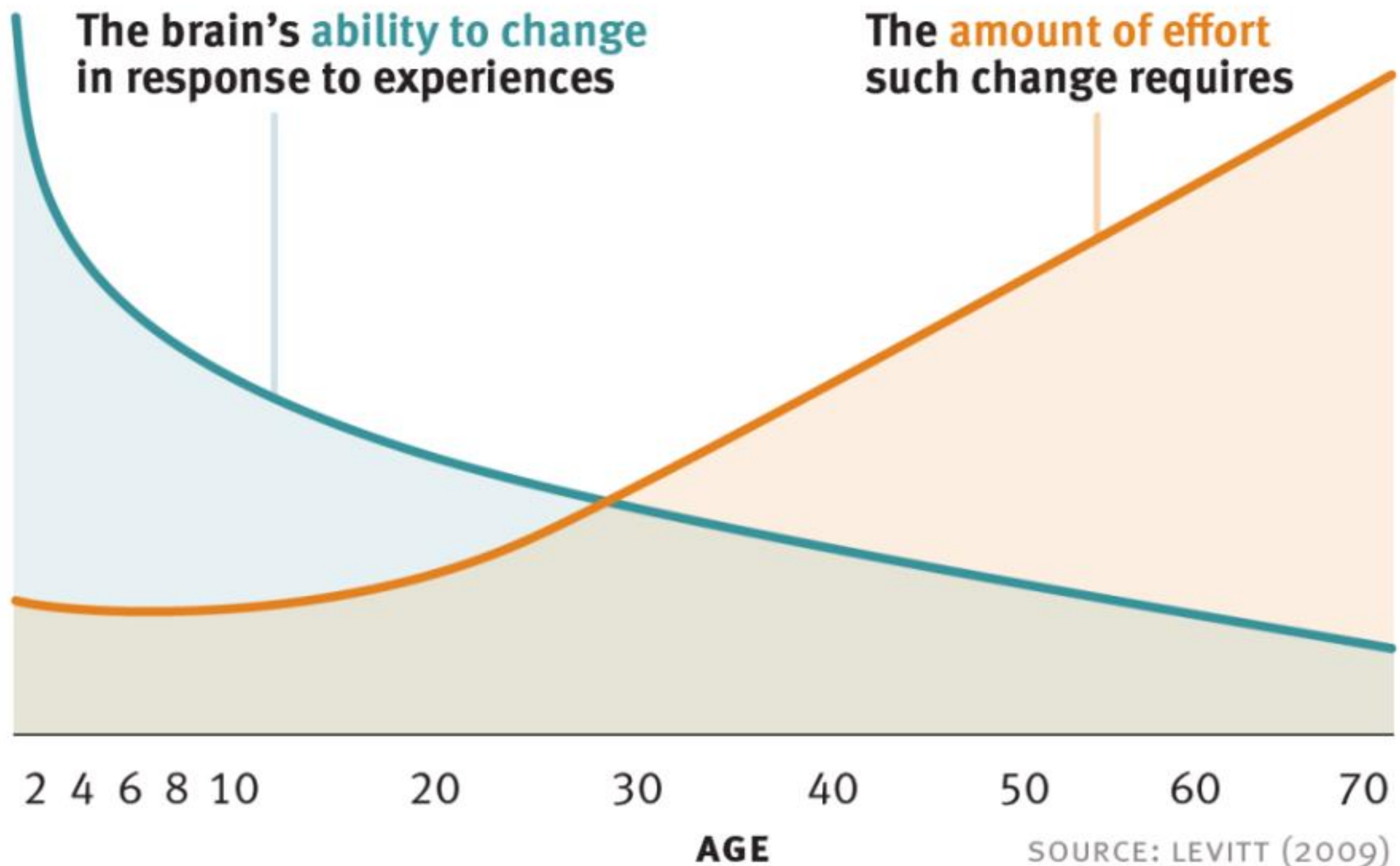
recover


Neuroplasticity

repair

**retrain
circuitry**

recovery



Center on the Developing Child  HARVARD UNIVERSITY

www.developingchild.harvard.edu

Source: <https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>

Good News:

Trauma Informed Integrated Care

- Enhance Positive Attachment and connections
 - self regulation
 - positive beliefs about oneself
 - motivation to act effectively
- Decrease secondary stressors and traumas
- Appropriate assessment and treatment
- ID and Cope with traumatic reminders
- General Sense of Safety

- Relationship – neutral, lack of stigma, longitudinal, continuity, point of first contact – only?

- Opportunity – look at long term health effects
(Amaya – Jackson, 2014)

- “A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.” – Gillece, 2012

Screening – What is right for your practice?

- How? When? What to do with Positive Screens?
- How the questions are asked – relationship – neutral, lack of stigma
- Provider comfort
- Parent/patient comfort – get their input on which screener to use
- Universal Inquiry about stressors:
 - “Since the last time I saw your child, has anything really scary or upsetting happened to your child or anyone in your family”
- (Cohen, Kelleher & Mannarino, 2008)
- Tools:
- Ages and Stages
- Survey of Well-Being of Young Children (SWYC)
- <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Screening/Pages/Screening-Tools.aspx>
- <https://www.seekwellbeing.org>
- <https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/Developmental-Behavioral-Psychosocial-Screening-and-Assessment-Forms.aspx>

Part of the Solution

- Medical providers are often the only contact families have with trauma responsive systems

(Source: CDC.gov)



Strengthen economic supports to families

- Strengthening household financial security
- Family-friendly work policies



Change social norms to support parents and positive parenting

- Public engagement and enhancement campaigns
- Legislative approaches to reduce corporal punishment



Provide quality care and education early in life

- Preschool enrichment with family engagement
- Improved quality of child care through licensing and accreditation



Enhance parenting skills to promote healthy child development

- Early childhood home visitation
- Parenting skill and family relationship approaches



Intervene to lessen harms and prevent future risk

- Enhanced primary care
- Behavioral parent training programs
- Treatment to lessen harms of abuse and neglect exposure
- Treatment to prevent problem behavior and later involvement in violence

Universal Precautions

- Understanding the relationship between previous trauma and present coping and illness
- Creating an atmosphere of respect and trust, emphasizing patient strengths, striving for cultural competence, and seeking to minimize re-traumatization
- Providers can screen for trauma and, once identified, provide emotional support and validation, as well as refer to appropriate in-clinic and community resources to address the trauma.
- Self-care – insight into your own trauma and coping strategies

Importance of Treatment Teams



Increased continuity of care



Defined roles can lead to effective collaboration and improved patient outcomes



Increased job satisfaction and reduced burn out



Address health complexity, patient defined goals and support the patient to be an active participant in health



Behavior a strong predictor of health outcomes

Building Healthy Teams

- Five key factors: trust, communication commitment, accountability and results
- Create role clarity, pathways for communication and point person for health goals
- Culture of professionalism can develop a culture of interprofessionalism
- Deal with challenges to team care openly and quickly

Patient Centered Biopsychosocial Care Planning



Patient driven health goals – developed in collaboration with PCP and health team



Creating Continuity of Care – identifying goals in treatment, adherence barriers, follow through, stressors



Building Care Teams – Who is on the team? Defined by best way to support patient to reach health goals. Defining roles.



Incremental Implementation –Support patient to develop new treatment goals as previous goals are accomplished

References

- ASTHO Brief on primary prevention strategies for ACEs: <http://www.astho.org/generickey/GenericKeyDetails.aspx?contentid=20543&folderid=5150&catid=7184>
- ASTHO's Essentials for Childhood Policy Guide: <http://www.astho.org/prevention/essentials-for-childhood-policy-guide/>
- ASTHO's Early Brain Development Technical Assistance Framework and Database: <http://www.astho.org/earlybrain/Library/>
- Cohen JA, Kelleher KJ, Mannarino AP. Identifying, Treating, and Referring Traumatized Children: The Role of Pediatric Providers. *Arch Pediatr Adolesc Med.* 2008;162(5):447-452. doi:10.1001/archpedi.162.5.447
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Marks, J. S. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Gone, J. P., Hartmann, W. E., Pomerville, A., Wendt, D. C., Klem, S. H., & Burrage, R. L. (2019). The impact of historical trauma on health outcomes for indigenous populations in the USA and Canada: A systematic review. *American Psychologist*, 74(1), 20-35. <http://dx.doi.org/10.1037/amp0000338>
- Perry, B. D. (2002). *Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture.* *Brain and Mind.*
- <https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>
- <https://www.slideshare.net/MCChangaris/changaris-beneath-the-skin-interrupting-the-pathways-to-pathology>
- <https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html>
- <https://www.cdc.gov/brfss/>



Brain Break Activity



Evidence Based Practices for Children Who Have Experienced Trauma

BECKY PARTON, MSW, LICSW

Project Coordinator, Dartmouth Trauma Interventions
Research Center

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Becky Parton, MSW, LICSW**, Project Coordinator, Dartmouth Trauma Interventions Research Center

Evidence Based Practices For Children That Have Experienced Trauma

BECKY PARTON, MSW, LICSW

DARTMOUTH TRAUMA INTERVENTIONS RESEARCH CENTER



Love and belonging are the irreducible needs of all men, women and children. We are hardwired for connection-its what gives purpose and meaning to our lives. The absence of love, belonging and connection always leads to suffering.

~Brené Brown

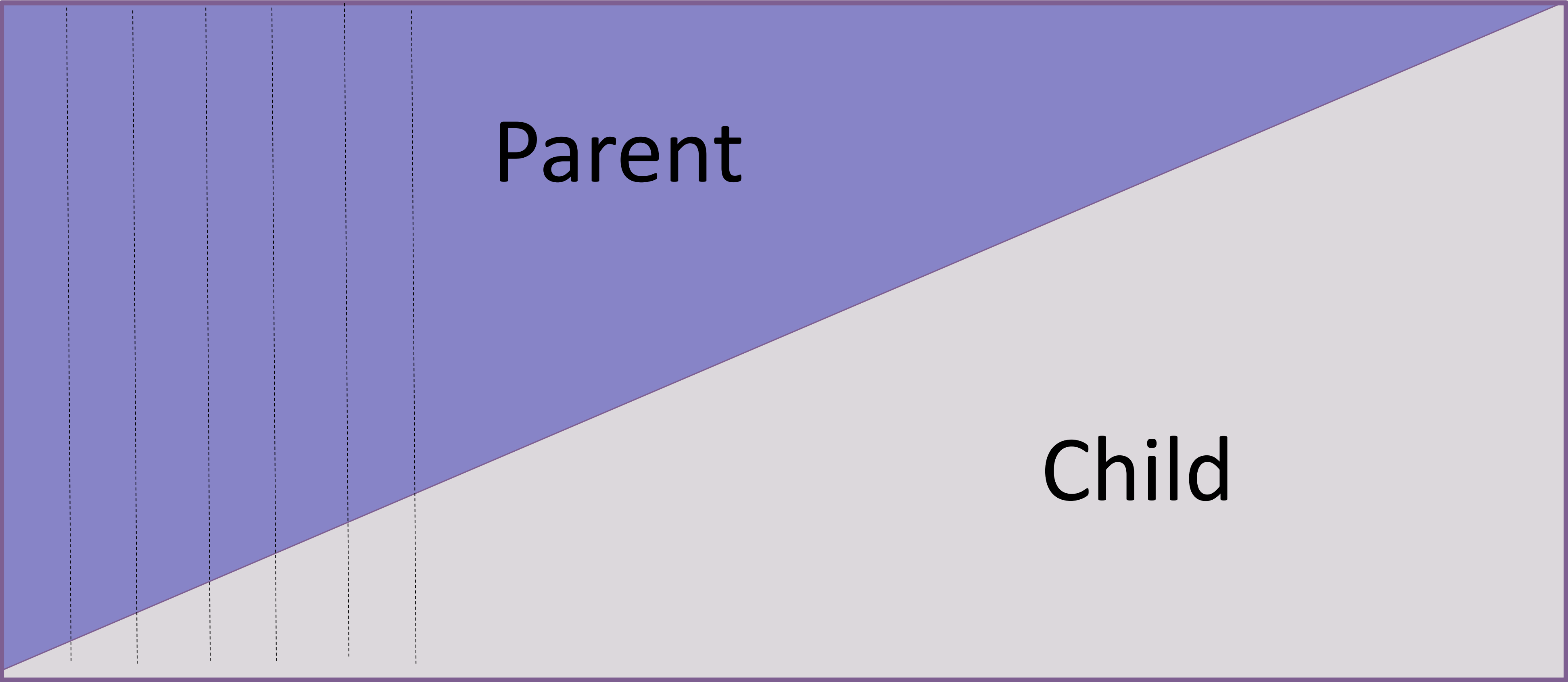
It's about relationships

We learn from our caregivers

- Language for, behaviors for, context for emotions
- How to be in relationships with others
- What are our cultural norms? What is expected of us as we explore the world?

Co-Regulation and Self-Regulation

Based on Bruce Perry lecture, 2016



Who is providing the regulation?

0 1 2 3 4 5 18

Age

Co-Regulation & Working Models

As infants, we lean on parents for regulation

- Observation
- Attunement

Develop beliefs about self, others, world based on experiences with caregivers- becomes our “Internal Working Model”

Dr. Dan Siegel- We see ourselves through our caregiver’s eyes

Four S's of parenting: Dan Siegel

Our children need to be:

Seen — this is not just seeing with the eyes. It means perceiving them deeply and empathically — sensing the mind behind their behavior, with what Dr. Siegel calls "mindsight"

Safe — we avoid actions and responses that frighten or hurt them

Soothed — we help them deal with difficult emotions and situations

Secure — we help them develop an internalized sense of well-being

From: <https://www.parentmap.com/article/the-four-ss-of-parenting-dan-siegels-whole-brain-child>

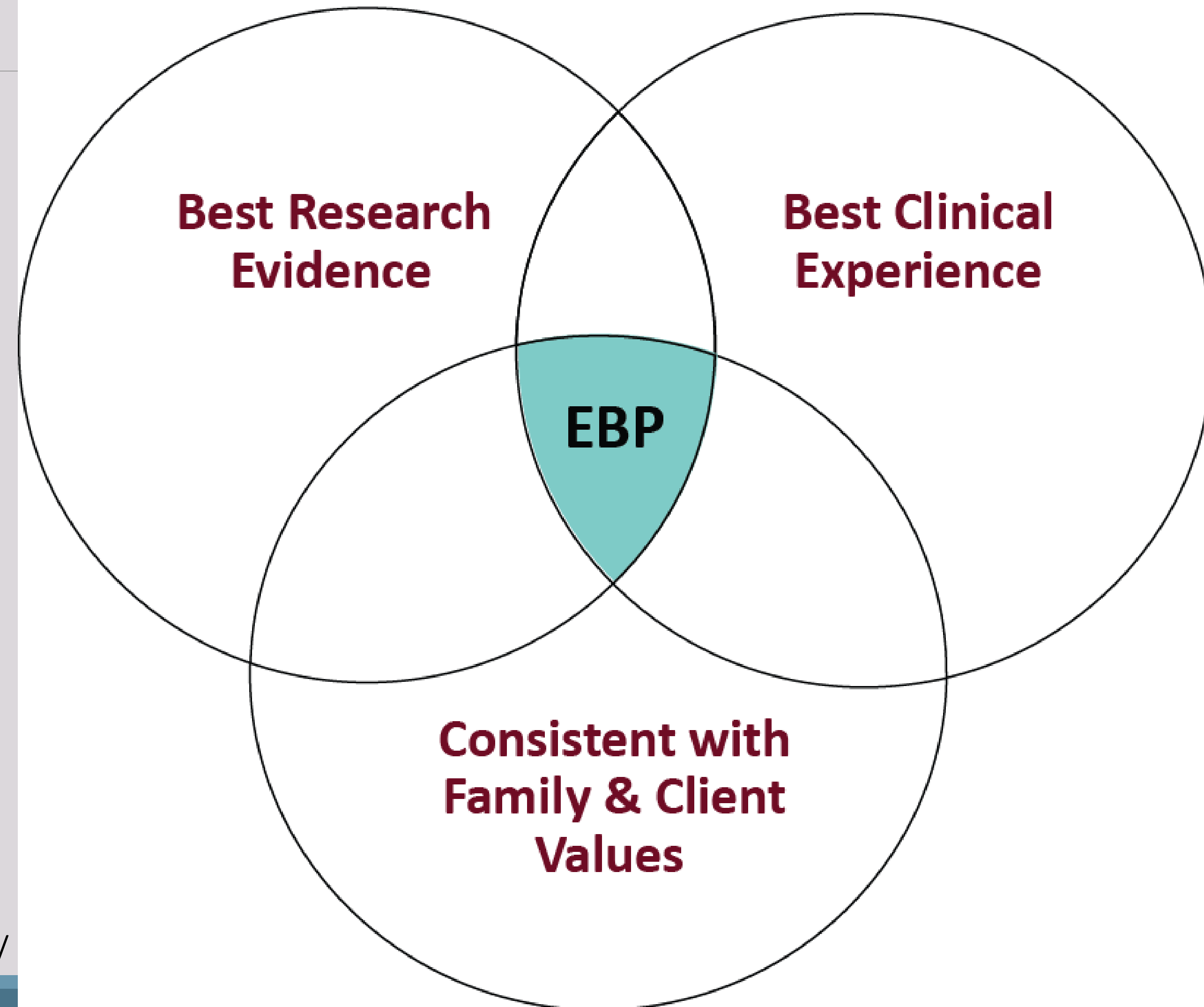
(Siegel & Payne Bryson, 2011)

Evidence Based Practices

There is intuition,
educated practice
and EVIDENCE
BASED PRACTICE

Image from: <http://www.cebc4cw.org/home/understanding-evidence-based-practice/>

CEBC's Definition of EBP for Child Welfare



[Based on Institute of Medicine, 2001]

Why pick an Evidence Based Practice?

Studies have shown the treatment to be effective

- ❖ EBPs are associated with specific diagnosis', designed to treat a specific set of symptoms
- ❖ Often EBPs are standardized, have some form of a manual or set of instructions
- ❖ Therapists must meet minimum requirements (education level, training, consultation)
- ❖ Therapy will be delivered in a generally similar way across therapists

Which models are Evidence Based for Young Children?

According to NREPP (2018), Programs with EFFECTIVE OUTCOMES:

Attachment and Biobehavioral Catch-up (ABC) (6-24 months)

Child Parent Relationship Therapy (3-8)

Partners with Families and Children- Spokane (involved with CW)

Theraplay (0-18)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (ages 3-17)

Child-Parent Psychotherapy (CPP) (ages 0-6)- on the legacy list

Nurturing Parenting Programs (group therapy for parents)- on the legacy list

Parents as Teachers (working with parents of 0-Kindergarten)- on the legacy list

Young Child Trauma Treatments on CEBC

RATING OF 1 (WELL SUPPORTED BY RESEARCH EVIDENCE):

EMDR (2-17 y.o., adults)

Trauma-Focused Cognitive Behavioral Therapy (3-17)

RATING OF 2 (SUPPORTED BY RESEARCH EVIDENCE):

CPP (0-6)

RATING OF 3 (PROMISING RESEARCH EVIDENCE):

Combined Parent-Child Cognitive Behavioral Therapy (3-17)

Alternatives for Families: A Cognitive Behavioral Therapy (5-17)

Bounce Back (5-11)- directed at the child only, school based

Preschool PTSD Treatment (3-6 y.o.)- parent not in the room-use TV monitors to observe sessions

Which models are Evidence Based for Adolescents?

According to CEBC, Programs WELL SUPPORTED BY RESEARCH EVIDENCE:

Eye Movement Desensitization and Reprocessing (EMDR) (ages 2-adult, but most providers will only use with adolescent and up)

Prolonged Exposure Therapy for Adolescents (ages 12-18 but has been used as young as 6)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (ages 3-18, but most NH agencies use it with 7-18)

PROMISING RESEARCH EVIDENCE:

Seeking Safety (Adolescent Version)

Parent Training Programs

78 Programs listed on the NREPP site, 3 are highly rated:

Parent-Management Training- Oregon Model (Ages 3-12)

- Direct work with child and family

The Incredible Years (two programs ages 2-6 or 5-10)

- Group parent education

Triple P- Positive Parenting Program (0-12)

- Combination of group and/or individual, personalized to meet the need

(Developmental Services Group, 2015)

Which EBPs are available in NH?

CPP

Theraplay (no clinicians listed as completing Level 1 training or higher)

TF-CBT (most clinicians use with children over 7)

EMDR (many are trained for working with adults, some will see adolescents)

The Incredible Years

Review of models

Child Parent Psychotherapy (CPP)

Age range: 0 – 6 years

Typically 50 sessions (1 year or more)

- ❖ Relationship-based form of intervention focused on parent-child interactions and perceptions
- ❖ Developed to treat young children exposed to interpersonal violence
- ❖ Based on play and understanding a child's thoughts and feelings based on their play

Demonstrated Outcomes for CPP

Improvements in:

- ❖ Child PTSD symptoms
- ❖ Child behavior symptoms
- ❖ Child representational models
- ❖ Attachment security
- ❖ Maternal PTSD symptoms
- ❖ Maternal symptoms



(Cicchetti, Rogosch, & Toth, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Weston, & Pawl, 1991; Lieberman & Van Horn, 2006; Toth et al., 2002; Toth et al., 2006)

NH Providers Trained in CPP

- ❖ 116 Clinicians trained by DTIRC from 2013 to 2016 (approx. 104 completed consultation requirements, some have left agencies, changed jobs)
- ❖ 29 Clinicians participated in a Learning Community from either March 2016- Sept. 2017 or Oct. 2017- March 2019 & met requirements to be “rostered”

www.nhchildparentpsychotherapy.com/

Theraplay

NOT the same as “play therapy”

Focused on 4 essential components of parent-child relationships:

- Structure
- Engagement
- Nurture
- Challenge

<https://theraplay.org/>



Demonstrated Outcomes for Theraplay

- ❖ Fewer internalizing symptoms
- ❖ Improved family communication
- ❖ Improved child symptoms: assertiveness/
confidence, trust, social communication

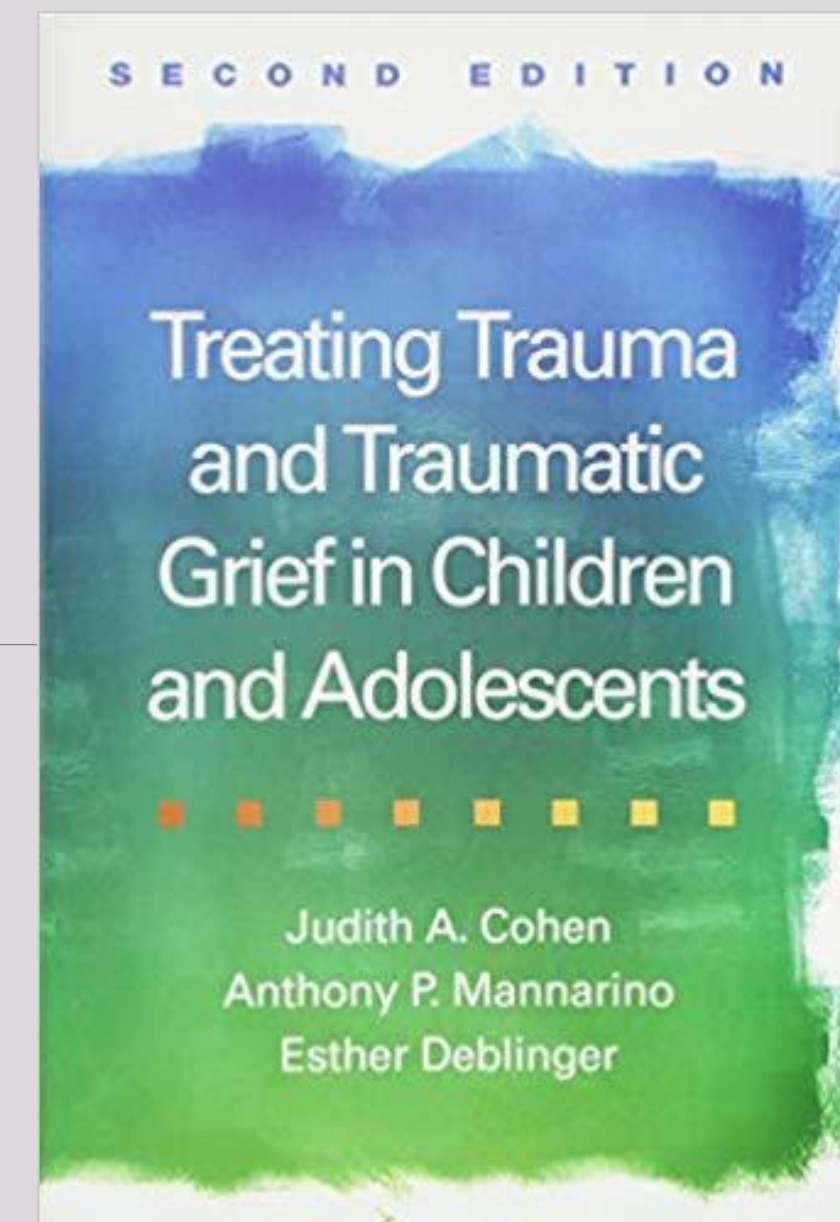
Summarized from <https://theraplay.org/theraplay-research>

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- ❖ Ages 4-18 (sometimes listed as age 3)- but often in NH starts at age 7
- ❖ Originally designed to be 8-16 sessions; in reality, with children and youth with complex trauma, it takes considerably longer
- ❖ Can be delivered in diverse settings – outpatient, residential, in home may be possible

TF-CBT Outcomes

- ❖ Trauma-Focused CBT is the most rigorously tested treatment for traumatized children and families
- ❖ Improved PTSD, depression, anxiety, shame and behavior problems compared to client-centered or nondirective therapy
- ❖ Improved parental distress, parental support, and parental depression compared to client-centered or nondirective treatment



Summarized from <https://tfcbt.org/category/research-public/> and <https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/>

NH Providers Trained in TF-CBT

- ❖ **Over 100 clinicians trained by DTIRC** (95 finished training and required consultation from 2013-2016)
- ❖ There is online training that is free
<https://tfcbt.org/> <https://tfcbt2.musc.edu/>
- ❖ Some of the insurance agencies have been providing training, there is national certification with longer training/LC

Eye-Movement Desensitization and Reprocessing (EMDR)

- ❖ EBP for adults, but is used with children as well
- ❖ Developed to treat a 1 time traumatic event (in as little as 1-3 sessions) and chronic trauma (no set number of sessions)
- ❖ Uses imagery and body based interventions
 - ❖ Following therapists finger, light
 - ❖ Tapping
 - ❖ Headphones
- ❖ Based on the idea of replicating REM sleep, providing bilateral stimulation, integrating both sides of the brain

EMDR Outcomes

Improvement in:

- ❖ PTSD symptoms
- ❖ Anxiety symptoms
- ❖ Depression symptoms
- ❖ Overall mental health functioning



Summarized from: <http://www.nrepp.samhsa.gov/> and <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=199>

The Incredible Years

- ❖ 12-20 week parenting class (2-3 hours each)
- ❖ Focus on:
 - ❖ Strengthening parent-child interactions and relationships
 - ❖ Reducing harsh discipline
 - ❖ Fostering parents' ability to promote children's social, emotional, and language development

Incredible Years Outcomes

According to NREPP, research shows improvement in:

- ❖ Parenting skills
- ❖ Child externalizing problems
- ❖ Child emotional literacy, self-regulation, and social competence
- ❖ Teacher classroom management skills
- ❖ Parents' involvement with the school and teachers
- ❖ Parents were more positive, supportive, more consistent*

Previously available on <https://www.samhsa.gov/nrepp>

*From current review of research available at <https://www.cebc4cw.org/program/the-incredible-years/>

Promising Practices Available in NH

Trust-Based Relational Intervention (TBRI)[®]

❖ Connecting Principles

❖ Empowering Principles

❖ Correcting Principles

<https://child.tcu.edu/>

TCU Institute of Child Development

Based on the science behind complex trauma and attachment. You must first help a child feel safe, connected, before correcting behavior.

“Stay Calm No Matter What

See the Need Behind the Behavior

Meet the Need Find a Way

Don't Quit If Not You, Then Who?”

Not an EBP, but considered a “promising practice”

Can be used by non-clinical, non-masters level staff
They have trainings for schools, residential treatment centers,
foster parents

Circle of Security (COS)

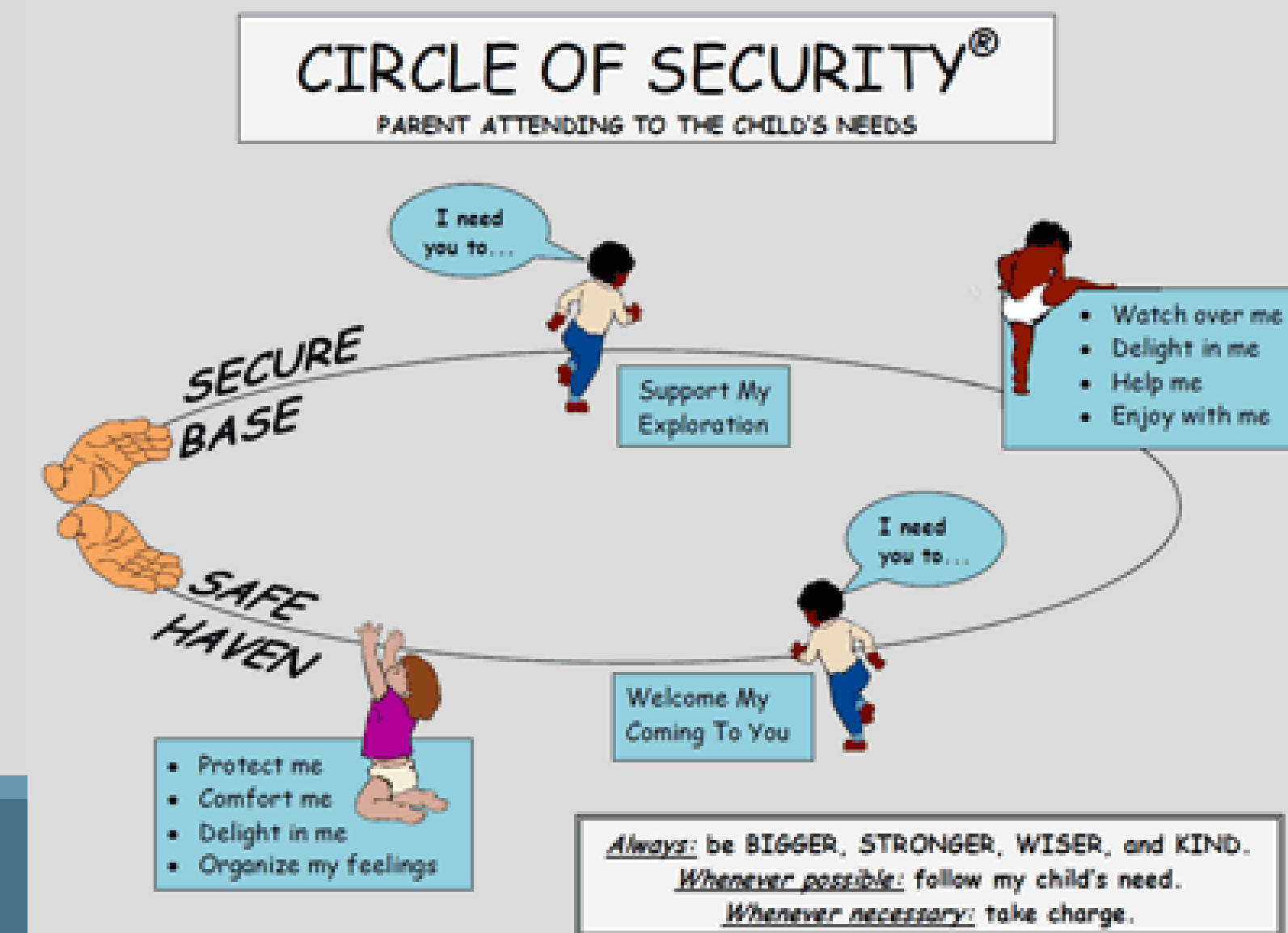
- ❖ Ages 0-6, targeted at parents
- ❖ Psychoeducation about attachment, understanding behavior and skill building for parent

Home Visiting (COS-HV4)– promising research evidence for preventing and treating abuse and neglect (CEBC)

- ❖ 4 home visits, review of video interaction

Circle of Security Parenting (COS-P) not rated on CEBC

- ❖ Typically a parenting group, review material together over 8 weeks
- ❖ Can be delivered individually and/or in home



Picture from: http://circleofsecuritynetwork.org/the_circle_of_security.html

Helping the Noncompliant Child (HNC)

- ❖ Ages 3-8
- ❖ Skills training program for parents
- ❖ Focused on positive interactions between caregiver/child; ignore minor behaviors, provide appropriate limit setting and consequences
- ❖ Typically therapist, caregiver and child together, can be done with a group
- ❖ Meant to be short term

Core Components of Treatment for Complex Trauma

Safety

Self Regulation

Self Reflective Information Processing

Traumatic Experience Integration

Relational Engagement

Positive Affect Enhancement

(Cook et al., 2005)

Those who feel lovable, who love, and who experience belonging simply believe they are `worthy` of love and belonging.... They are able to get to this belief by developing practices that enable them to hold on to the belief that they are worthy of love, belonging, and joy.

~Brené Brown



References

- Barnett, E., Rosenberg, H., Rosenberg, S., Osofsky, J., & Wolford, G. (2014). Innovations in Practice: Dissemination and Implementation of Child-Parent Psychotherapy in Rural Public Health Agencies. *Child and Adolescent Mental Health, 19*(3), 215–218.
- Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology, 18*(3), 623-649
- Cicchetti, D., Toth, S.L., & Rogosch, F.A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development, 1*, 34-66.
- Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex Trauma in Children and Adolescents. *Psychiatric Annals, 35*(5), 390-398.
- Developmental Services Group. (2015). NREPP Learning Center Literature Review: Parent Training Programs. Retrieved from <http://www.nrepp.samhsa.gov/Docs/Literatures/NREPP%20Learning%20Center%20Lit%20Review%20Parent%20Training%20Programs.pdf>
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships. *Journal of the American Academy of Child & Adolescent Psychiatry, 14*(3) 387 – 421.
- Ghosh Ippen, Van Horn, & Lieberman (2016). CPP Training Manual version 2.0. San Francisco: Child Trauma Research Program, UCSF.
- Lieberman, A.F., Ghost Ippen, C., & Van Horn, P. (2015). *Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy With Young Children Exposed to Violence and Other Trauma* (2nd ed). Washington, DC: ZERO TO THREE.
- Lieberman, A., Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal Of The American Academy Of Child And Adolescent Psychiatry, 45*(8), 913-918.
- Lieberman, A.F., Padron, E., Van Horn, P., & Harris, W.W. (2005). Angels in the Nursery: The Intergenerational Transmission of Benevolent Parental Influences. *Infant Mental Health Journal, 26*(6), 504–520.

References (cont'd)

Lieberman, A., Van Horn, P., & Ippen, C. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal Of The American Academy Of Child And Adolescent Psychiatry, 44*(12), 1241-1248.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62*(1), 199-209.

Lieberman, A.F., & Van Horn, P. (2008). *Psychotherapy With Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment*. NY, NY: Guilford Press.

Perry, B. (2016). Treating Developmental Trauma. Presented by NFI Vermont; May 24, 2016; Essex Junction, VT.

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) (2010). Child-Parent Psychotherapy Intervention Summary. Retrieved from: <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=194>

Siegel, D., & Payne Bryson, T. (2011). *The whole brain child: 12 revolutionary strategies to nurture your child's developing mind*. New York, NY: Bantam Books.

Toth, S. L., Rogosch, F. A., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology, 74*(6), 1006-1016.

Toth, S.L., Maughan, A., Manly, J.T., Spagnola, M., & Cicchetti D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology, 14*, 877-908.

ZERO TO THREE (2016). Planting Seeds in Fertile Ground: Actions Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health. Retrieved from: <https://www.zerotothree.org/resources/1221-planting-seeds-in-fertile-ground-steps-every-policymaker-should-take-to-advance-infant-and-early-childhood-mental-health>

<http://nrepp.samhsa.gov>

<http://www.cebc4cw.org/home/understanding-evidence-based-practice/>

<http://www.cebc4cw.org>



Networking Break



Personal Perspective on Trauma and the Impact on Receiving Health Care

MICHAEL SKINNER

Founder, Director, Performer, Trainer, Advocate, and Spokesperson, The Surviving Spirit

Consultant, Trainer, National Center for Trauma Informed Care, Substance Abuse and Mental Health Services Administration

Michael Skinner Music and Advocacy

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Michael Skinner**, Musician and Spokesperson, The Surviving Spirit



Brain Break Activity



Panel: Trauma-Informed Care in Practice

MODERATOR: JAN THOMAS, ADRN

Project Director, NH Citizens Health Initiative

LISA DIBRIGIDA, MS, MD

Associate Medical Director, Pediatrics, Child Health Services at Manchester Community Health Center

PETER FIFIELD, EdD, MLADC, LCMHC

Substance Use Disorder Program Manager, Behavioral Health Department

VERONICA TRIACA, MD

Director of Pelvic Medicine and Reconstructive Surgery Program, Concord Hospital Center for Urologic Care

Clinical Associate Professor of Surgery, Geisel School of Medicine at Dartmouth

PRESENTER DISCLOSURE

The following individuals have responded that they have nothing to disclose:

- **Presenter: Janet Thomas, ADRN, Project Director PTN, NH Citizens Health Initiative** at the Institute for Health Policy and Practice at the University of New Hampshire
- **Presenter: Lisa DiBrigida, MS, MD, Associate Medical Director-Pediatrics, Child Health Services** at Manchester Community Health Center
- **Presenter: Peter Fifield, Ed.D, MLADC, LCMHC, Substance Use Disorder Program Manager, The Doorway** at Wentworth-Douglas Hospital
- **Presenter: Veronica Triaca, MD, Director Pelvic Medicine and Reconstructive Surgery Program, Concord Hospital Center for Urologic Care**

Trauma Informed Care Policy and Procedure?

Peter Fifield Ed. D MLDAC, LCMHC

Manager of Substance Use Disorder Services

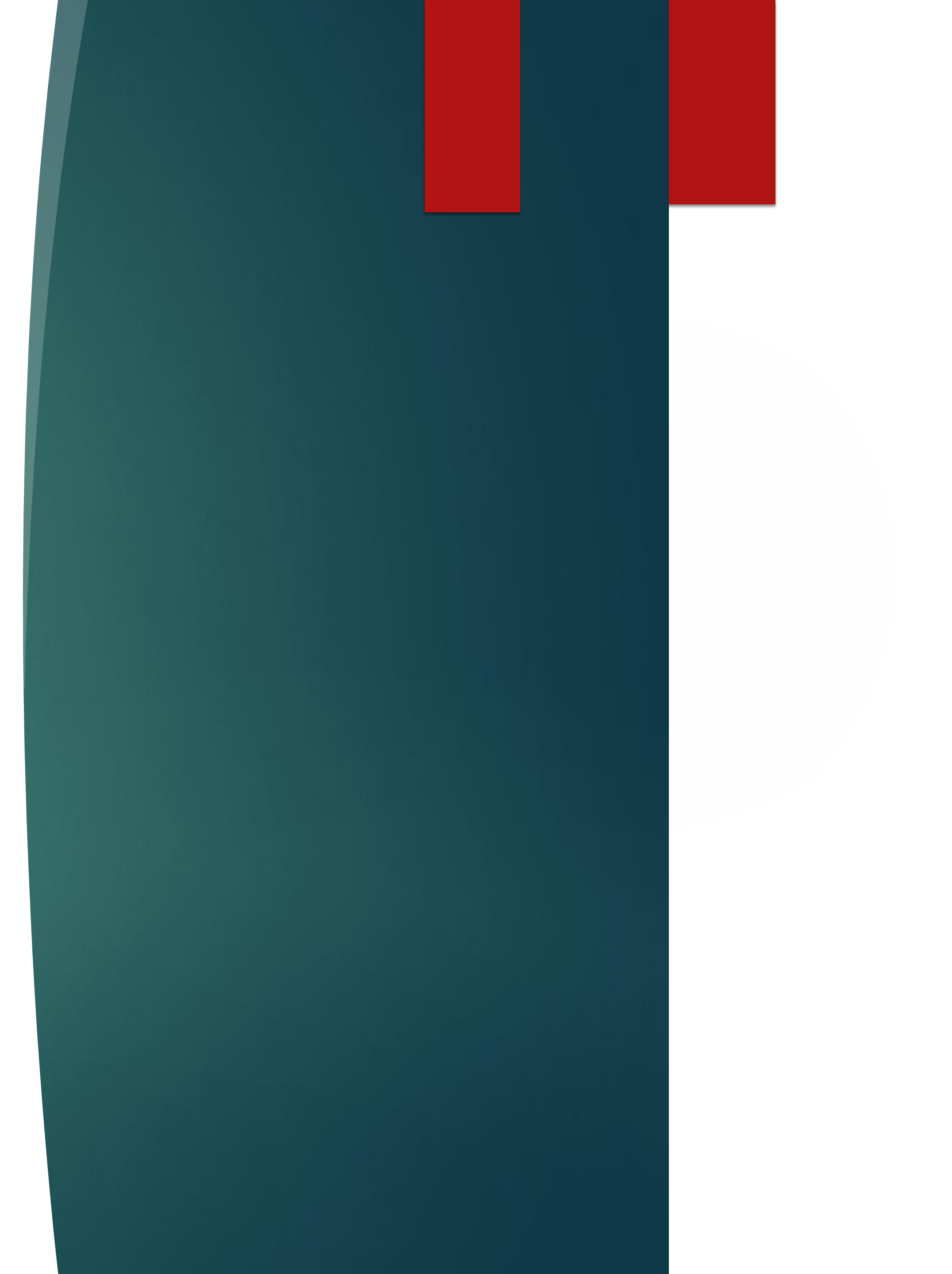
Wentworth-Douglass Hospital

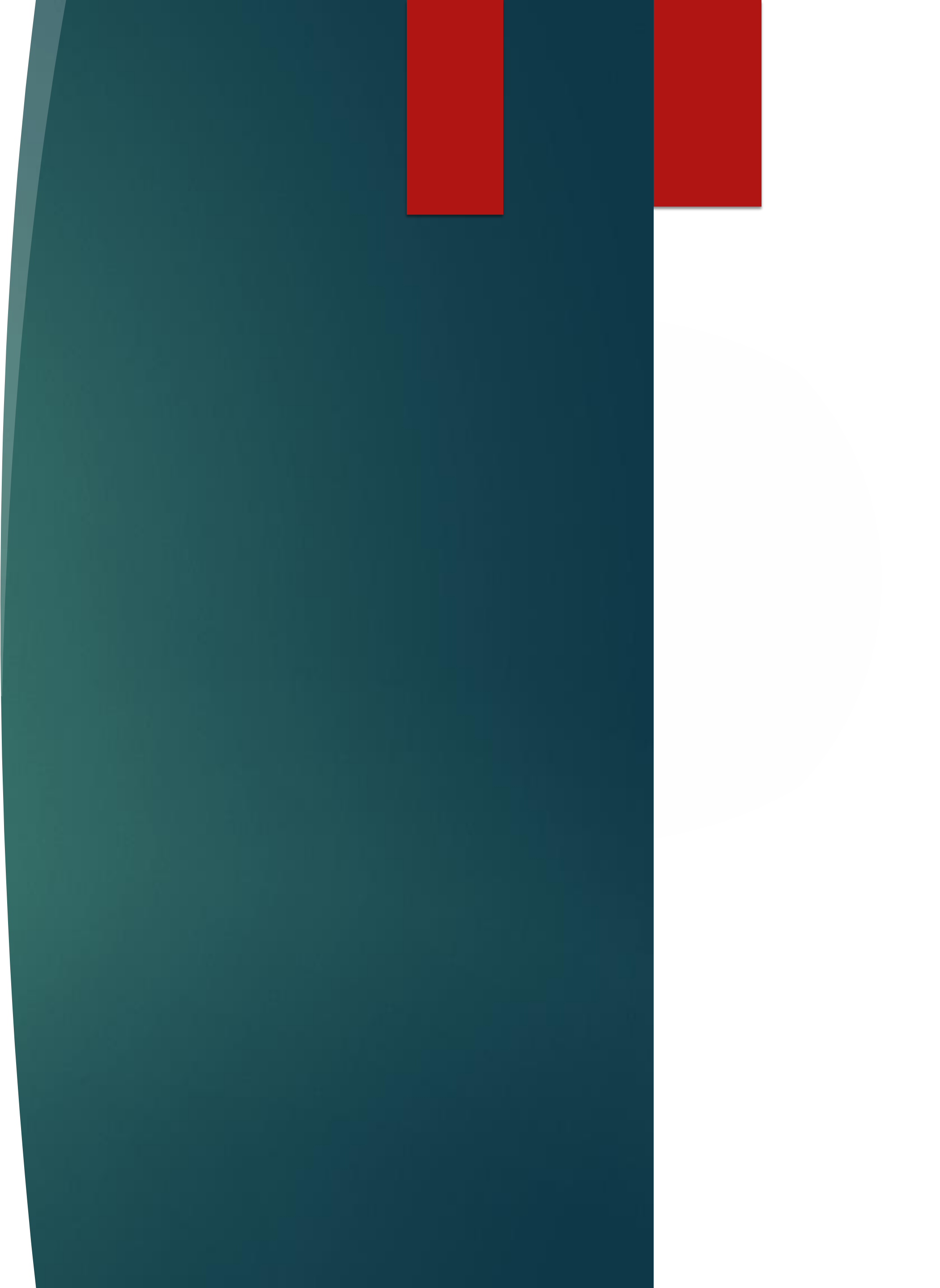
Adjunct Faculty University of New England School of Education





Organizational Practices



- 
- ▶ You need a champion—some one to lead and follow
 - ▶ Engage patients in planning
 - ▶ Patient/Family Advisory Council
 - ▶ Training of all staff in TIC concepts—talking the talk and walking the walk

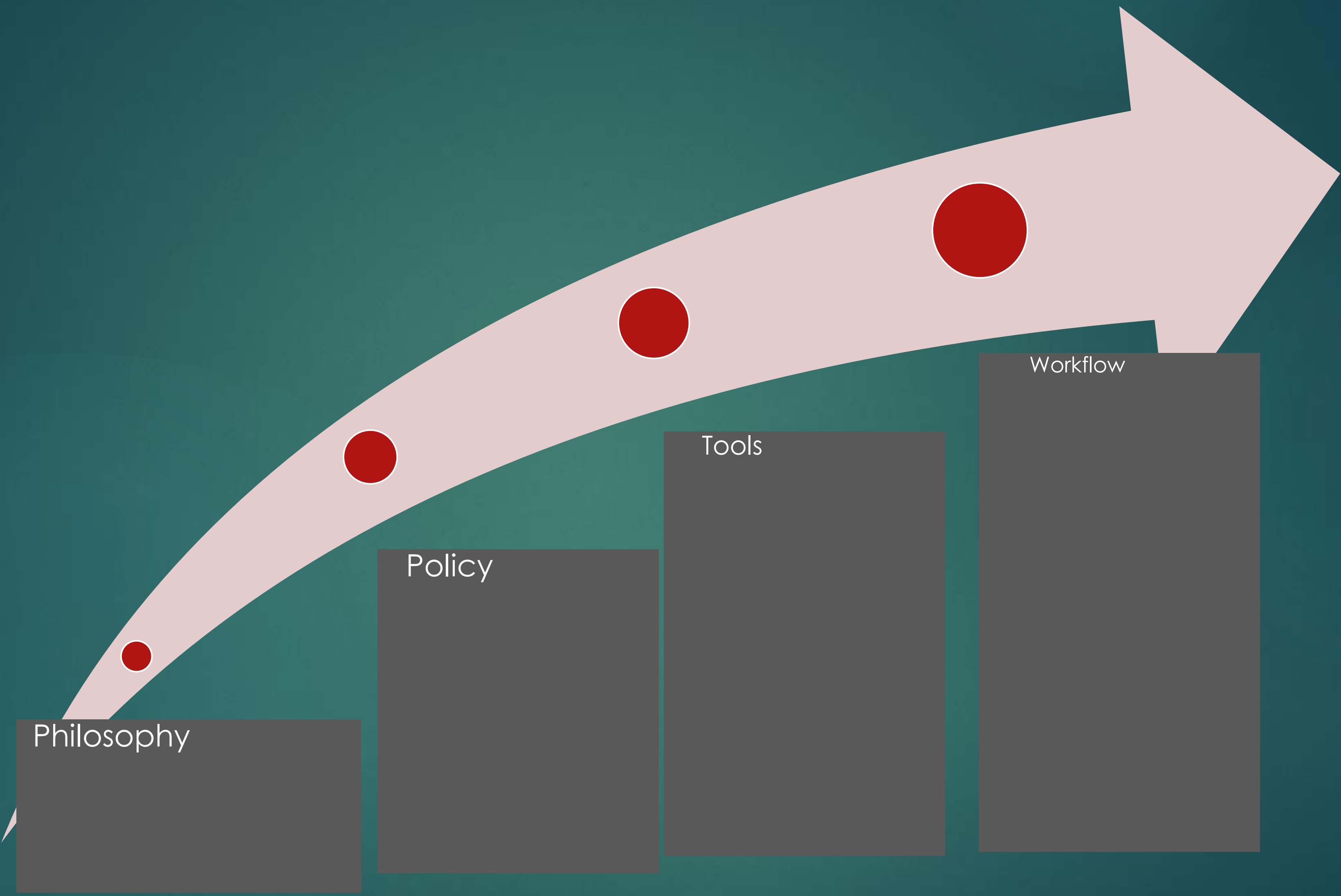
- 
- ▶ Creating the environment of safety—full survey of all environmental elements
 - ▶ Prevent re-traumatization of clients and staff—utmost goal
 - ▶ Intentional hiring processes—put this in the job description

Clinical Practices

- 
- 
- ▶ Involve the patients in the treatment process
 - ▶ Screen for trauma and assess resilience
 - ▶ Train staff in TIC treatment approaches
 - ▶ Create robust community relationships/referrals sources

Trauma Informed Evaluation

- ▶ Focus Groups or facilitated discussion
- ▶ Interviews
- ▶ Self-administered surveys
- ▶ Regardless of method chosen
 - ▶ Consider environmental and interviewer factors relative to trauma
 - ▶ Remind participants participation is voluntary
 - ▶ Be transparent when explaining what the purpose is



Philosophy

Policy

Tools

Workflow



Words Matter:

- ▶ *Protest any labels that turn people into things. Words are important. If you want to care for something, you call it a 'flower;' if you want to kill something, you call it a 'weed.'"*

Resources



- ▶ Menschner, C. & Maul, A. (2016) Key Ingredients for Successful Trauma-Informed Care Implementation. Center for Healthcare Strategies



WENTWORTH-DOUGLASS HOSPITAL

MASSACHUSETTS GENERAL HOSPITAL SUBSIDIARY



LISA DIBRIGIDA, MS, MD

Associate Medical Director, Pediatrics, Child Health Services at Manchester Community Health Center

“Team Pod”- Shared Clinic Space Fosters Consultation & Collaboration



Behavioral Health Integrated Care: The Concord Hospital Pelvic Medicine Experience

Veronica Triaca, M.D.

Director Pelvic Medicine, Continence and
Sexual Health Program at Concord Hospital

*NH Citizens Health Initiative Behavioral Health
Integration Learning Collaborative*

May 1st, 2019



No Disclosures



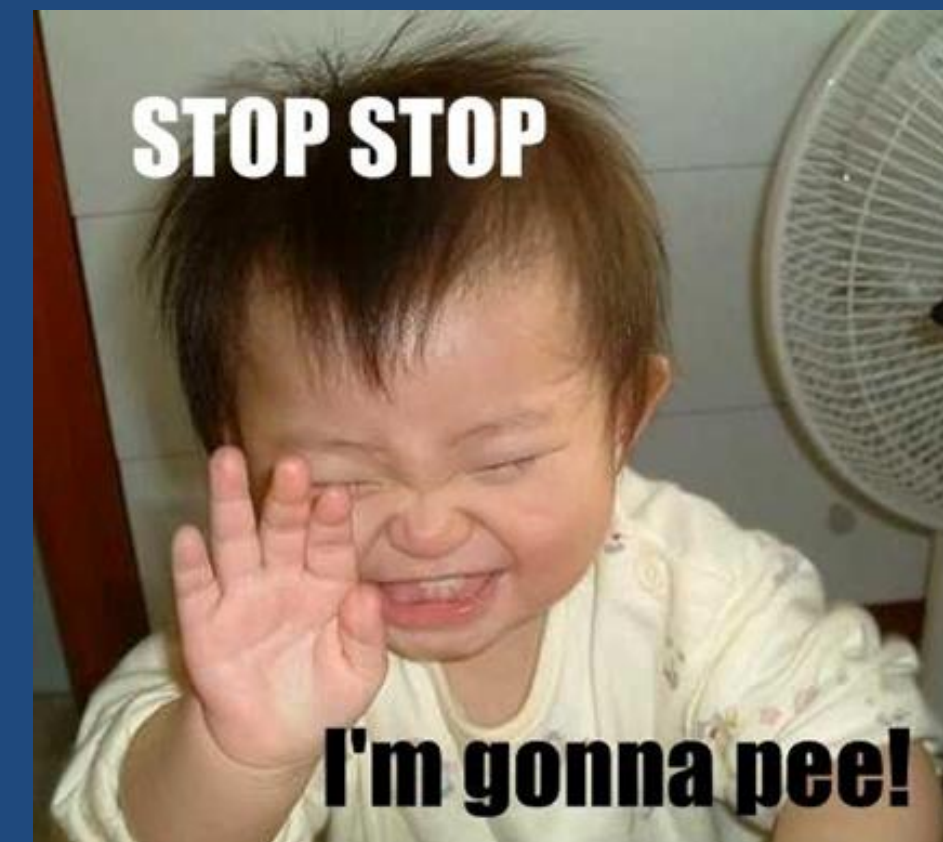
Objectives

- Review Pelvic Medicine Program at Concord Hospital
- Review Integrated Behavioral Health in the care of the Pelvic Medicine patient



Female Pelvic Medicine and Reconstructive Surgery (FPMRS)

- Pelvic Organ Prolapse
- Urinary Incontinence
- Fecal Incontinence/Defecatory dysfunction
- Overactive bladder
- Pelvic pain/Painful Bladder Syndrome
- Female Sexual Dysfunction
- Post menopausal symptoms
- Vulvovaginal skin disorders
- Recurrent Urinary tract infections
- Pelvic floor muscle dysfunction



FPMRS

- Urologist or Gynecologist who, by virtue of education and training, is prepared to provide consultation and comprehensive management of women with complex benign pelvic conditions, lower urinary tract disorders, and pelvic floor dysfunction.
- Comprehensive management includes diagnostic and therapeutic procedures necessary for the ***total*** care of the patient with these conditions and complications resulting from them



Rationale for the Creation of a Pelvic Medicine Program at Concord Hospital

- Pelvic medicine is a hybrid specialty that lends itself well to coordinated integrated multidisciplinary care
- At least 50% of our pelvic pain patients have a history of trauma
- Improvement in quality of care delivered



Goals

- To develop an integrated and coordinated multidisciplinary program for the treatment of female pelvic disorders
- To assemble a team of care givers with an interest and expertise in pelvic medicine
- To centralize and coordinate care



“Players”

- PRIMARY PLAYERS
 - Urologist(s) Gynecologist(s)
 - Female Pelvic Medicine and Reconstructive Surgery Certification
 - Advanced Provider(s)
 - Physical Therapist(s)
 - Behavioral Therapist(s)
- ADJUNCT SPECIALTIES
 - Colorectal Surgeon
 - Gastroenterologist
 - Nutritionist
 - Sex Therapist
 - Complimentary Medicine

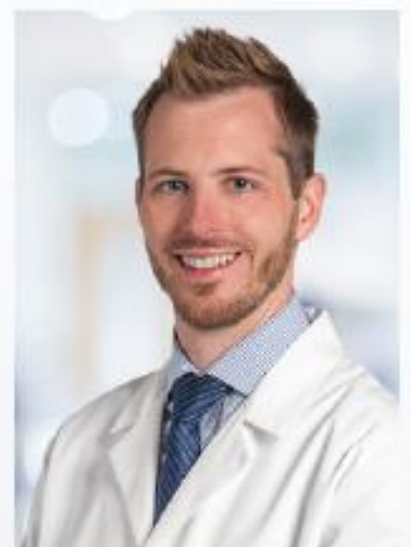


Who are we?

Pelvic Medicine, Continenence and Sexual Health



Veronica Triaca, MD



Brian Marks, MD



Joanne Gutt, PA-C



Cathy Yi, MD
Gynecologist



Katherine Cail, APRN



Sheryl Cheney, RPT



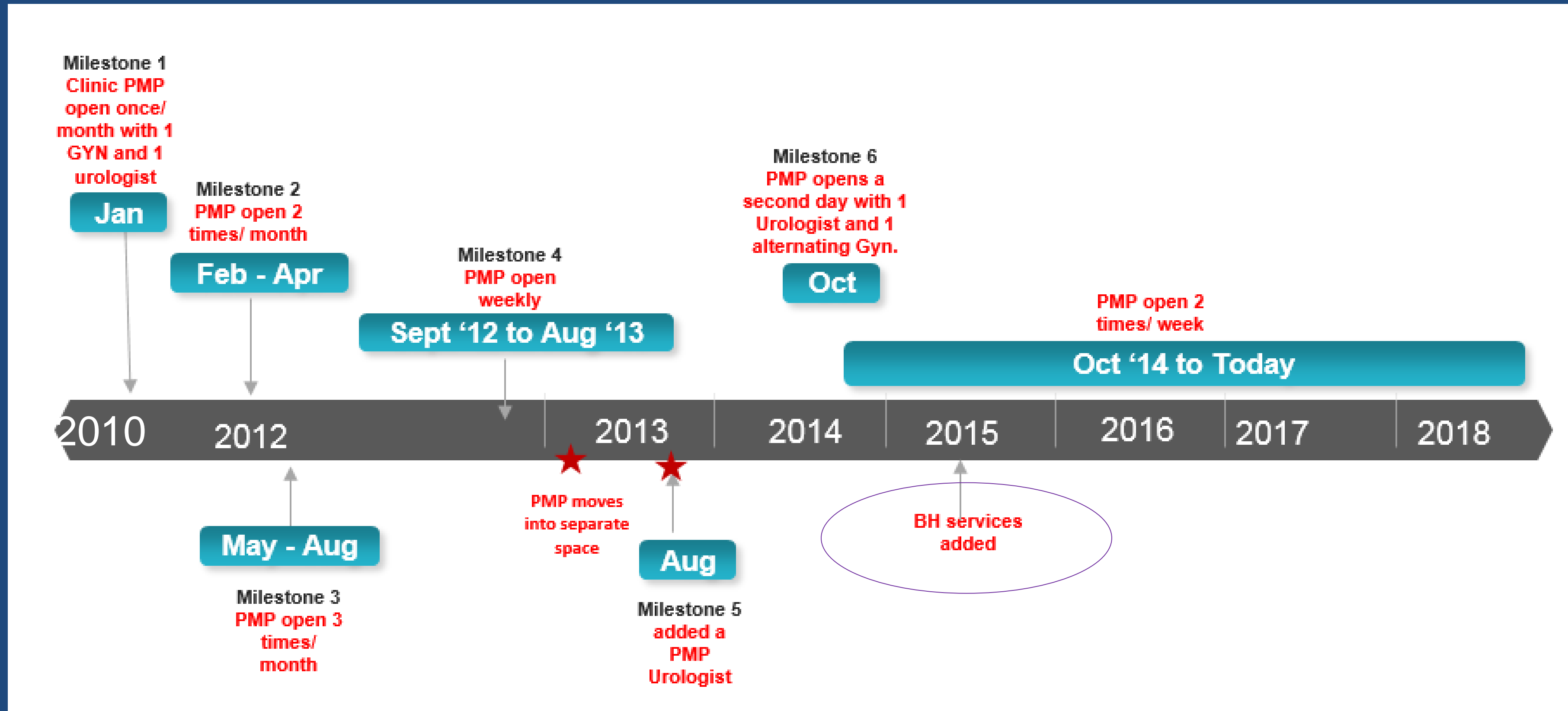
Jennifer Savage, LSW



Stacey Lillios, RPT



History

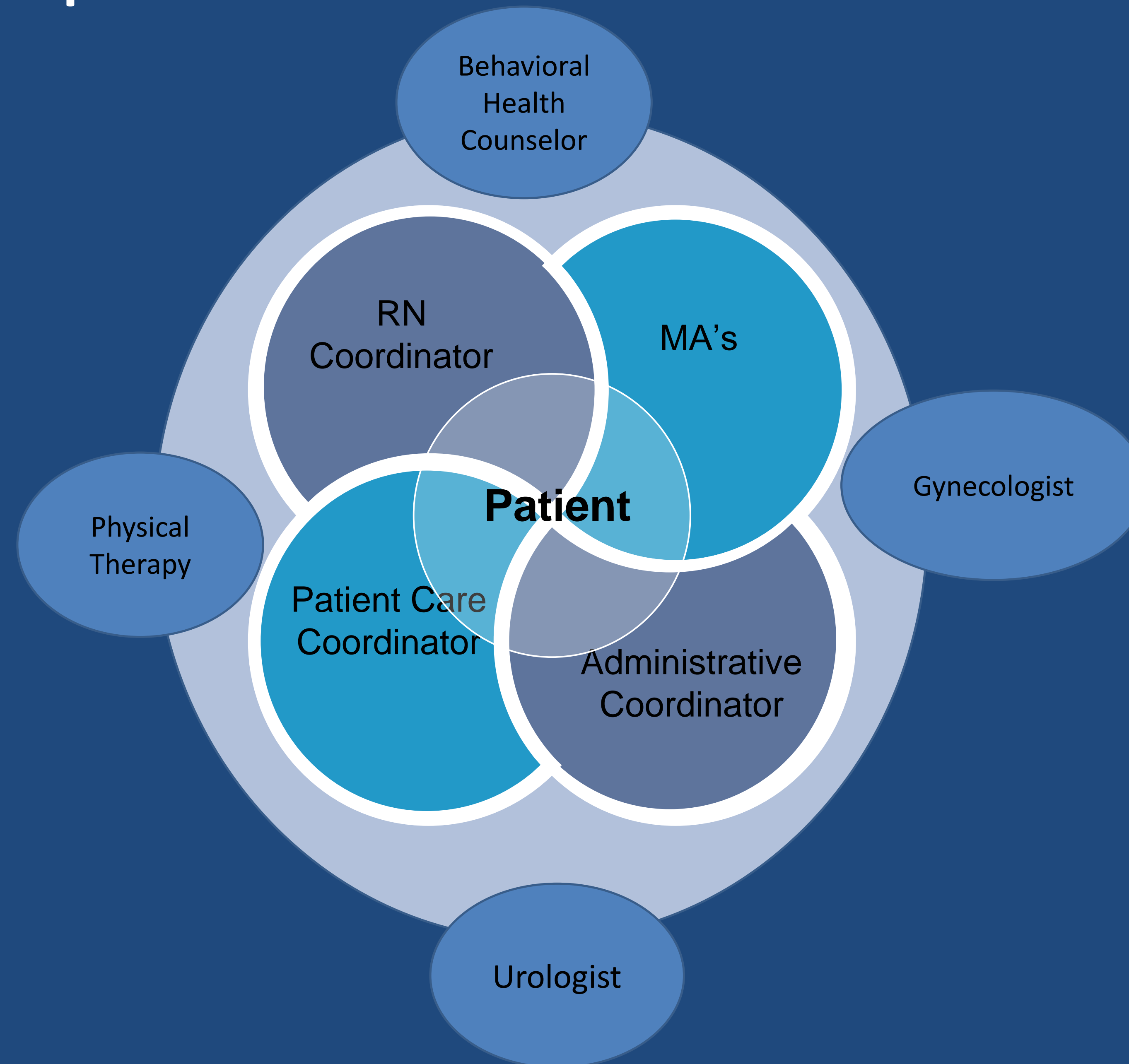


Experience to date

- Outpatient Coordination of services
 - Dedicated Clinic Space
 - Thrice Weekly multidisciplinary clinic
 - Dedicated Nurse Practitioner
 - Katie Cail, APRN
 - Present at the clinic
 - GYN, UROLOGIST, NP
 - Dedicated core Physical therapists, Sheryl Cheney, RPT; Stacey Lillios, RPT
 - Dedicated Behavioral Therapist
 - Dedicated Clinical Coordinator, Tracee Sawyer RN
 - Dedicated Administrator, Naomi Marcoux



Patient experience



Reality

- Trauma affects many of my patients
- Being able to address their condition meant to acknowledge and address their history of trauma
- Integrated behavioral care



Case

- 35 y/o female with concerns of incomplete bladder emptying
- Multiple visits to ED for urinary retention
- History of chronic pelvic pain
- PMH/PSH: anxiety, chronic constipation, multiple laparoscopies, hysterectomy



Case

- 62 y/o female with urinary frequency and urgency, urinary incontinence.
- PMH/PSH: bipolar disorder, fecal incontinence, IBS, chronic abdominal and pelvic pain



Urinary Incontinence, Depression and Post-traumatic Stress Disorder in Women Veterans

Bradley *et al* Am J Obstet Gynecol. 2012 Jun; 206(6)

- 968 women mean age 38.7 ± 8.7 years were included.
- 19.7% reported urgency/mixed UI
- 18.9% stress UI
- PTSD (OR [95%CI] = 1.8 [1.0, 3.1]) but not depression (OR [95%CI] = 1.2 [0.73, 2.0]) was associated with urgency/mixed UI.
- Stress UI was not associated with PTSD or depression.

- Conclusion



- In women veterans, urgency/mixed UI was associated with PTSD but not

Corticotropin releasing factor: a mediator of emotional influences on bladder function.

Klausner AP, Steers WD J Urol. 2004 Dec;172-3

- Evidence linking overactive bladder (OAB) and bladder pain with anxiety and depression
- CRF expressed in areas of the central nervous system that control voiding and response to stress.
- CRF is increased during anxiety, depression and pain.
- Epidemiological studies reveal an association between anxiety and voiding disorders.



Bladder dysfunction in sexual abuse survivors.

Davila GW *et al* J Urol 2003, Aug 170(2)

- 58 sexual abuse survivors and 51 controls were included in the statistical analysis.
- Of abuse survivors 72% and of controls 22% reported ever experiencing urinary incontinence symptoms ($p < 0.001$).
- Many symptoms of stress incontinence, urge incontinence and voiding dysfunction were also reported by a greater percent of abuse survivors than controls



Is abuse causally related to urologic symptoms? Results from the Boston Area Community Health (BACH) Survey

Eur Urol. 2007 Aug;52(2):397-406

- Data from the Boston Area Community Health (BACH) survey, a community-based epidemiologic study of many different urologic symptoms and risk factors.
- 5506 adults, aged 30-79 yr (2301 men, 3205 women; 1770 black [African American], 1877 Hispanic, and 1859 white respondents)
- 33% reporting urinary frequency, 12% reporting urgency, and 28% reporting nocturia.
- All three symptoms are positively associated with childhood and adolescent/adult sexual, physical, and emotional abuse ($p < 0.05$)



Characterization of a clinical cohort of 87 women with interstitial cystitis/painful bladder Peters KM *et al* Urology. 2008 Apr;71(4):634-40

- 87 women with bladder pain
- 52% reported a history of abuse, often in more than one life stage
- Common comorbidities were pelvic pain (93%), allergies (86%), and sexual dysfunction (72%).



Trauma and posttraumatic stress disorder in women with chronic pelvic pain.

Meltzer-Brody S *et al* *Obstet Gynecol.* 2007 Apr;109(4):902-8.

- 713 women seen in a referral-based pelvic pain clinic
- 46.8% reported having either a sexual or physical abuse history.
- 31.3% had a positive screen for PTSD
- trauma history was associated with worse daily physical functioning due to poor health ($P<001$), more medical symptoms ($P<001$), more lifetime surgeries ($P<001$), more days spent in bed ($P<001$), and more dysfunction due to pain ($P<.001$).
- PTSD was highly related to most measures of poor health status ($P<001$)

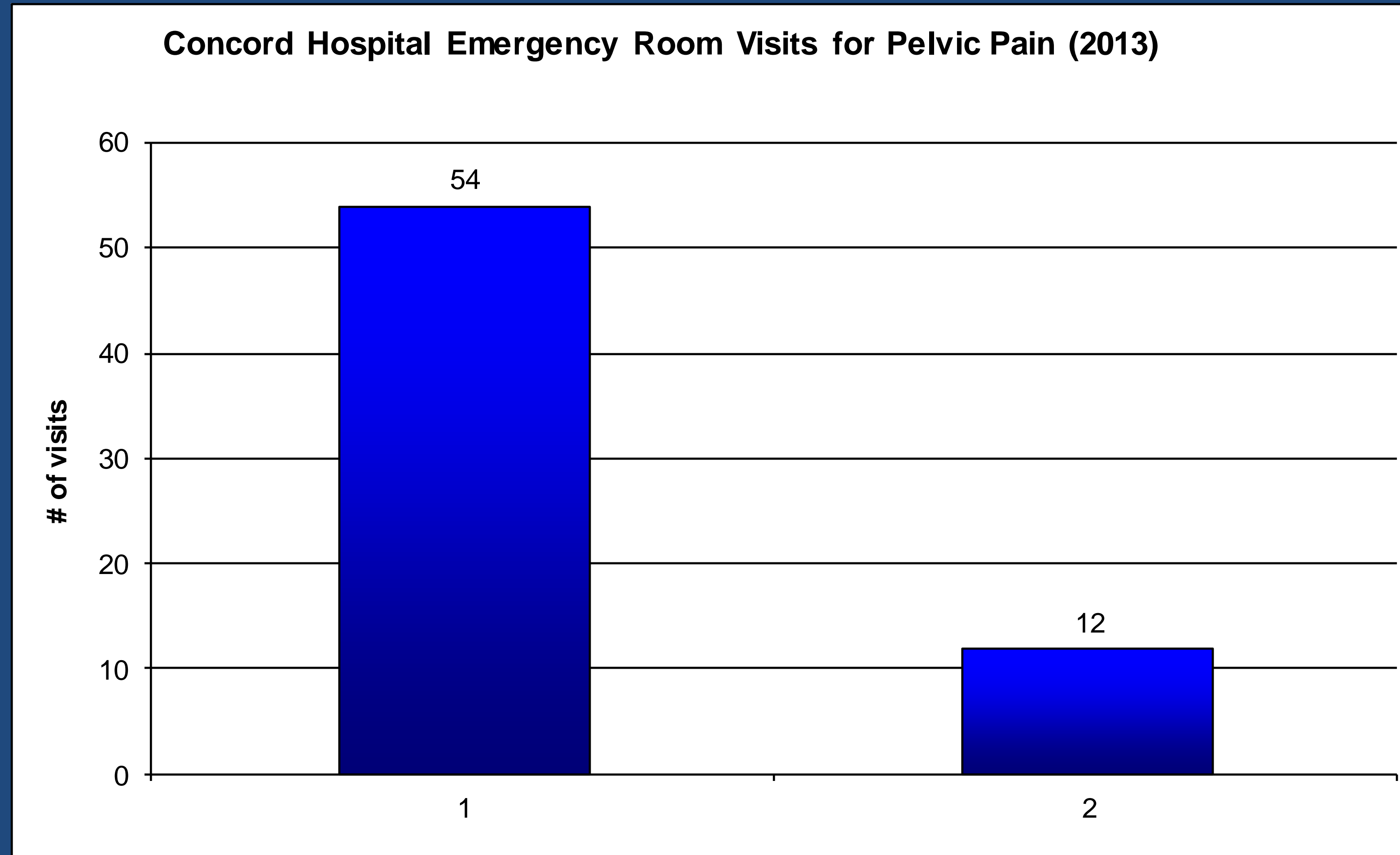


Pelvic Pain

- Estimated direct medical costs for outpatient visits for chronic pelvic pain for the U.S. population of women aged 18–50 years are \$881.5 million per year
- 15% have time lost from paid work
- 45% have reduced work productivity



Pelvic Medicine Program Impact



Before evaluation in PMC

After evaluation in PMC



118 patients, seen with a diagnosis of pelvic/abdominal pain

Conclusion

- Integrated Behavioral Health is essential for the successful outcome of the Pelvic Medicine patient
- Coordinated and multidisciplinary approach to care is essential for patients with pelvic disorders



Concord Hospital Pelvic Medicine, Continence and Sexual Health Program

<https://www.concordhospital.org/services/urology/pelvic-medicine-continence-and-sexual-health/>

Tel: 603-224-3388 or 603-227-7000 x2221

vtriaca@crhc.org

nmarcoux@crhc.org



The screenshot shows the Concord Hospital website page for the Pelvic Medicine, Continence and Sexual Health Program. The page features the Concord Hospital logo at the top, a breadcrumb trail (Home > Care & Treatment > Urology > Pelvic Medicine, Continence and Sexual Health), and a "Jump to Section Links" dropdown menu. The main heading is "Pelvic Medicine, Continence and Sexual Health Program". Below this is a blue button with a hand icon and the text "Inquire about becoming a patient." The page also includes a testimonial section with a photo of a woman riding a horse and the text: "If pelvic floor disorders, sexual function concerns, incontinence, bladder dysfunction or pelvic organ prolapse are impacting your quality of life, our Pelvic Medicine, Continence and Sexual Health Program's team of pelvic medicine specialists — Dr. Veronica Triaca, Dr. Cathy Yi, and Dr. Brian Marks — can offer you a full spectrum of care and trained and..."

CLOSING REMARKS

JEANNE RYER, MSc, EdD

Director, NH Citizens Health Initiative

CONTINUING EDUCATION CREDITS

For those who would like 3.5 CME, CNE, CEU, or SW CEU credits, please fill out the survey using the link below.

<https://www.surveymonkey.com/r/EvalBHLCMay2019>

STAFF CONTACT INFORMATION

Annie Averill	annie.averill@unh.edu	Devan Quinn	devan.quinn@unh.edu
Felicity Bernard	felicity.bernard@unh.edu	Jeanne Ryer	jeanne.ryer@unh.edu
Corina Chao	corina.chao@unh.edu	Janet Thomas	janet.thomas@unh.edu
Katherine Cox	katherine.cox@unh.edu	Holly Tutko	holly.tutko@unh.edu
Marcy Doyle	marcy.doyle@unh.edu	Dee Watts	delitha.watts@unh.edu
Hwasun Garin	hwasun.garin@unh.edu	Kelsi West	kelsi.west@unh.edu
Sally Minkow	sally.minkow@unh.edu		



CONTACT US



VISIT US

www.citizenshealthinitiative.org



SEND US A NOTE

info@citizenshealthinitiative.org