SAFE SPACES WEBINAR SERIES

Part 2: Building a Culture of Trauma-Informed Care for Patients

Wednesday, March 18, 2020 at 2:00 pm ET

NATIONAL
NURSE-LED CARE
CONSORTIUM
a PHMC affiliate

National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a nonprofit member-supported organization working to strengthen community health through quality, compassionate, and collaborative nurse-led care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Direct, nurse-led healthcare services
- Policy research and advocacy
- Training and technical assistance support

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Question & Answer

- Click Q&A and type your questions into the open field.
- The Moderator will either send a typed response or answer your questions live at the end of the presentation.

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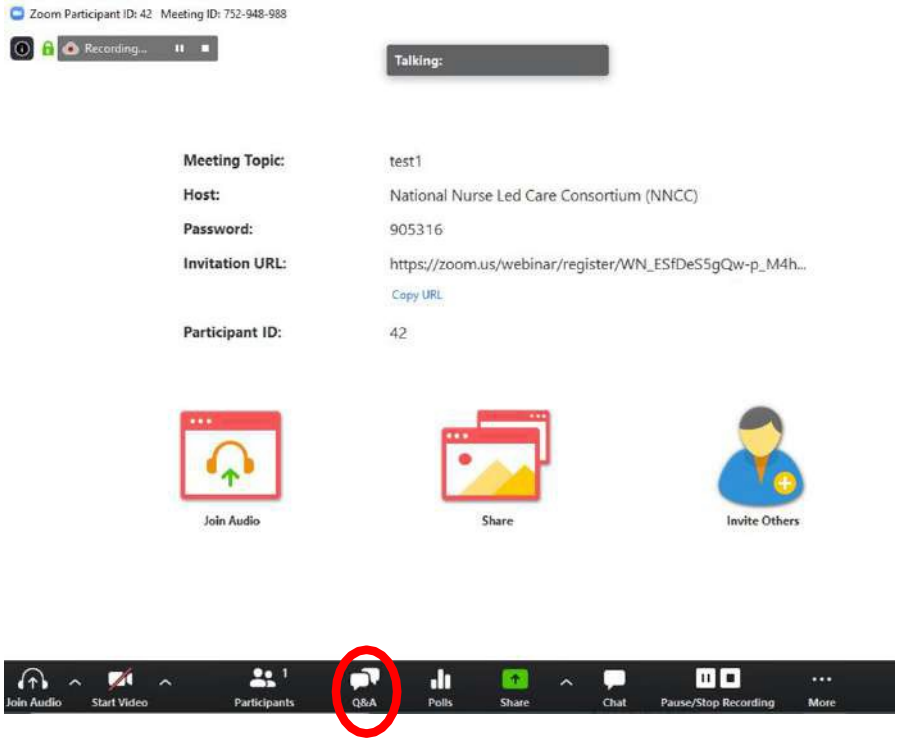

Poll

Does your organization have integrated behavioral health and primary care?

- Yes
- No
- Not sure

To what extent does your organization utilize trauma-informed primary care?

- Never
- Rarely
- Sometimes
- Most of the time
- All of the time

Speakers

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Trauma-informed Environments and Interactions with Patients

Sharday Lewis, MPH
Sarah Flinspach

March 18, 2020

Presenters

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Trauma-Informed Services

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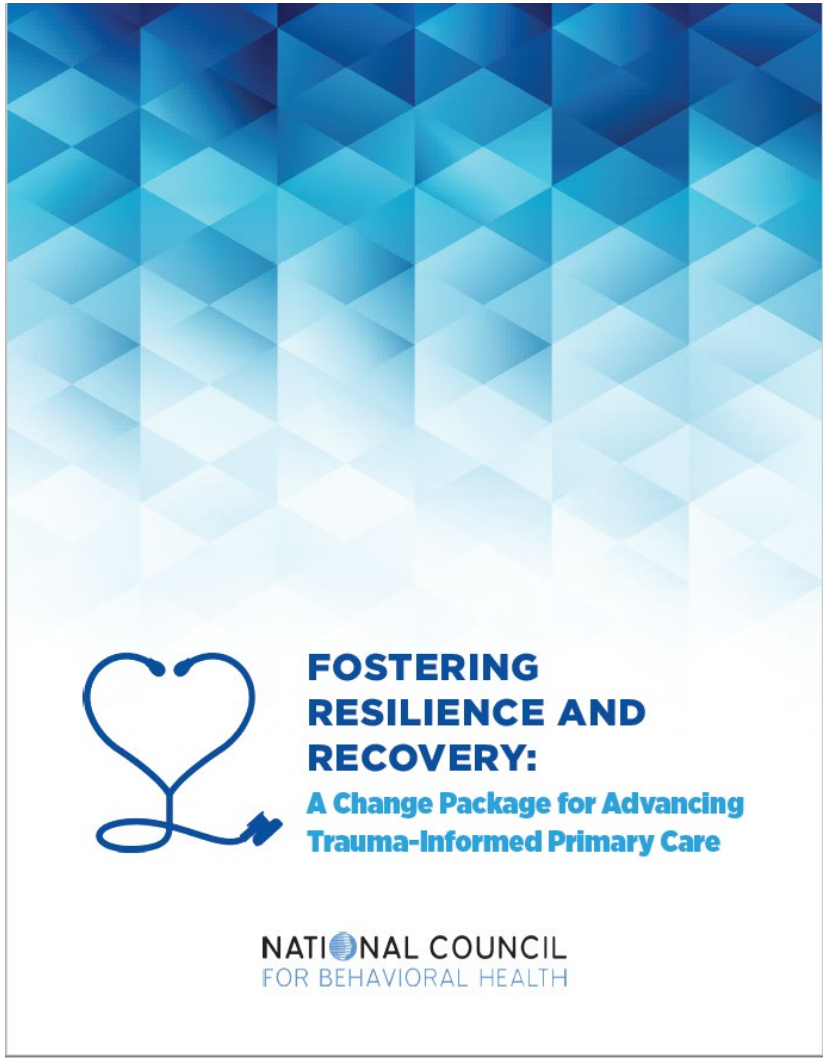
Why Trauma-informed Care for Primary Care Patients?

- The ACE Study revealed a *20-year* life expectancy gap between individuals with high and low ACE scores
  - Trauma leads to brain dysregulation and chronic stress that negatively affects development, health outcomes and life expectancy
  - Theory: identifying trauma histories + addressing trauma as part of care = improved health outcomes and wellness
- Supports integrating primary care and behavioral health services
- Benefits: improving clinical decision-making by equipping providers to identify and respond to trauma and building collaborative care networks to increase providers' capacity to address holistic needs

Change Package for Trauma-Informed Primary Care

- A practical toolkit that is specific enough for clinicians and practices to implement and measure progress, and yet generalizable enough to be scaled in multiple settings
  - **Implementation Guidance:** Generalizable enough to be relevant across the primary care setting paired with…
  - **Operational Changes:** Clear-cut enough to spur specific actions and practice transformation on the individual agency level



https://www.thenationalcouncil.org/fostering-resilience-and-recovery-a-change-package/

Prerequisite: Safety, Security, and Trust

Creating safe, secure and trusting environments

- Enhances the ability of staff to provide services in a non-traumatizing way
- Supports health and wellness of employees and patients

Safety includes physical and psychological safety

Without safe environments, neither patients nor staff will feel comfortable to engage in an inquiry process, particularly around sensitive topics

Action Steps

Conduct an environmental assessment

- Sights, sounds, smells, touches, and tastes may lead to stress responses
- Complete assessment using: Environmental Assessment Tool, Hotspots for Activation Worksheet

Assess patient safety

- Use Safe and Secure Environment Survey to gather their input
- Ask for patient preferences

Establish trauma-informed rooming policies

- Empower patients to choose who is or is not present during the visit
- Seek to build relationships
- Conversation over checklist
- Trauma-informed physical exam (Elisseou, Puranam, Nandi)

Provide universal education materials

- Easy-to-understand information for all patients
- Introduction to trauma, resilience, resources, and services
- Consider language and cultural resonance

Ensure staff safety

- Considerations for patients apply to staff as well
- Staff who feel safe help create safe environments

Quick Tips for Greetings and Intake

- When assisting a patient to another location, ask the patient whether they would like to walk ahead of, behind or beside the staff member escorting him or her. This enforces the trauma-informed principles of empowerment, voice and choice and safety.
- Inform patients of every step in the initial intake and offer them a choice about whether to proceed with any steps that are optional to emphasize the choices they have and the possibility of mutuality in their relationship with the service provider.
- Arranging the examination room to fit patients' general preferences and comfort also reinforces physical and emotional safety.
- Ask patients their preference on who should be in the examination room with them and always allow them an opportunity to meet one-on-one with their provider.

Quick Tips for Patient Interactions

- Always ask permission before doing anything that involves or will impact the patient.
- Explain why you are doing what you are doing.
- Avoid looking at a computer or device while engaging with patients.
- Apply trauma-informed principles to tools and use tools adapted for individuals with histories of trauma, including the trauma-informed physical exam tool.
- Get immediate feedback from patients by using postcard-sized anonymous surveys they can leave in a box on their way out of the office or by sending a survey via email.

Identify and Respond to Trauma Among Patients

Establishing patient trust and safety are critical to support disclosure and acceptance of resources

Disclosures of life-threatening situations require immediate response, but disclosures of past trauma do not require immediate intervention beyond empathy and an offer to talk about the impact and resources

Education, inquiry, and response supports better understand of the connections between trauma and health

Action Steps

Page 47 of the Change Package

Prepare for trauma inquiry and response

- Establish policies and clinical pathways for identifying and responding to trauma
- Develop an adequate referral network
- Provide education to patients about the connection between trauma and health
- Build staff capacity to conduct trauma inquiry
- Prevent retraumatization among patients

Inquire for and respond to recent trauma requiring immediate intervention

- Comply with mandated reporting laws
- Affirm that they do not deserve that treatment, express concern for safety, offer resources and connection to partners

Conduct inquiry for trauma

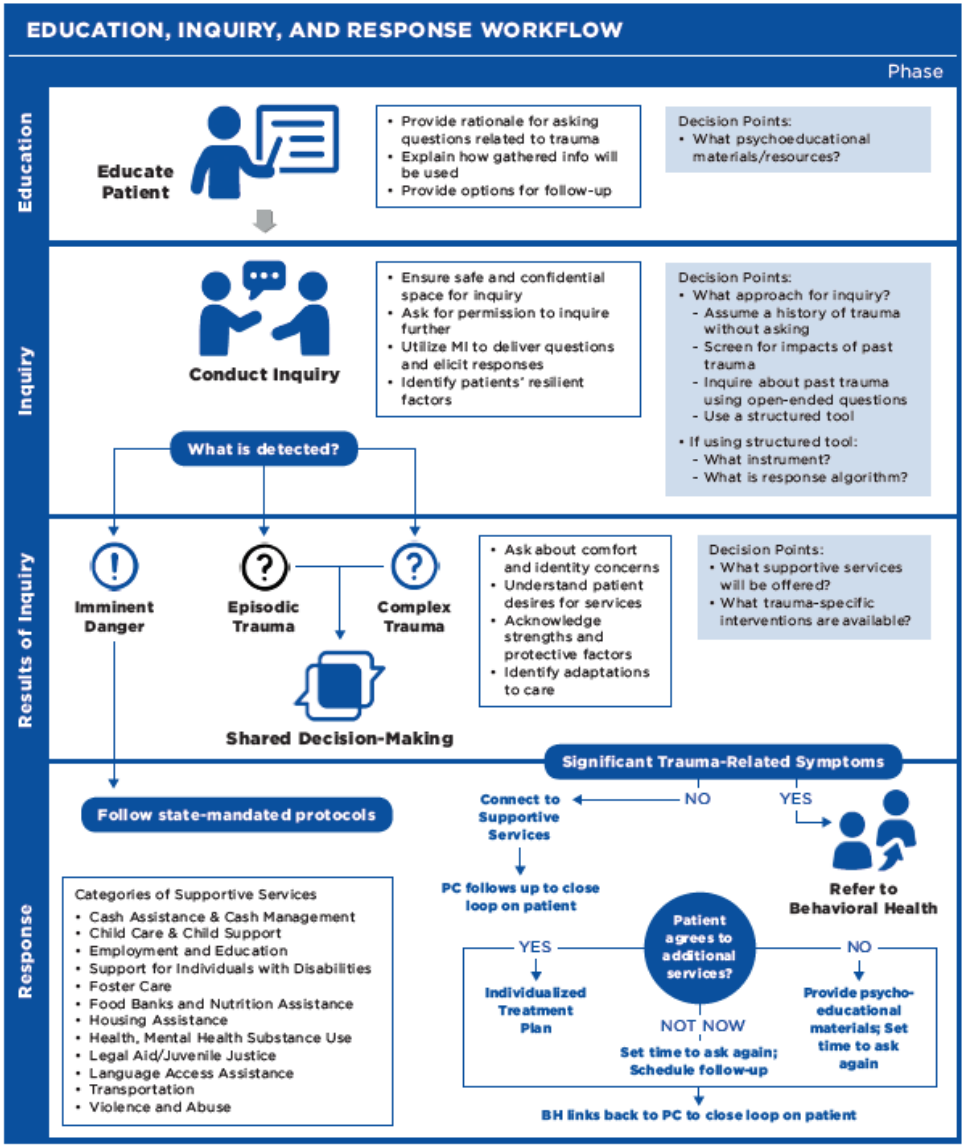
- Option 1: Assume trauma history
- Option 2: Screen for impact of trauma
- Option 3: Use open-ended questions
- Option 4: Use a structured tool

Respond to trauma disclosures

- Statement of empathy and nonjudgmental compassion
- Adapt care to patient's needs and strengths
- Use trauma-specific interventions

Preparation is #1

- Know your road map before you take the trip!
  - Establish your clinical pathway
  - Expand your referral network
    - IPV services
    - Recovery community organizations
    - Housing
    - Legal services
- Staff training on each step
  - Motivational interviewing, shared decision-making, collaborative documentation
- Patient education
  - Universal education
  - Rationale for asking questions



Conduct Inquiry for Trauma

OPTION 1

Assume a History of Trauma Without Asking

Referrals can be offered to onsite or community-based interventions that address experiences and consequences of past trauma regardless of whether a patient chooses to disclose their trauma history.

OPTION 2

Screen for the Impacts of Past Trauma Instead of for the Trauma Itself

Common conditions highly correlated with trauma, such as anxiety, depression, posttraumatic stress disorder, chronic pain and substance use disorders, can be more effectively addressed when services are trauma-informed and offer evidence-based trauma-specific interventions.

OPTION 3

Inquire About Past Trauma Using Open-ended Questions

Open-ended questions about past trauma sensitively included in a routine history allow patients to disclose any form of trauma they feel is relevant to their health and well-being.

OPTION 4

Use a Structured Tool to Explore Past Traumatic Experiences

Multiple validated scales exist to screen for past trauma. Carefully consider why, when, how and by whom it will be administered, as well as who will have access to the information.

Also ask about resilience!

"In the past, which of your strengths have you relied on to 'bounce back' after difficult experiences?"

Your Response

Sample Script

"I am sorry this happened to you. Thank you for sharing this with me. This information can help me understand how best to care for you. Trauma can continue to affect our lives and health. Do you feel like this experience affects your health or well-being?"

"In light of what you've shared today, is there anything I can do to make you feel more comfortable during our appointments together?[72] Do you have any concerns we should address before moving forward? I will note it in the record for future appointments and you can always change or add to it later."

"You mentioned that heroin makes you feel calm when you are very stressed and that you have a goal to stop using but are not ready to now. So, let's talk about how you can stay safe when you use heroin. What ideas do you have? Are you familiar with steps to prevent and respond to an overdose, such as using with a friend and carrying naloxone?"

Remember!

- Seek to build safety, security, and trust
- Conversation over checklist; relationship above all
- Ask permission
- Prepare before you implement
- Consider strengths and resilience in treatment care plan, too

Contact us!

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Download the Change Package: https://www.thenationalcouncil.org/fostering-resilience-and-recovery-a-change-package/

Trauma Informed Care

for Patients in the Primary Care Setting

Maxwell Wagenknecht, LCSW
Sean Pepley, LCSW

Joseph J. Peters Institute

- Was founded in 1955
- There are 3 separate branches of JJPI
  - Survivor Services: includes both adults and children and families
  - Safety and Responsibility Services, includes: Relational Violence Program, Sexual Behavior Program which includes adult and adolescent outpatient services as well as adult Partial Hospitalization services
  - Prevention and Training
- Involved in multiple grants, collaborations with the city and other partners, as well as the school district

What is Trauma?

- SAMHSA describes individual trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."
- Effects behavioral health (PTSD, Depression, Anxiety), chronic physical health conditions.
- Substance use and other risky factors (self-injury, risky sexual behaviors, etc.) have been linked to trauma

-SAMHSA, 2019

Symptoms of Trauma

- **Some common mental and emotional symptoms that might indicate that a patient may have experienced trauma include:**
  - Distressing memories
  - Bad dreams or nightmares
  - Severe emotional distress or physical reactions to situations that remind you of the event
  - Staying away from events, places, or objects that remind you of the trauma
  - Avoiding thinking or talking about the event
  - Feeling depressed, guilty, worried, irritable or aggressive.
  - Losing interest in activities that were once enjoyable
  - Having trouble remembering the traumatic incident

Symptoms of Trauma (Cont)

- **Physical Health symptoms can include:**
  - Hypertension
  - Heart disease
  - Stroke
  - Diabetes
  - Obesity
  - Intestinal issues and ulcers
  - Sexual dysfunction
  - Chronic pain
  - Obesity and diabetes
  - Respiratory problems

Trauma and Development

- Exposure to trauma alters normal development and can change the structure of the brain
- Human brains do most development after birth
  - Environment (including trauma) can physically alter brain structure
  - Effects cognition, emotion, behavior
- Exposure to chronic stress/continued crisis
  - Creates state of chronic hyperarousal
    - Change in central nervous system

Chronic Hyperarousal

- Brain and body react by relying on basic survival skills
  - The brain is not able to attend to typical tasks which results in problems with judgement, mood, behavior
- Can become "stuck" in survival mode and continue to use skills that are maladaptive outside of trauma experiences
  - Impaired cognitions (problems with decision making and problem solving)
  - Learned helplessness (sense of disempowerment)
  - Impoverished relationships (unresolved interpersonal conflict)
    - Distortions in perceptions of relationships can lead to revictimization

What do we see?

- Focus on looking for danger
  - Group member who can't follow along with session but can tell you how many sharp pencils are in cup on center of table
- Extreme responses
  - Man who reacts by punching someone who accidentally bumps into him
- Extreme thinking
  - Participant who refuses to sit with their back to the door while completing intake so they can't be attacked from behind
- Hypersensitive to minor threats
  - Woman from a neighborhood with significant community violence who jumps out of her chair when she hears a car backfire
- Power/Control
  - Participant who threatens staff regarding minor misspelling of their name

Trauma Reenactment

- Whatever we did kept us alive today so it will probably keep us alive tomorrow
  - Habits/Routines typically help be more functional long term
    - Morning routine- less time thinking about steps
- Trauma responses can be dangerous, harmful, less functional
  - Survival skills that are useful when you're being attacked being used when you're on a frustrating call about your place on the waitlist for a therapist
    - Familiar (worked before)
    - Increased vulnerability to stress- experience a serious threat even when none present
    - Behavior as a way to signal emotion- unconscious way to alert distress

Trauma Reenactment

- Replaying of past trauma experience with people who are presently in person's life
  - Behaviors and relationships
- Trauma changes brain, impacts attachment and relationships and changes expectations on how others will react and respond to them
- Without context of their experiences their reenactments may be interpreted as other symptoms
  - Psychosis, suicidality, etc.

Trauma Reenactment with Participants & Staff

- Three roles typical with interpersonal trauma and subsequent reenactment
  - Victim, Persecutor, Rescuer (often no real rescuer but a wish for one)
  - Trauma reenactment can be unhealthy for participants and staff
    - Being a rescuer sounds more appealing than other roles- can never rescue our clients because their trauma has already happened
    - Focus on breaking patterns and re-scripting their futures
- How to respond to attempts at reenactment
  - Be aware of your own reactions towards the client and know your own triggers (counter-transference)
    - Have an awareness of things that are likely to make you feel like victim, persecutor, rescuer
  - Change your behavior/your language to stop recreating their trauma
    - Change from blaming language (manipulative, attention seeking) to terms that more accurately describe what they are doing in relation to their experience
    - Acting differently than those who have hurt them (moving away from punishment responses that replicate their past)

Examples of Reenactment

A participant who has a long history of sexual abuse is told during her initial visit to the Health Center is told that she will need to go to the hospital due to an extremely high blood pressure reading. The participant responds with immediate verbal aggression and threatens violence, resulting in the police being called.
Without trauma lens- psychotic, aggressive

With trauma lense- Participant felt coerced to go to the doctor. Coercion felt dangerous to her due to sexual abuse history and her desire to protect her body from being examined (possibly hurt) by doctor was similar enough to sexual abuse experience to trigger angry feelings and explosive behaviors. Her experience in relationships is either to be abused or to abuse which resulted in her behaviors.

Changing Perspective

- When people are faced with behavior we don't understand as "normal" for a situation- "What's wrong with you"
- Move from blaming language and view of others as sick or bad to one that acknowledges their experiences as influencing current functioning- "What happened to you"
- Change their experience with your language and responses
  - Participants who struggle with managing emotions learn from others who can manage their emotions

SELF Model

- Provides framework to focus intervention with participants, families, staff and organization
- Overall focus on solution rather than problem

SELF Model

- Safety
  - Physical safety- your body is safe from physical harm
  - Psychological safety- you are safe with yourself
  - Social safety- you are safe with other people
  - Moral/Ethical Safety- you and other people are safe and consistent with your conscience, beliefs, values
- Emotion Management
  - Naming/giving words for emotions
  - Managing emotions (versus supression or expression)
  - Trading in actions for words

SELF Model

- Loss
  - Acknowledging the past
  - Saying goodbye through rituals or rites of passage
  - Moving on- beginning to plan for the future
  - Refraining from reenactment- disrupting old and dysfunctional patterns
- Future
  - Changing trajectories- disrupting past behaviors
  - New attractors- finding inspiration that pulls you toward something better
  - Making different choices- being active rather than passive
  - Imagination- believing things can be different
  - Vision-taking time to think about what can and will be different

Parallel Process

- Refers to complex interactions between participants who have experienced traumas, stressed staff, pressured organizations and oppressive social and economic environments
- When systems have significant relationships with each other they tend to develop similar thoughts, feelings and behaviors
  - When driven by stress we find a traumatized and traumatizing environment

Action Plan

- Action plans are taught in any first aid course
- Mental Health Crisis Action Plan
  - ALGEE
- ALGEE action steps do not necessarily need to be followed in a fixed order
  - Use personal judgement and be flexible about responding to the person needing help

ALGEE

- Action A: Assess for risk of suicide or harm
  - Approach the person to determine if there is a problem, assess for any crises and assist the person in dealing with those crises
  - If the person appears to be at risk of harming self or others you must seek professional help immediately, even if the person does not want it
- Action L: Listen non judgmentally
  - People in distress want to feel heard before being offered help or resources
  - Successful non judgemental listening
    - Allows listener to hear and understand what's being said
    - Creates space for person in distress to feel able to communicate without being judged

ALGEE

- Action G: Give reassurance and information
  - Includes emotional support (empathy, voicing hope) as well as offering practical assistance with tasks that may seem overwhelming in the moment
  - Can also provide information about mental health problems
- Action E: Encourage appropriate professional help
  - May not be aware of all options/services available to them
    - Medication, therapy, support for family members, Educational assistance, vocational assistance, housing assistance, etc.
- Action E: Encourage self-help and other support strategies
  - Suggest self-help strategies or encourage support from family, friends, etc.
    - Peer Specialists

De-escalation Strategies

- Use a gentle caring, tone of voice
- Engage in active listening free from judgement
  - Clarifying, paraphrasing, open-ended questions
  - Does not mean you're agreeing, just expressing understanding
- Use positive words instead of negative
  - "Stay calm" versus "don't fight"
- Keep your voice low and with a steady pace
- Stay calm with voice and behavior (avoid nervous behaviors)
- Make any requests simple and specific

De-escalation Strategies

- Redirect attention
  - Learned skill that assists in shifting the focus or direction of energy (ie. changing topic of conversation when no longer productive)
- Be respectful, even when setting limits or calling for help
- Respond selectively- answer information questions no matter how rudely asked
  - "Why do I have to fill out all these fucking forms"
- Be honest
- Explain limits & boundaries in a firm but respectful tone
- Give choices where both alternatives are safe
  - "Would you like to take a minute and continue our meeting calmly or would you prefer to stop now and come back tomorrow when things can be more relaxed"

De-escalation Strategies

- Empathize with feelings, not behaviors
- Trust your instincts- if it’s not working or you feel unsafe stop

What to Avoid

- Multi-tasking while listening
- Ordering (You must...you have to…)
- Threatening (if you don't, then…)
- Preaching (you should…)
- Lecturing (this is why you're wrong…)
- Judging (you'll never change)
- Excusing (it's not so bad)
- Labeling (you're being unrealistic)
- Being defensive (even if comments/insults directed at you)
- Arguing
- Convincing

What to Avoid

- Get loud/Trying to yell over a screaming person
- Answering abusive questions (“why are all therapists liars”)
- Lying
- Volunteering extra information which may further upset/escalate

Tips for Providers

- Take time for self care throughout the day
  - Take a second to breathe in between patients
- You are not going to solve everything within a 15 minute visit
  - Its ok to validate the patients emotions but don't feel like you need to open up their entire history in the visit
- Get to know your behavioral health workers well and utilize their services

INCORPORATING TRAUMA-INFORMED CARE INTO PRACTICE

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"ACEs are the singular greatest public health threat facing our nation today"

Dr. Robert Block, Former President of the AAP

- Cultural Change
  - Organization wide
  - Senior administration buy in
- Education
  - initial and ongoing
- Team-based Approach to Care
  - Professional and non-professional

- Partnered with The Health Federation
  - Education staff
- Built on currently existing structures and collaboration
  - Behavioral Health Consultants
  - JJPI
- Trauma-informed environment

- Trauma as a Social Determinant of Health
- Incorporated into SDH Screening

- Health Leads Screening Tool

modified – 4 behavioral health questions --
alcohol, drugs, smoking, trauma

PHMC Social Services Assessment

Name / Date of Birth / Date

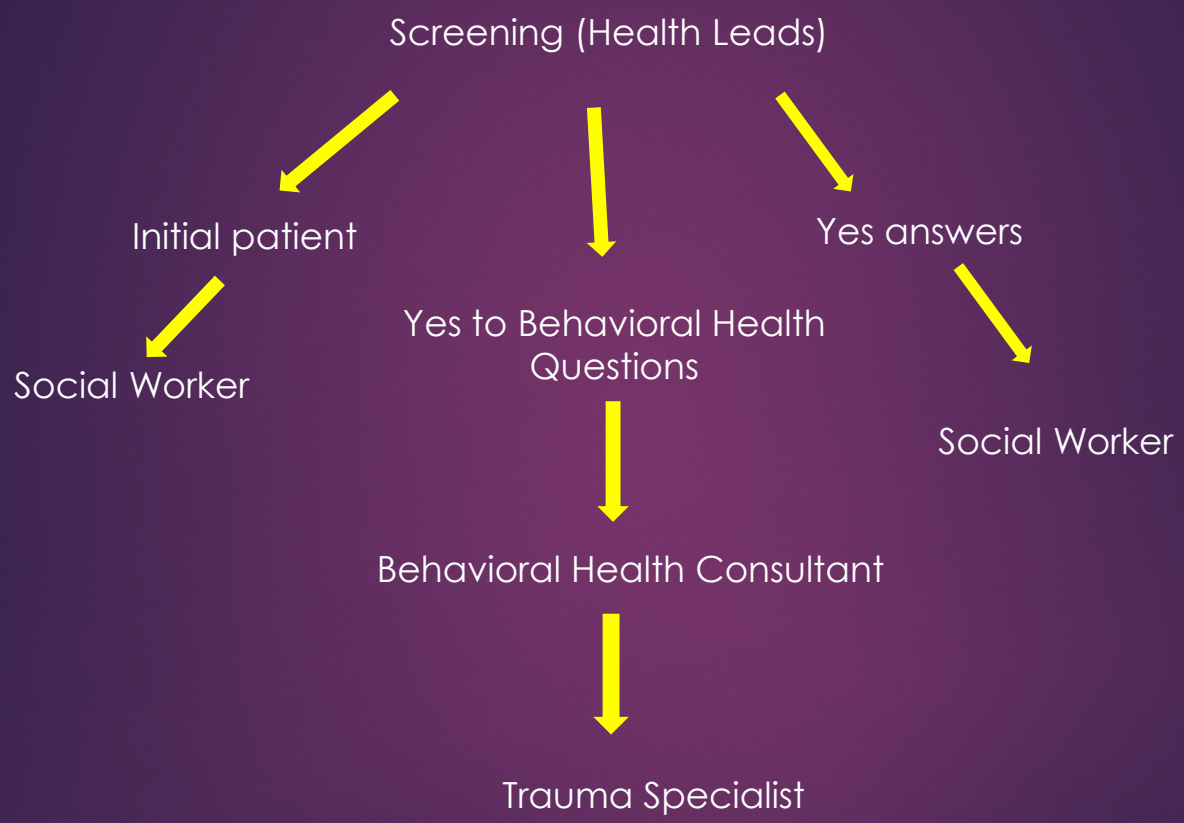
There are staff on site to help you with non-medical needs too. Answering the questions below will help connect you those staff and services.

	Yes/No		
In the last 6 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y	N	Prefer Not to Answer
In the last 6 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y	N	Prefer Not to Answer
Are you worried that in the next 2 months you **may not have stable housing?**	Y	N	Prefer Not to Answer
Do problems getting **child care make it difficult for you to work or study?**	Y	N	Prefer Not to Answer
In the last 6 months, have you needed to see a doctor, **but could not because of cost?**	Y	N	Prefer Not to Answer
In the last 6 months, have you ever had to go without health care because you **didn't have a way to get there**?	Y	N	Prefer Not to Answer
Do you ever need help **reading hospital materials**?	Y	N	Prefer Not to Answer
Do you often feel that you **lack companionship**?	Y	N	Prefer Not to Answer
Do you need assistance in getting a form of **identification** (e.g. ID, birth certificate, social security card)?	Y	N	Prefer Not to Answer
In the past year, have you or someone you known been **worried about your drinking?**	Y	N	Prefer Not to Answer
In the past year, have you **used any drugs** that were not prescribed to you?	Y	N	Prefer Not to Answer
In the past 30 days, have you **used cigarettes, e-cigarettes**, hookah, cigars/cigarillos, pipe, or smokeless tobacco?	Y	N	Prefer Not to Answer
Have you ever experienced violence or trauma in any setting? (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)	Y	N	Prefer Not to Answer

Initial patients

Annual updates

Self administered


Screening (Health Leads)
Initial patient
Social Worker
Yes to Behavioral Health Questions
Behavioral Health Consultant
Trauma Specialist
Yes answers
Social Worker

Questions?

Please type your questions into the Q&A pod.

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