



SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Trauma-Informed Care Innovation Community: Screening and Assessing for Trauma

Presenters:

Linda Ligenza, LCSW, CIHS

Glenda Wrenn Gordon, MD, MSHP

Shana Grady, Psy.D

May 5, 2016

Setting the Stage: Today's Moderator



Madhana Pandian
Associate

SAMHSA-HRSA Center for Integrated Health Solutions

**Slides for today's webinar will
be available on the CIHS
website:**

www.integration.samhsa.gov

Under About Us/Innovation Communities

Our format:



Structure

Presentations from experts

Polling You

At designated intervals

Asking Questions

Responding to your written questions

Follow-up and Evaluation

Ask what you want/expect
and presentation evaluation

Listserv

Look for updates from:
[trauma_informed_care_ic](#)

Linda Ligenza, LCSW SAMHSA-HRSA Center for Integrated Health Solutions – TIC IC Facilitator



Presenters

Glenda Wrenn, MD is a psychiatrist and health policy/mental health services researcher at Morehouse School of Medicine where she directs the Division of Behavioral Health in the Satcher Health Leadership Institute and serves as Interim Co-Director of the Kennedy Center for Mental Health Policy and Research. Dr. Wrenn's passion and overall research aim is to help create environments where individuals adversely impacted by trauma will face a path forward that makes it easier for them to recover and build a good life.

Shana Grady, Psy.D is a clinical psychologist who currently practices full-time within an integrated primary care safety-net clinic in Fairfax, Virginia. She has led efforts to adopt trauma-informed care within this setting. She is also a field supervisor and guest lecturer at Argosy University Professional School of Psychology, Washington DC campus.

Webinar Agenda

Linda:

Introduction and overview of screening and assessment domain standards

Dr. Wrenn:

Key factors involved in screening and assessing for trauma

Dr. Grady:

Challenges and practical tips

Definitions: Screening & Assessment of Trauma

Screening - brief, focused inquiry to determine an individual's experience of traumatic events or current events that might be traumatizing - experiencing of invasive thoughts, feelings or behaviors associated with trauma

Assessment - more in-depth exploration of the nature and severity of the traumatic events and the consequences on a person's life including current distressing symptoms

Importance of Screening & Assessment

Necessary to developing collaborative relationships with trauma survivors and offering appropriate services

Necessary in order to avoid re-traumatization, honoring the dictum: “Above all, Do No Harm”

Sets the stage for building resilience, recognition of a survivors strengths and builds a healing alliance

(Harris & Fallot, 2001)

Consequences of Failing to Screen and Assess for Trauma

- Many users of mental health services are upset at not being asked about abuse (Lothioan & Read, 2002)
- Inhibiting or holding back one's thoughts, feelings and behaviors is associated with toxic stress
- Not to inquire may further re-victimize the client (Doob,1992)
- Childhood sexual abuse is the single strongest predictor of suicidality regardless of other factors (Read et al., 2001)
- Any attempt to address suicide reduction that does not include assessment of childhood sexual trauma will fail (Hammersley, 2004)

Ten Questions Doctors are Afraid to Ask

“Talking to patients about adverse childhood experiences shouldn't be any different than asking them about domestic violence or their drinking — awkward topics that doctors routinely broach now.” – Dr. Jeffrey Brenner

<http://n.pr/1Gc3xN9>

(NPR, March 3, 2015)

Domain 1. Screening and Assessment Standards

System is in place to:

- sensitively, routinely and universally screen patients for trauma
- sensitively inquire and respond to current adverse life experiences
- address the connection between trauma and physical health concerns
- complete comprehensive trauma assessment for patients with positive screens
- identify patients needing referral and to follow up on referral process

Guiding Principles for Screening and Assessment

Safety

Respect

Transparency

Person-centered

Shared decision making

Strengths based

Culturally sensitive

Voice, choice and self-advocacy

Belief that full recovery is possible

Poll Question #1

Who do we have in attendance?

A) PCP or Psychiatrist

B) Leadership

C) Nursing Staff

D) Behavioral Health Specialist

Transforming Usual Care: Key Factors in Trauma-Informed Care

Glenda Wrenn Gordon, MD, MSHP

Dr. Wrenn is a psychiatrist and health policy/mental health services researcher at Morehouse School of Medicine where she Directs the Division of Behavioral Health in the Satcher Health Leadership Institute and serves as Interim Co-Director of the Kennedy Center for Mental Health Policy and Research.

Although much of her current research focuses on systems of care improvements related to the culturally-centered integration of behavioral health and primary care, Dr. Wrenn's passion and overall research aim is to help create environments where individuals adversely impacted by trauma will face a path forward that makes it easier for them to recover and build a good life.

Dr. Wrenn has helped to advance integration in several large health systems and individual practices of all sizes. She is a community engaged researcher, with frequent knowledge exchanges in the community through speaking and events; and also serves as an advisor for several local, regional, and national health-related organizations.



Poll Question #2:

Please identify one barrier to screening and assessing for trauma

Use the **chat box** to indicate this barrier in one to three words?

Poll Question #3

At this moment, what is your level of comfort with the screening and assessment process?

- A) Expert
- B) Intermediate
- C) Novice
- D) Need more information

The Future is Coming

This is Where We're Going

Not Sure You Want to Go There?



Key System-level Factors

- Leadership
 - Mind your “no’s”
- Readiness to Change
- Knowledge, Skills, and **Experience**
- SMART Objectives
 - Short and long term goals
 - Design early wins

Primary Care Provider (PCP) Leadership Role

- Lead with enthusiasm and authenticity
- Own challenges and hesitancy to change
- Apply trauma lens to practice culture
- Ask great questions
- Engage in review of cases within multidisciplinary teams
- Help build better bridges to behavioral health provider referral networks
- Develop trusting relationships

Time Constraints



Cultivating Resilient Responses

Expected Complaint

We don't want to "open up" something we don't have time for

We only have 12 minutes, it's not enough time to screen

I'm just not comfortable bringing this up with a primary care patient

Resilient Response

Addressing trauma will save time in the long run and will help you see problems accurately

Try out a few PDSA cycles of screening and see how long it takes

If your patient had HIV/AIDS you would probably feel uncomfortable uncovering that too

Why are you asking these questions?

Plan in Advance...

- What to do with screening results
- How to follow up with positive results
- Recognizing hidden trauma narratives and False negative screening results
- Building referral networks and on-site trauma-informed response capacity

Do—Study—Act

N=1 is a powerful test of change

- Debrief often and early
- Select good change days
- Scale good processes, forget failures quickly
- Don't give up on reluctant partners, but it's okay to deflect attention

Implementation Example: VA Women's Center of Excellence (COE)

- Educational training environment funded in 2012 to serve women veterans
- Services Offered: Gynecology, Psychiatry, Primary Care, Dermatology, Cardiology, Tele-retinal, Acupuncture, Joint Injection
- High proportion of Military Sexual Trauma and PTSD

VA W-COE

- 1000 female patients
- Existing use of PHQ-2->PHQ-9 and PTSD 4 question screener->PCL-5
- Existing access to trauma specific services
- Screening by nursing staff with variable methods (**only discovered this with direct observation**)

New Trauma-Informed Practices

- **All providers (re)trained in recognition** of trauma-related conditions (PTSD, Depression, Reproductive trauma)
- **Weekly interdisciplinary didactic** on various topics including mental health
- Special **review of clinical scenarios** (pelvic exam, tearful patient, angry hostile response to screening)
- **Daily Huddles** and **Debriefs** when needed

Impact

- High patient satisfaction of clinic compared to other areas of care
- High show rates to trauma recovery program when patient referred
- High provider satisfaction and scores of self reported measure of team communication
- Nursing, registration, and even our cleaning staff adopted improved trauma awareness

Implementation Perils: Reflections from an integrated primary care safety-net clinic

Lessons Learned from Trauma-Informed Primary Care Initiative-TIPCI Project June 2015-Mar 2016

Shana Grady, Psy.D, MSc

Dr. Shana Grady, PsyD is a clinical psychologist who currently practices full-time within an integrated primary care safety-net clinic in Fairfax, Virginia. She is also a field supervisor and guest lecturer at Argosy University Professional School of Psychology, Washington DC campus.

Dr. Grady is deeply committed to increasing access and overcoming barriers to culturally sensitive mental healthcare. Her international experience in the U.S and U.K, provides a dynamic perspective to how we consider and empower those who experience challenges to their mental well-being.



Overcoming screening challenge 1: Time



Problem: “We don’t have time... We have too much to do already!”

Solution: Incorporate brief screening tool into existing workflow

Overcoming screening challenge 2: Language/Cultural differences

Any tool needs to meet the needs of non-English speaking, culturally diverse patients with varying levels of literacy. Renders most self-report measures inappropriate

Solution: Brief verbal screening, at triage.



Overcoming screening challenge 3: Selecting appropriate screening tools (*What are we screening for?*)

- Experience of traumatic life events? (ACE, LEC)
- Signs of PTSD? (e.g. PC-PTSD)
- Signs of other mental health concerns? (depression, anxiety, substance use, etc.)

Screening Process

PILOT PHASE:

Piloted 10 question screener
(adapted from ACEs/LEC)

PCP, Triage nurse and BH
provider offered screening to
all identified patients

All patients provided with trauma
information and opportunity for
follow-up with Behavioral
Health Specialist

POST-PILOT:

2 question screener at triage

MAs/nursing staff to offer
screening to all new pts and
annual physicals

Repeat screening?

All patients provided with trauma
information and opportunity to
follow up with Behavioral
Health Specialist

Example screening tool (for triage staff/PCPs)

“We like to make sure we do all we can to take care of our patient’s overall health and wellbeing. Did you know that past and present life stress can have serious effects upon health and healing (**provide ACE handout**)? It has been shown that past experiences of painful or what we might call “traumatic life events” (such as abuse, violence, loss...etc) can lead to physical, emotional and mental health difficulties. We’d like to ask you a couple of questions about some of your experiences (**obtain verbal consent**). We have a team member available if you’d like to talk further about any of this after your PCP visit”.

1) Have you ever had an experience so upsetting that you think it changed you spiritually, emotionally, physically or behaviorally? For example, leading to problems:...

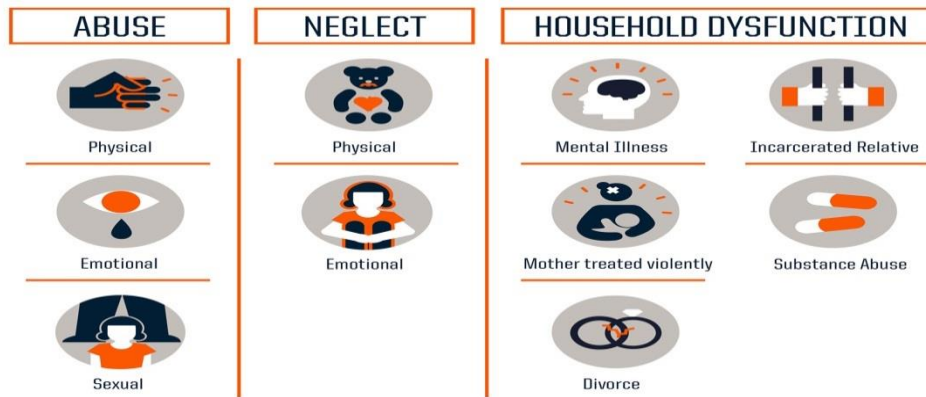
- sleeping (nightmares), eating, completing daily tasks, being around others or going places...? (**behavioral**)
- with excessive physical body pain/discomfort (**physical**)
- periods of prolonged sadness/tearfulness, increased fear or irritability/anger (**emotional**)

2) Do you think any of these problems bother you now?

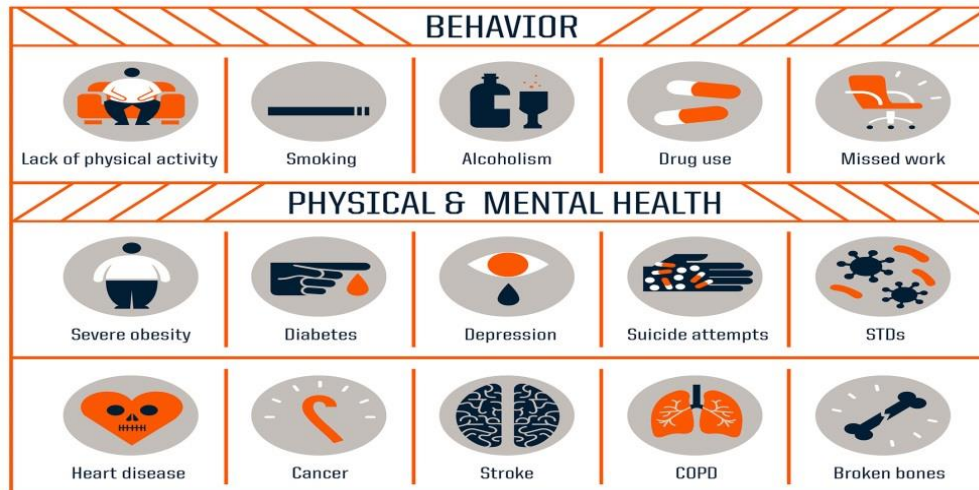
Patient handout/flyer

Did you know that...?

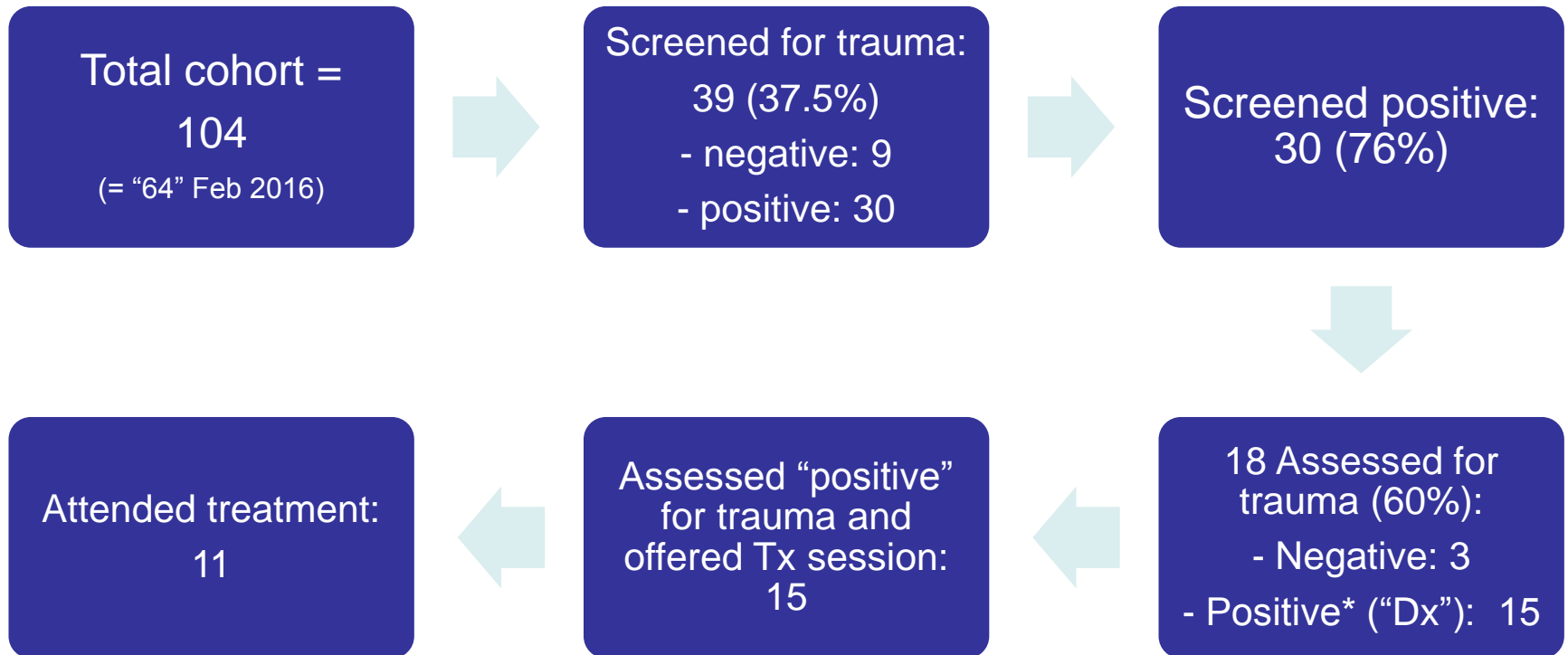
... the more **traumatic early experiences** we have, such as:



... the more at risk we become for **health problems later** in life

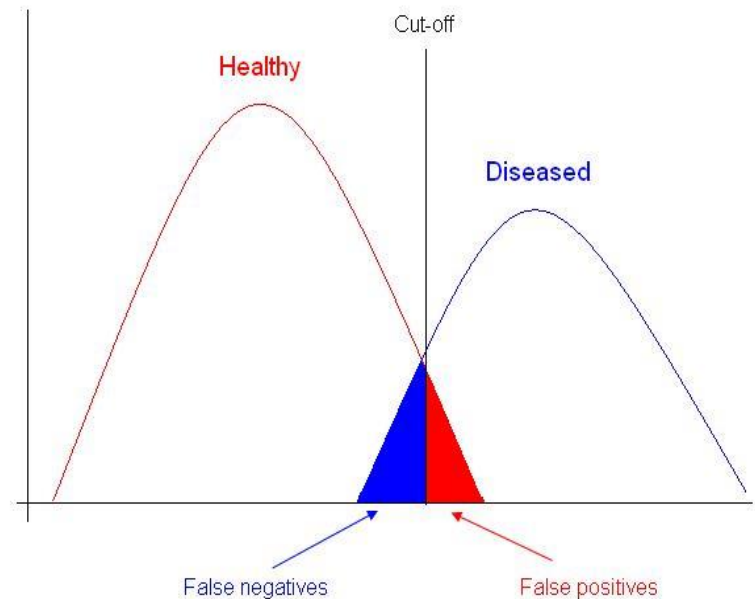


Workflow screening and data flow chart



Interpretation of Screening Results

- Treat all “scores” as tentative
- Main function of screening: share information about trauma/stress and health with as many people as possible, **increasing awareness** about what can help
- Good assessment = crucial



Assessment Tools

Clinical interview conducted by BH provider. Informed by choice of tools:
PHQ-9, GAD-7, PC-PTSD, AUDIT (“Patient Stress Questionnaire”)

SCID (Structured Clinical Interview for DSM); “STRESS” (Structured Trauma-Related Experiences and Symptoms Screener; inventories 25 ACEs *and* assesses symptoms of PTSD)

Background History (Family, Occupational, Social etc.)

Assessment Outcome: Therapy or not?

- Many patients who might benefit from therapy may not attend follow-up. Thus, important for behavioral health provider to **prioritize main current needs**... (risk assessment, crisis stabilization, support)
- “Intervention” starts from screening & education. Not all patients need, want or are suitable for “therapy”. May benefit from CM, care coordination, referral to outside resources. Present options (empower by choice)

Treatment Options

Universal SCREENING AND EDUCATION allows services to reach many (whether they *disclose* or not, *false negatives*). Increases access to (and can de-stigmatize use of) mental health service.

Stepped care approach to mental/behavioral health treatments helps meet demands that increased screening may create (by providing “least burdensome” and most efficient treatment possible”)

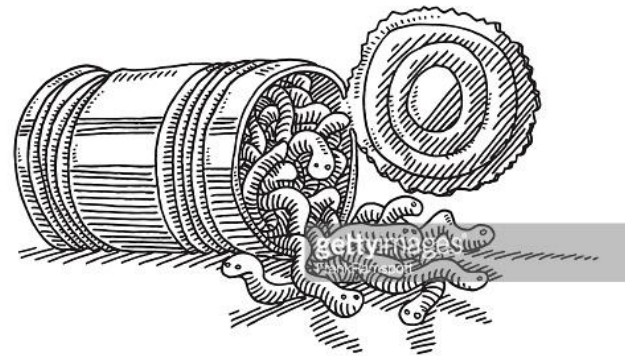
Primary care therapy interventions, examples:

- 1:1 brief therapy
- Psychoeducation stress/DM classes and groups
- Case management, staff consultation
- CBT/seeking-safety principles. Coping skill, supports and resiliency development. “Phase 1: **Safety and crisis stabilization**”

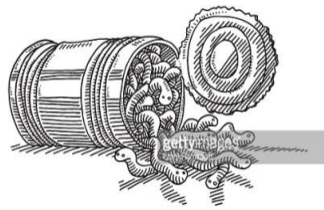
Refer on if patient requires higher level of care

Overcoming screening challenge 4: Fear of opening the can

- What if the patient reacts badly?
- How are we going to deal with all these open cans?



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“Closing the Can” (providing containment until we can help further.. *as needed*)



- Providing **empathic containing responses** and **offering a safe space** for same day follow up **assessment with behavioral health provider** is containment in itself (even if patient declines, they are aware of available services)
- Take care not to underestimate patients’ own capacity to cope (e.g. choosing not to disclose may be a helpful coping strategy in that moment)
- Validating and reinforcing evidence of patient’s strengths, **resilience** and survival capacity (e.g. “consider all it took to get up and make it to this appointment today...”, “plans, next steps?”)
- Regular in-house **staff training** and consultation space (*Workforce Development, Domain 3*)

A patient's story...

“Imelda” 49F . Presented to PCP for DM follow up/med refill. “Non-compliant with meds”. ACEs = 8. A1C = 13.3

Initial Assessment. Presenting symptoms: some low mood and mild anxiety, occasional sleep disturbance (worked nights). Trauma history: Fled El Salvador aged 15. Witnessed parents and brothers killed
Preliminary Diagnosis: Deferred. Anxiety NOS. **Did not seem to be significantly impacting current function**

Pt's goals: Wished to focus on anxiety related to **current** marital problems. “Felt sad after last visit thinking about parents. Ok once got home and focused on children”

PC therapy focus: stress (marital) management education, wellness promotion (meds, exercise, sleep – understanding and overcoming the barriers. Explored beliefs about DM)

Tx Outcome: Pt reported i) ↑ ways to manage marital stress, ii) Adhering to meds / more healthy lifestyle habits. Reduced A1C = 8.9 (5m on)

Impressions/ lesson learned:

- Understanding patient's focus/**goals** (MI approach). In light of multiple traumas and current stressors, patient continues to function and manage day-to-day activities. High resilience, assets++
- Current stressors may take priority over past traumas (where to start 1st?)

Another patient's story

39 y.o. Spanish-speaking female. ACE Score: 1 (parental divorce)

No sig concerns or functional impairments at Assessment except for “sometimes have trouble sleeping...”

Door handle moment s2. Following week disclosed horrendous hx of multiple traumas (including witnessing family's murder, fled to this country, raped)

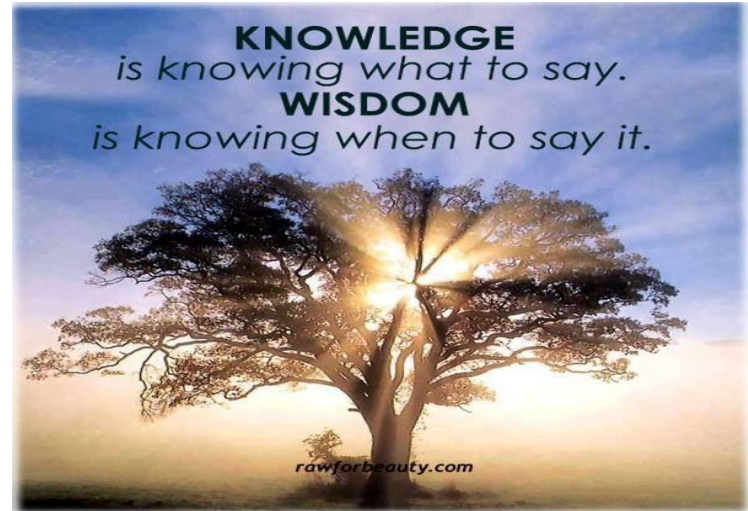
Outcome: Pt expressed relief upon disclosure. Enabled dialogue that continued to make links between past history and current function (in addition to sleep disturbance, revealed underlying low mood, avoidance, emotional eating)

Impressions/lessons learned: **Trust** can take time to build. Patients benefit from the mere knowledge of having a safe space they can come to, if/when they need to, (if *they* chose to). **Recovery happens within context of safe space and trusting relationships**

What to say, when...?

Sometimes when I say "I'm okay", I want someone to look me in the eyes, hug me tight, and say, "I know you're not"

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PEOPLE WILL FORGET
WHAT YOU SAID, PEOPLE
WILL FORGET WHAT YOU
DID, BUT PEOPLE WILL
NEVER FORGET HOW YOU
MADE THEM FEEL.

MAYA ANGELOU

Goals moving forward...

Main priority: Continue to **develop awareness** (and plant the seeds...) throughout the population we serve



What happens next...?

Endless possibilities for **growth**



Key Points

- Ensure that staff feel comfortable with screening and assessing for trauma through education, training and conversations about trauma and TIC principles and practices
- Involve staff in development of screening and assessment process so they “own” it
- Use quality improvement process to check to see if tool and process are working
- Use huddles and team meetings to share information about impact of trauma on individuals and to see all aspects of care through a “trauma-informed lens”
- It’s all about the ‘relationship’ and every person plays a key role

Poll Question #4

Following this webinar, what is your level of comfort with the screening and assessment process?

- A) Expert
- B) Intermediate
- C) Novice
- D) Need more information

Additional Resources

SAMHSA's Tip 57 – Trauma-Informed Care in Behavioral Health Services, Appendix D – Screening and Assessment Instruments

<http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

National Council Screening and Assessment Guide

http://www.integration.samhsa.gov/about-us/CIHS_TIC_IC_Screening_and_Assessment_Guide.pdf



A Guide to GPRA Data Collection Using Trauma- informed Interviewing Skills



Grantee Data Technical Assistance Program

November 2015



Questions

Webinar Schedule

Webinar Number	Date	Time
June #6	Jun. 16	2 - 3pm
July #7	Jul. 21	2 - 3pm
August #8	Aug. 18	2 - 3pm

Thank you for joining us today!

**Please take a moment to provide
feedback by completing the survey at
the end of today's webinar**

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