Integrating Behavioral Health & Public Health Special Strategy Meeting

National Council for Behavioral Health
April 22nd, 2018, 9:00am – 4:30pm

Gaylord National Resort & Convention Center
National Harbor, MD
Welcome!

Linda Rosenberg, MSW
President & Chief Executive Officer
National Council for Behavioral Health
Welcome!

Tom Hill, MSW
Vice President, Practice Improvement
National Council for Behavioral Health
Centers for Disease Control and Prevention

Andrea Young, PhD
Associate Director for Science
Center for State, Tribal, Local & Territorial Support
(proposed)
Overview of the Day

Taslim van Hattum, MPH, LCSW
Director, Practice Improvement
National Council for Behavioral Health
Panel #1
Role of Behavioral Health Systems within a Public Health Model

Moderator: Shelina Foderingham, National Council for Behavioral Health

Giang Nguyen, County of Santa Cruz Health Services Agency
Tiosha Bailey, Chicago Department of Public Health
“Cruz to Health” –
Breaking Down Silos to Implement Whole Person Care

Giang Nguyen, BSN, MSN
Director
County of Santa Cruz Health Services Agency
WHOLE PERSON CARE
Cruz to Health

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
ANNUAL CONFERENCE 2018

Giang T. Nguyen
April 22nd, 2018
Whole Person Care – A Statewide Pilot

• A component of California’s Department of Health Care Services (DHCS) Section 1115 Medicaid Waiver: Medi-Cal 2020
• $3 billion pilot program
• Funded through December 2020
• Leverages local funds to draw down federal financial share
What is Whole Person Care?

• 25 county-based Whole Person Care (WPC) pilot programs to:
  • improve care coordination
  • enhance data sharing
  • improve integrated patient-centered care across sectors
  • meet patients’ holistic needs, such as housing and social services
  • reduce high utilization of multiple systems
  • lead through collaborative leadership
  • improve patient health outcomes

• WPC services are those not billable to Medi-Cal
Statewide Target Population

• Medi-Cal beneficiaries
• High users of multiple systems
• Patients with persistent poor health outcomes
• Examples:
  • Homeless or at risk of homelessness
  • Persons with serious mental illness
  • Post-incarcerated individuals
  • Frequent users of emergency rooms or emergency psychiatric facilities
  • Transitional Aged Youth (TAY)
  • Persons with co-occurring chronic medical conditions
Statewide Key Components

- Breaking down silos through data sharing
- Pilot testing innovations with flexible financing
- Outcomes and Metrics based
  - Universal Metrics
  - Variant Metrics
- Quality Improvement through Rapid Plan Do Study Act (PDSA) cycles
- Statewide formal evaluation
WPC – C2H: Program Overview

• Whole Person Care – Cruz to Health tests innovations to improve care management and health outcomes of Medi-Cal beneficiaries with co-occurring chronic conditions, complex needs, and history of high utilization of multiple systems

• Funding:
  • California Department of Health Care Services - Medi-Cal 2020 waiver
  • Mental Health Services Act Innovations grant

• Project timeline:
  • July 2017 – December 2020
WPC – C2H: Goals

- Develop performance standards, establish shared accountability
- Integrate systems for better coordination
- Improve client function and clinical outcomes
- Reduce costly and avoidable utilization
- Build a care coordination model with evidence-based interventions
- Promote community tenure

Innovations & PDSAs
WPC – C2H: Target Population

• Adult Medi-Cal beneficiaries of Health Services Agency clinics with the following risk factors:
  • A mental health and/or substance use diagnosis and
  • At least two (2) of the following:
    • Two (2) or more chronic health conditions (e.g. diabetes, hypertension)
    • Prescribed five (5) or more medications for chronic health conditions
    • Homeless or at risk for homelessness
    • Four (4) or more psychiatric hospitalizations in a 12-month period
    • Two (2) or more medical hospitalizations in a 6-month period
    • Institutional living in the last 12-months or currently living in an IMD or jail

Referrals not meeting the above criteria may still qualify dependent on the demonstrated need and program capacity.
WPC – C2H: Examples of Key Benefits to Clients

• **Increased communication** between care team members and across systems resulting in shared treatment planning (via bi-directional data sharing)

• Expanded **behavioral health team** of multidisciplinary resources that include:
  • Mental health clinician, primary care clinician, case manager, nursing staff, medical assistant, occupational therapist

• **Housing navigation** and **Peer Supports**
WPC – C2H: Examples of Key Benefits to Clients

• **Housing assistance** - Security deposit and/or first and last month’s rent (up to $4,500/enrollee)

• **Tenancy Supports** - One-time transition expenses of goods and services (up to $3,000/enrollee)

• **Telehealth devices** – help with managing chronic psychiatric and medical conditions (e.g. depression, hypertension, diabetes)

• **Integrated Illness Management and Recovery (I-IMR)** – ~Four-month, weekly skills building program for co-occurring psychiatric and medical conditions
WPC – C2H: Services Updates

Available Services

Behavioral Health Intensive Support Team
- Nursing, OT, Care Coordination

Intensive + Intermediate Housing Support
- Housing navigation
- Peer support

Housing Assistance
- Up to $4,500 for security deposit/first & last mo. rent

To Launch

HIO/HIE Integration platform
- Late Spring

Telehealth device program
- Expected delivery April/May

Integrated Illness Management Recovery (I-IMR)
- Early May

Pending State Approval

Tenancy Supports
- One-time expenses (i.e. goods, services and housing set-up costs)

Not all clients will receive all services; appropriateness of services determined by clients’ care teams and by capacity
WPC – C2H: Key Benefits to Clients – Telehealth Devices

- Phillips Tele-Friend wireless telehealth device
- 8” Samsung touchscreen tablet
- Pre-programmed with content corresponding to primary psychiatric and medical diagnoses
- Daily 5-10 min interactive sessions
- Monitored daily by MAs
- Incentives possible with adherence
# WPC – C2H: Enrollment as of February 2018

<table>
<thead>
<tr>
<th>Program Enrollment</th>
<th>JULY</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>Year 2 Total</th>
<th>Program Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Enrollees</td>
<td>178</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>16</td>
<td>20</td>
<td>16</td>
<td></td>
<td></td>
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<tr>
<td>Disenrolled</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Agreed/Consented</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Enrollees</strong></td>
<td><strong>178</strong></td>
<td><strong>178</strong></td>
<td><strong>179</strong></td>
<td><strong>181</strong></td>
<td><strong>184</strong></td>
<td><strong>200</strong></td>
<td><strong>220</strong></td>
<td><strong>236</strong></td>
<td><strong>200</strong></td>
<td><strong>236</strong></td>
</tr>
</tbody>
</table>
### WPC Enrollees by Target Population

**July - Dec 2017 (Program Year 2)**

*Note: Enrollees can be in multiple target populations.*

#### Number of Enrollees

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Number of Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI and/or SUD</td>
<td>193</td>
</tr>
<tr>
<td>High utilizer</td>
<td>60</td>
</tr>
<tr>
<td>Chronic medical conditions (≥ 2)</td>
<td>75</td>
</tr>
<tr>
<td>Homeless</td>
<td>75</td>
</tr>
<tr>
<td>At risk for homelessness</td>
<td>19</td>
</tr>
<tr>
<td>Jail/IMD</td>
<td>2</td>
</tr>
</tbody>
</table>

#### Total

| Total (n) | 426 |

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**WHOLE PERSON CARE**

**CRUZ TO HEALTH**
WPC – C2H: Partners
# WPC – C2H: Care Coordination

## Care Coordination Strategies

### Health Improvement Partnership (HIP)
- Organize Care Coordination Workgroup, facilitate case management discussions

### Santa Cruz Health Information Exchange (HIE)
- Training on strengths-based case management model for WPC and community partners
- Identify community’s data sharing needs and develop care coordination application
- Care plans accessible in new application and integrated with EHR systems

### IT integration
- County’s EHR systems (Epic, Avatar), HIE application, and telehealth devices
WPC – C2H: Data and Metrics

<table>
<thead>
<tr>
<th>Universal Metrics</th>
<th>Variant Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ED utilization</td>
<td>• Timely case management following discharge or release</td>
</tr>
<tr>
<td>• General hospital utilization</td>
<td>• Coordinated case management</td>
</tr>
<tr>
<td>• Timely follow-up after psychiatric</td>
<td>• All-cause readmissions</td>
</tr>
<tr>
<td>hospitalization</td>
<td>• Psychiatric rehospitalizations</td>
</tr>
<tr>
<td>• Initiation and engagement in SUD</td>
<td>• Hospital coordination: medication lists at discharge, timely documentation</td>
</tr>
<tr>
<td>treatment</td>
<td>• Depression remission (PHQ-9)</td>
</tr>
<tr>
<td>• Comprehensive care planning</td>
<td>• Suicide risk assessments</td>
</tr>
<tr>
<td></td>
<td>• Control of diabetes, hypertension</td>
</tr>
<tr>
<td></td>
<td>• Substance abuse counseling (SBIRT)</td>
</tr>
<tr>
<td></td>
<td>• Housing referral outcomes</td>
</tr>
<tr>
<td></td>
<td>• Permanent supported housing project</td>
</tr>
</tbody>
</table>
## WPC – C2H: Data and Metrics

<table>
<thead>
<tr>
<th>Additional Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• EMS utilization</td>
</tr>
<tr>
<td>• Health care costs</td>
</tr>
<tr>
<td>• Telehealth program and I-IMR program:</td>
</tr>
<tr>
<td>• Psychiatric symptoms, blood glucose, SpO₂, BMI</td>
</tr>
<tr>
<td>• Health self-efficacy (Self-Rated Abilities for Health Practices)</td>
</tr>
<tr>
<td>• Health self-management of symptoms (Integrated Illness Management Recovery scale)</td>
</tr>
<tr>
<td>• Client satisfaction</td>
</tr>
</tbody>
</table>
Questions & Thank you!

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wholepersoncare@santacruzcounty.us

Website:
www.santacruzhealth.org/wholepersoncare

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Meeting Behavioral Health Demands in High-Need Communities through Strengthening Infrastructure

Tiosha Bailey, MPH
Deputy Commissioner, Health Promotion
Chicago Department of Public Health
Chicago Department of Public Health (CDPH): What We Do

**Vision:** A city of thriving communities where all residents are able to live healthy lives

**Mission:** To promote and improve health by engaging residents, communities and partners in establishing and implementing policies and services that prioritize residents and communities with the greatest need.

- Approximately 600 employees, over 100 personnel titles
- Six Bureaus

- Annual Budget: $160M
Healthy Chicago 2.0

Foundational elements
- Data and Research
- Root Causes of Health (Built Environment, Economic Development, Housing, Education, Access to Health Care & Human Services
- Partnerships & Community Engagement

Priority Health Concerns
- Behavioral Health
- Child & Adolescent Health
- Chronic Disease
- Infectious Disease
- Violence
Healthy Chicago 2.0 Development Process

1. Partnership Development
2. Visioning
3. 4 MAPP Assessments
   - Community Themes & Strengths
   - Forces of Change
   - Local Public Health System
   - Community Health Status
4. Identify Strategic Issues
5. Formulate Goals, Objectives & Strategies

**Launch Healthy Chicago 2.0**

**Plan**

**Action**

- Evaluate
- Implement
Behavioral Health

CDPH has built strong partnerships and is investing in community providers. As a result, Chicago’s behavioral health system is stronger, offering more services in more communities than ever before.
GOAL

Chicagoans have access to coordinated systems that effectively address behavioral health

OBJECTIVE

Increase utilization of mental health treatment among those with greatest need by 10%

STRATEGIES

• Strengthen and promote the use of telehealth
• Conduct an assessment of behavioral healthy system capacity
• Develop and make widely available a behavioral health resource inventory
• Strengthen and promote programs that provide intensive case management for people leaving jail or prison
• Train the city’s workforce in trauma-informed service delivery
Effective prevention (primary, secondary and tertiary) and treatment are delivered

**GOAL**

Reduce prescription opiate abuse

Reduce opiate overdose by 20%

**OBJECTIVES**

**STRATEGIES**

- Promote the use of medication-assisted treatment
- Expand access to opioid use disorder treatment through campaigns, physician buprenorphine training & FQHC treatment capacity
- Expand opioid overdose education & naloxone distribution programming
Thank You!!

Tiosha Bailey, Deputy Commissioner- Health Promotion Bureau
Tiosha.Bailey@cityofchicago.org
Phone: 312-747-8841

Link for Healthy Chicago 2.0 Plan
https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/HC2.0Plan_3252016.pdf
INTEGRATING BEHAVIORAL HEALTH AND PUBLIC HEALTH

WHAT CAN WE PROVIDE YOU WITH AT NATCON 2018?

TELEMEDICINE
- Psychiatric nursing
- Zero suicide
- Children + Youth
- Collaboration

MAT services
- Mental health
- Prevention
- Homelessness
- Access to care
- Care coordination
- Integration
- Psychiatry treatment
- Tribal access to care
- Opioids

CRIMINAL JUSTICE
- Crisis!

SUNDAY APRIL 22ND 2018

ENJOY YOURSELF!

LET'S LEARN FROM EACH OTHER TO FURTHER INTEGRATION!

I WANT TO LEARN MORE ABOUT POPULATION HEALTH.

INTEGRATION IS CRITICAL.
Panel #2
Substance Use – Prevention, Treatment & Legislation

Moderator: Nick Szubiak, National Council for Behavioral Health

Matilde Castiel, City of Worcester MA
Mark Wilson, Jefferson County Department of Health
Tom Hill, National Council for Behavioral Health
Facing Addictions-Related Disparities through Treatment, Stigma Reduction & Care Coordination

Matilde Castiel, MD
Commissioner of Health & Human Services
City of Worcester MA
Maximizing Multidisciplinary Collaboration to Address Substance Use and its Public Health Implications

Mark Wilson, MD
Health Officer
Jefferson County Department of Health
Opportunities and Challenges Presented by the Opioid Epidemic

Tom Hill, MSW
Vice President, Practice Improvement
National Council for Behavioral Health
Action Planning & Small Group Work

- Focus on efforts related to role of **substance use disorders, prevention, and treatment**.
Panel #3
Cadre of ‘Care’ – Trauma Informed, Integrated & Collaborative Care

Moderator: Karen Johnson, National Council for Behavioral Health

Lynda Zeller, Michigan Division of Behavioral Health
Duane Stansbury, Warren County Health District
Shannon Dial, Dept. of Family Services, Chickasaw Nation
Linda Henderson-Smith, National Council for Behavioral Health
Using Data & Screenings to Close Gaps in Treatment

Michigan Perspective: Two Challenge Areas

April 22, 2018 Nat Con Conference

Lynda Zeller, Deputy Director
Behavioral Health & Developmental Disabilities Administration
Two Examples in Michigan
Using Data and Screening to:

- Reduce over prevalence serious mental illness and addiction in jails
- Earlier identification of opioid misuse and risk of addiction
Reduce Over Prevalence SMI in Jails

Using uniform screening and Intervention at six Intercept points
Prevalence of SMI across Eight Jails

Identification of SMI by K6 Score

<table>
<thead>
<tr>
<th></th>
<th>K6=9+</th>
<th>K6=13+</th>
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<tbody>
<tr>
<td>TOTAL</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>H</td>
<td>11%</td>
<td>22%</td>
</tr>
<tr>
<td>B</td>
<td>12%</td>
<td>22%</td>
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<tr>
<td>D</td>
<td>11%</td>
<td>21%</td>
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<td>J</td>
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<td>21%</td>
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<tr>
<td>I</td>
<td>11%</td>
<td>19%</td>
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<tr>
<td>E</td>
<td>9%</td>
<td>18%</td>
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<tr>
<td>A</td>
<td>10%</td>
<td>18%</td>
</tr>
<tr>
<td>G</td>
<td>9%</td>
<td>16%</td>
</tr>
</tbody>
</table>

NOTE: Recent BJS Data (2017) - using K6 cut score of 13 - found 26% national prevalence in jails.
Assessing Risk/Needs Across Four Domains: SUD/MH/Housing & Recidivism Michigan Jails

<table>
<thead>
<tr>
<th></th>
<th>0-1 risks</th>
<th>2 risks</th>
<th>3-4 risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>No SMI</td>
<td>51%</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>SMI</td>
<td>10%</td>
<td>36%</td>
<td>54%</td>
</tr>
</tbody>
</table>
B. Michigan is one of several states that have joined over 420 counties in an initiative to reduce the number of people with mental illnesses in jails.

In May 2015, a call to action was issued to counties, and in response, 420+ counties have passed resolutions.

**Strategies to Focus on Four Key Outcomes**

1. **Reduce** the number of people with mental illnesses booked into jail

2. **Shorten** the length of stay for people with mental illnesses in jails

3. **Increase** the percentage of people with mental illnesses in jail connected to the right services and supports

4. **Lower** rates of recidivism

**System Improvements**

- Police—mental health collaboration programs
- CIT training
- Crisis diversion centers
- Screening and assessment in jails
- Pretrial mental health diversion
- Bail policy reform
- Expansion of community-based treatment
- Streamline access to services
- Leverage federal, state, and local resources
- Apply Risk-Need-Responsivity principle
- Apply the Behavioral Health Framework
- Ongoing program evaluation

Source: CSG Justice Center, CJAB Conference Presentation, April 2017.
Early identification of opioid misuse & addiction risk

Surveillance, Prescription Monitoring, Data informed strategy
OPIOID ADDICTION IS A GROWING PROBLEM.

In Michigan alone, an average of five people die from opioid overdose every day. Help us change the numbers and stop this deadly epidemic.

All Drug Deaths 2011 2016
Total number of overdose deaths in Michigan involving any drug.
1,359 2,356

All Opioid Deaths 2011 2016
Number of deaths that involved at least one type of opioid (including prescription drugs, heroin, fentanyl or any other opioid), or one or more opioids combined with other drugs.
622 1,699

Opioid Prescriptions
Total number of opioid prescriptions written by any licensed prescriber in Michigan.*
2011 2016
10,441,714 11,028,495

NAS Cases
Neonatal abstinence syndrome (NAS) is a group of conditions associated with drug withdrawal in newborns after being exposed in utero.
2011 2016
630 927*

People in SUD Treatment for Opioids or Heroin
Total number of people receiving publicly funded drug treatment services in Michigan.
2011 2016
22,234 32,473

*2016 Data.
FACTS of Michigan's PIHP Region 2:

- Region 2 has the highest per capita number of Medicaid beneficiaries with an Opioid Use Disorder diagnosis in the state.

A ranking of opioid needs in Michigan's 83 county shows nearly half (12) of the top 25 are located within Region 2:

- Crawford
- Alpena
- Roscommon
- Iosco
- Kalkaska
- Otsego
- Wexford
- Grand Traverse
- Oscoda
- Cheboygan
- Benzie
- Emmet

Prioritization of Need by Quartile:

- Lowest Need
- Low-to-Mid Need
- Mid-to-High Need
- Highest Need

Prioritization Methodology (percent weight in parentheses):

- Percent of Medicaid Beneficiaries with an Opioid Use Disorder Diagnosis (50%)
- County Health Rankings – Health Outcomes (5%)
- County Health Rankings – Health Factors (5%)
- Opioid Hospitalizations per 100,000 (15%)
- Opiate Prescriptions per 100,000 (10%)
- Heroin Deaths per 100,000 (10%)
- Opioid Deaths per 100,000 (10%)

Sources:

- MDHHS (2018). Compilation of Opioid Diagnosis and Outcomes Data

March 2019
Thank you!

Lynda Zeller
zellerl2@michigan.gov
Implementing Integrated & Trauma-Informed Care across County Behavioral Health & Primary Care Clinics

Duane Stansbury, RS, MPH
Health Commissioner
Warren County Health District
LEVERAGING PARTNERSHIPS TO SUCCESSFULLY INTEGRATE CARE ACROSS THE CHICKASAW NATION

Dr. Shannon Dial, LMFT
Brief Description of System

- The tribal population is more than 66,000 citizens, with more than 35,000 of those citizens living in Oklahoma.
- Four health facilities, including a hospital, to serve our 13 counties
  - Serve any native with CDIB card
  - More than a million visits a year for around 60,000 people
  - ER – 4,500 average visits a month
  - Dental – 55,000 visits a year
- Behavioral Health
  - 5 Psychiatrists
  - 1 Psychologist
  - 30 Therapists (half integrated and half traditional outpatient)
  - Integrated in primary care, dental, women’s clinic, diabetes clinic, pediatrics, internal medicine, ER, ICU, Acute Care
Integrated Care

◦ What we were doing wasn’t working, needed a plan B
◦ Got everyone together and hoped to get them excited
  ◦ Governor
  ◦ Health Leadership
  ◦ Mental Health Leadership
  ◦ Clinicians
  ◦ System
◦ Demonstrated what’s not working
◦ Demonstrated the solution of IC
◦ Look for champions
Of those who die by suicide.....

- 45 percent visit their PCP within one month (*Luoma, Martin, & Pearson, 2002*)
- 20 percent visit their PCP within 24 hours (*Pirkis & Burgess, 1998*)
- 73 percent of the elderly visit within one month (*Juurinink et al., 2004*)
- 77 percent who die by suicide visited primary care in the year prior
- 32 percent who die by suicide visited a mental health services provider in the year prior
Logistics

- Decide current staff who have potential in integrated care – pick wisely
- Get them trained, get yourself trained, get passionate about the cause
- Look at space logistics in the clinic
- Prep the clinic teams with leadership help – providers, nurses, front desk staff
  - Share with them how what you’re current BH clinic is doing isn’t working (use numbers)
  - Share with them numbers of where people ARE coming to appointments
  - Let them know that BH has to go to the patient because only few will come to us
  - Ask for a consideration of changing thinking to see medical and behavioral health as paired treatment for improved outcomes
- Ask people to just try it! (https://www.chickasaw.net/Services/Medical-Family-Therapy.aspx)
Lessons Learned

- Integrated Care Core Team has to be well versed
- Integrated Care was a great foundation for Zero Suicide Implementation
  - ZS – 125,000 screened in our first year
  - Supports The Joint Commission expectations for suicide screening and assessment
- Integrated Care is more than just putting a BH clinician in a medical clinic
  - Can’t let people default to just medical social work
  - Epistemological Shift
- Integrated Care requires continuous marketing, training, quality checking
- Solid integrated care implementation sets the stage for numerous partnerships
  - Pediatric obesity, Obesity, Hep C clinic, prenatal classes, Integrated Psychiatry
Infusing Trauma-Informed Care to Address Systemic Trauma in Communities

Linda Henderson-Smith, PhD, LPC
Director, Children and Trauma-Informed Services
National Council for Behavioral Health
Four Sources of Systemic Trauma

- Institutional Based
- Intergroup Conflict Based
- Social Structural Violence Based
- Globalization Based
Dynamics of Systemic Trauma

Social exclusion and rejection

Linear and Non-Linear Cumulative

Systemic Trauma

Intersectionality

Identity Annihilation Anxiety

Anxiety
Levels of Systemic Trauma

- Individual
- Institutional
- Structural
Effects of Systemic Trauma

Symptoms of Historical Trauma:
- Depression
- Anxiety
- Isolation
- Loss of Sleep
- Anger
- Discomfort around white people
- Shame
- Fear and Distrust
- Loss of Concentration
- Violence and Suicide

Resilience. This, too, shall pass.
Where There is Hope
Systemic Trauma Approach

Source: Dahlgren and Whitehead, 1991
Culturally-Sensitive Trauma-Informed Care

- Recognizing cultural variation in the subjective perception of trauma and traumatic stress responses
- Understanding the role of beliefs in the interpretation of trauma and the recovery process
- Helping to restore a sense of safety through trust-building
- Attending to the distress in the way that the individual defines it
- Working within and through the family structure to promotion emotional and social support and utilization of coping resources

Healthcaretoolbox.com
Considerations in providing Culturally-Sensitive TIC
How to Assess: Culturally Sensitive Trauma-Informed Care

...questions providers should ask

**LISTEN**
...for variations in understanding. Ask:
- What is your understanding of what’s happened?
- What is worrying you the most?
- What does your family think about it?

**BE OPEN**
...to involving other professionals. Ask:
- Who do you normally turn to for support?
- Who else should be involved in helping your child?
- Are you open to outside referrals and resources?

**RESPECT**
...different communication practices. Ask:
- Who typically makes the decisions about your child?
- What information should be shared with your child?
- Is there anyone else you would like me to talk to?
Reduce **DISTRESS**
Promote **EMOTIONAL SUPPORT**
Remember the **FAMILY**
Ten Strategies for Effective Cross-Cultural Communication

- Think Twice
- Ask Questions
- Distinguish Perspectives
- Build Self-Awareness
- Recognize the Complexity
- Avoid Stereotyping
- Respect Differences
- Listen Actively
- Be Honest
- Be Flexible

Source: jordanerickson@weebly.com
Build Relationships

Honor voice and choice
Partner with people
Request feedback
Ensure comfort

“Keep the Human in Human Services”

Dr. Pat Deegan
<table>
<thead>
<tr>
<th>Trauma-Informed</th>
<th>Resilience-Focused</th>
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<tbody>
<tr>
<td><strong>REALIZES</strong> the widespread impact of trauma and understands potential paths for recovery</td>
<td><strong>IDENTIFIES</strong> programs and best practices proven to build resiliency at both individual and systemic levels</td>
</tr>
<tr>
<td><strong>RECOGNIZES</strong> the signs and symptoms of trauma in individual and systemic levels</td>
<td><strong>INOCULATES</strong> the system culture from the effects of stress and trauma <em>proactively</em> rather than reactively by having a strategic plan</td>
</tr>
<tr>
<td><strong>RESPONDS</strong> by fully integrating knowledge about trauma into policies, procedures and practices</td>
<td><strong>INSTILLS</strong> a shared vocabulary and skills for resiliency into every aspect of the life of the system</td>
</tr>
<tr>
<td><strong>RESISTS</strong> re-traumatization</td>
<td><strong>IMPROVES</strong> the health of the entire system by promoting restoration, health and growth in ongoing ways</td>
</tr>
</tbody>
</table>
Cultural Adaptation of Interventions

- **Relevance**: Is this health promotion topic relevant to the target population?
- **Evidence base**: What is the best intervention to address this health topic within this population?
- **Stage of Intervention**: What stage(s) of the intervention program should be adapted?
- **Ethnicity**: What elements of ethnicity are most important to consider for this population?
- **Trends**: What are the shifting trends within this population?

Liu, et. Al, 2012
Building Community Resilience Strategies

**Equitable Opportunity**
Restorative justice, healing circles, economic empowerment & workforce development, increased community wealth and resources

**People**
Rebuild social relationships & broken social networks; strengthen social norms that encourage healthy behaviors, community connection and community oriented positive social norms

**Place**
Create safer public spaces through improvements in the built environment through addressing parks, housing quality and transportation; reclaim and improve public spaces
What Can I/We Do Next?

What do I/we need to....
✓ Stop Doing
✓ Start Doing
✓ Do More of
Contact Information

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Action Planning & Small Group Work (Phase 3)

- Focus on efforts related to trauma-informed, collaborative, and integrated care.
Behavioral Health World Café

Please pick a table and sit down with your peers to engage in 10-minute discussions around the assigned topic area.

- Suicide/Suicide Prevention
- Workforce Development & Training
- Trauma + Communities
- Substance Use Disorders
- Tribal/State Partnerships
Report Outs

ONE (1) Volunteer per table to share highlights from action plan/table discussions.
YOU GET A THANK YOU
YOU GET A THANK YOU
YOU GET A THANK YOU
YOU GET A THANK YOU
EVERYBODY GETS A THANK YOU