Seeding a System's Response to Trauma

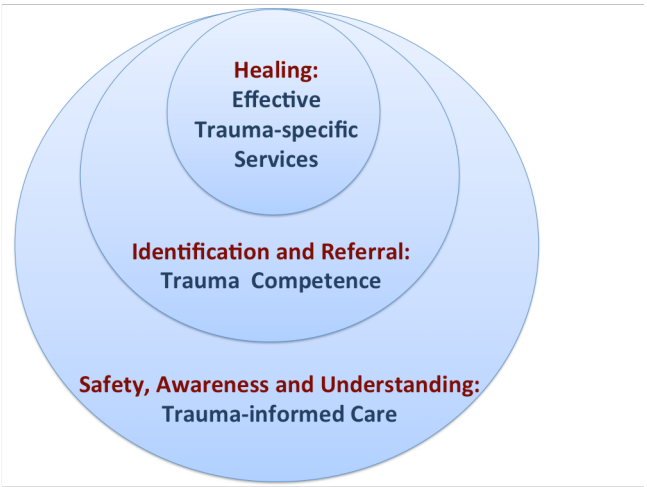
Philadelphia's Integrated Network of Trauma-informed and Trauma-focused Behavioral Health Care

This paper is the second in a series on system and community responses to trauma, published by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). The paper was written by Pamela Woll, MA, CADP based on interviews with key players in the Philadelphia Trauma Transformation: DBHIDS Commissioner Arthur C. Evans, Jr., PhD, OmiSade Ali, MA, CADC, CCS, Ava Ashley, MA, JD, Steven Berkowitz, MD, Sandra Bloom, MD, Judith Cohen, MD, Edna Foa, PhD, Matthew Hurford, MD, Kamilah Jackson, MD, MPH, Antonio Valdés, MBA, Kalma Kartell White, MEd, CPRP and Arturo Zinny, LPC, MA. (Additional information about these sources is listed on page 6.) The first paper in the series is entitled "Safety, Strength, Resilience and Recovery: Trauma-informed Systems and Communities," and the third is "Meeting Trauma with Transformation: The Evolution of Philadelphia's Behavioral Health Response." They are meant to inspire change agents in other systems and communities to meet the challenge of trauma, carrying with them the hope gained and lessons learned in Philadelphia.

When the symptoms of human suffering overwhelm the many systems set up to address them, it is easy to focus only on the symptoms and forget to heal the wounds. This is the story of one city's behavioral health system and its efforts to build a network of vigilance, compassion, healing and empowerment.

Just as many experiences can add to the burden on an individual's, a family's or a community's capacity to cope, so can the effects of toxic stress and trauma branch out into almost any area of life—physical, psychological, developmental, educational, occupational, economic, medical, behavioral, social, spiritual, cultural or legal. These effects can be complex and tightly interwoven, often hidden under chronic illness, mental health challenges, addiction, patterns of victimization, legal problems, problems at school, troubles in the family or the workplace, destructive relationships or "just plain old bad behavior."

Determined to reach into the center of the problem, the Philadelphia Department of Behavioral Health and disAbility Services (DBHIDS), under the leadership of Commissioner Arthur C. Evans, Jr., PhD, is in the fifth year of a multifaceted Trauma Transformation effort. (See the companion paper, "Meeting Trauma with Transformation: The Evolution of Philadelphia's Behavioral Health Response.") The paper that follows describes the second phase and most tangible product of the transformation process: the integrated roll-out of three evidence-based trauma-focused practices, nested within an evidence-supported model of trauma-informed care.



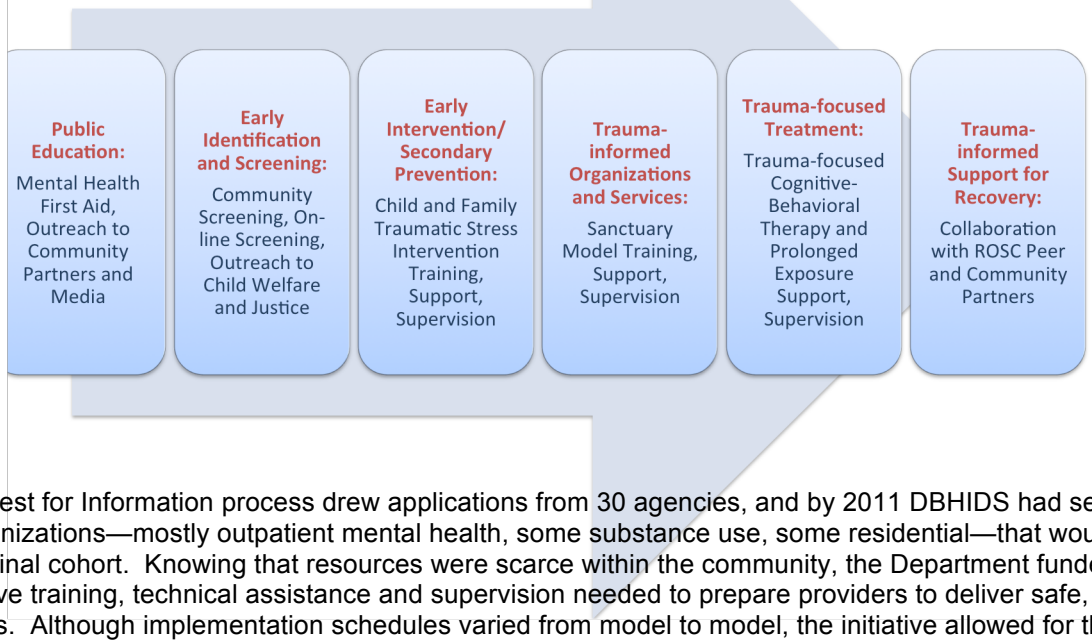
The Seeds of Transformation

The behavioral health Trauma Transformation began with a recognition that trauma is important, widespread and often unaddressed in our service systems. The early goals of the process were simple, but not easily met:

- Raise awareness and understanding of trauma in behavioral health settings.
- Ensure that behavioral health providers meet at least a minimum level of trauma competence, including the ability to identify post-trauma effects and connect people with trauma-focused services.
- Ensure that effective trauma-focused treatment is available to a variety of populations.

In 2009, DBHIDS found a partner for this endeavor in Steven Berkowitz, MD, developer of the Child and Family Traumatic Stress Intervention, and encouraged his recruitment to the University of Pennsylvania. Then in 2010 they reached out to three more local experts and national leaders in the response to trauma. For trauma-focused treatment they contacted Judith Cohen, MD, co-developer of Trauma-Focused Cognitive-Behavioral Therapy and Edna Foa, PhD, developer of Prolonged Exposure Therapy. For the trauma-informed care component, the Department reached out to Sandra Bloom, MD, co-developer of The Sanctuary Model.

Knowing how easy it is for serious problems to slip by unnoticed or unaddressed, they envisioned an integrated network with multiple opportunities for identifying and addressing trauma-related challenges, including posttraumatic stress disorder (PTSD), anxiety disorders and depression. This would feature a cadre of trauma-informed agencies, each with expertise in evidence-based trauma-focused treatment for its population of focus (adults and/or children or youth). Portals to this network would include improved awareness and identification of challenges within the community; screening programs in a variety of community settings; and, for children/youth and their families, trauma-focused intervention in community and behavioral health settings.



A Request for Information process drew applications from 30 agencies, and by 2011 DBHIDS had selected the 21 organizations—mostly outpatient mental health, some substance use, some residential—that would make up the original cohort. Knowing that resources were scarce within the community, the Department funded the extensive training, technical assistance and supervision needed to prepare providers to deliver safe, effective services. Although implementation schedules varied from model to model, the initiative allowed for three years to prepare two waves of providers, and DBHIDS reimbursed agencies for staff time devoted to training. Given the high cost of failure to address trauma safely and effectively, these expenses seemed well justified.

Identification, Referral and Intervention

Community Outreach: The background for all this work is the community, where many people never find their way to the services they need. One road to a community-wide response is the city's large-scale implementation of Mental Health First Aid (MHFA). This program trains community members and public safety personnel to identify, understand and respond to signs of behavioral health conditions and crises. Other resources include Community Intervention Training for first responders, and Community Response Teams that take a Psychological First Aid approach toward responding to events that require emotional support and psychoeducation.

> "If you think along the lines of a public health model, it's informing all the people who are the sentinels, the people who see these kids and families early on, and helping them become trauma informed. We show them there are things to be done, and that kids and families do get better."
>
> —Steven Berkowitz, MD

Behavioral Health efforts have also taken strength from collaboration with trauma initiatives underway within the School District, Department of Human Services (DHS, the city's child welfare agency), Police Department and a number of other valued partner agencies and programs. For example, in the realm of children's services:

- Change agents have forged strong alliances with schools, Head Start, Early Head Start, community centers, hospitals, pediatricians and juvenile justice, and with interested faith communities, primarily with clergy.
- There have been presentations at police stations throughout the metropolitan area. Probation and law enforcement personnel know that one benefit of identification and intervention is the opportunity to interrupt the cycle, understanding that the experience of trauma, particularly among youth, increases the risk that they will become victims or perpetrators of crime and violence.
- When children who have been injured are discharged from the Emergency Department, their parents or caregivers receive a list of traumatic stress symptoms to watch for, like any list of discharge instructions.
- Community partners have received information about the impact of trauma and suggestions for talking—and listening—to children who have had potentially traumatic experiences.

Screening and Referral: Effective screening in multiple systems is another important safety net. Early training of providers in trauma-focused care revealed gaps in this area, including a need for more system-wide effort in:

- Training providers to use evidence-based instruments (e.g., the Posttraumatic Diagnostic Scale[1])
- Increasing and improving coordinated links between screening and appropriate trauma-focused treatment
- Educating clinicians, intake coordinators and other staff about the critical importance of early diagnostic screening and referral to trauma-focused treatment, to address these challenges earlier in their progression

Child and Family Traumatic Stress Intervention: In 2012, the Department received a Substance Abuse and Mental Health Services Administration (SAMHSA) grant to establish the Philadelphia Alliance for Child Trauma Services (PACTS). Undertaken in partnership with the Penn Center for Youth and Family Trauma Response and Recovery, PACTS is a consortium of behavioral health agencies tasked with establishing a continuum of care for youth, including an integrated approach to screening, assessment, intervention and treatment. The Child and Family Traumatic Stress Intervention (CFTSI) is a central element of that approach.

CFTSI is an evidence-based family-strengthening intervention, tested for use with acute trauma (beginning services in the first month after trauma exposure), to prevent PTSD. It is used with children and youth ages seven to eighteen who have recently had potentially traumatic experiences and developed new trauma-related symptoms (particularly those that show risk of PTSD or depression). Its goals are to reduce symptoms, prevent long-term disorders, identify children in need of longer-term behavioral health care and ease the transition to trauma treatment. CFTSI focuses on both the child and the family, preparing caregivers to provide more effective support to children and teaching both caregivers and children skills for coping with post-trauma symptoms. A number of PTSD and mood questionnaires are also woven into the model, to gather information and to improve caregiver/child communication about the child's experiences. Developed by Steven Berkowitz, MD, CFTSI has been shown to reduce the risk that youth will develop full or partial PTSD.

> "Evidence-based practices don't exist in isolation, but in the context of a system. Rather than focus solely on training practitioners in a practice, we ask how we can develop the capacity to address this challenge within our system. This brings up a whole set of implementation issues, not only training and treatment, but also screening and identification, getting people to the right places, ongoing training and supervision and ensuring that the services people receive will be sustained."
>
> —Arthur C. Evans, Jr., PhD

Clinicians have been trained to deliver this intervention in a variety of community-based settings. This has the double value of making youth and their parents more comfortable and strengthening collaboration among behavioral health, the community and allied service systems.

Trauma-focused Treatment

In 2011, the Department introduced two trauma-focused evidence-based practices for people who have developed mental health challenges (e.g., PTSD, anxiety, depression, behavior problems) a month or more after trauma exposure: Trauma-focused Cognitive-Behavioral Therapy (for children and youth) and Prolonged Exposure (for adults). Sixty-five clinicians received intensive training, supervision and support. To promote adoption of these models, the first 12-16 months were heavily focused on training key supervisors in each participating organization, grounding them thoroughly in the models and giving them opportunities to practice and refine their skills. Many of those supervisors have become supporters and champions of these models in their organizations and effective leaders and supervisors of the therapists whose training would follow theirs.

Trauma-Focused Cognitive-Behavioral Therapy: Like CFTSI, Trauma-focused Cognitive-Behavioral Therapy (TF-CBT) is a brief evidence-based practice designed to empower children, youth and families in the service of healing and recovery. TF-CBT is the treatment counterpart of CFTSI, for children and youth who have developed mental health challenges (e.g., PTSD, anxiety, depression) following trauma. TF-CBT practitioners work with children and their families together for twelve to eighteen sessions, helping them understand trauma and its effects; learn how to manage thoughts, feelings and behavior; communicate more effectively within the family; and tell the story of their traumatic experiences. For parents, the focus also includes improving parenting skills and making the home a safe place for all family members. Developed by Judith Cohen, MD, Anthony Mannarino, PhD and Esther Deblinger, PhD, Trauma-focused Cognitive-Behavioral Therapy is the best-supported and most widely disseminated evidence-based practice for people in this age group with trauma-generated symptoms or disorders (www.musc.edu/tfcbt). It is effective with diverse groups.

In the multi-year process of preparing providers to deliver TF-CBT, faculty began by working intensively with 10 agencies representing a variety of cultures, levels of care (outpatient, residential, inpatient/outpatient) and geographical locations within the city. When TF-CBT is in full operation within the system, providers will be able to serve at least 550 children each year, with an eye toward serving all who need this treatment.

> "The most pleasant surprise has been the general receptivity, everybody saying, 'Oh, yeah, that makes sense!' I thought there would be a lot more push-hack, but people really have been receptive. They get it."
>
> —Steven Berkowitz, MD

Prolonged Exposure: The adult treatment component of Philadelphia's trauma transformation uses Prolonged Exposure (PE) Therapy for Posttraumatic Stress Disorders. With nearly 30 years' worth of exemplary evidence behind it, Prolonged Exposure is designed to help people with PTSD process the memories connected with their traumatic experiences and gain a sense of mastery over their lives. PE addresses, not only PTSD symptoms, but also depression, anxiety, anger and guilt. Developed by Edna Foa, PhD, Prolonged Exposure combines education about the treatment, breathing retraining, talking through the trauma (imaginal exposure) and approaching situations in real-world settings that people tend to avoid because they are related to the trauma (in vivo exposure). The course of this treatment is generally between eight and fifteen sessions, each session lasting 90 minutes.

In the first round of training, clinicians attended a four-day PE workshop that included lectures on the model, "how-to" presentations, videotapes and role-plays. The workshop was followed by intensive supervision, in which therapists practiced and learned PE through their work with two patients. Each session with those patients was videotaped and reviewed by supervisors at the Center for the Treatment and Study of Anxiety (CTSA), with feedback and correction given to the therapist before the next session. They also had the option of additional consultation with CTSA supervisors on an ongoing, as-needed basis. After the first round, project leaders took some time to evaluate the results and enhance their approach before starting the second round.

Trauma-informed Care

> "People at the bottom of the hierarchy want life to be better and to be more effective, more trauma informed. But they can only do that in the context that the values that apply to clients apply to them, too—all the way up."
>
> —Sandra Bloom, MD

The Sanctuary Model: The Sanctuary Model, the trauma-informed care component of this network of services, is very much the primer coat that makes all these colors come alive. Developed by Sandra Bloom, MD, Joseph Foderaro, LCSW, Ruth Ann Ryan, MSN, CS, Brian Farragher, LCSW, MBA, Sarah Yanosky, LCSW and Linda Harrison, Med, LPC, this model provides a framework for understanding the universal impact of toxic stress and trauma, and for engaging members of an organization, a system or a community—including ways of keeping people active and interested and tools for working through conflicts.

One central theme of the Sanctuary Model is that the process of change and healing is essentially the same whether it is taking place in someone receiving services, in the service provider, in the organization, in the family or in the community. The guiding principles of the model are the Seven Sanctuary Commitments, to be embraced at all levels of the organization if the process is going to work: 1) commitment to nonviolence, 2) emotional intelligence, 3) social learning, 4) open communication, 5) democracy, 6) social responsibility and 7) growth and change. This model also relies on S.E.L.F., the four key domains of healing: Safety (in self, relationships and environment), Emotions (identifying and modulating emotions), Loss (feeling grief and recognizing that change includes loss) and Future (new roles, new ways of relating, new identity as a "survivor").

Sanctuary at Work: The Children's Crisis Treatment Center

The Children's Crisis Treatment Center (CcTC) was the first agency in Philadelphia to implement the Sanctuary Model throughout the organization, from the CEO through line staff. CcTC had been taking trauma-informed approaches since the late '70s, but in Sanctuary they have found a practical, tangible way of structuring these approaches and weaving trauma-informed language and principles into all their processes.

"We got lucky," said Executive Director Antonio Valdés. "Five members of the executive team went to the first five-day training and got engaged from that first day." Now more than 25 staff members have attended the training and have brought the Sanctuary principles and practices home. They even start each weekly team meeting in the Sanctuary Model's Community Meeting format, asking each person:

- How are you feeling?
- What is your goal for this meeting?
- Who can you ask for help?

"At the beginning it might have sounded like 'Kumbaya'," said Valdés, "but then people began to understand that this is creating direction and purpose for them, helping them understand the emotional effects playing out in the system, helping them re-group rather than resort to gossip and blame." Each staff member carries his or her own pocket-sized safety plan, with helpful reminders for those difficult moments. Topics and principles within the model are also built into the agency's policies.

Valdés considers The Sanctuary Model a tool for managing organizational culture. "It gives us structure and language to communicate, to teach and remind staff that these are the values we have. This is a mechanism that gives me a way to do what I've always wanted to do. As a CEO, I know this is the direction I want to move the organization in—to inspire people and create a sense of purpose."

Lessons Learned: Preparation, Dissemination and Integration

Preparation and Dissemination of Evidence-based Practices: System leaders offered a number of recommendations to service systems planning to bring in new practices, including a good look at:

- Common screening processes and the prevalence of specific challenges (e.g., PTSD) system wide
- The need for trauma-focused services for various populations, at various levels of intensity
- Treatment providers' readiness and willingness to adopt highly structured trauma-focused models
- Accurate ways of recognizing and measuring success—beginning the process with clear outcome measures

There must be a "good fit" among practices, providers, people receiving services and their stages of trauma recovery. Providers need direction and support in determining where a model is safe and appropriate; where it can and/or should be modified to fit their participants' cultures, circumstances or complexity; and at what degree of modification those changes might mean the evidence of its effectiveness no longer applies.

Effective training is expensive, and systems will find it challenging to raise the resources necessary to fund the extensive training needed to implement these evidence-based practices. Provider organizations also have their own financial challenges in bringing these practices "on-line," even beyond the resources it takes to cover for staff who are attending training. Organizations may need to change their screening and intake tools, change or add to their supervisory processes and continue to keep their clinicians' skills honed through follow-up training and technical assistance—all valuable efforts, because the common thread is trauma and its effects: The most important consideration is the safety of the individual receiving services, the family and the community. The value of these investments—in prevention of chronic illness, disability and human suffering—is incalculable.

Integration of Trauma-informed and Trauma-focused Services: At the beginning, these projects and practices may have seemed like separate initiatives, all addressing important issues in effective ways. But the human being is not a collection of separate and unrelated challenges, and people often need human support as they move from one source of help to another. DBHIDS and its many partners have worked, and are still working, to build the best infrastructure they can. They are determined to connect these services in thoughtful and intentional ways, share resources and build the relationships necessary to address the complexities of individual, family and community life. Integration begins with an understanding that no individual, no agency, no system can do it alone.

Acknowledgments

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