The Central Role of Relationships With Trauma-Informed Integrated Care for Children and Youth

Jonathan D. Brown, PhD, MHS; Melissa A. King, PhD, MPAff; Lawrence S. Wissow, MD, MPH

From Mathematica Policy Research, Inc (Dr Brown), Washington, DC; Department of Health, Behavior, and Society, Johns Hopkins Bloomberg School of Public Health (Drs King and Wissow), and Division of Child and Adolescent Psychiatry, Johns Hopkins School of Medicine (Dr Wissow), Baltimore, Md
The order of the authors is alphabetical reflecting equal contributions to the concepts discussed in this article.
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Address correspondence to Lawrence S. Wissow MD, MPH, 550 North Broadway, 9th Floor, Baltimore, MD 21205 (e-mail: Lwissow@jhmi.edu).

ABSTRACT

OBJECTIVE: Primary care plays an essential role in the primary and secondary prevention of children's mental health problems. A growing series of trials have shown the capacity of primary care providers to deliver care that specifically addresses risks to healthy social and emotional development by incorporating mental health services into their routines and integrating their work with the mental health care system. In this article elements common to various integration schemes that seem essential to their success are described.

METHODS: Narrative review, combining conclusions from 3 previous systematic reviews.

RESULTS: Trusting, personal relationships between patients and providers, and among collaborating providers, are a critical element of successful trauma-informed integrated care. Patient-provider relationships are essential to disclosure of sensitive concerns, to engaging patients in care, and to designing care that is responsive to individual patient needs. Studies of patient-centered care and psychotherapy suggest ways that these relationships can be built and maintained. Provider-provider relationships are, in turn, essential to coordinating the work of the range of providers and services needed to address trauma prevention and treatment. These relationships can form within a variety of organizational structures but building them might require staff training, redesign of work flows, and support from organizational structures and goals.

CONCLUSIONS: A variety of interventions at the patient-provider, clinical site, system, and policy levels can foster relationships and provide the foundation for care capable of addressing promotion of social and emotional well-being in general and trauma prevention and treatment in particular.

KEYWORDS: communications; integrated care; primary care; trauma-informed care

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PRIMARY CARE PLAYS an essential role in the prevention of children's mental health problems.[1] Health maintenance in childhood is designed to promote nurturing parent-child interactions and detect individual, family, and social threats to development.[2] Although still small in number, several trials have shown that primary care providers can provide care that addresses risks to psychosocial development in general and to social and emotional development in particular.[3–6]

One of these risks is "trauma," defined as events (including physical injury but also threats to social and emotional well-being) that create difficult-to-manage levels of psychological and physiologic stress. In recent years, clinicians, scientists, and advocates have pointed out the connection between trauma and a wide range of health problems across the lifespan.[7–9] The brain's response to threats varies greatly according to an individual's social and developmental status and his or her beliefs about the causes of the threat and ability to survive or overcome it.[10] When threats are interpreted as life-threatening or negatively life-changing, we refer to them as traumatic and become concerned about short-term and long-term effects on health.[11]

Primary care's role in trauma prevention and treatment comes from what primary care provides—a safe, multigenerational place for advice and information about social, developmental, and somatic issues related to health[12]—plus what primary care can achieve in partnership with specialty health and community services. Collaboration and coordination of primary, specialty, and community care

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has long been promoted as a way of addressing co-occurring somatic and mental health needs.[13,14] Collaboration can take many forms. At one extreme, a primary care team manages a patient's care, coordinates as needed with specialists, and makes referrals to community services; at the other extreme, for individuals with severe and chronic health problems, a specialist manages care, coordinates as needed with generalists, and works in close partnership with community services supporting the individual and family. In the middle is a model in which care is more shared and providers operate within an organized team, sometimes working in the same location, and can flexibly shift their roles to meet patient needs as they evolve over time.

All of these variants potentially address what the Agency for Healthcare Research and Quality (AHRQ) calls "integrated care." Integrated care has 3 core dimensions: first, that for any given patient, actions and decisions across providers are coordinated to maximize benefit and minimize the chance of harmful or wasteful overlaps in treatment plans; second, that coordination is grounded in information about the patient that, with consent, is readily shared and mutually evaluated; and third, that the structure and content of care that emerges is customized to reflect the patient's unique needs and desires.[15,16]

Integrated care, compared with traditional approaches involving detection and referral, can positively affect mental health. Trials embedding specially-trained clinicians in primary care have shown success treating younger children's behavioral problems and adolescents' depression.[3,17] The success of these programs depends not only on their structure—colocation of specialist providers, enhanced case detection and referral systems—but also on the way that clinicians in the programs develop relationships with patients and with each other. In a meta-analysis of integration efforts targeting adult depression little association between the extent to which programs had structural elements of integration in place and the odds of patients' depression improving was reported.[15] Another study sought to improve care for child mental health problems through universal screening in primary care and easy, electronic referrals. These structural interventions increased the rate of screening and referral, but only 17% of families followed through with their mental health appointments.[18]

What appears necessary is the ability to develop trusting relationships between patients and providers and among the group of providers involved (see also Magen and DeLisser, in this issue).[19] At the patient level, relationships promote disclosure of sensitive concerns,[20,21] engage patients in care[22] and developing treatment plans responsive to individual needs. Among providers and organizations, relationships are key to care coordination.[23] In this article we elaborate on the role of relationships in trauma-informed integrated care. We focus on 3 levels: 1) therapeutic relationships between patients and health care providers, 2) relationships among providers at a given health care site that determine its work culture and climate, and 3) relationships among providers across sites, specialties, and organizations that need to work together to help families experiencing trauma. Our conclusions are drawn from 3 related systematic reviews: one that examined studies of general mental health screening in pediatric primary care, one that searched specifically for programs focused on trauma prevention and treatment in pediatric primary care, and one that examined the effect of organizational culture and climate on pediatric primary care.[4,24,25]

RELATIONSHIPS BETWEEN PATIENTS AND HEALTH CARE PROVIDERS

Integrated care cannot function without disclosure of concerns and agreement on a course of treatment, both of which are dependent on trusting patient-provider relationships.[20,22,26] Screening for exposure to trauma has frequently been called for as part of trauma-informed care,[1] and relationships are essential to screening, promoting forthright answers to instruments, and facilitating the discussion of results.[24] Trauma poses particular difficulty for forming relationships because of the way in which it can lead to avoidance of difficult topics, increased vigilance, and strong emotional reactions. However, in existing mental health and trauma-related studies in pediatric primary care, relatively little attention has been given to building relationships before embarking on screening or treatment. Among the screening studies reviewed, very little description was provided about how the purpose or process of screening was discussed with parents or youth, and most of the studies (18 of 27) in which youth were being screened did not say how confidentiality would be managed. Only 3 of the 10 detection/treatment interventions reported in the review of trauma treatment in primary care included active, experiential training in how to communicate with families. One study had trainees conduct supervised interviews with children in a variety of clinical settings[27]; one, which focused on detection of domestic violence, used role play to help clinicians learn to ask parents and adolescents about violence exposure[28]; another, focused on violence prevention, also used role play to guide trainees' discussions of screening results.[29]

The literature gives several suggestions for ways to build relationships. First, studies underline the fact that patients have therapeutic interactions with everyone they meet in health care settings, not just the provider they are formally visiting. The interactions that promote disclosures of sensitive topics begin at the clinic door. A study at a health center serving recent immigrants involved training medical assistants to better elicit concerns and to show empathy as they obtained previsit information.[30,31] Parents who felt better about their interaction with the medical assistant subsequently felt more positive about their interaction with their child's physician and said that they were more likely to disclose psychosocial concerns during their child's visit. In a different study, among adults, patients' perception of how staff interacted with each other related to their trust in their physicians' judgment.[22]

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