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

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## 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

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]

Second, there is an extensive literature on the ability of patient-centered and closely related "common factors" skills[32] to influence disclosure of psychosocial issues, engagement with treatment recommendations, and mental and somatic health outcomes.[33] The common factors include development of a bond between the patient and provider, agreement on the goals and methods of care, and perceptions that the provider is capable of providing help (Table). Across psychotherapies, variation in these factors contributes more to outcomes than do differences between treatments or therapists' adherence to a particular treatment protocol.[39] Much of the interactional style involved in patient-centeredness and common factors overlaps with the style of motivational interviewing and other approaches to helping individuals struggling with complex decisions and conflicting emotions, as is often the case among those experiencing trauma.[40] The style addresses situations with strong emotional overlays where ambivalence, demoralization, and anger create barriers to collaboration, and where it can be difficult to chose among possible treatment directions. Providers create a setting where patients can feel comfortable exploring options while retaining or gaining a sense of control.

As with other aspects of mental health care, primary care pediatricians have expressed hesitancy to inquire about or discuss trauma. Concerns include lack of time and referral resources, but also the potentially troubling nature of families' trauma experiences and similarities to what the pediatrician might have experienced her or himself.[41] Several groups including the American Academy of Pediatrics[42] and the Academy on Violence and Abuse[43] have developed training materials that orient clinicians to the relational challenges posed by trauma. Green and colleagues developed a trauma-specific variant on communication skills training specifically for internists and family physicians that addressed communication skills as well as the emotional difficulties involved in discussion of trauma among patients as well as providers.[44] In a quasi-experimental study, they were able to show that training increased patients' sense of partnership with their provider, although to a smaller extent among patients reporting post-traumatic stress disorder symptoms compared with those without such symptoms.[45]

## Relationships Among Practice Staff Members

As integrated care has rolled out over the course of practice transformation in adult as well as pediatric care, attention has focused on the culture and climate of the organizations involved.[46,47] Organizational culture and climate have been associated with staff-level outcomes such as job satisfaction[48]; service-level outcomes such as patient engagement and trust[22]; and patient-level outcomes such as recovery.[49] They also relate to staff receptivity to and success with undertaking service changes.[50]

Organizational climate refers to staff members' experiences within an organization—in our case, a health care site—and how those experiences affect their own well-being.[51] Climate influences how individuals work with each other, especially as they are asked to adapt day-to-day to the needs of patients, and over the longer term to changes in the community they serve and the system in which they work.[52] Many characteristics of effective

**Table.** Summary of Mental Health Communication Skills for Primary Care: Domains, Training Goals, and Specific Skill Examples

| Domain | Training Goal | Specific Skills (Examples) |
|---|---|---|
| Elicit parent and child mental health concerns | Promote provider feelings of competency | See parallels between pediatric and mental health diagnostic and treatment processes; see applicability of pediatric developmental and behavioral advice to initial mental health treatment |
| | Manage time in visit | Manage rambling or long lists of concerns; set priorities[34] |
| | Promote agreement on goals and means of care | Avoid serial rejection of advice |
| | Demonstrate to family provider's interest in psychosocial topics | Elicit full range of concerns; listen attentively; respond with empathy and interest[35] |
| | Engage child as well as parent | Address talk to parents and children; use basic techniques from family therapy to promote turn-taking |
| Partner with families to find acceptable forms of treatment | Develop acceptable plans for treatment or further diagnosis | Offer choices and ask for feedback; anticipate and respond to ambivalence, resistance |
| | Address barriers to treating mental health problems | Ask about readiness to hear provider's assessment and recommendations; ask about barriers to pursuing chosen treatment[36] |
| Increase expectations that treatment will be helpful | Respond to patient/family hopelessness, anger, and frustration | Use techniques from "solution focused" cognitive therapy to identify practical goals, first steps, and sources of self-esteem[37]; manage negative affect between parent and child during visit[38] |

interactions among staff parallel characteristics that facilitate patient-provider interactions: mutual trust, recognition of a diversity of perspectives, openness to new ideas, sensitive and respectful behavior toward others, a flexible use of multiple styles of communication, and willingness to learn about others beyond their work identities.[53] Studies of adult health services have shown that a positive climate attenuates the effect of high workloads on quality of care and is associated with fewer patient complaints and stronger patient trust in providers' treatment recommendations.[22,54] Studies in pediatric primary care and community-based services have reported that negative aspects of climate including the perceived burden of mental health care and higher levels of job stress, and positive aspects such as perceived autonomy, role clarity, and leadership support are associated with decreases and increases in identification of mental problems,[55] service provision,[56] uptake of new mental health services,[57] and improvement in functioning among children served.[58]

Studies have also long noted that staff are subject to what has been called "vicarious trauma" as they help families with trauma exposures.[59,60] As the ubiquity of trauma has been recognized, there has been more recognition that some staff stress labeled as "vicarious" is, in fact, related to the staff members' own trauma exposures and the extent to which families' experiences bring these exposures to mind. Finding ways to acknowledge these dynamics, and to make the work environment a healing one for staff as well as for clients, is an important aspect of organizational climate in trauma-informed care.[61,62]

Organizational culture is defined as the values (and associated behavioral norms and assumptions) shared among staff for a particular aspect of the organization's mission.[51] The Substance Abuse and Mental Health Services Administration's National Center for Trauma Informed Care defines a trauma-informed culture as one that first and foremost recognizes the ubiquity of trauma's role in the genesis of behaviors, emotions, and somatic symptoms while embracing a model of healing and resilience rather than one of irrevocable harm.[63] Clinicians need to consider trauma as among the possible roots of a patient's behaviors and emotional and somatic symptoms, and the role the trauma could play in families' choices relating to care-seeking and diagnostic and treatment interventions. Above all, a trauma-informed culture does all it can to make sure that the process of care is not itself traumatizing, and families are not asked to behave "normally" in the face of ongoing trauma.[63,64]

In an ongoing systematic review of the empirical organizational context literature, few examples of interventions designed to specifically foster trauma-informed cultures and climates have been identified.[25] On the basis of the more than 3000 titles/abstracts screened thus far, only a handful studied the effects of interventions on organizational context or, even less commonly, the effects of changes in context on outcomes. Two examples related to trauma-informed care in child health and welfare settings are "Availability, Responsiveness, and Continuity" (ARC) and "Building Mental Wellness" (BMW). Glisson and colleagues' ARC for children's community mental health clinics included "team-based clinician- and management-focused activities" introducing principles of effective service systems, providing tools to identify and address service barriers, and developing attitudes and behaviors for service improvement.[65] The goal was to create a context conducive to innovation and effectiveness, including participatory decision-making, openness to job redesign, and conflict resolution. Youth treated in ARC clinics made faster and greater gains in health compared with control clinics, and the effect of ARC was mediated by changes in culture and climate.

The Ohio Chapter of the American Academy of Pediatrics' BMW Learning Collaborative addressed core factors for mental health service implementation in primary care, including knowledge, attitudes, and behavioral skills (individual staff level), culture, climate, structure/processes and technologies (site level), and community linkages (health system level) (http://ohioaap.org/projects/building-mental-wellness). BMW included on-site trainings introducing staff, as a group, to interactional skills with families and tips for creating a mental health-friendly office. Practices worked individually and together,[66] assessing and receiving feedback on their office climate and mental health culture. Practices also assessed the need for and made office structure/process and technology changes, including redefining work flows, networking with nearby mental health providers, and screening for mental health concerns.

Evaluation of BMW revealed that the group training sessions imparted knowledge and influenced culture and climate.[57] Participants said BMW had helped them change their perspectives toward families, increasing empathy and reinforcing that mental health was a core practice value; they described a shift in focus from "labeling mental illness" to "whole health and wellness." Staff said that they also found themselves interacting more flexibly and effectively with each other, reporting positive changes in perceptions of role clarity, job importance, and an altered perspective on the burden of mental health care on workload and time.

## RELATIONSHIPS BETWEEN PRIMARY CARE PROVIDERS AND SPECIALISTS

Medical home standards as well as guidelines for integrated care emphasize processes for achieving integration among collaborating providers, including registries, tracking referrals, and mechanisms for communication of patient information.[67,68] However, in an analysis of integrated care across 16 sites in the US Veterans Administration (VA) it was reported that although setting up structures and processes was important, relationships—between leadership and providers, and between primary care providers and specialists—were critical to successful implementation of integrated care.[23] In the systematic review of primary care trauma interventions described previously, we again found only 1 program that explicitly trained pediatric providers to work across professional lines (in this case with social workers).[29]

Several key aspects of cross-professional interaction emerged as important in the VA study. Primary care providers wanted to interact with mental health staff on a personal level so they could develop trusting relationships and individualized ways to communicate. For example, although electronic records and referral systems facilitated interactions, they lacked the richness of information needed for effective handoffs. Providers also wanted ways to negotiate referral criteria for patients they believed needed help. Leadership was able to overcome these barriers by creating opportunities for informal interactions between primary care providers and specialists and encouraging them to try novel or individualized ways of collaborating. Training that created a shared expertise and common vocabulary for problems further facilitated collaborative care.

Similar findings came from a very different setting than the VA, a state program designed to support primary care providers' ability to help families with children's mental health concerns.[69] The program's core intervention is a telephone "warm line" that primary care providers can call for informal mental health consultation. In contrast to the VA program, the telephone consultants do not provide direct patient care. Still, one of the factors that promoted primary care providers' willingness to call was face-to-face training from the consultants. The face-to-face training supplied primary care providers with an overlapping fund of knowledge, and gave primary care providers as well as specialists familiarity with each other's thought processes. Previously, primary care providers reported they had hesitated to call for fear of feeling uninformed or receiving information that did not suit their patients.

## Conclusion and Recommendations

Care for children and families experiencing trauma requires teams of resilient clinicians capable of responding to multifaceted problems that resist simple solutions. At its best, integrated care addresses these problems by bringing together a flexible and mutually supportive team that can innovate on the fly to meet family needs and over time to shape services to meet population needs. Structural interventions that facilitate these goals are indispensable but not sufficient. A relational base involving empathy, respect, trust, reflection, and information sharing is required at the patient, practice, and system levels. Evidence is accumulating that, at each level, these relationships can be facilitated, enhanced, and linked to improvements in outcomes of care.

Within the larger context of developing a trauma-informed approach to care, and knowing that practice transformation is multifaceted and takes time,[70] we list recommendations targeting relationships at multiple levels:

At the patient level, staff orientation should include awareness that traumatic experiences, whether acute, chronic, or mixed, can change the way our minds and bodies work in the moment, in the long term, or at particular stages in development.[8] People who have experienced trauma might respond to everyday situations—including receiving health care—differently from those who have not had traumatic experiences. When patients seem to be unexpectedly anxious, irritable, or avoidant, being gentle and curious might uncover a reason. It is important to be aware of when patients and their family members have experienced trauma—but there is no one way to find out.

- Facilities can incorporate questions about trauma into screening or history-taking but only after exploring acceptable ways of doing this in the populations served, including learning how to frame the questions (or which questionnaires might be suitable) and developing mechanisms for following up on positive as well as negative responses.
- Staff can learn simple approaches to helping patients control emotional responses and feel more comfortable during visits. A variety of easily taught techniques target relaxation, visualization, and breath control.[71]

Staff can work on a core set of communication skills for which brief training can have lasting effects (Table).[72] Deciding what to do about trauma is never straightforward, and at times listening is the best or only initial response. Generic guides to shared decision-making are available for use by patients alone or in conjunction with providers.[73] Trauma challenges the linear medical model of formulating problems and developing treatments. Instead, trauma usually comes bundled with multiple contributing causes, multiple symptoms, and a range of possible "treatments" that involve social, psychological, and medical responses.

At the practice level, various means can be used to understand the patient experience:

- Patient/family representatives are important participants in planning, training, and quality monitoring efforts. Nurturing their participation, and changing processes to make it possible, might take effort, but guidelines are available.[74]
- Other simple but powerful approaches include making "walkthroughs" in which staff openly take on the role of patients and follow their path in obtaining various services offered at the site.
- The COMPASS (Care of Mental, Physical, and Substance-use Syndromes) Primary Health and Behavioral Health questionnaire is a self-assessment tool designed to facilitate group discussions about behavioral health-related culture in primary care (http://www.integration.samhsa.gov/operations-administration/assessment-tools).

As discussed previously, there is convincing evidence that organizational culture and climate have an effect on clinical outcomes. Creating a "trauma-friendly culture" requires:

- Investment in making the clinical workplace one that promotes the health of those who work there as well as those who receive treatment.
- Investment in mechanisms that allow for teamwork—time for huddles, informal consultation, well-run case conferences.
- Consciously formulating "cases" broadly to avoid unbalanced approaches (I only do what I know how to do).

- Helping staff at all levels and across all disciplines develop trusting relationships and efficient ways of sharing information and insights. The National Coalition for Dialogue and Deliberation (www.ncdd.org) provides materials for a wide range of participatory approaches to building consensus and promoting change.
- The integrated care "Toolkit" from the National Child Traumatic Stress Network's Pediatric Integrated Care Collaborative (http://web.jhu.edu/pedmentalhealth/PICC.html) includes a trauma-specific readiness assessment and links to other tools related to providers' trauma-related stress and resilience.

At the system level, policy makers can remove barriers and create incentives to building relationships among clinicians of different disciplines and workers at related agencies:

- County and city health officers can promote cross-disciplinary training and clinical interaction through workshops, mixers, maintaining up-to-date directories of services, and dissemination of population-based data that highlight clinical needs.
- State policy makers can support initiatives promoting interdisciplinary work, including informal consultation services linking primary care and mental health providers,[75] modifications to payment mechanisms so that consultation among providers or participation in team meetings can be reimbursed,[76] and support for payment mechanisms that do not put a premium on productivity over clinical outcomes.[35,77]

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