Integration Track
*(All times in Eastern time)*

**Wednesday, June 24, 2020**

There are no Integration Sessions on Wednesday

**Thursday, June 25, 2020**

3:00 – 4:15 PM Breakout Session Number 2
Trauma Track | Integration Track
The Impact of a Trauma-Informed Therapeutic Relationship in Reducing Symptoms related to ACEs
*Presented by Vanessa Snyder, PhD, LPC, LMFT and Hannah Boos, BS and William Goodwin, BS*

Kaiser Permanente’s 1998 Adverse Childhood Experiences (ACE) Study, the largest study of its kind, produced shocking results that continue to change the landscape of understanding childhood traumatic experiences as well as treatment for somatic and mental health problems in adulthood (Herzog & Schmal, 2018; Felitti et. al, 1998). However, according to one of the original researchers in this study, there has been a slow move from the biomedical model to a biopsychosocial approach to treatment. In an effort to create a trauma-informed clinical mental health training program, Richmont Graduate University has incorporated an integration of holistic, trauma-informed education and training, a clinical foundation in the Interpersonal Process and therapeutic alliance, as well as a steady increase in trauma-informed supervision to address the clinical needs of those in treatment with a history of childhood trauma. Using the ACE questionnaire along with the Clinical Outcomes in Routine Evaluation (CORE) assessment, Richmont’s trauma-informed counseling centers have measured levels of ACEs along with pre and post-test measures of subjective categories for the following: current risk; negative symptoms (depression, anxiety, trauma and somatic experiences); subjective well-being, and functioning (general and relationship). The results of this study will be examined to inform clinicians and educators on an effective treatment modality for clients presenting with problems associated with early adverse childhood experiences.

5:00 – 6:30 PM Breakout Session 3
Integration Track
Integrated Care and Effective Collaboration With Physicians
*Presented by Joseph Kertesz, MA, LPC, NCC*
Primary care medical providers are the initial source for diagnosing and treating a majority of the people with diagnosed mental health disorders. They also write the majority of psychotropic medication prescriptions. Therefore, many people in need of mental health services are currently being treated by their physicians and some are receiving medications from them. A growing trend in healthcare is to integrate mental health professionals in medical settings. Some insurers are exploring rewarding those primary care clinics that implement the integrated model. However, there is very little written or taught about preparing mental health professionals in how to communicate with medical providers. It is imperative that the mental health provider learn to communicate effectively with physicians in order to maximize the care to their clients. This is true whether the mental health provider is in an integrated setting or is in a freestanding clinical practice. It is also very useful for them to learn these skills as a way to build a large referral base. Many primary care physicians recognize the need to refer mental health concerns out to specialists because the PCP does not have the time nor the expertise to appropriately treat these issues. Mental health providers are in the perfect position to assist with this challenge. The presenter has over 40 years of experience working in an integrated setting.

Friday, June 26, 2020

11:00 AM – 12:00 PM Breakout Session Number 1
Integration Track
Interprofessional Education: Suicide Prevention in Integrated Care Settings
Presented by Amanda C. La Guardia, PhD, LPCC-S and Michael D. Brubaker, LICDC-CS and Benjamin Hearn, LPC

Health professions are rapidly shifting to competency-based models of training (e.g., Frank et al., 2010; Puntl, et al. 2013) wherein competencies are commonly characterized by specific quantifiable skills (Rodolfa et al., 2005, 2014). Competency-based training tends to focus on improvement of three domains: (1) factual knowledge, (2) attitudes, and (3) skill acquisition (as reflected by self-rated confidence/efficacy or expert-rated performance; Cramer et al., 2016; Frank et al., 2010; Rose, 2013). Several studies have examined preliminary effectiveness of competency-based training in suicide risk among psychology and psychiatry trainees. Two studies (McNiel et al., 2008; Hung et al. 2012) collectively evaluated workshop and standardized patient exercise modalities of training among psychiatric residents. McNiel et al. (2008) demonstrated resident improvement in documentation and learner confidence in working with suicidal patients. The rationale for suicide prevention training in the health professions is multifaceted. First, working with suicidal patients or clients is both common and potentially traumatic to health professionals (e.g., Baruch et al., 2013; Blau et al., 2013). Because the volume of suicides has steadily increased, all 50 states have adopted suicide prevention plans, resulting in suicide prevention programs in a variety of settings where a range of healthcare workers are employed, including educational, medical, mental health, and family service agencies (American Foundation for Suicide Prevention, AFSP, 2016). From a policy perspective, suicide prevention training is increasingly becoming a requirement for licensure or
continuing education for many health professionals. The recent AFSP (2016) review of state laws concerning health professional suicide prevention training requirements show that six states currently require such training, with three others recommending it. Beyond legislative initiatives, many health and behavioral health training programs are integrating interprofessional education and training into coursework requirements. Overall, there is a clear and growing trend requiring interprofessional education in mental health and suicide prevention training for aspiring health professionals. This presentation will include current and relevant interdisciplinary research on competency-based training effectiveness regarding suicide prevention. Research results from institutional and community competency-based trainings will be integrated to highlight how interprofessional education can promote competency and professional self-efficacy in integrated care environments.

OR

Trauma Track | Integration Track
Sleeping with the Enemy: Identifying and Treating Trauma-Related Sleep Problems
Presented by David Engstrom, Ph.D., ABPP, DMHCS
Disturbed sleep, especially insomnia, is a major contributing factor to physical and mental illness. Sleep deprivation results in numerous costs to the individual and society. The components of "normal" sleep will be detailed, as well as definitions of insomnia and statistics regarding disturbed sleep in the US. The relationship between stress and insomnia will be discussed and connected to how overproduction of cortisol can disturb sleep, due to its physiologically arousing properties. It is reported that between 70-91% of clients with PTSD experience chronic insomnia, primarily due to their state of chronic arousal. Research has indicated that insomnia often arises in clients with a history of childhood maltreatment and trauma. Childhood maltreatment has been associated with elevated cortisol levels. One study shows that frequent experience of physical and/or emotional abuse led to clinically relevant sleep pathology over 200% higher than in those who reported no abuse. The prevalence of childhood abuse will be described and current assessment techniques will be explained, including the ACEs evaluation. Several sleep assessment tools will be provided to attendees including a basic Sleep Log or diary for clients to self-report their sleep patterns and the Pittsburgh Sleep Quality Index for more intensive evaluation of sleep problems. Ten basic rules of sleep hygiene will be outlined and reviewed in detail, with guidance for clients. The landmark "three P's" of treatment of insomnia will be presented for evaluation: Predisposing factors, Precipitating events and Perpetuating mechanisms. The question of whether to treat the insomnia directly or the traumatic experiences first will be discussed, with emphasis on the possibility that both can be treated simultaneously. Finally, several therapeutic techniques will be described and applied, including Cognitive Behavior Therapy for Insomnia (CBT-I), mindfulness-based treatment for insomnia, Trauma-Focused CBT (TF-CBT) and Dialectical Behavior Therapy for posttraumatic stress disorder related to childhood sexual abuse.