Spring 1-2016

PSYX 631.02: Intervention - Rural Integrated Behavioral Health

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Psychology 631 (02): Psychological Interventions:

Rural Integrated Behavioral Health

(Intervention: Rur Int Beh Hlth)

Spring, 2016
David Schuldberg, PhD

Partially supported and funded by a grant from the Montana Health Care Foundation (MHCF; PI's: Robohm, Fiore, Schuldberg)
(Grant funds will support course-associated student travel costs)

Course Information

Monday & Wednesday 11:10 – 12:30
CPC 121

Instructor Information

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Introduction

This new course is a look into, and experience of, the future of mental health care delivery. It will describe and discuss Integrated Behavioral Health in primary care; introduce the Patient Centered Medical Home model of primary care; provide practical introduction to a variety of behavioral health approaches & techniques; and, address explicitly how to make IBH training relevant to rural Montana and Montana workforce needs -- all through a mix of classroom and "lab" experiences.

Course Summary

This course is open to graduate students in clinical and school Psychology, Social Work, Counselor Education, and local partners.

This course will include introductions to Integrated Behavioral Health models, population-based health care, didactic training in clinical techniques, and exposure to issues facing rural settings.

Rationale and Specific Course Objectives

This course is being offered in collaboration with and support from a grant from the Montana Health Care Foundation to the "Rural Integrated Behavioral Health (RIBH)" program (Robohm, Fiore, Schuldberg PIs), which aims to develop, refine, and evaluate a curriculum to facilitate behavioral health care workforce development in Montana. The RIBH program will combine knowledge gained from our successful AHEC/HRSA projects, with needs assessment and engagement in local rural communities throughout the state.

The curriculum is being piloted as this UM course in Spring, 2016, and we will seek funds to extend it (Phase 2) to train and certify rural providers across the state. This will set the stage for systems changes allowing further integration of care across settings (Phase 3).

Integrated behavioral healthcare (IBH) – where mental and physical health professionals work closely together to provide care for the whole patient – can address a number of problems in health care, including both mental and physical health. IBH is emphasized in health care's Triple Aim: improving the patient experience, improving population health, and reducing the cost of health care. Integrated behavioral healthcare is a requirement of the new Patient Centered Medical Home model of care in implementing the Affordable Care Act.

Addressing mental and physical health needs simultaneously has demonstrated many advantages, including reducing hospitalization, increasing patient engagement, improving chronic disease care, raising outcomes, reducing errors, and lowering costs. Such models can be particularly effective for patients who do not generally seek mental health care, but where behavioral health issues compromise health status.

Unfortunately, the practices and training to develop interdisciplinary partnerships and implement integrated behavioral healthcare models successfully have yet to be developed fully, particularly in rural areas in Montana with scarce providers. There is also a lack of training for mental health professionals in the needs of rural residents, with a high rate of turnover. Consequently, residents often rely on primary care physicians for mental health care, and providers have larger patient loads and higher burn-out rates.

In addition, many exiting integrated models presuppose the existence of supporting infrastructure and capacity, which are less likely to be present in rural settings. Many of the on-line training resources available do not address the added challenges facing rural areas (e.g., distances, lack of public transportation, social isolation, confidentiality fears, caregiver stress and isolation). Few graduate programs have established comprehensive rural mental health training for their students. Integration is vital for the success of health care reform and is lagging in its implementation.

This course:

In this course students, faculty, and visitors will develop and pilot an integrated behavioral health care curriculum for graduate students training for behavioral health care careers and professions. One important goal of the course will be workforce development. We plan to educate graduate students in clinical psychology, social work, and counselor education about integrated behavioral health care to increase the number of behavioral health trainees prepared to deliver care in this way. To that end, the course will introduce our students to integrated behavioral health concepts, strategies, and techniques and prepare them to work on integrated health care teams.

There is a significant field work component to the course: the enrolled students will be required to conduct needs assessment and outreach in at least 5 hospitals and clinics (total) in communities around Montana. This field work assignment will help students to (a) gauge interest in integrated behavioral health care, (b) assess community need and preparedness, (c) identify local obstacles and challenges to behavioral health care integration, and (c) identify important stakeholders. While gleaning information that will help refine the curriculum for broader applications, this assignment will also familiarize students with rural communities around the state, to help reduce cultural barriers to their practicing in such settings. Students will explore desire, preparedness, needs, and perceived barriers for addressing integrative behavioral health in clinics and hospitals in rural Montana and visit residency and other sites in Anaconda, Dillon, Hamilton, Libby, Plains, Polson, Ronan, Stevensville, Browning, Wolf Point, and other communities. Attention will be paid to cultural issues of rural and rural minority communities throughout.

The course will develop collaboration and communication models that will work in Montana settings. Interactions among trainees, supervisors, and colleagues in local settings will ground the curriculum in actual needs, obstacles, and on-the-ground experiences. AHEC, FMRWM, and interested programs will then refine and disseminate the curriculum for testing and further evaluation.

Thus, students will visit primary care settings across the state; interact with Montana primary care and mental health practitioners; conduct formal needs assessments of various institutions & agencies; develop summaries of needs and plans for further professional development; develop materials and modifications for future course offerings; and, develop the groundwork for new health care programs.

Course Expectations and Evaluation

Assigned Readings

Complete assigned readings prior to class and come prepared to discuss. Part of the class work will involve evaluating and selecting readings that will be useful for constructing Integrated Behavioral Health "Toolkits" that will be useful across topics and at various levels of professional training.

Class Participation

Class participation (and thus attendance) is required. It is expected that all students will contribute to discussions, demonstrating a familiarity with the readings and the ability to think creatively and independently. Class participation will be worth 15% of students' grades. If you must miss class (i.e. for a medical reason), please let me know in advance by e-mailing or leaving a voice mail (x4183). Because this class involves travel to rural communities, and because life happens, at time class participation will need to be virtual, and the course will cover the use of the GoToMeeting platform for distance learning.

Assignments

(These will be described further in class.)

1) Shadowing, observation, or interview assignment (15%)

2) Article review and toolkit development (15%)

3) Site visits and needs assessment (55%)

Note-taking
Note taking is encouraged in this class as a method of extracting, clarifying, and organizing information relevant to ethical and clinical decision-making. Role of notes will be discussed in class.

Grading
Plus and minus grades are used as follows: > 93% = A, > 90% = A-, > 87% = B+, > 83% = B, > 80% = B-, > 77% = C+, > 70% = C, etc. Note that final grades of C+ and below are not considered passing grades. Allowance is made for improvement over the semester. Please talk to the professor if you have any questions or concerns about how you are doing in the class.

The GoToMeeting platform
This will allow occasional virtual class attendance, presentations, and visits with other sites.

Important useful links (to be expanded)
Information on HIPAA and other privacy law

Note: The APA brochures on Moodle provide a better brief introduction to the HIPAA requirements.

Moodle on-line system
All course materials (or relevant links) are available via Moodle

Course announcements, additional class materials, and discussion forum will be on the Moodle platform

Make sure to use your official UM e-mail address with this system. You will need to have and use a university e-mail address and to check it regularly.

IT Central Help Desk: 243-4357 (8am-5pm); or italk@umontana.edu

Other requirements: Attendance in class is required; please come to class on time and stay for the entire period. See information on cell phone and Internet etiquette at end of syllabus.

Course Guidelines

1) This schedule is subject to change. Students are responsible for knowing about changes in assignments and schedules that may be announced in class or on Moodle.

2) Through the first fifteen (15) instructional days of the semester, students may use Cyberbear to drop courses. For courses dropped by the fifteenth instructional day, no fees are charged and courses are not recorded.

3) Friday, February 12 is (I think) the last day to drop, change a section, or change grading options without a drop/add form. After this date, a grade of "WP" or "WF" will appear on the transcript. Petitions to drop will be granted only in documentable emergency cases. Note that course failure, in and of itself, does not constitute an emergency. There will be no exceptions, so please plan accordingly.

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5) Students with disabilities have the responsibility to declare their disability to the instructor at the beginning of the course if they require accommodations, and they also have the responsibility to arrange for such accommodations with Disability Services for Students (Lommasson Center 154). The instructor will work collaboratively with the student and DSS to provide these accommodations. If examination accommodations are arranged, please advise the professor and confirm the arrangements before each exam.

6) Departmental and University policies regarding Incompletes do not allow changing "Incomplete" grades after one year after an "I" has been granted.

7) Cell Phones and related technology. Students are expected to practice cell phone and computer etiquette in class. Make sure cell phones and pagers are turned off (or set to vibrate) during class. Please do not engage in excessive texting or online activity during class; nevertheless, looking something important up and sharing it with the class is still considered cool. Cell phones use, texting, use of mp3 players, etc. are not permitted during in-class exams, if any.

8) Plagiarism or cheating of any kind will not be tolerated. Plagiarism is stealing or passing off the ideas or words of another as one's own without properly crediting the source. This behavior is unethical and a violation of the Student Conduct Code. The instructor also reserves the right to assign an "F" as a final grade if either cheating or plagiarism occurs.

9) All students must practice academic honesty. Academic misconduct is subject to an academic penalty by the course instructor and/or a disciplinary sanction by the University.

10) All work in this class is to be carried out in accordance with the APA *Ethical Standards* and associated documents, as well as the UM Conduct code.

Course Schedule (Version 1)

DATES	SELECTED TOPICS	TENTATIVE READINGS (THEORY, ASSESSMENT, INTERVENTION, TEAMING)
Week 1 **Jan 25 – 29**	**Introduction to the course** Summary of our MtHCF grant TA's role Shadowing Needs assessment in a rural setting (travel) **Context of the course** Historical background. From health care crisis to health care reform. The Affordable Care Act (Obamacare) and the patient centered medical home.	Read MtHCF Grant Proposal Berwick, D.M., Nolan, T.W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs: At the Intersection of Health, Health Care and Policy, 27(3),* 759-769. The affordable care act: A brief summary Auxier, A.M., Miller, B.F., & Rogers, J. (2013). Integrated behavioral health and the Patient-Centered Medical Home. In M.R. Talen & A.B.

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	Networks and systems of healthcare Silos in rural practice and elsewhere The team approach. Introduction to "the teamable moment." Barriers to IPE and team practice: Cultures and stereotypes Introduction to GotoMeeting Introduction to the needs assessment Relationship building Population-based health care **Degrees of integration**	Valeras (Eds.), *Integrated Behavioral Health in Primary Care: Evaluating the Evidence, Identifying the Essentials* (pp. 33-52). New York, NY: Springer. Patient Centered Medical Home Resource Center Collins, C., Hewson, D., Munger, R., & Wade, T. (2010). Evolving models of behavioral health integration in primary care. New York: Milbank Memorial Fund.
Week 2 **Feb 1 – 5**	**Service delivery in the rural healthcare environment. Rural communities, customs and cultures.** Aspects of behavioral health in rural healthcare: Rural mental health. Ethical and boundary issues. The rural context Health and Mental Health Disparities More on systems of care: **Resource mapping** The notion of "parity" The Montana Context **Note: Rural considerations will be woven throughout the course.** **Assessment tools, 1:** SF-36 Exercise	Miller, B. F., Petterson, S., Brown Levey, S. M., Payne-Murphy, J. C., Moore, M., & Bazemore, A. (2014). Primary care, behavioral health, provider colocation, and rurality. *J Am Board Fam Med, 27*(3), 367-374. [MHIA] (2015). Parity or Disparity: The State of Mental Health in America. MT BH Barometer Montana Workforce report Perhaps: NRHA: The future of rural behavioral health
Professor out of town **Feb 3** **In-class video**	**Weds:** **The Quiet Revolution on PBS** In Maine, Grubin meets Dr. David Loxterkamp, who practices family medicine with a team of doctors working to treat patients with chronic illnesses. In Mississippi, a state with more diabetes cases than any other, Grubin finds a rural health clinic fighting diabetes with the aid of an electronic communications device that provides greater access to medical care, helping patients take responsibility for managing this devastating chronic disease. In Alaska, the documentary follows Native	

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	Alaskans who own and operate their own health system, caring for 65,000 people across 107,000 square miles. In spite of the number of patients and the vast distances between them, they are determined to foster an empathetic relationship between patients and their health care providers. In San Francisco, Grubin visits a health care facility for seniors called On Lok, dedicated to making it possible for frail, elderly Americans in need of nursing home care to live with dignity in their own homes.	
Week 3 **Feb 8 – 12**	Diversity issues in the rural context; rural minority mental health Cultural adaptations and EBPs Core competencies: Discipline specific or crosscutting? Core competencies in counseling and SW. Core competencies as across disciplines Disciplinary differences (see IPE, below)	Rural Health Disparities readings TBA Gone, J. P., & Alcantara, C. (2007). Identifying effective mental health interventions for American Indians and Alaska Natives: A review of the literature. *Cultural diversity & ethnic minority psychology, 13*(4), 356-363. Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: preliminary findings and issues in evidence-based practice and reservation culture. *Advances in School Mental Health Promotion, 5*(1), 51-62. Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services*, 63(2), 147-153. Nash, J.M., McKay, K.M., Vogel, M.E., & Masters, K.S. (2012). Functional roles and foundational characteristics of psychologists in integrated primary care. *Journal of Clinical Psychology in Medical Settings, 19,* 93-104. Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, DC: Interprofessional Education Collaborative. Retrieved on January 12, 2014 from http://www.aacn.nche.edu/education/pdf/IPECReport.pdf. Strosahl, K.D. (2005). Training behavioral health and

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		primary care providers for integrated care: A core competencies approach. In W.T. O'Donohue et al. (Eds.), *Behavioral Integrative Care: Treatments that Work in the Primary Care Setting* (pp. 15-52). New York: Brunner-Routledge. Glidewell, J. C. (1959). The entry problem in consultation. *Journal of Social Issues, 15*(2), 51-59.
	Positive psychology, wellness, and positive mental health.	Robinson, P.J. & Reiter, J.T. (2007). Start-up: What to do and how to influence PCPs. In: *Behavioral Consultation and Primary Care: A Guide to Integrating Services* (pp. 165-193). New York, NY: Springer.
	Getting to know you: Outreach and entry. "The entry problem." Entry into Settings More on: Inter professional education (IPE) principles. Disciplines and turfs in healthcare. Starting get down to work.	Haley, W.E., McDaniel, S.H., Bray, J.H., Frank, R.G., Heldring, M., Johnson, S.B., Lu, E.G., Reed, G.M., & Wiggins, J.G. (2004). Psychological practice in primary care settings: Practical tips for clinicians. In R.G. Frank, S.H. McDaniel, J.H. Bray, & M. Heldring, M. (Eds.), *Primary Care Psychology* (pp. 95-112). Washington, DC: American Psychological Association. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer, A.C. (2009). Building an integrated primary care service. In: *Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention* (pp. 11-20). Washington, DC: American Psychological Association.
Week 4 Feb 15 – 19 [Monday holiday]	Introduction to the needs assessment assignment.	Readings on needs assessment, resource mapping
	Mental health in hospital and clinic. Brief and high quality. Benefits of time-limited therapy.	Kessler, R. & Stafford, D. (2008). Primary care *is* the de facto mental health system. In: R. Kessler & D. Stafford (Eds), *Collaborative Medicine Case Studies: Evidence in Practice* (pp. 9-21). New York, NY: Springer.
	Toward integrated Mental Health Care **MENTAL HEALTH COMPETENCIES: 1** Mental health and counseling, interviewing skills	Review (Collins et al., 2010) Selections from Willer, J. (2014). *The beginning psychotherapist's companion* (2nd edition).
	Psychoeducation Case formulation (DSM-5 and ICD-10)	DSM/ICD Crosswalks
	Clinical notes and the Electronic Health Record (EHR); HIPAA "Psychotherapy notes;" assessment materials shredding **Mental health issues 1: Emergency MH**	

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	Emergency Department issues: Urgent mental health care; danger to self and others. **Mental health issues 2: Depression and suicide** Depression treatment in primary care; Gatekeeper interventions for suicide prevention: ASIST and SafeTalk Suicide prevention in the ER **Mental health issues 3:** Serious Mental Illness (SMI) in a rural setting, Part 1. The recovery movement in Serious Mental Illness. Psychosis in the emergency department Liaison with CMHCs Pharmacology and the non-physician, introduction	Jarrett, E.M. (2009). The primary care consultant toolkit: Tools for behavioral medicine. In L.C. James & W.T. O'Donohue (Eds.), *The Primary Care Toolkit: Practical Resources for the Integrated Behavioral Care Provider* (pp. 133-167). New York: Springer. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer, A.C. (2009). Depression, anxiety, and insomnia. In: *Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention* (pp. 85-91). Washington, DC: American Psychological Association. PHQ materials BIC Materials Vol. 1, Chapter 1 from Davidson, L, Harding, C., & Spaniol, L. (Eds.). (2005). *Recovery from severe mental illnesses: Research evidence and implications for practice*, Volumes 1 and 2. Boston: Boston University Center for Psychiatric Rehabilitation. Harding, C. M. & Zahniser, J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *ACTA Psyciatrica Scandinavica*, 90 (suppl 384), 140 – 146. *(*Davidson, Harding, & Spaniol, Volume 1, p. 115*)* Brun, C. & Rapp, R. C. (2001). Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social Work*, 46, 3, 278–288. Farkas, M. D., O'Brien, W. F., Cohen, M. R. & Anthony, W. A. (1994). Assessment Planning in Psychiatric Rehabilitation. In J. R. Bedell (Ed.), *Psychosocial Assessment and Treatment of Persons with Severe Mental Disorders*. Philadelphia, PA: Taylor & Francis.
Week 5 **Feb 22 – 26**	Health psychology and Behavioral medicine. Behavioral health. Wellness in medicine.	Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer, A.C. (2009). Common behavioral and cognitive interventions in primary care: Moving out of the specialty mental health clinic. In: *Integrated Behavioral Health in Primary Care: Step-by-Step*

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	Behavioral medicine and Interventions 1: Physical Health Issues	*Guidance for Assessment and Intervention* (pp. 31-53). Washington, DC: American Psychological Association.
	Health Behaviors	Resources to be reviewed and selected
	Blood pressure	Selections from Hunter et al Toolkit
	Pain	Selections from other Toolkit PCBH Patient education protocols
	Assessment of health behaviors; health behavior self- assessment:	Glasgow, R.E., et al. (2005). Practical and relevant self-report measures of patient health behaviors for primary care research. *Annals of Family Medicine, 3(3),* 73-81.
	Introduction to substance use and abuse Substance abuse treatment is crucial; availability and lack of services; LAC credentialing in Montana; Substance abuse treatment records and mental health records: An unresolved issue in Primary care	Readings TBA
	Motivational interviewing with alcohol and substance use	MI Materials
Week 6 Feb 29 (!) – March 4	Week 6: Mental health and healthcare systems issues; counseling roles; systems agencies and resources Mental Health Interventions in Primary Care; stepped models of care	DiTomasso, R.A., Cahn, S.C., Cirilli, C., & Mochari, E. (2010). Evidence-based models and interventions in primary care. In R.A. DiTomasso, R.A., B.A. Golden, & H.J. & Morris (Eds.), *Handbook of Cognitive-Behavioral Approaches in Primary Care* (pp. 83-99). New York, NY: Springer.
	Mental health issues 3: Counseling, psychotherapy, and assessment; assertiveness and communication; couples and children.	Belar, C.D. & Deardorff, W.W. (2009). Pitfalls in practice. In: *Clinical Health Psychology in Medical Settings: A Practitioner's Guidebook (2nd Edition)* (pp. []). Washington, DC: American Psychological Association.
	Liaison with schools. Justice. Other agencies. When to refer. Where to refer. Liaison with family and community. Case management 101.	Munger, R.L. & Curtis, R. (2012). Brief treatment: A model for clinical guidelines in integrated care. In R. Curtis and E. Christian (Eds.), *Integrated Care: Applying Theory to Practice* (pp. 59-74). New York, NY: Routledge.
	The "difficult patient;" "legitimate diagnosis."	Redondo, R. M., & Currier, G. W. (2003). **Emergency**

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		Psychiatry: Characteristics of Patients Referred by Police to a Psychiatric Emergency Service. *Psychiatric Services, 54,* 804-806.
Week 7 **Mar 7 – 11**	**Behavioral medicine and Interventions 2:** Healthy eating Obesity: A cautious approach Coping with diagnosis and illness; existential factors in primary care Stress management and Emotion Regulation; relaxation training; hypertension revisited **Mental Health Issues 3:** Somatization Drug Seeking	**Toolkit review and recommendations** Dornelas, E.A., Gallagher, J. & Burg, M.M. (2014). Reducing stress to improve health. In K.A. Riekert, J.K. Ockene, & L. Pbert (Eds.), *The Handbook of Health Behavior Change (Fourth Edition)* (pp. 229-244). New York: Springer. Cucciare, M.A. & Lillis, J. (2009). Somatization in primary care. In L.C. James & W.T. O'Donohue (Eds.), *The Primary Care Toolkit: Practical Resources for the Integrated Behavioral Care Provider* (pp. 307-322). New York: Springer. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer, A.C. (2009). Health anxiety (Hypochondriasis). In: *Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention* (pp. 239-253). Washington, DC: American Psychological Association.
Week 8 **Mar 14 – 18**	Record keeping and billing; EHR SOAP format Medical economics 101. Financing and coding Introduction to HIPAA Privacy and encryption The bright side of the EHR	LLau, F., Price, M., Boyd, J., Partridge, C., Bell, H., & Raworth, R. (2012). Impact of electronic medical record on physician practice in office settings: a systematic review. *BMC Medical Informatics and Decision Making, 12,* 10. Cameron, S., & turtle-song, i (2002). Learning to write case notes using the SOAP format. *Journal Of Counseling & Development*, *80* (Summer), 286-292 Cummings, N.A., O'Donohue, W.T., & Cummings, J.L. (2009). The financial dimension of integrated behavioral/primary care. *Journal of Clinical Psychology in Medical Setting.* Springer article link Shore, J. H., Brooks, E., Anderson, H., Bair, B., Dailey, N., Kaufmann, L. J., & Manson, S. (2012). Characteristics of telemental health service use by American Indian veterans. *Psychiatric Services*, 63(2), 179-181

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	Technology in IBH, Part 1: Self—monitoring Tele-health Introduction to tele-supervision	SAMHSA-HRSA (2013). *The Business Case for Behavioral Health Care*. NCTSN Cat II materials on telephone Learning Collaboratives, if available
Week 9 **Mar 21 – 25**	**Screening tools:** Assessment and Screening **"Bring an instrument" day** **Behavioral health interventions for primary care, 3:** Eating disorders	**Review of assessment tools (brief) for** *PTSD* *Depression* *QOLI* *SF-36*
Week 10 **Mar 28 – Apr 1** ***Due: Shadowing/ Observation Assignment***	**More on Psychopharmacology**	Decristofaro, C. (2012). Pharmacologic competency. In R. Curtis and E. Christian (Eds.), *Integrated Care: Applying Theory to Practice* (pp. 75-123). New York, NY: Routledge. Mir & Roberts (2012). The principles of prescribing in primary care mental health. *Mir, S. & Roberts, C. (2012). The principles of prescribing in primary care mental health. In G. Ivbijaro (Ed.), *Companion to Primary Care Mental Health* (pp. 203-240). New York: Wonka and Radcliffe Publishing. Schultz, E. & Malone, D.A. (2013). A practical approach to prescribing antidepressants. *Cleveland Clinic Journal of Medicine, 80(10),* 625-631.
Week 11 **Apr 4 – 8**	**Spring Break, No class**	
Week 12 **Apr 11– 15**	**Mental Health Issues 4** Trauma & PTSD Acute trauma, and life-threatening situations; emergencies and disasters; Psychological First Aid PTSD Secondary Traumatic Stress (STS) and self-care Anxiety (revisited) and Stress	NCSTI Psychological First Aid Field Manual Leskin, G.A., Morland, L.A., & Keane, T.M. (2005). Integrating PTSD services: The Primary Behavioral Health Care model. In W.T. O'Donohue et al. (Eds.), *Behavioral Integrative Care: Treatments that Work in the Primary Care Setting* (pp. 129-141). New York: Brunner-Routledge.
Week 13 **Apr 18 – 22**	**Practice with children** PracticeWise demonstration	Kolko, D. J., & Perrin, E. (2014). The integration of behavioral health interventions in children's health care: services, science, and suggestions. *J Clin Child Adolesc Psychol, 43*(2), 216-228.
Week 14. **Apr 25 – 29**	**Consultation and supervision; support** Tele-supervision	TBA

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	More on self-care	
Week 15 May 2 - 6	**Wrap-up and conclusions**	
Exam Week May 9 - 13	**Evaluation Report due, time TBA**	