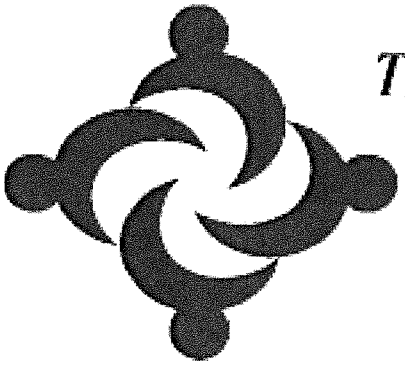


THE CENTER FOR
THERAPEUTIC INTERVENTIONS

Well Woman Orientation

The Center for Therapeutic Interventions 7477 E 46th Pl

Tulsa, Oklahoma 74145

918-384-0002 Fax 918-384-0004

COMMUNITY SERVICE COUNCIL

Improving Oklahomans' Lives Through Research, Planning & Action

Healthy Women Healthy Futures OKLAHOMA

Healthy Women, Healthy Futures Oklahoma (HWHF) is an evidence-based practice founded in 2008 that focuses on underserved populations with the highest birthrates and disparities in maternal and child health. HWHF is based in Life Course Theory (LCT), which addresses the importance of early programming to one's future health and development through both intergenerational programming (a woman's pre-pregnancy health) and prenatal programming (in utero).

We focus on reducing participants' risk factors, which diminish health, and improving their protective factors by improving their access to primary care and other health services, and through health education, referral and care coordination.

OUR VISION ***To improve the health of women and future generations.***

OUR MISSION ***To provide education, skills and support to create behavior changes that improve the physical, emotional, financial and social health of non-pregnant women, their families and future generations.***

To ensure that health promotion is provided in a manner that is culturally appropriate, culturally responsive and preserves cultural integrity, HWHF trains and supervises community peer educators:

Promotoras (Latinx women through Community Service Council's *Power of Families Project*)

Sia Mah Nu (Zomi/Burmese women through Community Service Council's *Burmese Peer Educator Program*)

We also subcontract with the Community Service Council's (CSC) ***Healthy Start*** initiative to provide Behavioral Health Care Coordination and Interconception Case Management to women and children enrolled in the Healthy Start program.

Both CSC's and Tulsa Health Department's Healthy Start programs use HWHF's health promotion materials to educate their participants.

CORE COMPONENTS

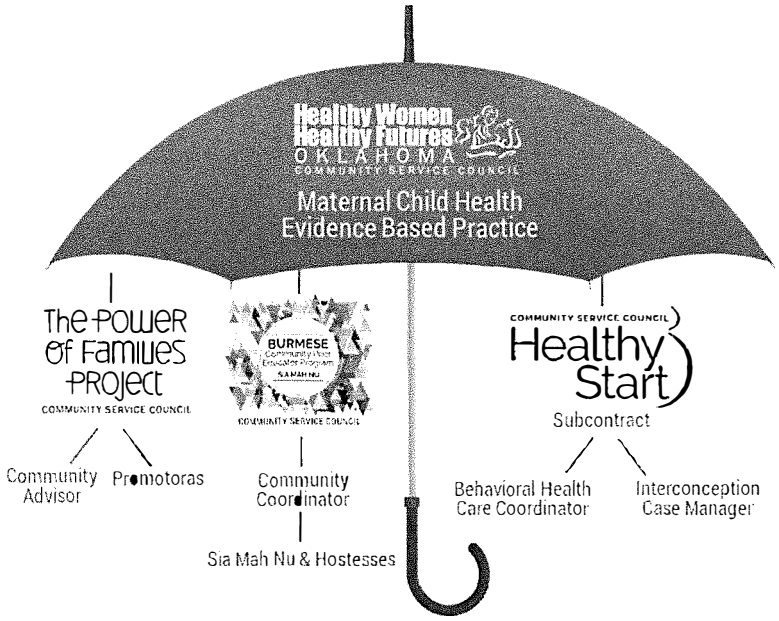
ASSESSMENT – of women's pre-pregnancy risk factors, including social determinants of health and family environment, and of infant and toddler's social and physical development

EDUCATION – health promotion classes provided in one of three languages (English, Spanish, Zopaw/Zomi (a Burmese dialect)) to address women's physical, emotional, social and financial health risks

CONNECTION – through referrals to medical homes, community services and resources

PARTNERSHIPS with Community Service Council's Healthy Start, Burmese Peer Educator and Power of Families Project programs, Tulsa area community schools, early childhood education centers, libraries, and community agencies serving Tulsa County

For More Information
Su An Phipps, RN, PhD
Director
918-295-1222
sphipps@csctulsa.org



TAKE CONTROL INITIATIVE

DATA CONVEY A RANGE OF POSITIVE OUTCOMES IN TULSA COUNTY IN PART AS A RESULT OF TCI'S EFFORTS:

- The teen birth rate has decreased 57.7% from TCI Baseline (2009) through 2018
- Abortions have decreased 51.2% from TCI Baseline through 2017
- In 2018 older adolescents aged 20-24 are nearly twice as likely to hold a high school diploma or GED when they gave birth than they were in 2016. Achievement increased from 41% to 79%, which is a likely outcome of both contraceptive access and improved wrap-around service intervention

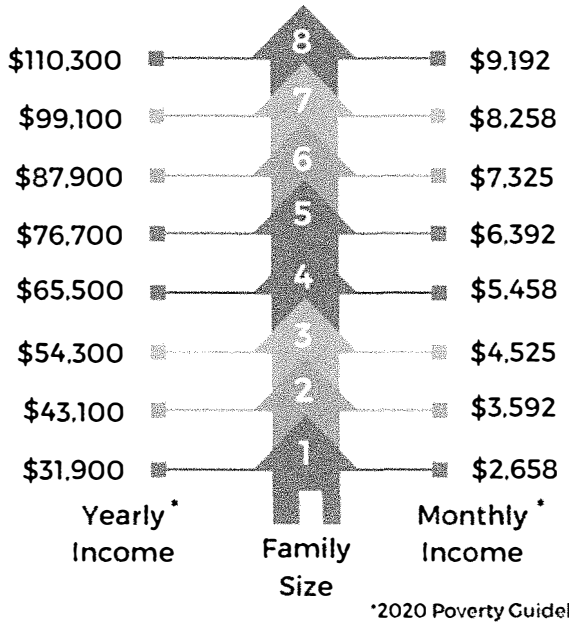
ACCORDING TO A 2019 LITERATURE REVIEW RELEASED BY THE INSTITUTE FOR WOMEN'S POLICY RESEARCH:

- Contraceptive access in a woman's early years increased her annual earnings in her early 40's by 11%
- Contraceptive access by age 20 reduced the probability that women (aged 16-44) lived in poverty by 8%
- Access to federally funded family planning programs reduced the share of children living in poverty by 7.4%

WHO IS ELIGIBLE FOR THESE CLINICAL SERVICES?

(You must meet all criteria)

- Individuals of reproductive age
- Wanting access to birth control
- Living in Tulsa County
- Income at or below 250% of the Federal Poverty Level



*2020 Poverty Guidelines

TULSA COUNTY ZIP CODES

FOR TCI ELIGIBILITY

NORTH

74021* 74055* 74070*
74073* 74106 74110
74115 74116 74117
74126 74130

Includes: Owasso | Sperry
Collinsville | Skiatook

CENTRAL

74103 74104 74105
74112 74114 74119
74120 74135

Includes: Downtown | Midtown

EAST

74015* 74108* 74128
74129 74134 74145
74146

Includes: Catoosa

SOUTH

74008 74011 74012
74014 74033 74037
74047* 74133 74136
74137

Includes: Broken Arrow | Jenks
Bixby | Glenpool | Tulsa Hills

WEST

74050* 74063* 74066*
74107 74127* 74131*
74132

Includes: Sand Springs

Source: THD, CHNA 2016

*FYI- INDICATES A ZIP CODE THAT FALLS BOTH IN TULSA COUNTY AND ANOTHER COUNTY BUT IS STILL ELIGIBLE FOR TCI

Find a Clinic

COMMUNITY HEALTH CONNECTION | ELLEN OCHOA

12020 East 31st Street
Tulsa, OK 74146
(918) 622-0641
Hours: Monday-Friday: 8am–6pm
Teen Clinic: Tuesday: 1:30pm – 6pm
Saturday: TEMPORARILY SUSPENDED

COMMUNITY HEALTH CONNECTION | KENDALL-WHITTIER

2321 East 3rd Street
Tulsa, OK 74104-3327
(918) 622-0641
Hours: Monday-Friday: 8am-6pm
Teen Clinic: Thursday: 1:30pm – 6pm

INDIAN HEALTH CARE RESOURCE CENTER

550 S Peoria Avenue
Tulsa, OK 74120
(918) 588-1900
Hours: Monday-Friday: 6:45am-6pm
Walk-in hours: Mon: 6:45am-5pm
Tues-Fri: 6:45am-5:15pm
(First Friday of Every Month: 6:45am-12pm)

MORTON | EAST TULSA FAMILY HEALTH CLINIC

11511 E 21st. Street
Tulsa, OK 74129
(918) 295-6185
Hours: Monday-Friday: 8:30am-5:30pm
Saturday: 9am-1pm
(First and Third Thursday of Every Month: 12pm-5:30pm)

MORTON COMPREHENSIVE HEALTH SERVICES

1334 North Lansing Avenue
Tulsa, OK 74106
(918) 587-2171
Hours: Monday-Friday: 8am-5:30pm
Saturday: 9am-1pm
(First Thursday of Every Month: 12pm-5:30pm)

OSU OBSTETRICS AND GYNECOLOGY | SOUTH TULSA

8803 South 101st E. Ave.
Tulsa, OK 74133
(918) 586-4500
Hours: Monday-Thursday: 8am-5pm
Friday: 8am-12pm

OSU PHYSICIANS | OBSTETRICS AND GYNECOLOGY

717 South Houston Ave, Suite 200
Tulsa, OK 74127
(918) 586-4500
Hours: Monday-Thursday: 8:30am-5pm
Friday: 8:30am-3pm

OSU WOMEN'S HEALTH CENTER

2345 Southwest Blvd
Tulsa, OK 74107
(918) 561-8543
Hours: Monday-Friday: 8am-5pm

OU PHYSICIANS | FAMILY MEDICINE

1111 South Saint Louis Avenue
Tulsa, OK 74120
(918) 619-4400
Hours: Monday: 8am-9pm
Tuesday-Friday: 8am-5pm

OU PHYSICIANS | WOMEN'S HEALTH CARE SPECIALISTS

4444 East 41st Street
Third Floor, Suite B
Tulsa, OK 74135
(918) 619-4400
Hours: Monday-Friday: 8am-5pm

PLANNED PARENTHOOD

1007 S. Peoria Ave.
Tulsa, OK 74120
(918) 582-4710
Hours: Monday: 11am-5pm
Tuesday: 11am-7pm
Thursday: 11am-6pm
Friday: 8am-1pm

TULSA HEALTH DEPARTMENT | CENTRAL REGIONAL HEALTH CENTER

315 South Utica
Tulsa, OK 74104
(918) 582-9355
Monday: 8am – 12pm
Tuesday – Friday: 8am – 5pm

TULSA HEALTH DEPARTMENT | COLLINSVILLE COMMUNITY HEALTH CENTER

1201 West Center
Collinsville, OK 74021
(918) 596-8650
Monday: 1pm – 5pm

TULSA HEALTH DEPARTMENT | JAMES GOODWIN HEALTH CENTER

5051 South 129th East Avenue
Tulsa, OK 74134
(918) 582-9355
Hours: Monday: 8am-5pm
Tuesday–Friday: 7am–5:30pm

TULSA HEALTH DEPARTMENT | NORTH REGIONAL HEALTH CENTER

5635 N. Martin Luther King Jr. Avenue
Tulsa, OK 74126
(918) 582-9355
Monday: 8am – 4pm
Tuesday: 8am – 5pm

TULSA HEALTH DEPARTMENT | SAND SPRINGS HEALTH CENTER

306 East Broadway
Sand Springs, OK 74063
(918) 591-6100
Thursday – Friday: 8am – 5pm

What do I need to know before my wellness visit?

A wellness visit is usually pretty straightforward — it's not a test that you pass or fail. But there are a few things you can do to feel more prepared for it.

Where can I go for a wellness visit?

You can go to your local Planned Parenthood Center, a health clinic, or your private doctor. You can often see a regular doctor for wellness visits, or you can see a gynecologist who specializes in women's health.

How much does a wellness visit cost?

Wellness visits are a key part of preventive care. Thanks to the Affordable Care Act, (AKA Obamacare), as long as you have health insurance, all of your preventive care should be covered at no cost to you. If you don't have insurance, the costs can vary. Your nearest Planned Parenthood Center. can talk with you about your payment options. Many people qualify for free or low-cost wellness exams at Planned Parenthood health centers.

How should I prepare for my wellness visit?

You don't need to do much to get ready for a wellness visit. But here are some tips to make your wellness visit go as smoothly as possible.

- Go on a day when you don't have your period, or it's at least fairly light — unless you have a bleeding problem that your doctor or nurse wants to see.
- Make a list of the questions you want to ask your doctor or nurse. Write them down so that it's easier to remember them during your appointment.
- Ask if you can have a friend or parent in the room with you if that would make you feel more comfortable

Can I get a wellness exam during my period?

Try to get a wellness exam on a day when you don't have your period — unless you have a bleeding problem that your doctor or nurse wants to check out. Certain lab tests that you get during a wellness exam are better to do when the swab won't get mixed with period fluid. If your period is going to be really light during your appointment, it might be okay. If you think you'll have your period when you're supposed to go in for an exam, call your doctor's office to see if you should reschedule your appointment. They'll let you know if it's ok to come in during your period or not.

Planned Parenthood Locations:

Peoria Health Center- 1007 S Peoria Ave. Tulsa, OK 74120 918-858-4661
Edmond Clinic- 3431 S. Boulevard, Suite 108 Edmond, OK 73013 405-348-9904
OKC Clinic - 619 NW 23rd Street OKC, OK 73103 405-528-2157

Partner Violence Screen (PVS)

The 3 question PVS is a short screening tool for interpersonal violence that may be used as a follow up tool to screen a pregnant or parenting MIHP beneficiary. It may not be used in place of the Maternal Risk Identifier (MRI) or Infant Risk Identifier (IRI) which ask additional questions.

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?

2. Do you feel safe in your current relationship?

3. Is there a partner from a previous relationship who is making you feel unsafe now?

Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF.(2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. Journal of Trauma, 54, 352-55.

If a woman answers the PVS screen affirmatively. Please pull the POC2 for Abuse/Violence.

In safety planning, an abuser's threats with a weapon or threats to kill should be rated as particularly serious, as should a possible murderer's access to a gun.

THE NUMBERS

Women are killed by intimate partners—husbands, lovers, ex-husbands, or ex-lovers—more often than by any other category of killer.[1] Homicide of women is a leading cause of death in the United States among young African American women aged 15 to 45 years.[2] [The preceding sentence was revised March 11, 2014.] Intimate partner homicides make up 40 to 50 percent of all murders of women in the United States, according to city- or State-specific data-bases (as opposed to the Federal Supplementary Homicide Reports).[3] Significantly, the Federal report doesn't have an ex-boyfriend/ex-girlfriend category, which accounts for as much as 11 percent of intimate partner homicides of women and for 2 to 3 percent of intimate partner homicides committed by women.

In 70 to 80 percent of intimate partner homicides, no matter which partner was killed, the man physically abused the woman before the murder.[4] Thus, one of the primary ways to decrease intimate partner homicide is to identify and intervene promptly with abused women at risk.

1. Mercy, James A., and Linda E. Saltzman, "Fatal Violence Among Spouses in the United States, 1976–85," *American Journal of Public Health* 79 (1989): 595–599; Bailey, James E., Arthur L. Kellermann, Grant W. Somes, Joyce G. Banton, Frederick P. Rivara, and Norman B. Rushforth, "Risk Factors for Violent Death of Women in the Home," *Archives of Internal Medicine* 157(7) (1997): 777–782; and Bachman, Ronet, and Linda E. Saltzman, *Violence Against Women: Estimates From the Redesigned Survey*, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics and National Institute of Justice, 1995 (NCJ 154348).
2. Centers for Disease Control and Prevention, Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Data Source: National Center for Health Statistics, National Vital Statistics System, http://www.cdc.gov/injury/wisqars/leadingcauses.html. [This citation was revised March 11, 2014.]
3. Campbell, Jacquelyn C., "If I Can't Have You, No One Can: Power and Control in Homicide of Female Partners," in *Femicide: The Politics of Woman Killing*, ed. Jill Radford and Diana E.H. Russell, New York: Twayne Publishers, 1992: 99–113; and Langford, Linda, Nancy Isaac, and Stacey Kabat, "Homicides Related to Intimate Partner Violence in Massachusetts," *Homicide Studies* 2(4) (1998): 353–377.
4. Pataki, George, *Intimate Partner Homicides in New York State*, Albany, NY: State of New York, 1997; Office of Justice Programs, *Violence by Intimates;* Campbell, "If I Can't Have You"; McFarlane, Judith M., Jacquelyn C. Campbell, Susan A. Wilt, Carolyn J. Sachs, Yvonne Ulrich, and Xiao Xu, "Stalking and Intimate Partner Femicide," *Homicide Studies* 3(4) (1999): 300–316; and Campbell, Jacquelyn C., *Assessing Dangerousness: Violence by Sexual Offenders, Batterers, and Child Abusers*, Newbury Park, CA: Sage Publications, 1995.

This study did not examine the risk faced by men of intimate partner homicide when the woman was suicidal, so this factor's weight was not determined.[5] However, since the question of whether a woman is suicidal is important for prevention efforts, the researchers recommend that it remain on the assessment.

The Safety Plan

In safety planning, an abuser's threats with a weapon or threats to kill should be rated as particularly serious, as should a possible murderer's access to a gun. Thus, the researchers suggest that the legal prohibition against gun ownership

for those convicted of domestic violence is especially important to enforce, and any protection order should include firearms search-and-seizure provisions.

However, criminal justice practitioners making decisions about an alleged batterer's bail or sentencing should keep in mind that more than a third of women who had a score of 4 or higher were not murdered. The research showed that only a score of 8 or 9 reliably identified those women who were killed. Thus, while the current cutoff score of 4 suggests the need for great caution and for protective action, it does not reliably identify a woman's risk of death.

NCJ 196547

In safety planning, an abuser's threats with a weapon or threats to kill should be rated as particularly serious, as should a possible murderer's access to a gun. Thus, the researchers suggest that the legal prohibition against gun ownership for those convicted of domestic violence is especially important to enforce, and any protection order should include firearms search-and-seizure provisions.

For more information

- Background information on the Danger Assessment plus the full text of the questionnaire is available at http://www.son.jhmi.edu/research/CNR/homicide/DANGER.htm.

Notes

1. Pataki, George, *Intimate Partner Homicides in New York State*, Albany, NY: State of New York, 1997; Campbell, Jacquelyn C., Phyllis W. Sharps, and Nancy Glass, "Risk Assessment for Intimate Partner Violence," in *Clinical Assessment of Dangerousness: Empirical Contributions*, ed. Georges-Franck Pinard and Linda Pagani, New York: Cambridge University Press, 2000: 136–157; Bennett, Lauren, Lisa Goodman, and Mary Ann Dutton, "Risk Assessment Among Batterers Arrested for Domestic Violence," *Violence Against Women: An International and Interdisciplinary Journal* 6(11) (2000): 1190–1203; and Weisz, Arlene N., Richard M. Tolman, and Daniel G. Saunders, "Assessing the Risk of Severe Domestic Violence: The Importance of Survivors' Predictions," *Journal of Interpersonal Violence* 15(1) (2000): 75–90.
2. An actuarial instrument is one that provides weightings and published scores that have been shown through formal and independent research to predict violent outcomes. See Roehl, Jan, and Kristin Guertin, *Current Use of Dangerousness Assessments in Sentencing Domestic Violence Offenders*, Pacific Grove, CA: State Justice Institute, 1988; and Quinsey, Vernon L., Grant T. Harris, Marnie E. Rice, and Catherine A. Cormier, *Violent Offenders: Appraising and Managing Risk* (1st ed.), Washington, DC: American Psychological Association, 1998.
3. Campbell, Jacquelyn C., Daniel Webster, Jane Koziol-McLain, Carolyn Rebecca Block, Doris Williams Campbell, Faye Gary, Judith M. McFarlane, Carolyn Sachs, Phyllis W. Sharps, Yvonne Ulrich, Susan A. Wilt, Jennifer Manganello, Xiao Xu, Janet Schollenberger, and Victoria Frye, "Risk Factors for Femicide in Abusive Relationships: Results From a Multisite Case Control Study," *American Journal of Public Health* (93) (2003): 1089–1097.
4. See Sharps, Phyllis W., Jacquelyn C. Campbell, Doris Williams Campbell, Faye Gary, and Daniel Webster, "The Role of Alcohol Use in Intimate Partner Femicide," *American Journal on Addictions* 10(2) (2001): 1–14, for a complete multivariate analysis of substance abuse of both the perpetrator and victim in these data.
5. Browne, Angela, Kirk R. Williams, and Donald G. Dutton, "Homicide Between Intimate Partners," in *Homicide: A Sourcebook of Social Research*, ed. M. Dwayne Smith and Margaret A. Zahn, Thousand Oaks, CA: Sage Publications, 1999: 149–164.

CHILDBIRTH, BREASTFEEDING AND INFANT CARE:

Methadone and Buprenorphine

Are you pregnant, taking methadone or buprenorphine, and want to know how this may affect your delivery, ability to breastfeed, or your newborn?

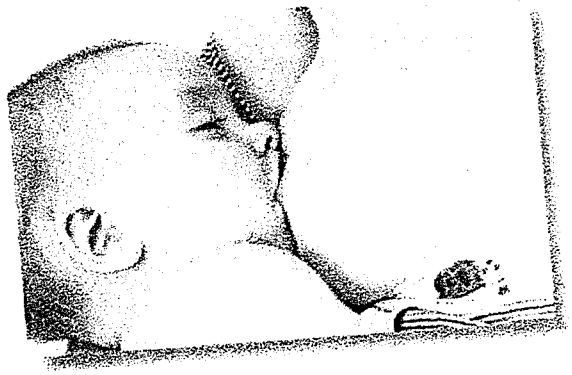
Or are you a pregnant woman using heroin or prescription opioids and considering treatment with methadone or buprenorphine?

HOW SHOULD I PREPARE FOR DELIVERY?

- Choosing a doctor and hospital with experience in methadone and buprenorphine during labor and delivery can be helpful.
- Select a doctor for your baby *(a pediatrician or family physician)* and meet before delivery to talk about the care of your baby.
- Find out whether you can tour the nursery before your baby is born to learn about how the nursery cares for opioid exposed infants.

WHAT ABOUT PAIN RELIEF DURING AND AFTER DELIVERY?

- Your usual daily methadone or buprenorphine dose will not treat pain.
- Discuss pain control for childbirth and after delivery with your physician during prenatal care.
- Meet with the anesthesia doctor to discuss your labor and delivery pain. This meeting can happen before labor or early in labor.
- If you are having a planned cesarean delivery or have one after labor, discuss postoperative pain.
- The doctors on Labor and Delivery MUST know that you are taking methadone or buprenorphine so that you are not given labor pain medications such as Stadol and Nubain which can cause withdrawal in women taking methadone or buprenorphine.



WHAT ABOUT CHILD PROTECTIVE SERVICES?

- Many babies and mothers get tested for drugs and alcohol at delivery -- this might include methadone and buprenorphine
- Having a positive drug test, even if it's for prescribed medications, may mean that social workers or a child protection agency will want to talk to you and your family.
- A child services worker may come to your home to see how safe the environment is for your baby.
- Please talk to your doctor and other health care providers about the child protection laws in your state.

HOW DOES OPIOID WITHDRAWAL AFFECT THE BABY AFTER DELIVERY?

- After delivery, the baby no longer receives nutrients and medications such as buprenorphine and methadone from the mother's bloodstream. Your baby may develop withdrawal – called Neonatal Abstinence Syndrome (NAS).
- Not all babies born to moms on methadone or buprenorphine develop NAS.
- Each baby shows withdrawal differently. The following are some of the most common signs in opioid exposed babies:

Tremors or shakes	*Crying*	*Frequent yawning*
Poor feeding/sucking	*Sleep problems*	*Stuffy nose*
Fever	*Sneezing*	*Tight muscles*
Vomiting	*Diarrhea*	*Loose stool (poop)*

- These signs may happen from birth to 7 days after delivery and can last days, weeks, or months.
- Your baby may need medication to treat these symptoms and make the baby feel better. The baby's dose will then be decreased over time, until the symptoms have stopped.
- Your baby may be watched for four or five days in the hospital to see if medication will be needed.
- If a baby has NAS, it does not mean that he or she will have long-term problems.

CAN I BREASTFEED IF I AM TAKING BUPRENORPHINE OR METHADONE?

- Breastfeeding is usually encouraged for women who are taking methadone or buprenorphine, except in some cases.
- Breastfeeding is not safe for women those with HIV, taking certain medicines that are not safe in breastfeeding, or who are actively using street drugs.
- Only very small amounts of methadone and buprenorphine get into the baby's blood and may help lessen the symptoms of NAS.

HOW WILL PAYING A NEWBORN AFFECT MY RECOVERY?

- The weeks and months after the baby is born can be a stressful time for women in recovery. Be sure to continue counseling, and use parenting support programs.
- Do not make a decision to stop your opioid medication too quickly or too soon because this increases the risk of relapse.
- It is important to discuss decisions about your medication with your doctors and your counselors. *For further information, please see brochure Pregnancy and Methadone and Buprenorphine.*

Eat, sleep and console tool decreases length of stay and post natal use of opiates

27 April 2019

A new quality improvement tool called Eat, Sleep and Console (ESC) shows consistent signs of improved care of opioid-exposed newborns in neonatal intensive care units (NICUs). Findings from the study will be presented during the Pediatric Academic Societies (PAS) 2019 Meeting, taking place on April 24—May 1 in Baltimore.

"The opioid epidemic has had an enormous impact on newborn care and our goal in this project was to improve the care of opioid-exposed newborns at our hospital using quality improvement methods to adapt previously demonstrated successful approaches that focused on three things; simplified assessment of newborns experiencing opioid withdrawal, engaging and educating families in best practices to support their babies through drug withdrawal symptoms, and minimizing exposures of babies to medications," said Susan Townsend, MD, one of the authors of the study. "Our philosophy is to 'use hugs, not drugs' in treating newborn opioid withdrawal symptoms. This approach was effective in rapidly reducing hospital stay for this large group of patients."

To conduct this study, a quality improvement (QI) process was initiated using an ESC tool in a NICU. It included all opioid exposed newborns admitted to this NICU. A multidisciplinary team met monthly to direct process change using plan-do-study-act (PDSA) cycles, change from Finnegan Score (FS) to ESC, emphasize non-pharmacologic care, increase family involvement, and use morphine on an as-needed basis instead of tapered methadone for medication treatment when needed. Clinical practice change was supported with education and charting tools, "just in time" teaching moments on bedside rounds and during morning unit huddles. As part of a statewide perinatal QI collaborative, it used a REDCap de-identified patient database to track length of birth hospitalization (LOS) and use of medication.

During the pre-intervention period in 2017, 635 infants were admitted to the NICU. Among these admissions, 71 infants (11.2%) had fetal opioid exposure, and 46 of these 71 infants (64.7%) were treated with methadone for neonatal abstinence (NAS) with an average LOS of 22.7 days. Between January 1 and October 31, 2018, there were 50 NICU admissions with fetal opioid exposure. Of these, 43 were greater than or equal to 34 weeks gestation and discharged home from the NICU. LOS decreased from a median 21 days in the first quarter (Q1) (n=12), to 5.5 days in the third quarter (Q3) (n=18). Use of medication to treat NAS decreased from 75% in Q1 to 27.8% in Q3, with median length of exposure to medication decreasing from 16 to two days.

Implementing a care path for newborns with fetal opioid exposure that relies on non-pharmacologic interventions and uses the ESC evaluation tool can substantially shorten hospital stays and decrease exposure to pharmacologic treatment for symptoms of NAS.

More information: Dr. Townsend will present findings from "Rapid Decrease in Length of Stay and Postnatal Use of Opiate Medication Using 'Eat, Sleep and Console' in a Single Center" on Monday, April 29 at 1 p.m. EDT.

Provided by American Pediatric Society

Gender Identity Gender Expression and Sexual Orientation

CTI will provide counseling and/or make referrals to counseling regarding, Women's general health issues, Intimate partner abuse or family violence, Sexual abuse, Reproductive health issues and Gender expression, gender identity and/or sexual orientation.
CTI will also provide or make referrals for all women served and their partners as appropriate for reproductive health services (family planning) and parenting skills as applicable.
CTI will make every attempt to assign you a counselor or specialized staff based on the characteristics and needs of women and staff are respectful and CTI will provide a safe treatment environment for everyone.
The safety and health of women is a primary concern for CTI. All women should feel safe while in the facility. The emotional climate is one that is respectful of women and ensures the maintenance of their dignity. CTI staff are sensitive to the specific needs of women and receive competency-based training in the characteristics and needs of women participating in our programs. CTI groups are gender specific and treatment service delivery can be based on gender identity, expression, or sexual orientation.
CTI assists our staff to be provision of culturally competent, developmentally appropriate, and trans-affirmative therapeutic practice regarding transgender and gender nonconforming individuals. Treatment guidelines are client focused and address intervention-specific recommendations for a clinical population or condition. These guidelines are intended to complement treatment guidelines for people seeking behavioral healthcare services as those set forth by the World Professional association for transgender health standards of care and the endocrine society.
CTI holds the beliefs and maintains the guidelines set by the APA regarding gender expression, identify and sexual orientation.
Foundational Knowledge and Awareness
1. We understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.
2. We understand that gender identity and sexual orientation are distinct but interrelated constructs.
3. We seek to understand how gender identity intersects with the other cultural identities of transgender and gender non-confirming (TGNC) people.
4. We are aware of how attitudes about and knowledge of gender identity and gender expression may affect the quality of care provided to TGNC people and their families.
Stigma, Discrimination, and Barriers to Care
5. We recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.
6. We strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNCaffirmative environments.
7: We understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.
Life Span Development
8. Those of us working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.
9. We strive to understand both the challenges that TGNC elders experience and the resilience they can develop.
Assessment, Therapy, and Intervention
10. We strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.
11. We recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.
12. We strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.
13. We seek to understand how parenting and family formation among TGNC people take a variety of forms.
14. We recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.
Research, Education, and Training
15. We respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.
16. We seek to prepare trainees in psychology to work competently with TGNC people.

RESOURCE IN TULSA
Dennis R. Neill Equality Center, Tulsa's resource for LGBT persons
621 E. 4th Street Tulsa, OK 74120
Hours: 9:00 am - 9:00 pm Monday through Sunday
Phone: (918) 743-4297
http://www.okeq.org

Preventing Sexual Violence

What is sexual violence?

Sexual violence is sexual activity when consent in not obtained or not freely given. It is a serious public health problem in the United States. Sexual violence impacts every community and affects people of all genders, sexual orientations, and ages—anyone can experience or perpetrate sexual violence. The perpetrator of sexual violence is usually someone known to the victim, such as a friend, current or former intimate partner, coworker, neighbor, or family member.

Sexual violence is associated with several risk and protective factors. It is connected to other forms of violence, and causes serious health and economic consequences. By using a public health approach that addresses risk and protective factors for multiple types of violence, sexual violence and other forms of violence can be prevented.[1]

How big is the problem?

Sexual violence affects millions of people each year in the United States. Researchers know that the numbers underestimate this significant problem as many cases go unreported. Victims may be ashamed, embarrassed, or afraid to tell the police, friends, or family about the violence. Victims may also keep quiet because they have been threatened with further harm if they tell anyone or do not think that anyone will help them.

Still, we do have data that show:

- **Sexual violence is common.** 1 in 3 women and 1 in 4 men experienced sexual violence involving physical contact during their lifetimes. Nearly 1 in 5 women and 1 in 38 men have experienced completed or attempted rape and 1 in 14 men was made to penetrate someone (completed or attempted) during his lifetime.[2]
- **Sexual violence starts early.** 1 in 3 female rape victims experienced it for the first time between 11-17 years old and 1 in 8 reported that it occurred before age 10. Nearly 1 in 4 male rape victims experienced it for the first time between 11-17 years old and about 1 in 4 reported that it occurred before age 10.[2]
- **Sexual violence is costly.** Recent estimates put the cost of rape at $122,461 per victim, including medical costs, lost productivity, criminal justice activities, and other costs.[3]

National Center for Injury Prevention and Control
Division of Violence Prevention

What are the consequences?

The consequences of sexual violence are physical, like bruising and genital injuries, and psychological, such as depression, anxiety and suicidal thoughts.[4]

The consequences may also be chronic. Victims may suffer from post-traumatic stress disorder, experience re-occurring gynecological, gastrointestinal, cardiovascular and sexual health problems.[4]

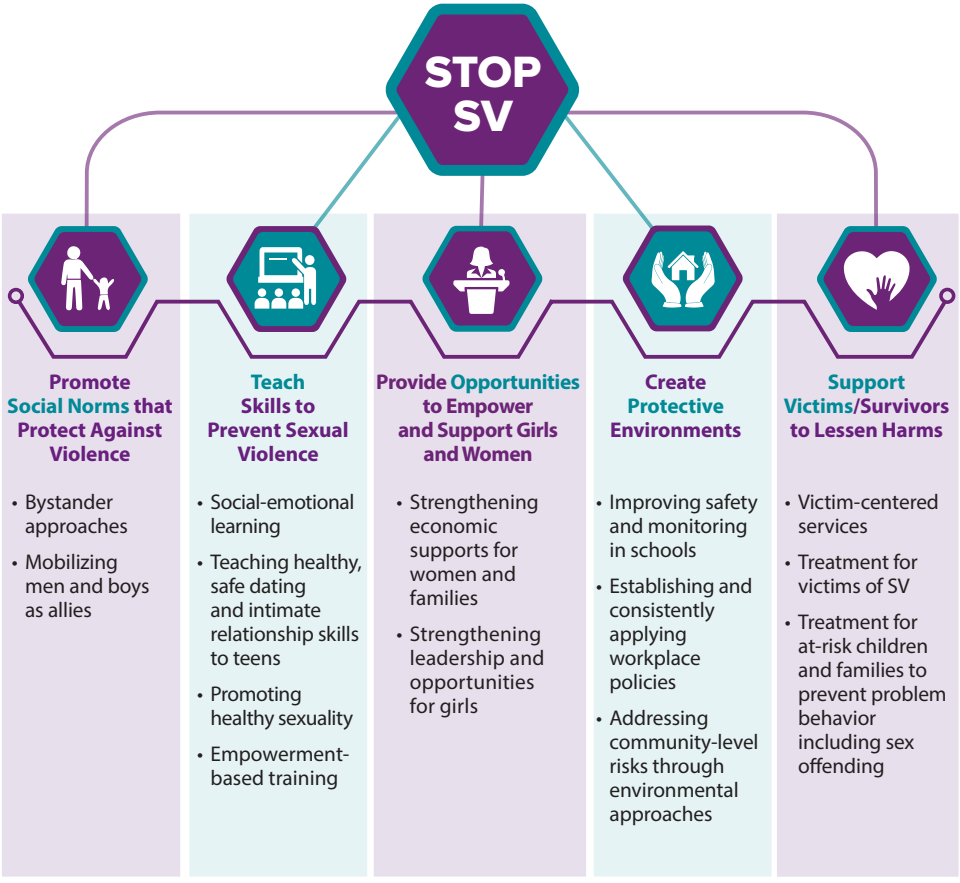
Sexual violence is also linked to negative health behaviors. For example, victims are more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual activity.[2]

The trauma resulting from sexual violence can have an impact on a survivor's employment in terms of time off from work, diminished performance, job loss, or being unable to work. These disrupt earning power and have a long-term effect on the economic well-being of survivors and their families. Readjustment after victimization can be challenging: victims may have difficulty in their personal relationships, in returning to work or school, and in regaining a sense of normalcy.[2]

In addition, sexual violence is connected to other forms of violence. For example, girls who have been sexually abused are more likely to experience other forms of violence and additional sexual violence, and be a victim of intimate partner violence in adulthood.[1] Perpetrating bullying in early middle school is associated with sexual harassment perpetration in adolescence.[5]

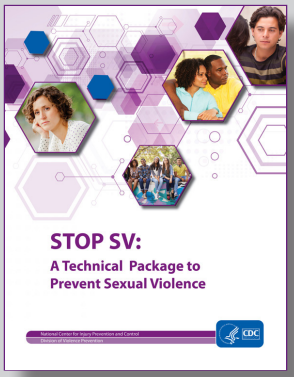
How can we stop sexual violence before it starts?

CDC developed a technical package to help communities take advantage of the best available evidence to prevent sexual violence. The strategies and approaches in the technical package are intended to impact individual behaviors as well as the relationship, family, school, community, and societal factors that influence risk and protective factors for violence.



STOP SV: A Technical Package to Prevent Sexual Violence

A **technical package** is a collection of strategies based on the best available evidence to prevent or reduce public health problems. The **strategy** lays out the direction and actions to prevent sexual violence. The **approach** includes the specific ways to advance the strategy through programs, policies and practices. The **evidence** for each of the approaches in preventing sexual violence and associated risk factors is also included.



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OUT OF THE SHADOWS

EXPOSING THE MYTHS OF HUMAN TRAFFICKING

HUMAN TRAFFICKING: LOOK BENEATH THE SURFACE

MYTH HUMAN TRAFFICKING IS ONLY SEX TRAFFICKING

TRUTH

OF THE 20.9 MILLION VICTIMS OF HUMAN TRAFFICKING GLOBALLY

- 68% FORCED LABOR
- 22% SEXUALLY EXPLOITED
- 10% STATE-IMPOSED FORCED LABOR

MYTH HUMAN TRAFFICKING VICTIMS WILL SELF IDENTIFY

TRUTH

50% OF VICTIMS HAD CONTACT WITH A HEALTH CARE PROFESSIONAL

NONE WERE IDENTIFIED AS A VICTIM.

MYTH HUMAN TRAFFICKING IS NOT IN MY COMMUNITY

TRUTH

30,000+ CASES OF POTENTIAL HUMAN TRAFFICKING REPORTED IN ALL 50 STATES, DC & US TERRITORIES

MYTH HUMAN TRAFFICKING ONLY AFFECTS THE VICTIM

TRUTH

THE CRIME OF HUMAN TRAFFICKING IS A SYMPTOM OF A SOCIETAL PROBLEM

HOW TO HELP

KNOW WHERE YOUR GOODS & SERVICES COME FROM

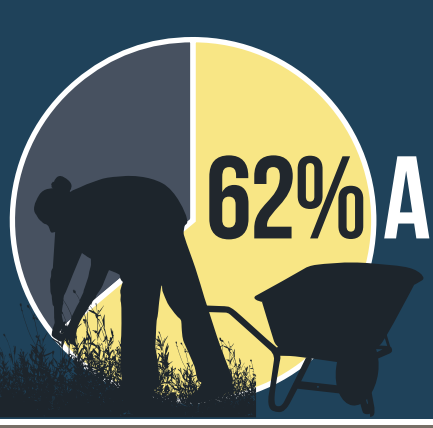
OFFER OPPORTUNITIES FOR AT-RISK INDIVIDUALS

REPORT IT: CALL THE NATIONAL HUMAN TRAFFICKING HOTLINE

MYTH HUMAN TRAFFICKING ONLY HAPPENS TO CHILDREN

TRUTH

SINCE 2012, NATIONAL HOTLINE CASES REPORTED:



62% ADULTS

MYTH HUMAN TRAFFICKING ONLY HAPPENS TO WOMEN

TRUTH

SINCE 2012, NATIONAL HOTLINE CASES REPORTED:

18% MEN

Human Trafficking is a crime and you can make a difference.

Since 2007, the National Human Trafficking Hotline has received over 168,554 calls and identified over 26,243 potential cases of human trafficking.
You can receive help, report a tip, or request information or training by calling:

National Human Trafficking Hotline

888-373-7888

acf.hhs.gov/endtrafficking

SOURCES

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https://www.acf.hhs.gov/otip/resource/publichealthlens

ADMINISTRATION FOR CHILDREN & FAMILIES

Preventing Child Abuse & Neglect

What are child abuse and neglect?

Child abuse and neglect are serious public health problems and adverse childhood experiences (ACEs) that can have long-term impact on health and wellbeing. This issue includes all types of abuse and neglect against a child under the age of 18 by a parent, caregiver, or another person in a custodial role (such as a religious leader, a coach, a teacher) that results in harm, potential for harm, or threat of harm to a child. There are four common types of child abuse and neglect:[1]

- **Physical abuse** is the intentional use of physical force that can result in physical harm. Examples include hitting, kicking, shaking, burning, or other shows of force against a child.
- **Sexual abuse** involves pressuring or forcing a child to engage in sexual acts. It includes behaviors such as fondling, penetration, and exposing a child to other sexual activities.
- **Emotional abuse** refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
- **Neglect** is the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, and access to medical care.

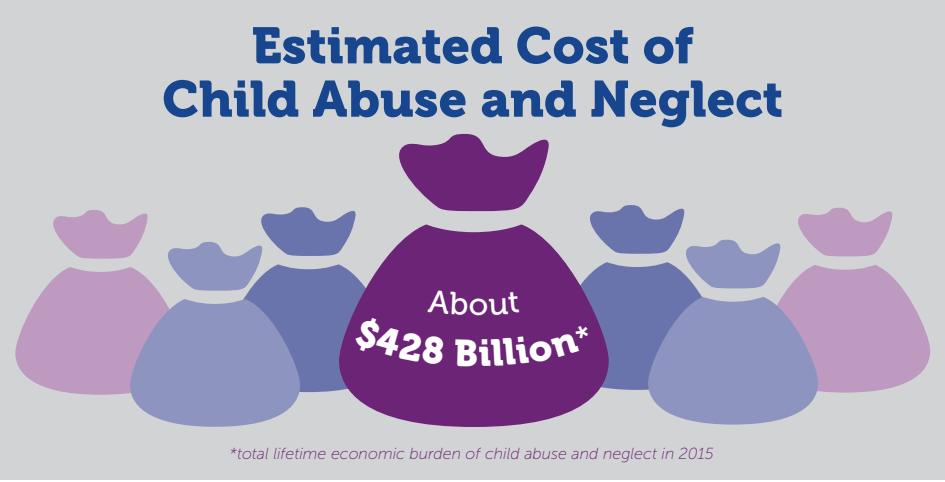
Child abuse and neglect are connected to other forms of violence through shared risk and protective factors.[1] This means preventing child abuse and neglect can also prevent other forms of violence.[2] Using a public health approach to address shared risk and protective factors, we can prevent child abuse and neglect from ever occurring.

How big is the problem?

Child abuse and neglect are common. At least 1 in 7 children have experienced child abuse and/or neglect in the past year, and this is likely an underestimate.[1] In 2018, nearly 1,770 children died of abuse and neglect in the United States.[3]

Children living in poverty experience more abuse and neglect. Rates of child abuse and neglect are 5 times higher for children in families with low socio-economic status compared to children in families with higher socio-economic status.[1]

Child maltreatment is costly. In the United States, the total lifetime economic burden associated with child abuse and neglect was approximately $428 billion in 2015.[4] This economic burden rivals the cost of other high profile public health problems, such as stroke and type 2 diabetes.



National Center for Injury Prevention and Control
Division of Violence Prevention

What are the consequences?

Children who are abused and neglected may suffer immediate physical injuries such as cuts, bruises, or broken bones, as well as emotional and psychological problems, such as impaired social-emotional skills or anxiety.[1]

Child abuse and neglect and other ACEs can also have a tremendous impact on lifelong health and wellbeing if left untreated. For example, exposure to violence in childhood increases the risks of injury, future violence victimization and perpetration, substance abuse, sexually transmitted infections, delayed brain development, lower educational attainment, and limited employment opportunities.[1]

Chronic abuse may result in toxic stress, which can change brain development and increase the risk for problems like post-traumatic stress disorder and learning, attention, and memory difficulties.[1]

How can we prevent child abuse and neglect?

Child abuse and neglect are preventable. Everyone benefits when children have safe, stable, nurturing relationships and environments. CDC has developed a technical package, also available in Spanish, to help communities take advantage of the best available evidence to prevent child abuse and neglect. The technical package includes strategies and approaches proven to impact individual behaviors, as well as family, community, and societal factors, that influence risk and protective factors for child abuse and neglect. They are intended to work in combination in a multi-level, multi-sector effort to prevent violence.

Strengthen economic supports to families

- Strengthening household financial security
- Family-friendly work policies

Change social norms to support parents and positive parenting

- Public engagement and enhancement campaigns
- Legislative approaches to reduce corporal punishment

Provide quality care and education early in life

- Preschool enrichment with family engagement
- Improved quality of child care through licensing and accreditation

Enhance parenting skills to promote healthy child development

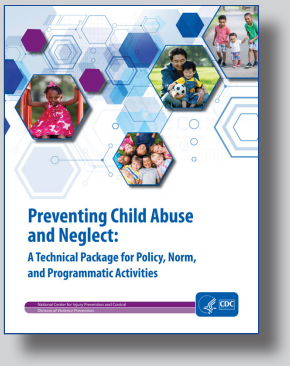
- Early childhood home visitation
- Parenting skill and family relationship approaches

Intervene to lessen harms and prevent future risk

- Enhanced primary care
- Behavioral parent training programs
- Treatment to lessen harms of abuse and neglect exposure
- Treatment to prevent problem behavior and later involvement in violence

Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities

A **technical package** is a collection of strategies based on the best available evidence to prevent or reduce public health problems. The **strategy** lays out the direction and actions to prevent child abuse and neglect. The **approach** includes the specific ways to advance the strategy through programs, policies and practices. The **evidence** for each of the approaches in preventing child abuse and neglect and associated risk factors is also included.



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The Center for Therapeutic Interventions (CTI)

Gender Identity Gender Expression and Sexual Orientation

CTI will provide counseling and/or make referrals to counseling regarding, Women's general health issues, Intimate partner abuse or family violence, Sexual abuse, Reproductive health issues and Gender expression, gender identity and/or sexual orientation.
CTI will also provide or make referrals for all women served and their partners as appropriate for reproductive health services (family planning) and parenting skills as applicable.
CTI will make every attempt to assign you a counselor or specialized staff based on the characteristics and needs of women and staff are respectful and CTI will provide a safe treatment environment for everyone.
The safety and health of women is a primary concern for CTI. All women should feel safe while in the facility. The emotional climate is one that is respectful of women and ensures the maintenance of their dignity. CTI staff are sensitive to the specific needs of women and receive competency-based training in the characteristics and needs of women participating in our programs. CTI groups are gender specific and treatment service delivery can be based on gender identity, expression, or sexual orientation.
CTI assists our staff to be provision of culturally competent, developmentally appropriate, and trans-affirmative therapeutic practice regarding transgender and gender nonconforming individuals. Treatment guidelines are client focused and address intervention-specific recommendations for a clinical population or condition. These guidelines are intended to complement treatment guidelines for people seeking behavioral healthcare services as those set forth by the World Professional association for transgender health standards of care and the endocrine society.
CTI holds the beliefs and maintains the guidelines set by the APA regarding gender expression, identify and sexual orientation.

Foundational Knowledge and Awareness

1. We understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.
2. We understand that gender identity and sexual orientation are distinct but interrelated constructs.
3. We seek to understand how gender identity intersects with the other cultural identities of transgender and gender non-confirming (TGNC) people.
4. We are aware of how attitudes about and knowledge of gender identity and gender expression may affect the quality of care provided to TGNC people and their families.

Stigma, Discrimination, and Barriers to Care

5. We recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.
6. We strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.
7: We understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

Life Span Development

8. Those of us working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.
9. We strive to understand both the challenges that TGNC elders experience and the resilience they can develop.

Assessment, Therapy, and Intervention

10. We strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.
11. We recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.
12. We strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.
13. We seek to understand how parenting and family formation among TGNC people take a variety of forms.
14. We recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Research, Education, and Training

15. We respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.
16. We seek to prepare trainees in psychology to work competently with TGNC people.

RESOURCE IN TULSA

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