Trauma Informed Care

1ST Annual
Mid-Ohio
"RSVP"
Conference
"Recovery, Success, Value, Purpose"
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by
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Within the next couple of weeks this presentation will be up at:
http://home.att.net/~LetFreedomRing

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Trauma Definition

1. **An event, series of events, or context that is emotionally overwhelming**
2. **The individual feels helpless or powerless to control the event(s) or situation**
3. **The person believes s/he is going to die**

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Definition

Trauma informed care is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services.

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Key Principles

Trauma Informed Care

- Integrates philosophies of quality care that guide all clinical interventions
- Is based on current literature
- Is informed by research and evidence of effective practice

(*Fallot & Harris*, 2002; *Ford*, 2003; *Najavits*, 2003)

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Exposure to Trauma
General Population

- Until recently, trauma exposure was thought to be unilaterally rare (combat violence, disaster trauma)
  (*Kessler et al.*, 1995)
- Recent research has changed this. Studies done in the last decade indicate that trauma exposure is common even in the middle class
  (*Ibid*)
- 56% of an adult sample reported at least one event
  (*Ibid*)

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Exposure to Trauma
Mental Health Population

- 90% of public mental health clients have been exposed
  (*Muesar et al.*, in press; *Muesar et al.*, 1998)
- Most have multiple experiences of trauma
  (*Ibid*)
- 34-53% report childhood sexual or physical abuse
  (*Kessler et al.*, 1995; *MHA NY & NYOMH* 1995)
- 43-81% report some type of victimization
  (*Ibid*)

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Exposure to Trauma
Mental Health Population

- 97 % of homeless women diagnosed with serious mental illness have experienced severe physical and sexual abuse - 87% experience this abuse both as child and adult
  (*Goodman et al.*, 1997)
- Current rates of PTSD in people diagnosed with serious mental illness range from 29-43%
  (*CMHS/HRANE*, 1995; *Jennings & Ralph*, 1997)
- Epidemic among population in public mental health system, especially women
  (*Ibid*)

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Exposure to Trauma
Mental Health Population

- 74 % of Maine's adult mental health inpatient consumers reported histories of sexual and physical abuse
  (*Craine*, 1988)
- Vast majority of adults diagnosed with BPD (81%) or DID (90%) were sexually or physically abused as children
  (*Herman et al.*, 1989; *Ross et al.*, 1990)

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Prevalence of Trauma in Mental Health Population

The literature substantiates that:

- Sexual abuse of women was largely under-diagnosed
- Coercive interventions like S/R caused trauma and re-traumatization in treatment settings
- "Observer violence" in treatment settings was traumatizing
- Complex PTSD, DID and related syndromes frequently misdiagnosed in treatment settings
- Inadequate or no treatment was common

(*Cook et al.*, 2002; *Fallot & Harris*, 2002; *Frueh et al.*, 2000; *Rosenberg et al.*, 2001; *Carmen et al.*, 1996)

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Implications

- There is considerable evidence that trauma and abuse are of urgent concern
- People with serious mental illness (SMI) are markedly at increased risk for trauma exposure
- Women are at particular risk; substance abuse and homelessness are significantly aggravating factors
  (*Cusack et al.*; *Muesar et al.*, 1998; *Muesar et al.*, in press; *NASMHPD*, 1998)

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Trauma Informed Care Systems

Key Features

Systems without Trauma Sensitivity	Trauma Informed Care Systems
Consumers are labeled & pathologized as manipulative, needy, attention-seeking	Are inclusive of the survivor's perspective
Misuse or overuse of displays of power - keys, security, demeanor	Recognition that coercive interventions cause traumatization / re-traumatization - are to be avoided
Culture of secrecy - no advocates, poor monitoring of staff	Recognition of the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with SMI/SED
Staff believe key role are as rule enforcers	Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness
Little use of least restrictive alternatives other than medication	Recognition that mental health treatment environments are often traumatizing, both overtly and covertly
Institutions that emphasize "compliance" rather than collaboration	Recognition that the majority of mental health staff are uninformed about trauma, do not recognize it and do not treat it
Institutions that disempower and devalue staff who then "pass on" that disrespect to service recipients.	Value consumer in all aspects of care
High rates of staff and recipient assault and injury	Neutral, objective and supportive language
Lower treatment adherence	Individually flexible plans approaches
High rates of adult, child/family complaints	Avoid all shaming / humiliation
Higher rates of staff turnover and low morale	Awareness/training on re-traumatizing practices
Longer lengths of stay/increase in recidivism	Institutions that are open to outside parties: advocacy and clinical consultants
	Training and supervision in assessment and treatment of people with trauma histories
	Focusing on what happened to you in place of what is wrong with you
	Asking questions about current abuse
	Addressing the current risk and developing a safety plan for discharge
	Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences.

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Trauma Assessment

- Purpose
  - Used to identify past history of trauma, violence, abuse, and related sequelae.
  - Assists with diagnostic reliability, clinical approaches and recovery progress.
  - Informs the treatment culture to minimize potential for re-traumatization.

(*Cook et al.*, 2002; *Fallot & Harris*, 2002; *Maine BDS*, 2000)

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Trauma Assessment

- Interview is conducted upon intake or shortly after
- Importance of therapeutic engagement during interview cannot be over emphasized
- Some clients will prefer to complete assessment alone
- Some will need several days to complete assessment *(Ibid)*
- Use of PTSD measures can add additional information.
  - Posttraumatic Diagnostic Scale for adults (*Foa et al.*, 1997)
  - Child PTSD Symptom Scale (*Foa et al.*, 2001)

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Trauma Assessment

- **Assessment**
  - Focusing on what *happened* to you in place of what is *wrong* with you (*Bloom*, 2002)
  - Asking questions about past and current abuse
    - Addressing current risk and developing safety plan for discharge
  - One person sensitively asking the questions
  - Noting that People who are psychotic and delusional can respond reliably to trauma assessments if asked appropriately *(Rosenberg*, 2002*)*

(*Fallot & Harris*, 2002; *Cook et al.*, 2002; *Ford*, 2003; *Cusack et al.; Jennings, 1998; Prescott*, 2000*)*

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Trauma Assessment

- Continued follow-up, preferably with same provider/clinician is suggested, due to sensitivity of issue.
- Can be done with de-escalation preference survey.

(Ibid)

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Trauma Assessment

- Should minimally include:
  - **Type**: childhood/adult rape, sexual, physical, emotional abuse or neglect, exposure to disaster
  - **Age** when the abuse occurred
  - **Who** perpetrated the abuse
  - Assessment of such symptoms as: dissociation, flashbacks, hyper-vigilance, numbness, self-injury, anxiety, depression, etc. *(Ibid)*

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Trauma Assessment

Results and "*positive responses*" must be addressed in treatment planning or assessment is useless.

Current JCAHO requirements are not generally considered sufficient

(Ibid)

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Trauma Assessment

- Other Mental Health factors to assess
  - History of S/R; involuntary IM medication experiences
  - Individual experiences in inpatient settings – fear, dissociation, anger. Powerlessness
  - Homelessness, addiction
  - Interest in working on a safety plan

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Trauma Assessment

- Informs plan of care
- Individualizes plan of care
- Serves as a training tool for staff
- Helps staff advocate for consumers
- Improves self awareness for consumer and staff about how past experience affects current behaviors

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Individual Crisis Prevention Plans

What are they?

Why are they used?

What elements make up a plan?

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What is a Crisis Prevention Plan?

A Crisis Prevention Plan is *more than just a plan.*

- Fundamentally it is an *individualized* plan developed in advance to prevent a crisis and avoid the use of restraint or seclusion.
- It is also:
  - A therapeutic process
  - A task that is trauma sensitive
  - A partnership of safety planning
  - A collaboration between consumers and staff to create a crisis strategy together
  - A consumer owned plan written in easy to understand language

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Other Names for Crisis Prevention Plans

- Safety Tool
- De-escalation Preference Tool
- Advance Crisis Plan
- Individual Crisis Plan
- Personal Safety Plan
- Personal Safety Form
- Safety Zone Tool

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Why Are Safety Tools Used?

Purpose:

- To help consumers during the earliest stages of escalation before a crisis erupts
- To help consumers identify coping strategies before they are needed
- To help staff plan ahead and know what to do with each person if a problem arises
- To help staff use interventions that reduce risk and trauma to individuals

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Essential Components

1. Triggers
2. Early Warning Signs
3. Strategies

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Crisis Prevention Plan

First, Identify <u>Triggers</u>

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More Triggers:

What makes you feel scared or upset or angry and could cause you to go into crisis?

- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- People yelling
- Room checks
- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Being stared at
- Other (describe)

_____

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No, not that Trigger …

Trigger, Roy Rogers' Horse

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More Triggers:

- Particular time of day/night_____
- Particular time of year_____
- Contact with family_____
- Other*_____

*** Consumers have unique histories with uniquely specific triggers - essential to ask & incorporate**

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These Triggers

- A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation):
  - bedtime
  - room checks
  - large men
  - yelling
  - people too close

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Crisis Prevention Plan

Second, Identify Early Warning Signs

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Early Warning Signs

- A signal of distress is a physical precursor and manifestation of upset or possible crisis. Some signals are not observable, but some are, such as:
  - restlessness
  - agitation
  - pacing
  - shortness of breath
  - sensation of a tightness in the chest
  - sweating

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Early Warning Signs

What might you or others notice or what you might feel just before losing control?

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Heart Pounding
- Singing inappropriately
- Pacing
- Eating more
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Rocking
- Can't sit still
- Swearing
- Restlessness
- Other _____

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Crisis Prevention Plan

Third, Identify Strategies

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Strategies

- Strategies are individual-specific calming mechanisms to manage and minimize stress, such as:
  - time away from a stressful situation
  - going for a walk
  - talking to someone who will listen
  - working out
  - lying down
  - listening to peaceful music

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Strategies:

What are some things that help you calm down when you start to get upset?

- Time alone
- Reading a book
- Pacing
- Coloring
- Hugging a stuffed animal
- Taking a hot shower
- Deep breathing
- Being left alone
- Talking to peers
- Therapeutic Touch, describe _____
- Exercising
- Eating
- Writing in a journal
- Taking a cold shower
- Listening to music
- Talking with staff
- Molding clay
- Calling friends or family (who?) _____

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More Strategies

- Blanket wraps
- Lying down
- Using cold face cloth
- Deep breathing exercises
- Getting a hug
- Running cold water on hands
- Ripping paper
- Using ice
- Having your hand held
- Going for a walk
- Snapping bubble wrap
- Bouncing ball in quiet room
- Using the gym

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Even More Strategies

- Male staff support
- Female staff support
- Humor
- Screaming into a pillow
- Punching a pillow
- Crying
- Spiritual Practices: prayer, meditation, religious reflection
- Touching preferences
- Speaking with therapist
- Being read a story
- Using Sensory Room
- Using Comfort Room
- Identified interventions:_____ _____

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What Does Not Help When you are Upset?

- Being alone
- Not being listened to
- Being told to stay in my room
- Loud tone of voice
- Peers teasing
- Humor
- Being ignored
- Having many people around me
- Having space invaded
- Staff not taking me seriously

"If I'm told in a mean way that I can't do something … I lose it."

-- Natasha, 18 years old

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Preferences in Extreme Emergencies

(to minimize trauma & re-traumatization)

Preference list continued…

- Medication
  - by mouth
  - by injection
- Preferred medication _____
- Prefer women/men
- Hold my hands, do not restrain my body
- Consider racial, cultural, and religious factors

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Mechanisms To Create a Trauma Informed Culture:

- Adopt philosophy of non-violence and non coercion
- Develop policies congruent with our stated values
- Identify & eliminate coercive practices
- Remove overt/covert expressions of power/control, and review rules objectively
- Examine and change our language
- Include consumers as full participants in treatment, programming, policy development
- Integrate peer supports and other natural supports
- Meaningfully change our environments

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