Supporting Culture Shifts in the Creation of Trauma Informed Care Environments

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Trauma

- “…Is a public health risk of major proportions…Moreover, it often compounds medical and psychological conditions and injuries. This information too often goes unrecognized or under-recognized by medical and mental health practitioners. We have a major education prevention and intervention issue.” (Courtois, 2012)

Abuse

- Physical (unwanted physical contact, restraining, confinement etc)
- Sexual (unwanted sexual behaviour, prevent use of contraception, forcing prostitution)
- Emotional (threats, monitoring, stalking etc)
- Financial (controlling, withholding, taking etc)
- Spiritual/Religious (attacking beliefs/practices, forcing person to join group, using beliefs to control & manipulate)

Abuse/Trauma & Mental Illness

- Persons diagnosed with mental illness &/or addiction are vulnerable to all forms of abuse/trauma
- This may have significant impact on their diagnosis, treatment & recovery

Evidence

Survivors of sexual abuse are at risk of long term effects including:

- Post traumatic stress disorder (PTSD)
- Depression
- Anxiety
- Low self-esteem
- Re-victimized
- Substance abuse
- Eating disorders
- Sexual dysfunction

(Gorey, Richter & Snider, 2001; Liem & Boudewyn, 1999; Wonderlich et al, 2001; RNAO BPG Woman Abuse, 2005)

Trauma & Substance Use

- High rates of drug & alcohol abuse in traumatized adults
- May use substance to numb trauma related thoughts & memories
- Individuals with trauma related mental health & substance use problems are often in crisis & rotate through services trying to get their needs met
- Alcohol problems found to be up to 15 times higher among women survivors of partner violence then in the general population

Trauma Specific Services

- Designed to treat the actual sequelae of trauma

Trauma Informed Care

Requires that organizations:

- Realize the prevalence of trauma
- Recognize how trauma affect all individuals involved, including its workforce
- Respond by putting knowledge into practice
- Reduce the use of restraint (mechanical, seclusion)
- Reduce the use of coercive & retraumatizing practices

6 Principles of Trauma-informed Practices

- Acknowledgement
- Safety
- Trustworthiness
- Choice & control
- Relational & collaborative approaches
- Strengths-based empowerment modalities

(Trauma Matters, 2013)

Public Health Approach

- Awareness of short & long term effects of trauma
- Implementing preventive, treatment, recovery & resiliency support services
- Build strong partnerships & networks
- Provide training & tools
- Inform pubic policy
- SAMHSA

System Approach

- Prevention of exposure to traumatic events
- Identify
- Early intervention response
- Treatment

Building Trauma Informed Systems

- Promote healing & recovery
- Maximize participant choice
- Strength based
- Person centred
- Safety of all (the individual, family members, staff, learners)

Changing Practice…Changing Care

- Introduced S/R reduction initiative & intro of TIC
- Introduced debriefing with trained peer support worker post seclusion & restraint
- Enhancing knowledge & skills of patients
- Enhancing knowledge & skills of staff
- Prevention strategies for vulnerable patients
- Support strategies for staff with ex. EAP
- Strengthening partnerships with community resources who serve clients with trauma, mental health & addiction issues

Workforce Development

- Training of staff on trauma
- Trauma & mental health & substance use
- Trauma-specific interventions
- Best Practices
- Policies

Skill Set of Providers

- Has knowledge & skills about trauma/abuse
- The safety of the patient
- Skill to ask about trauma/abuse
- Provide information
- Knowledge of community resources
- Carry out intervention
- Establish therapeutic relationship

Clinicians Responding to Disclosure

- Has knowledge & skills about trauma/abuse
- The safety of the patient
- Skill to ask about trauma/abuse
- Provide information
- Knowledge of community resources
- Carry out intervention
- Establish therapeutic relationship

What Should Clinicians Ask?

- Ask about current & historical experience with trauma/abuse

Which Patients are Routinely Asked about Trauma/Abuse

- All patients routinely
- Part of the health history/assessment
- At every new intimate relationship
- When S & S are present

What if Patient says “No”?

- Respect their response
- Advise the patient you are available should the situation ever change
- Assess again
- If patient says, “no”, but you suspect there is risk, assess & discuss risk, offer information

When Not to Ask

- Lack of privacy
- Assessment reveals that patient is unsafe
- If unable to have interpreter present

Approach

- Safety of all (the individual, family members, staff)
- Person-centred care (uniqueness, strengths)
- Holistic approach - The person is more than their diagnosis

Disclosure of Past Trauma/Abuse

- How do you feel about this now?
- Is there anything I can do for you now?
- Trauma/abuse can effect your health in many ways
- If patient believes trauma/abuse is still affecting them, then you might discuss it further or refer to someone who can meet the patient’s needs

Provide Validation

- Listen non-judgmentally
- Validate feelings
- “I am concerned for your safety & the safety of your children”
- “You are not alone & help is available”
- “I can help you”

Interventions

- Support for managing triggers that might set a memory or flashback
  - Acknowledge the person strengths
  - Identify positive strategies
  - Review unhealthy strategies
  - Work collaboratively
  - Introduce & practice of new strategies
  - Strategies for self-soothing
  - Grounding (breathing etc)

Referrals

- Advocacy services
- Support services
- Organizations that specialize in working with specific populations (teen, elderly, disabled, sensory impaired, ethnic/cultural, lesbian, gay, transgender, bisexual)

Purpose

- To describe clinical staffs' perceptions about the care of patients & to describe patients' perceptions about their care in clinical setting that is supporting a trauma informed care (TIC) approach

Design

- A single case study design
- Purposive sample
- 65 In-patients from 12 in-patient wards
  - Males 68% & Females 32%
- 65 Multidisciplinary clinical staff from 12 in-patient wards

Methods

- Focus groups or individual interviews with clinical staff
- Semi-structured questionnaire for patients
- Multiple sources of data: documents, artifacts & environmental description

Analysis

- Qualitative data: thematic analysis in 6 phases (Braun & Clarke, 2006)
- Quantitative data: descriptive statistics

Patient Findings

- 15% were familiar with TIC
- 22% indicated staff seemed knowledgeable & helpful about trauma/abuse
- 63% believed their care team worked together to assist them
- 20% had discussed their personal experience of trauma/abuse with their healthcare provider while in hospital
- 65% established a therapeutic rel'ship with staff

2011 Experience N=67	Yes %	2015 Experience N=65	Yes %
Safety	84	Hope	91
Staff Listen	79	Safety	85
Trust	76	Collaboration	85
Hope	76	Respect/Dignity	85
Respect/Dignity	74	Staff Listen	82
Comfort	73	Trust	78
Collaboration	72	Felt Understood	78
Acknowledge Strengths	72	Choice	77
Felt Understood	64	Acknowledge Strengths	77
Non-judgmental	61	Comfort	75

Staff Asked about Trauma/Abuse

Asked about Trauma N=65	freq	%
Yes	15	23
No	**47**	**72**
No answer	3	

Patient Experienced Trauma/Abuse

Experience of Trauma/Abuse N=65	*freq*	%
Yes	**42**	**65**
No	19	29
No answer	1	

Type of Trauma/Abuse

Type of Trauma N=65	%
Emotional	**66**
Physical	**58**
Sexual	**43**
Social	**42**
Financial	32
Religious	22
Environmental	15
Other	15
Ritual	9

Experience of Trauma/Abuse

Time of Experience n=47	Freq	%
Child	6	13
Adult	6	13
Child & Adult	**34**	**72**
Missing Information	1	

Staff (N=65) Findings

- 69% had participated in mandatory education
- 90% were familiar with TIC
- 98% wanted more knowledge & skills
- 98% reported lack of knowledge about trauma & community resources
- 77% indicated they were knowledgeable about their legal obligations with disclosure
- 100% reported that trust was an important aspect to developing a therapeutic rel'ship
- 94% used reflective practice

Staff (N=65)Findings

- 78% knew what to document when screening & responding to abuse
- 92% a safety plan is created when a patient discloses trauma/abuse
- 83% identified their setting as using routine universal screening for trauma/abuse
- 72% had screening strategies & initial responses for patients with trauma/abuse
- 88% indicated skills to foster an environment that facilitates disclosure of trauma/abuse

Themes - Staff

- More Knowledge & Skills about Trauma/Abuse
- More Knowledge about Trauma/Abuse & Culture
- More Knowledge & Skills about Sexual Abuse/Trauma
- Concerns about Experiences of Seclusion on Patients & Staff
- Staff & Trauma/Abuse Experiences

Conclusion

- Our population with mental health & addiction issues have high rates of trauma/abuse experiences as a child & an adult
- Staff are familiar with TIC & many have integrated it into their practice
- Patients are not familiar with TIC however their care experience reflects principles of TIC & some best practices
- 4 years after TIC implementation there is positive change in patients' care experience

Conclusion

- Some of the recommendations of the RNAO Best Practice Guideline on Women Abuse: Screening, Identification & Initial Response are being met
- Screening & assessment needs to improve
- The S/R Reduction Initiative needs to continue to reduce & eliminate the potential of trauma or re-traumatization
- Staff need further knowledge & skills re how to respond to disclosure, interventions, community resources, culture, sexual abuse, alternatives to seclusion/restraint, staff trauma & support

Implications

- Strong leadership support & a commitment to a culture shift in the organization is needed for sustaining TIC approach
- TIC champions are needed at all levels of MHAP
- Reduction of violence & the effects of violence in hospital & the community must be on-going
- Support & advocacy for individuals with mental health & addiction issues & trauma must reflect an inter-sectorial approach with social services & criminal justice

Implications/Recommendations

- Mental health & addiction services need to integrate with trauma treatment programs
- Engagement in QI re trauma informed care
- Engage the voice & participation of consumers
- Need to integrate an understanding about trauma informed care throughout the SJHH system of care
- Further research on TIC

Questions/Discussion

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