Trauma Informed Care in Long-term Care

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Oct. 2023

Conflict of Interest Declaration (1)

Not-for Profit organizations:

Sinai Health: Vice-President, Medical Affairs

Provincial Geriatrics Leadership Ontario (PGLO):

Medical Director, Geriatric Psychiatry

Conflict of Interest Declaration (2)

Funded grants: CIHR

Patents: nil

Relationship with industry: nil

Membership on advisory boards or speakers' bureaus: nil

Conflict of Interest (3)

No off-label use therapeutic recommendations will be made

Generic drug names will be used if referenced

Trauma Context Society (1)

Trauma is common: 70-80 % of over 65 yrs will have experienced at least one traumatic event (1)

Violence against women is common: 25 % of women experience intimate partner violence; 10 % survive rape over a lifetime (2,3)

First Nations people have survived a residential school system, the Sixties Scoop, and disproportionate rates of incarceration (5 % of population, 30% of Federal penitentiary population) (4)

Trauma Context Society (2)

Immigrant and refugee communities, racialized communities, and LGBTQ+ experience higher rates of physical violence and assault (5)

Health care system not account for, nor acknowledge, degree of trauma experienced by patients (6)

Trauma in Health Care

- Just more than 50 % of ER nurses experience physical or verbal abuse in any given week (7)
- 20 % of RPNs and PSWs report to have been physically assaulted more than **NINE** times in the previous year (8)
- Violence towards health care workers increasing (9)
- Violence against nurses is significant factor in nurses leaving nursing (10)

And then we experienced…….

COVID

Trust = safety

Post-Traumatic Stress Disorder (DSM 5)

A. Exposure to actual or threatened death, serious injury, or sexual violence.
B. Presence of one or more intrusions ass. with traumatic event as recurrent involuntary memories, dreams, dissociative, prolonged distress to internal or external cues, marked physiologic reactions to cues.
C. Persistent avoidance of cues.
D. Negative alterations in thoughts and mood ass. with traumatic event.
E. Alteration in arousal (irritability, reckless, hypervigilance, exaggerated startle, impaired concentration, sleep disturb.)

Post-Traumatic Stress Disorder

Specify: with dissociative symptoms (depersonalization or derealization)

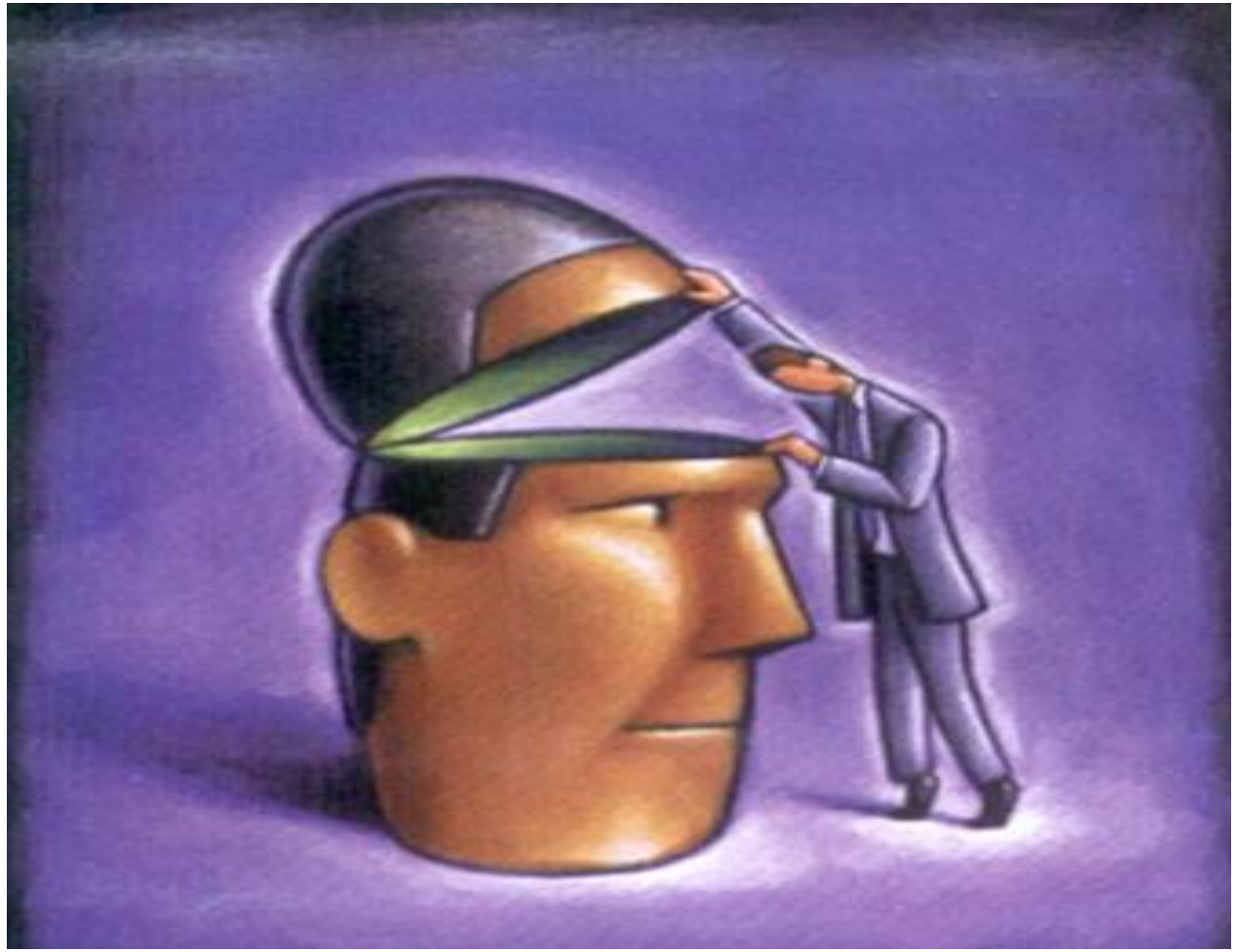
Specify: with delayed expression

Emotional life learned

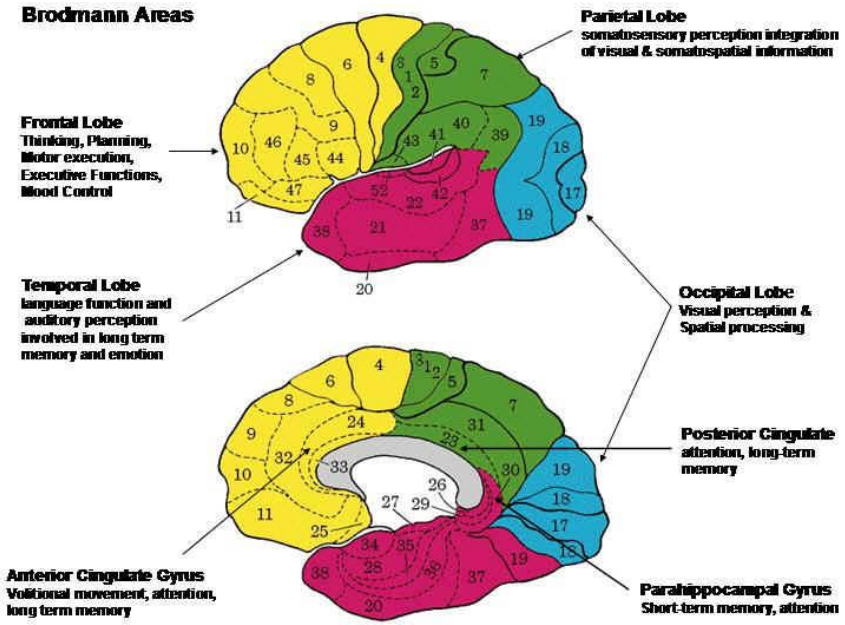
- Attachment theory
- “two-hit” model Winnicott
- Adult attachment styles
  - Self
  - Other

Adult attachment styles (relationship)

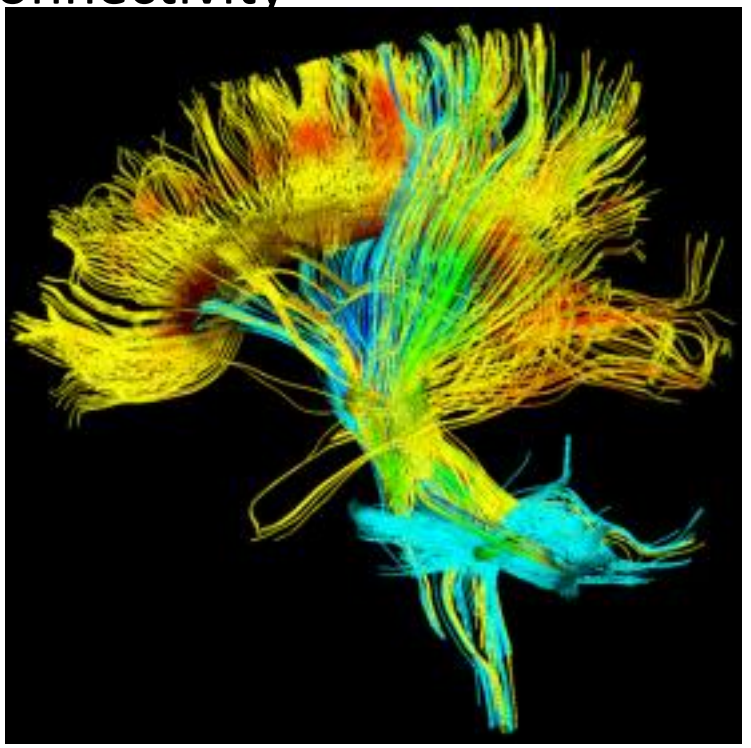
		other	
		+	-
Self	+	secure	dismissive
	-	dependent	insecure



structure



connectivity



Executive function

Planning

Organizing

Sequencing

Abstracting

“inner experience manager”

Trauma as common experience

- Intimate partner violence/sexual assault - rape
- Child abuse/neglect
- Political violence
- Imprisonment
- War

- Variablity of experience
- PTSD. Vs. Complex PTSD

Specific context - LTC

- Institutionalized care
- Idea of triggers/re-enactment -------→ flooding

- Loss of safety/inability of self to create safe space

- Moving beyond BPSD

Study

- Case review, three year period 2015 -2017; 225 consults
- Major neurocog. disorder, developed PTSD post admission to LTC.
- Initial 15 cases, 4 on closer review not meet criteria, 11 cases included

- Four homes, culturally focused care; 800 residents total
- Through Sinai Health System – Wellness Centre; Yee Hong LTC
- Previously presented AAGP Annual Conference 2018

Results

- 8 women, 3 men
- Average age 88 years
- Language: 7 Cantonese, 2 Mandarin, 1 Hakka, 1 Tamil
- Cognitive diagnosis: 5 VaD, 3 mixed, 2 AD, 1 PDD
- Cognitive testing: MMSE mean 11/30; range 0 – 23
- Trauma type: 9 war; 2 sexual assault/rape

So what …….

- Treatment implications …… team meetings, narrative, medication
- Family story
- Appropriate care

Trauma therapy

- Three stages:
  - Safety
  - Telling the story
  - Re-integration

  - Trauma and Recovery. Judith Herman

Trauma Informed Care

- Movement in health care broadly, recognizing the high prevalence of trauma
- Method of explicit attempt to meet needs of clients/patients
- Goal: build care system founded on safety for patient/family/clinicians

Three components:

1. Leadership commitment to recognizing trauma is part of regular human experience for patients/residents/staff; and this recognition means health care systems should be designed for this

2. Organizational level strategies to support staff: “don’t work with trauma alone”

3. Individual skill building

Quick aside Dialectical Behavioural Therapy (DBT)

Structured form of year long psychotherapy for specific population with severe self harm behaviours/suicide attempts/often trauma history

Several components: weekly group therapy (for skills learning), 1:1 24 hour a day access to therapy team for skills coaching in crisis, for therapists weekly process group support

Broad headings of skills: distress tolerance, mindfulness, emotional regulation, interpersonal effectiveness

Linehan, Marsha(1993) Skills training manual for treating Borderline Personality Disorder. New York: Guildford.

Trauma Informed Care Interventions:

- Brief (several hour) didactic session on trauma and role it lays in health care presentation
- Half day or full day collaborative workshop in which staff identified safety concerns and ways trauma could be reduced in practice – and then work plans developed to enact/support change
- Regular ward level brief facilitated staff meetings to check in on well-being and share coping strategies as a team
- Specific skills training in non-violent de-escalation, GPA, conflict mediation

Results

Elimination of restraint use in large urban trauma centre ER over a two year period (10)

80 % reduction in restraint use over a three year period on an in-patient psychiatry unit (11)

Organizational level trauma informed care principles (SAMHSA, 2014)(12)

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and Mutuality
5. Empowerment, Voice, and Choice
6. Cultural, Historical, and Gender Issues

In Long-term Care context

There is interest in introducing Trauma Informed Care in LTC settings (13,14)

Specific challenges are noted: resources, staff constraints, variation in financial models, highly regulated environments (15)

So what to do…….

Clear on why ?

Three components:

- Leadership commitment: (to idea, process, truth-telling)
- Individual skills training: decide on what this would be
- Organizational level support:
  - 1. didactic teaching (brief 1 – 2 hour session on prevalence trauma/PTSD)
  - 2. workshop for staff at all levels to identify 2-3 projects to help support residents/families/staff (ie. reduce restraint use, reduce physical assaultiveness, reduce transfer out in crisis, reduce staff burnout, reduce staff turnover) - key is that these are self-identified by staff after a discussion of trauma to improve resident/staff experience
  - 3. weekly support huddle/meeting structure to focus on staff coping in trauma experiences

No cookbook !

And yet there can be a consensus on process.

Opportunity to think about providing care differently.

Invitation: let’s do some of this work together, get in touch and we can put a group together to figure this out !

Co-design as fundamental basic principle

Thank you

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