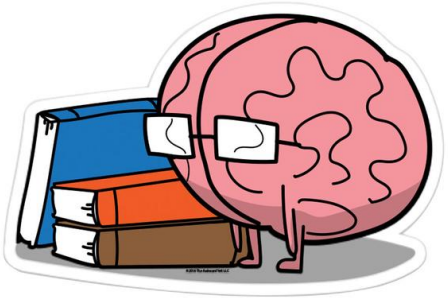
Trauma-informed care in aged persons (and youth) mental health

Viet Bui

Sunshine Aged Persons Mental Health Unit

Objectives

- Understand the neuro-biology of trauma
- Understand the importance of using trauma-informed care to reduce restricted intervention and violence
- Benefits vs barriers to implementation of this model of care
- Discuss cases seen on the ward
- Future suggestions



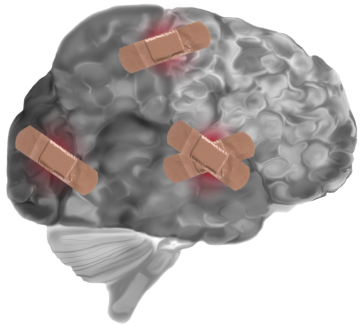
Source of image: The Awkward Yeti

Case study

- Case A: complex trauma (borderline personality disorder), help-seeking, challenging behaviours

- Case B: chronic schizophrenia, missed depot for 3/12, relapsed, first restarted depot needed restraint, second depot taken voluntarily with prompting from familiar staff member

- Case C: “it was nothing like on the TV”



What is trauma

Traumatic events involve actual/threat of death, harm or psychological injury that provoke intense feelings and distresses

Physical trauma, psychological trauma, emotional trauma

Can impact on physical, physiological, psychological and social well-beings -> affects mental health.

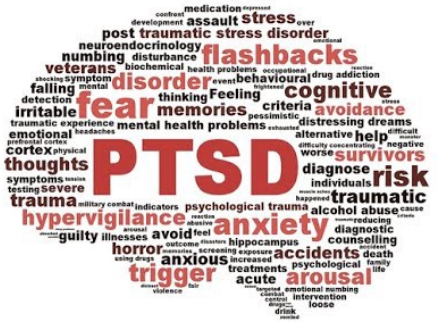


Image source: Google Image, ("Domestic Violence From a Feminist Perspective – Feminist Philosophy SP17 Class Magazine – Medium", 2018)

Neurobiology of trauma

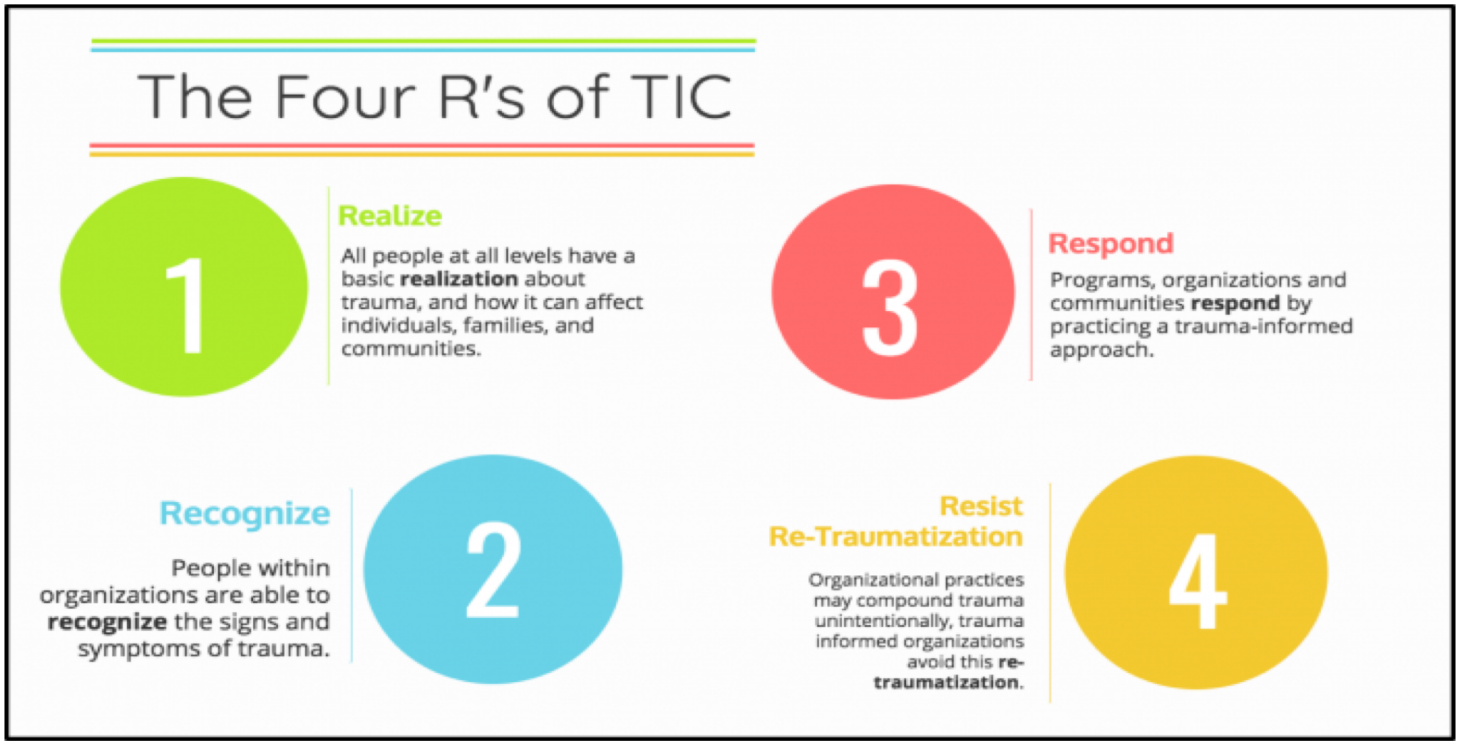
- The human body's natural response to threats is fight-or-flight
- Persistent threats of trauma cause changes to the neuro-endo-physiology -> high level of stress hormones
- Long term threats -> impaired fight-or-flight response

Source: (Adams, 2007; Koetting, 2016)

(Isobel & Edwards, 2017)

Trauma-informed care

- An approach/acknowledgement in response to high prevalence of traumatic experiences in mental health consumers
- Being aware of personal trauma and be sensitive to its impact on the MH consumers



Source: Children's Hope Inititive

(Isobel & Edwards, 2017)

Trauma-informed care

Source: "Children, Youth, & Families | Relias", 2018

Trauma-informed care in the aged population

- “The longer you go through life, the more trauma you accumulate”.
- Experience of famine, war, slavery, colonialism, violence, genocide, discrimination (ableism, racism, sexism) on top of physical/emotional/sexual abuse.
- Hospitalisation and illness precipitate traumatic responses in the elderly (case C)
- Being harmed by loved ones leave greater impact for the elderly
- They require trauma-informed care as much as the younger population

Benefits of implementing TIC

- Reducing restrictive intervention (early de-escalation and avoiding triggers)
- De-stigmatizing mental health
- Promoting personal recovery by targeting traumatic psycho-bio-social stressors
- Increase compliance, reduce substance use

- Cost effectiveness (‘less IPU, more CCU’) – less restrictive intervention

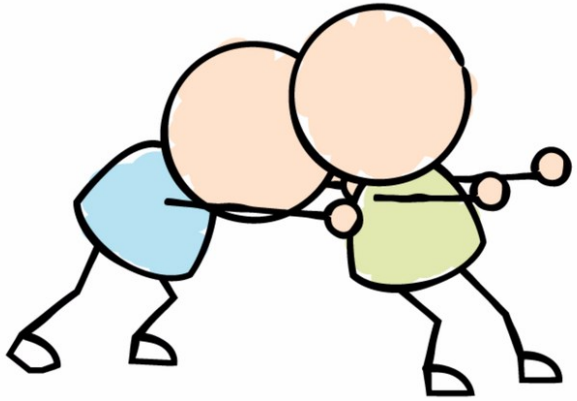
- Empathy and compassion

Source: Brene Brown on Empathy

Barriers of implementing TIC

- Ineffective screening
- Client's unwillingness to disclose / minimizing the trauma
- Some treatment models: isolating the disease and the person/situation

- Resistance from staff (lack of time, lack of training, redundancy)
- Fear of upsetting the person
- Working style (talking vs meds) and level of experience



Source: Google Image

Solutions

- Policy change and screening tools

- Training (cultural awareness), staff meeting and clinical supervision

- Riskman
- Data collection, audit and survey

- Environment

Discuss case study

- Case A: complex trauma (borderline personality disorder), help-seeking, challenging behaviours

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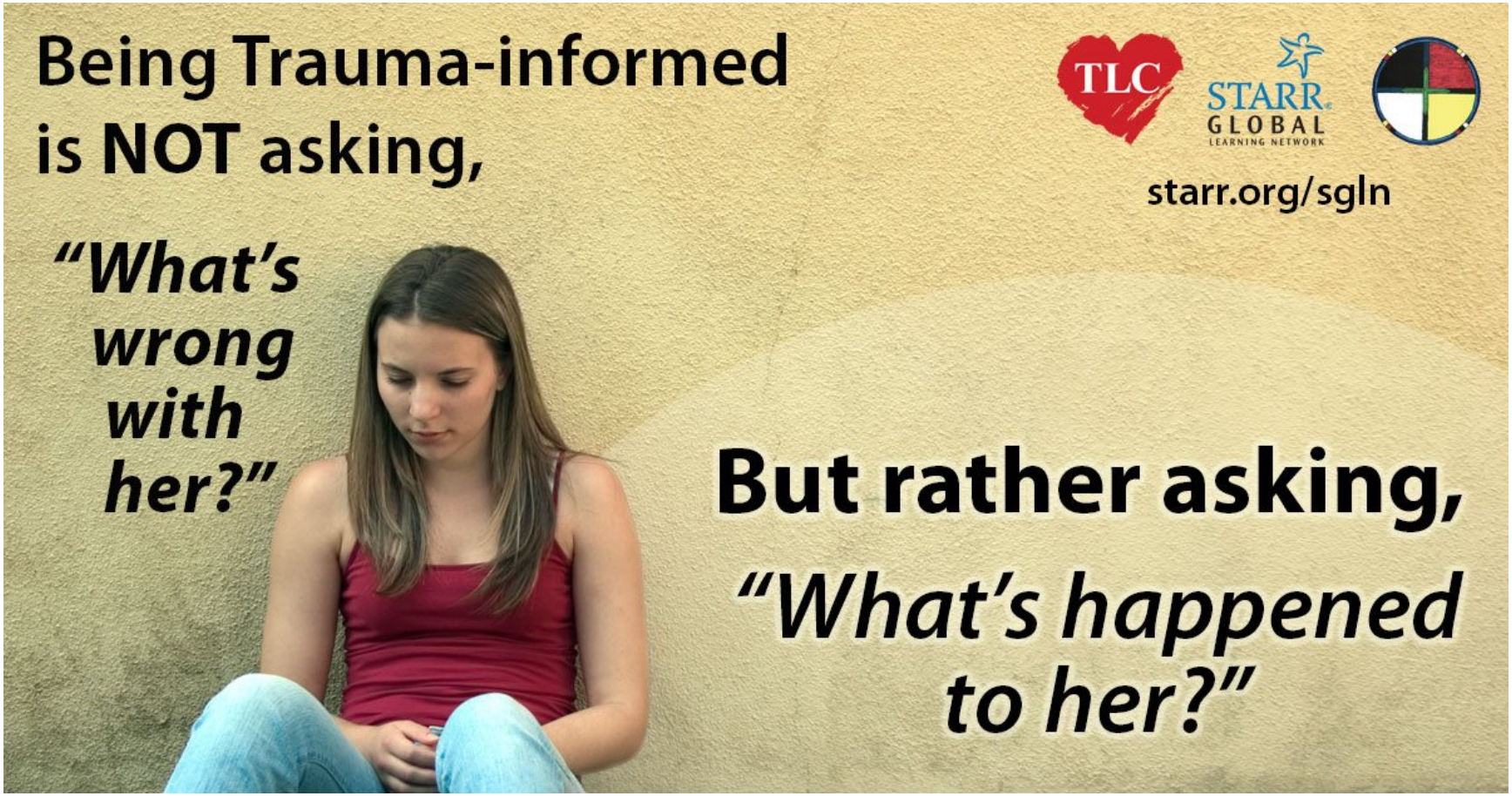
Future suggestions

We Need Compassion the Most When We Seem to Deserve it the Least

- ‘Trauma-informed’ or ‘person-informed’ care?
- Reducing restricted interventions (physical, chemical) – it is traumatic for the patient.
- Post-traumatic strength/trauma-informed growth (recovery focused approach) – ‘what doesn’t kill you makes you stronger’
- Raising awareness, revisiting the concept of TIC, be mindful about TIC, subconsciously applying TIC in practice – a learning process

Future suggestions



Source: http://starr.org

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