Trauma Informed Practices

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Trauma

The world breaks everyone,
and at the end, some are
stronger at the broken places.

-Ernest Hemingway

Ohio's CCOE in Mental Illness/Intellectual Disability

- Coordinating Center of Excellence in Mental Illness/Intellectual Disability
- Initiated in 2004
- Grant Funded Project:
  - Ohio Dept. of Developmental Disabilities
  - Ohio Department of Mental Health and Addiction Services
  - Ohio Developmental Disabilities Council

Ohio's Coordinating Center of Excellence in Mental Illness/Intellectual Disability

- Community Development
- Educational Programming
- Assessment Capacity

Community Development	Education	Assessment and Consultation
→ 38 Dual Diagnosis Intervention Teams developed → 62 counties covered by Dual Diagnosis Intervention Teams → >28,000 inquiries on the CCOE website → $582,646 mini grants awarded to local communities	→ 24,877 education attendees → 61,624 education contact hours → 554 programs directly sponsored, co-sponsored, and/or with CCOE partners providing educational programming	→ 975 provided ongoing psychiatric care → >150 new assessments annually → Regional assessment backup clinics in the CCOE network *Access Ohio Mental Health Center of Excellence.....*Dayton and Columbus, Ohio* *Nisonger Center (The Ohio State University).....*Columbus, Ohio*

Ohio's Telepsychiatry Project for Intellectual Disability

- **Prototype from 2005-2011** treating 90 individuals from 23 counties
- Telepsychiatry services **initiated in 2012**
- Virtual software which abides by patient privacy guidelines **(HIPAA Compliant)**
- Prioritize individuals from Developmental Centers and State Psychiatric Hospitals
- **All team members trained in Trauma Informed Care**

Telepsychiatry

- Simms et al 2011
- Research shows alliance is not compromised by use of videoconferencing.
- Medium made some patients feel less embarrassed and more able to express difficult feelings (**Fragile X Syndrome**)
- Clinicians length of time in the field affected their openness to the new technology

Telepsychiatry

- Leigh et al 2009
- Eighteen month period: 7,523 telepsychiatry appointments and 115,148 conventional
- No shows: 8% telepsychiatry vs 13 %
- Cancellation rate: 4.2% telepsychiatry versus 7.8%

Telepsychiatry

- Reduction in travel time, costs, ER visits and hospitalizations.
- Not necessary to be ‘tech savvy’
- Established programs use ‘buffet menu’ (phone, Email, MD-MD, MD-patient, etc) (**Nursing Facility**)
- Cancellation rate/show rate

Ohio's Telepsychiatry Project

- In rural communities ~50% of mental health care is provided by **primary care physicians.**
- Patients may have to travel long distances or ***forgo such services altogether.***
- Many patients prefer to be in a safe place. **CMS exemption in effect.**
- Increasing data shows reliability/validity are similar to face to face interaction.

Telepsychiatry Project Statistics

- For the first 120 individuals engaged in the program, **emergency room visits** decreased from 195 to 8 and **hospitalizations** decreased from 74 to 10 (comparisons are 12 months prior to telepsychiatry use to 12 months post treatment).
- A number of the individuals were discharged from state operated institutions and others were in danger of short-term admission, none of the 120 involved in the project were admitted or readmitted to state operated institutions. This saves the state approximately **$80,000 per person per year** in support costs.
- **Travel costs** were reduced in some cases by 68% by not having to travel distances for specialty psychiatric care.

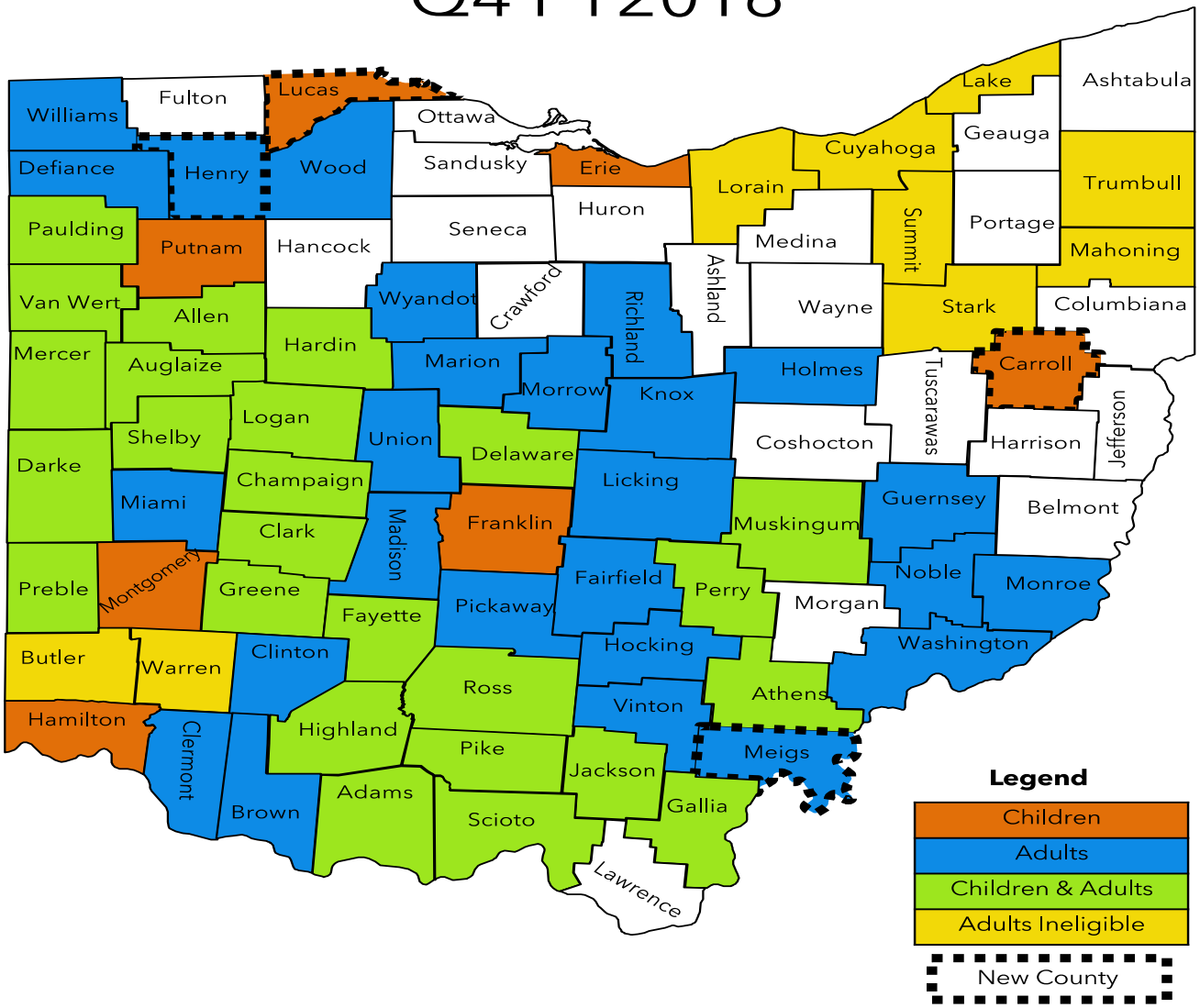
Telepsychiatry Project Outcomes

- **As of June 2016, >750 individuals from 58 counties** engaged in the project
- EOY stats for > 750 patients:
- Hospitalizations/12 months: 22
- ER Visits/12 months: 24
- DC Admission: 3**
- Discharged from DCs: 93

- **No wait list, no referrals denied**

Ohio's Telepsychiatry Project

Q4 FY2016



Aggression: A Form of Communication

- TRAUMA HISTORY
- Means of expressing frustration
- Learned problem behavior
- Expression of physical pain or acute medical condition
- Signal of acute psychiatric problem
- Regression in situations of stress, pain, change in routine, or novelty
- **ALL BEHAVIOR IS PURPOSEFUL**

BioPsychoSocial-Developmental Formulation

- *A complete gathering of information through interview, discussion with collateral data sources, review of clinical records, and contact with collaborating agencies that leads to a formulation, diagnoses and treatment plan. The goal is to address and understand the developmental needs of the individual in a meaningful way utilizing Trauma Informed Care principles as a universal precaution.*

Biological Aspects

- 85% have untreated, under-treated or undiagnosed medical problems
- Worsened by restrictions on care (labs, office visit frequency and length)
- Medications used in ways they were never intended, in unsafe ways, with **abbreviated monitoring protocols**

Communication Issues

- Talk to the patient
- Expressive language vs. receptive language
- Set the stage when appointment begins
- Summarize at the end

Interview Techniques and Considerations

- Sub-vocalizations
  - Reflects a strategy to vocalize the thought processes in the individual's mind ("hearing)" what they are thinking
  - Rehearse what is going to be said or to practice something the individual is planning to do
  - These should not be considered stalling tactics or an attempt to lie
  - Not the same as "talking" from person with a psychiatric disturbance (hallucination)

Commonly missed medical conditions

- *Seizure disorders*
- *Pain (chronic)*
- *Pulmonary (Asthma, Dysphagia, Infx)*
- *Autoimmune disorders*
- *Reflux (GERD)/Constipation/Other GI….*
- *Sleep apnea*
- *Extrapyramidal Side Effects*
- *Vitamin Deficiencies*

Most Common Causes of Behavioral Change

- Pain (physical or emotional)
- Medication side effects
- Sleep disorders
- Psychiatric illnesses

Trauma Informed Practices

- Research suggests that many people have some form of traumatic event in his or her lives *(SAMSHA, 2010)*. Some experts believe as many as 95% of individuals with ID have some level of traumatic stress. It makes sense to treat EVERYONE as if trauma has possibly occurred. Making sure someone feels **safe and in control** of their own lives will help someone with trauma, and will not hurt anyone who does NOT have a history of trauma.

Developmental Implications of Loss and Grief/ Piaget

- Sensorimotor stage: Profound ID; developmental age 0-2 years; reversible; constantly unfulfilled expectation
- Pre-operational Stage: Developmental age 2-7 years; Severe/Moderate ID; How will the loss affect me? Who will take care of me? Who will be my friend? Who will give me things?
- Concrete operations; Developmental age 7-11 years; Moderate/Mild ID; understands clear and specific explanations of loss and death; tend to take things literally

“Sit in the chair”

--Jerald Kay MD

“Ordinary” life event trauma may include:

- Feeling different
- Not being accepted
- Not being able to do what others do
- Moving or other big changes at home
- Having a disability and feeling “different” than others
- Being ignored
- Being misunderstood
- Failing at tasks

TRAUMA

- Normal response: banish it from consciousness
- When the trauma story is told, recovery can begin
- If the story is not told, trauma becomes a set of symptoms

TRAUMA

- **Trauma syndromes have a common pathway**
- **Recovery syndromes have a common pathway**
  - Establish safety
  - Reconstruct story
  - Restore connections

Trauma Informed Care

- Manipulating
- Lying
- Stealing
- We can explore these behaviors, determine the underlying meaning and assist the patient in communicating his or her needs more effectively.

Recovery

- Allow patients to save themselves
- Remember what your role is
- Not a savior or rescuer
- Facilitator, support
- Help reinstate renewed control
- The more helpless, dependent and incompetent the patient feels, the worse the symptoms become

Psychotherapy for ID

Flexible sessions	Length of therapy sessions should match the individual's attention span. For some patients, this may be no longer than 30 minutes.
Simplification of interventions	Break down intervention into smaller segments and reduce the complexity of the techniques being utilized.
Adjust language	Reduce level of vocabulary, sentence structure and length of thought to match the cognitive ability of the patient.
Augment interventions with activities	Use of activities can help to deepen change and learning and may include the use of drawing, therapeutic games, role play and homework assignments.
Involve caregivers	Important source of collateral information necessary to ascertain progress between sessions.
Increased length of care	Most research indicates that a longer length of treatment (1 to 2 years) is a best practice with this population. This allows the psychotherapy to move at a slower pace so that the clinician can spend additional time on each intervention utilized, ensuring that the skills being taught are internalized. It also allows for the inclusion of additional treatment stages which may be necessary.

Consensus Guidelines

- Rush AJ, Frances A. *The Expert Consensus Guidelines™: Treatment of Psychiatric and Behavioral Problems in Mental Retardation.* **American Journal on Mental Retardation 2000;105:159-228.**

- Aman MG, Crismon ML, Frances A, et al.: Treatment of psychiatric and behavioral problems in individuals with mental retardation: an update of the expert consensus guidelines. **Expert Consensus Guidelines, 2004.**

- International Guide for Using Medication. The **World Psychiatric Association** (WPA): Section on Psychiatry of Intellectual Disability (SPID)**1st September 2008**

- CLINICAL BULLETIN *of the* DEVELOPMENTAL DISABILITIES DIVISION. **International guide** to prescribing psychotropic medication for the management of problem behaviours in adults with intellectual disabilities. **World Psychiatry Assn 2010**

ACES Research

- The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego. **(1995-1997)**

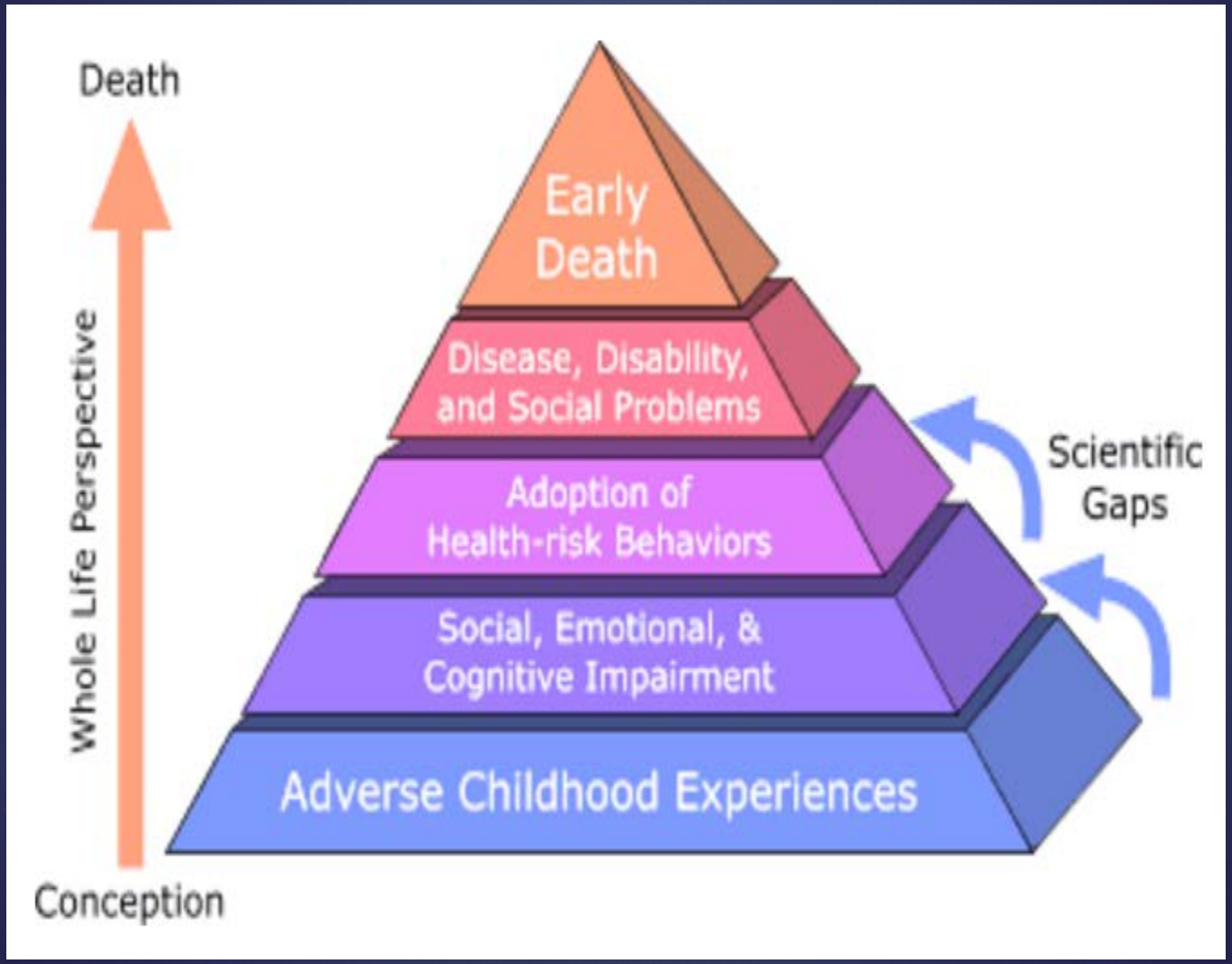
ACES Research

- The Family Health History and Health Appraisal questionnaires were used in the original study to collect information on childhood maltreatment, household dysfunction, and other socio-behavioral factors examined in the ACE Study.
- **CEQ designed by our group to reduce risk of re-traumatization**

ACES Research

- It is reported that individuals with **IDD** are more likely to experience various forms of trauma as well as increase in medical and neurologic conditions; this study will add to the prevalence data which may facilitate the move toward use of ***best practices*** and ***increased prevention*** in this medically fragile patient population.

ACES Pyramid



Prelim Observations

- How many individuals did not know this information (nor did their caregivers)
- Talking about trauma can cause it to resurface (in the context of active MH tx referrals can be made)
- If no family involvement, trauma is less likely to be reported
- At close of data collection, will compare age groups to determine if variations exist (20s greater or less exposure than 70s?)

Summary

Medications

- Medications prescribed should improve cognitive function (or at least not cause decline)
- Should treat conditions fully
- Should be similar to medications offered to anyone else with the same disorder

Summary

- ID does not protect one from developing MI
- ID does not make one resistant to the effects of psychotropic medications
- Danger of over-diagnosis AND under-diagnosis
- Every person in every agency should be trauma informed
- Myth that patients with ID can't benefit from mental health services including trauma informed approaches, psychotherapies and state of the art medication regimens

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