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Trauma Informed Transformations: *Innovations in COVID*

Mental Health Network

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Welcome

Linda Soars

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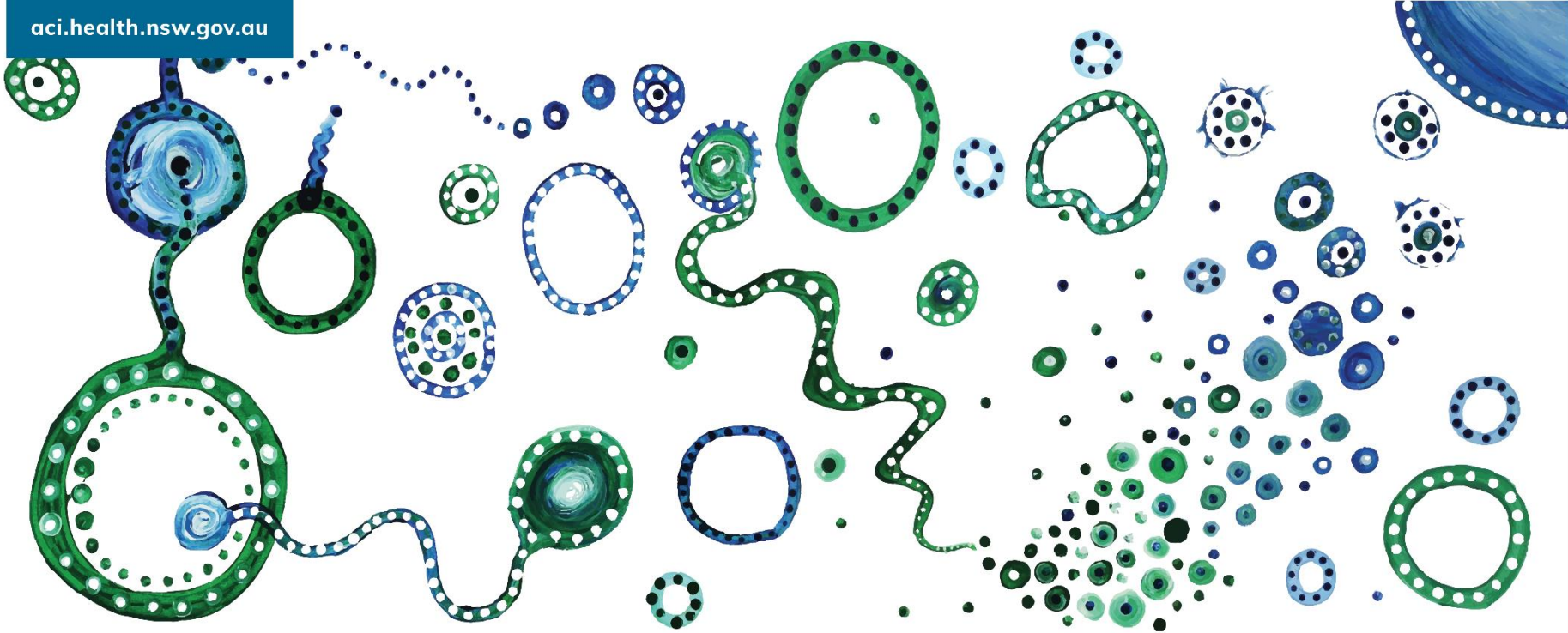

ACI acknowledges the traditional owners of the land that we work on.

We pay our respect to Elders past and present and extend that respect to other Aboriginal peoples present here today.

LIVED EXPERIENCE

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Findings from a Co-designed Trauma-informed Care and Practice project in Mental Health Services across NSW

Allyson Wilson, District Nurse Manager Inpatient Mental Health Services | MNCLHD Mental Health

Phillip Orcher, Aboriginal, Diversity and Culture Project Officer, ACI

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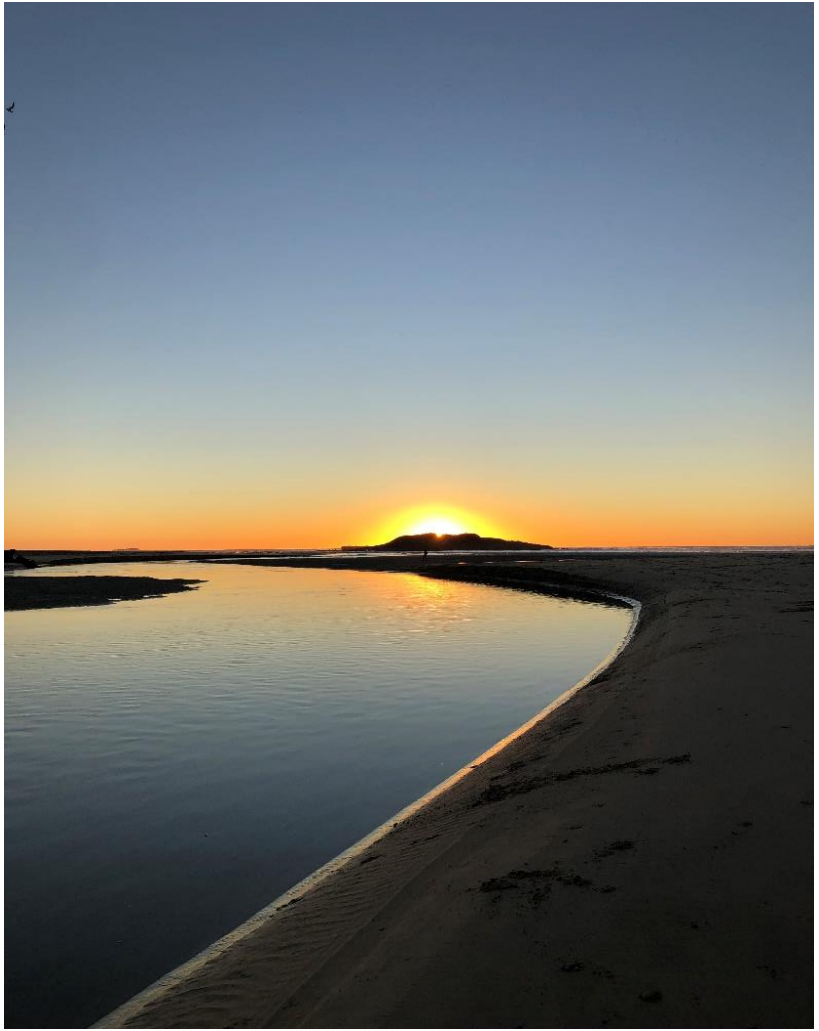
What is trauma-informed care?

‘four Rs of trauma informed care’

- ✓ Realise
- ✓ Recognise
- ✓ Respond
- ✓ Resist

Substance Abuse and Mental Health Services Administration (n.d).

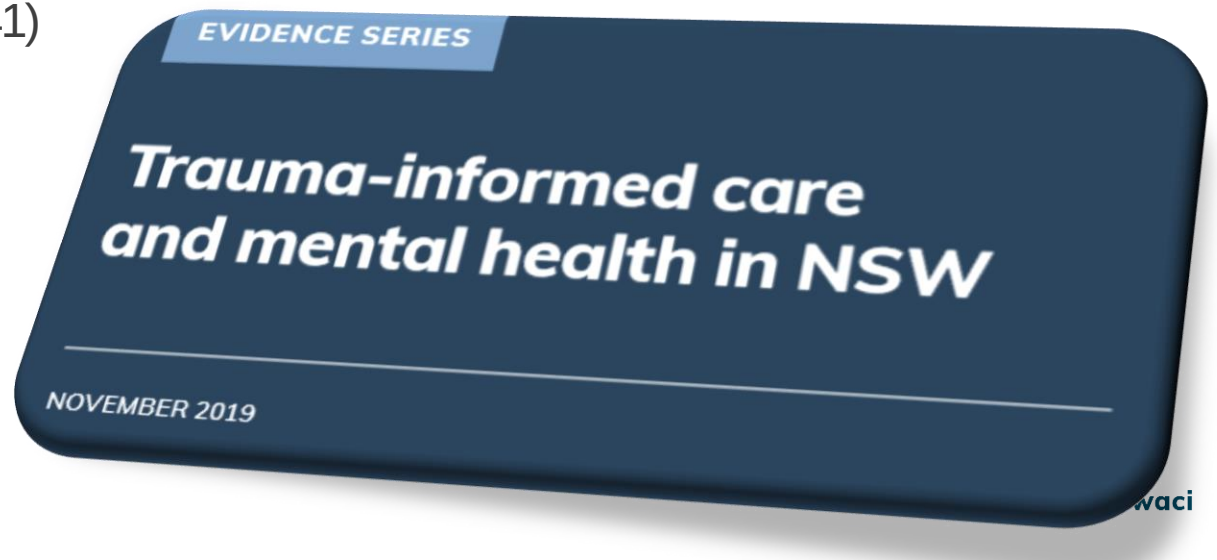


Trauma-informed care is commonly understood through the Principles of Trauma-informed Care

- Commenced in 2016
- Acknowledgements
- Our unique journey
- Diagnostics and state-wide survey
- Evidence series

What the evidence says:

- ✓ **Decreased use of seclusion and restraint** (p.39-44, 58)
- ✓ **Shorter length of stay, increase in rates of discharge to lower level of care, decrease in presenting problems** (p.45-47)
- ✓ **Better patient reported outcomes and coping skills** (p.48-50)
- ✓ **Fewer staff injuries** (p.41)
- ✓ **Cost benefits** (p.51,52)

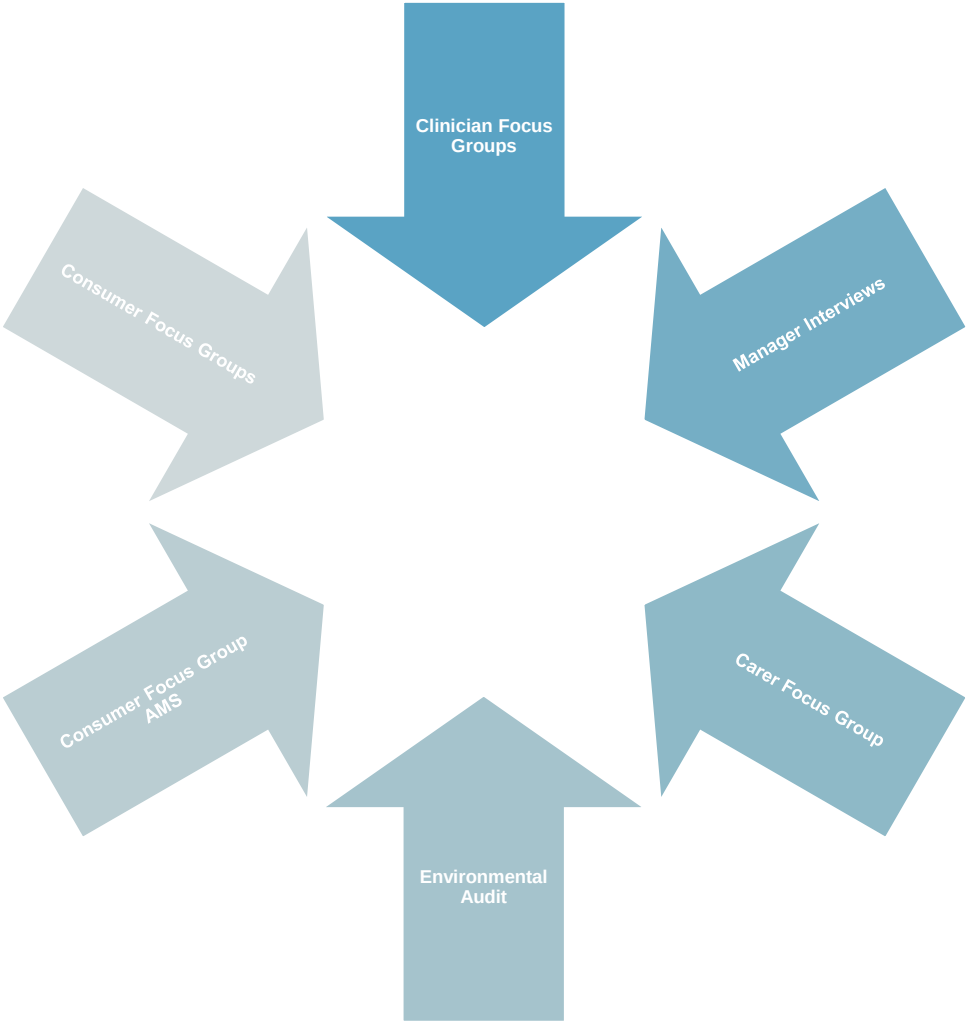


So, what did we do?

Diagnostics

- ✓ Ethics approval
- ✓ Data collection
- ✓ Data analysis
- ✓ Findings

Data collection



Data collection

Clinician focus groups

- 6 focus groups
- 64 clinicians
- (2 rural and 1 metro LHD)
- Community and inpatient clinicians

Consumer focus group

- 2 focus groups
- 10 consumers
- (2 regional and 8 metro participants)

AMS Consumer focus groups

- 5 Aboriginal and/or Torres Strait Islander AMS consumers (all metro participants)
- 1 focus group

Carer focus groups

- 1 focus group
- 10 carers
- (2 rural and 8 metro participants)

Manager Interviews

- 9 manager interviews
- (3 LHDs)

Environmental Audit

- 3 environmental observational audits conducted across two LHDs

Each focus group went for approximately 60 minutes. Open-ended questions were informed by the principles of trauma-informed care and practice, and based on the 2018 survey results.

Data Analysis

Focus Groups

- Audio recorded and transcribed verbatim.
- Transcript(s) de-identified and coded with NVivo software or manually.
- All transcripts explored against the principles of trauma-informed care.
- Using a content analysis approach.
- Themes were identified by synthesizing and analysing the codes.
- A constant comparison against the principles of trauma-informed care.

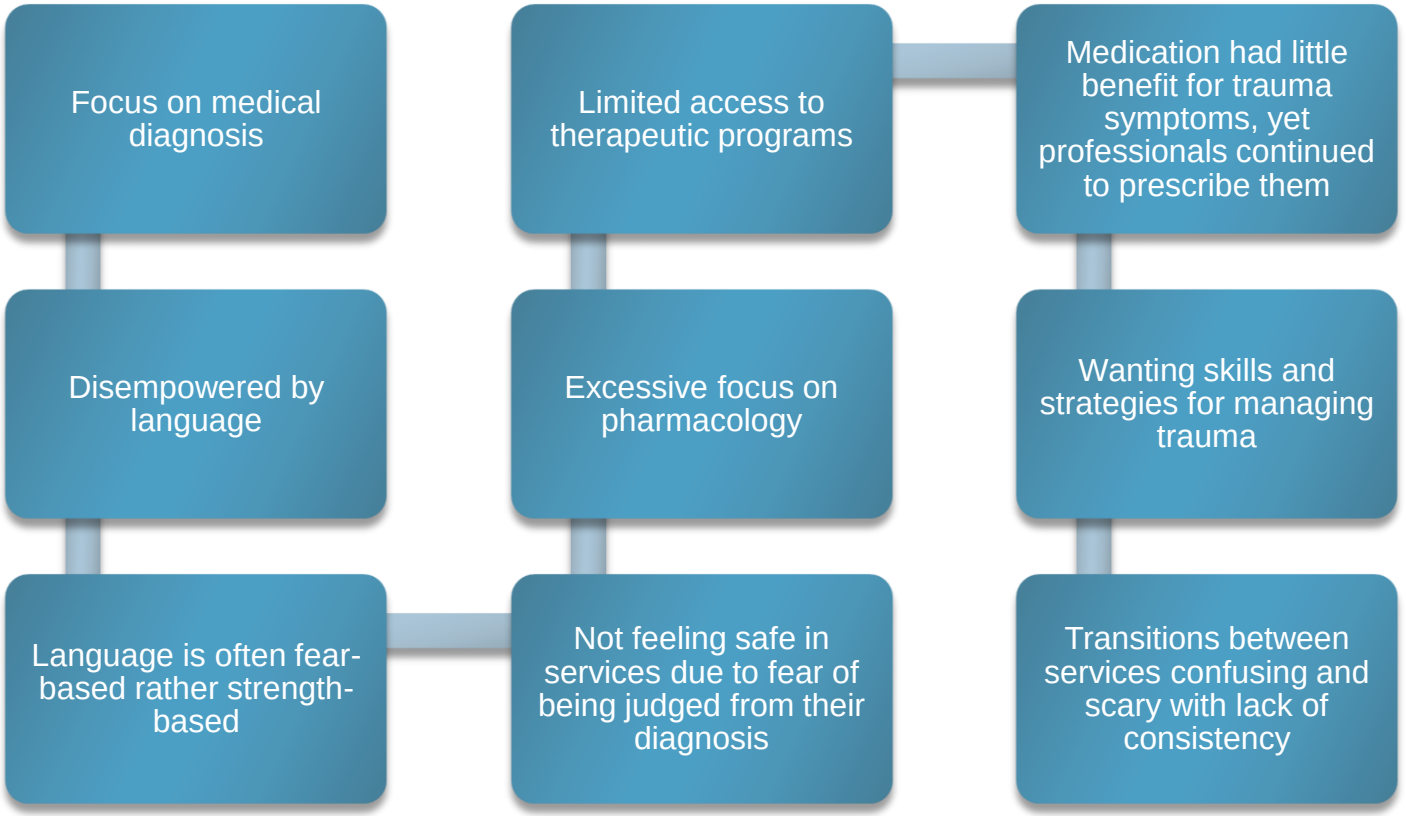
Environmental audit (snapshot)

- Observational field note data was documented and an in-depth analysis.
- A content analysis approach was used to explore and reveal emerging themes.
- 15 step challenge was used as an overall framework.

Findings: Carers Focus Group

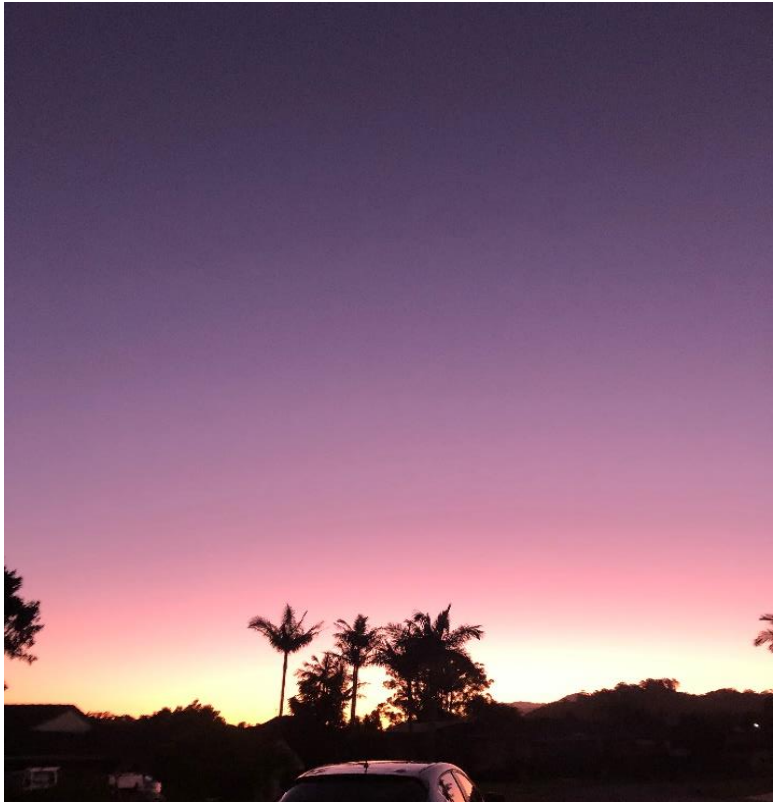
- Often not orientated to mental health services
- Unknown expectations and lack of inclusion
- Different policies and approaches among mental health services
- Services not acknowledging their lived expertise as carers
- Wanting to empower and support their loved ones in the community
- Need more carer representatives in services
- Mental health services must prioritise safety and minimising
- Mental health services must trauma and re-trauamtisation
- Want police and emergency services to be educated on TIC
- Lack of therapeutic programs and access to technology (mobile phones)
- Traumatising environment
- Services are not person-centered

Findings: Consumer Focus Groups



Consumer Focus Group: more findings

- Private practitioners not consulted
- Transparency led to trust
- Advance care planning and care planning were ways of demonstrating respect for consumers wishes
- Experiences of overall stigma and discrimination
- Concerns regarding medication not taken seriously or dismissed
- Many concerns regarding safe and therapeutic environments (unsafe and triggering – shared spaces)
- Staff lacking basic knowledge about keeping them safe
- Lack of awareness of trauma-specific information



Clinician focus group: findings

- Concerns regarding access and confidentiality in clinical supervision
- Welcomed the idea of shared medical records
- Wanting services to be designed around consumer needs
- Strong comradery within teams following critical incidents
- Concerns regarding speaking up in debriefs due to management being present
- In-house debriefs were favored over external providers
- Some services not providing any debriefing at all
- Excessive documentation requirements
- EMR adding to the workload of clinicians
- Seeking TIC training
- Wanting TIC training to be mandated however, overall feeling very fatigued with the large volume of mandatory training and training requirements

Clinician focus group: more findings

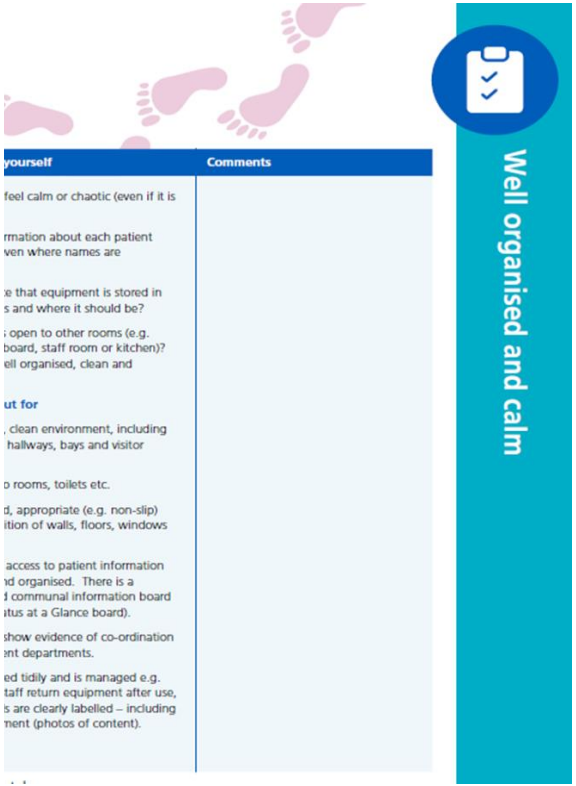
- Peer worker role under represented in services
- Some clinicians had a very limited (or no) understanding of the peer worker role
- Frequent reports of being poorly/under-resourced
- Reports of high staff turnover
- Reduced staff leading to limited capacity to provide TIC
- Allied health stretched
- Clinicians reporting AINs may help with routine tasks
- Burnout
- Vicarious trauma
- Traumatising events
- Lack of time

Manager Interviews: findings

- Need clear guidance with TIC
- Feel TIC is poorly understood
- Significant work is required to make the organisation trauma-informed
- Fatigued with numerous initiatives
- Messages need to be driven by the Ministry of Health
- Many services reporting large numbers of vacancies as a way of mitigating budget restrictions
- Lack of resources a significant challenge in driving TIC (e.g. not allowing staff release for training

Environmental Audit: findings

- One facility displaying numerous substantial pieces of Aboriginal art
- One facility had very limited visible Aboriginal artwork
- Use of colour to create a warm and homely atmosphere was particularly evident in two settings
- Positive interactions between consumers and staff were observed in two facilities
- Third facility consumers were isolated, with no interactions observed between staff and consumers, staff observed in the office area on the computers
- Two facilities offered some opportunities to access information about staff, care and weekly activities
- Third facility had no visible communication or activity boards
- One facility had starkly decorated bedrooms with shared bathrooms, cold and clinical in nature
- All facilities were mixed gender environments
- Two of the facilities had designated female and male-only areas



AMS consumer focus group: findings

Negative experiences were common across government sectors

Experiences of trauma and re-traumatization were commonly reported when accessing mental health services

Ongoing experiences of transgenerational trauma and the stolen generations impacted the ability for individuals and the community to trust government and mental health services

The impact of child displacement has led to loss of culture and continues to impact mental health wellbeing

Mistrust was widespread across government services

AMS provides unconditional mental health support.

Consumers accessing AMSs feel prioritized in relation their mental health needs

Aboriginal health workers were often referred to as 'family' moving beyond the traditional construct of clinician – consumer

Stigmatisiation was commonly experienced particularly in relation to substance issues

Government services commonly having Aboriginal artwork and workers not understanding the cultural significance of it

Mental health services need more Aboriginal workers

What is needed?

Trauma Informed Care

1. Enhanced collaboration between consumers, carers and clinicians
2. A stronger emphasis on safety for all
3. Improved education, training and governance in trauma informed care
4. Using new and improved models for mental health service delivery
5. Focus on culturally safe and competen services

1. Enhanced collaboration between consumers and carers and clinicians

- Orientation to services
- Restrictive rule examination
- Information about services and treatment
- Basic customer service skills
- Consistent communication with families
- Processes for collaborative decision making
- Advanced care planning

- Collaborative active care plans
- Formal carer support roles
- Increased Peer support roles
- Shared documentation
- Clear language
- Recovery oriented discharge summaries

2. A Stronger emphasis on safety for all

- Examination of admission processes
- Collaboration with Emergency Department staff and police around TIC
- Embedded formal and informal debriefing processes for staff
- Trauma sensitive clinical supervision
- Fatigue management – wellness programs
- Communication from leadership – acknowledgement of safety concerns

- Safety culture
- Awareness of tensions created by risk adversity
- Increased access to diversional, sensory modulation
- Trauma sensitive crisis support
- Access to technology and activities
- Individualised care plans
- Increased cultural safety

3. Improving education, training and governance in trauma informed care

- Relevant and accessible training
- Trauma specific training
- Inclusion of TIC in existing training
- How to talk about trauma
- Family focused practice
- Basic engagement skills

- Best practice examples
- Trauma screening tools
- Fidelity guides
- Clear messaging
- Implementation resources
- Workload examination
- Peer involvement in training
- TIC QI processes

4. Using new and improved models for mental health delivery

- Consistency across service settings
- Diversity of treatment approaches
- Diagnostic flexibility and review
- State wide approaches

- Layered leadership from Ministry down
- Improved transitions of care and communication of care plans
- Increased access to psychological therapies
- Conceptual and definitional clarity
- Resolution of wider system issues

5. Focus on culturally safe and competent services

- Aboriginal-led mental health services
- Being heard and listened to without judgement
- Fostering cultural connectedness
- Enhancing Aboriginal mental health workers
- Strong prioritisation of cultural safety

- Cultural training and education
- Aboriginal-led mental health care plans
- Relationship-focused healing
- Meaningfully supporting Aboriginal culture
- Aboriginal artwork
- Visibly tackling discrimination and stigmatisation

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Panel Discussion: *Innovations in COVID*

Lisa Thorpy, Service Development Co-ordinator, Trauma Informed Practice and Cultural Change NNSW LHD

Rosemary Gallagher, Clinical Nurse Consultant (MHPiP), NBM LHD

Nathan MacDonald, Clinical Nurse Consultant, Sydney LHD

Tracey Tay, Clinical Executive Director, Care Across the Lifecycle and Society, ACI

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COVID

- How has COVID impacted you?

Stress

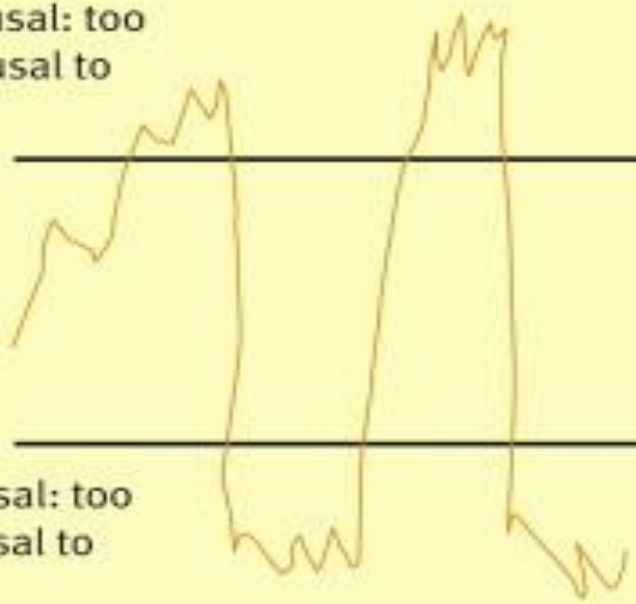
Stress Verses Distress

Stress – some stress has a beneficial effect on health, motivation, performance and well-being

Distress - the type of stress we refer to that usually has adverse and negative consequences attached

Distress is not a sign of weakness!!

The 'window of tolerance': maintaining optimal arousal for trauma-focused therapy



Emotional reactivity
Hypervigilance
Intrusive imagery
Obsessive/cyclical cognitive processing
Tension, shaking, ungrounded

Hyperarousal: too much arousal to integrate

'Window of tolerance'
Optimal arousal zone

Hypoarousal: too little arousal to integrate

Flat affect
Inability to think clearly
Numbing
Collapse

(Adapted from Ogden and Minton 2000)[10]

Compassion for self and others

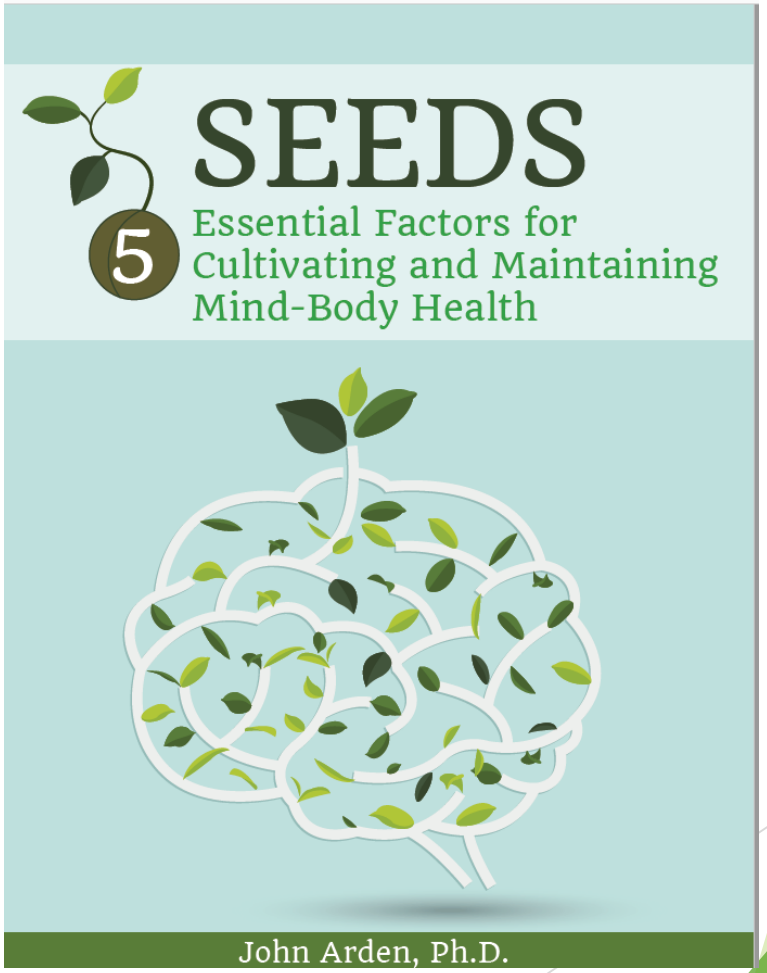
- **What it is:**
  - Kindness Vs Judgement
  - Experience common to humanity Vs being the only one
  - Mindfulness Vs over-identification

- **It is NOT:**
  - Self-pity
  - Self-indulgence
  - Self-evaluation

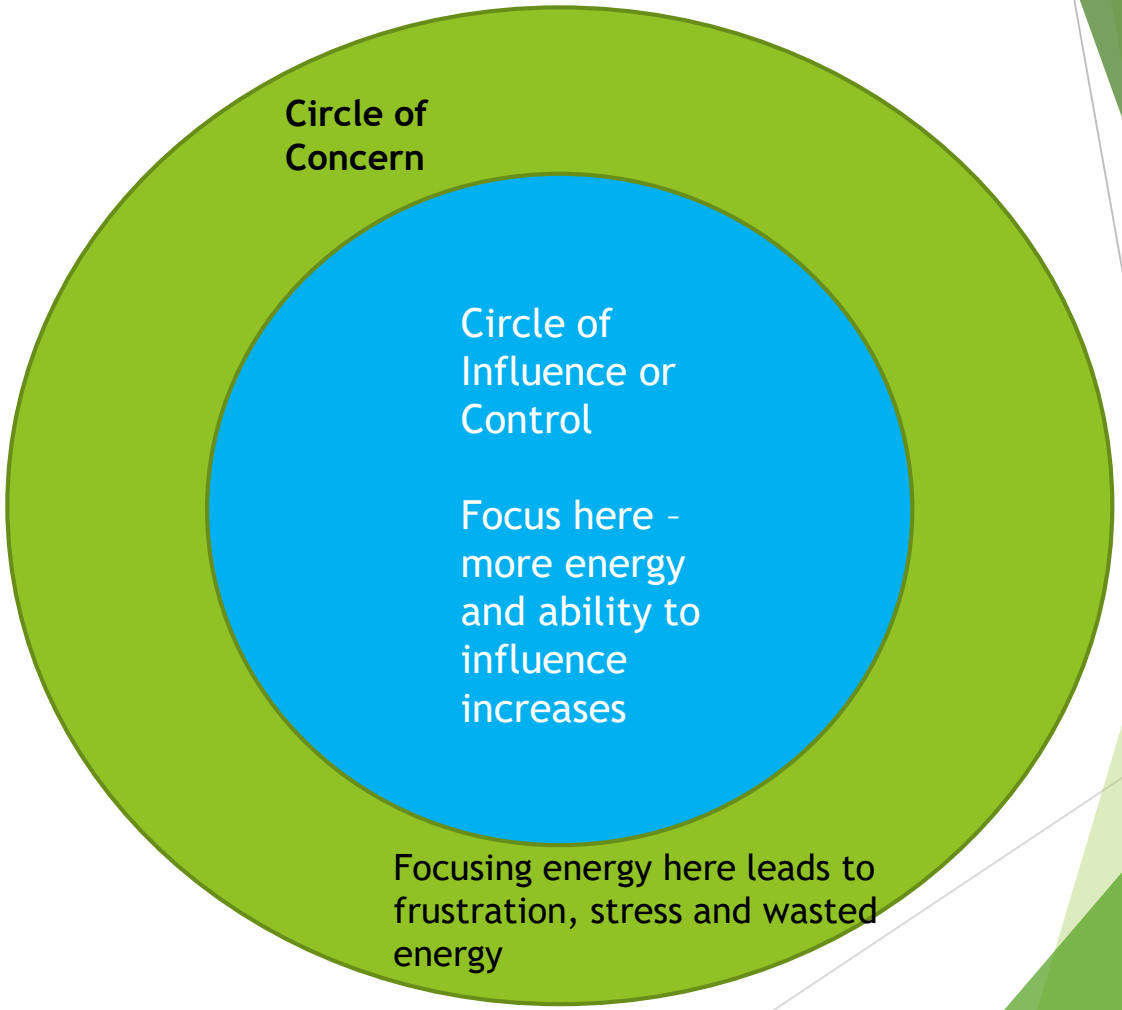
- Dr Kirsten Neff

Domains of Resilience

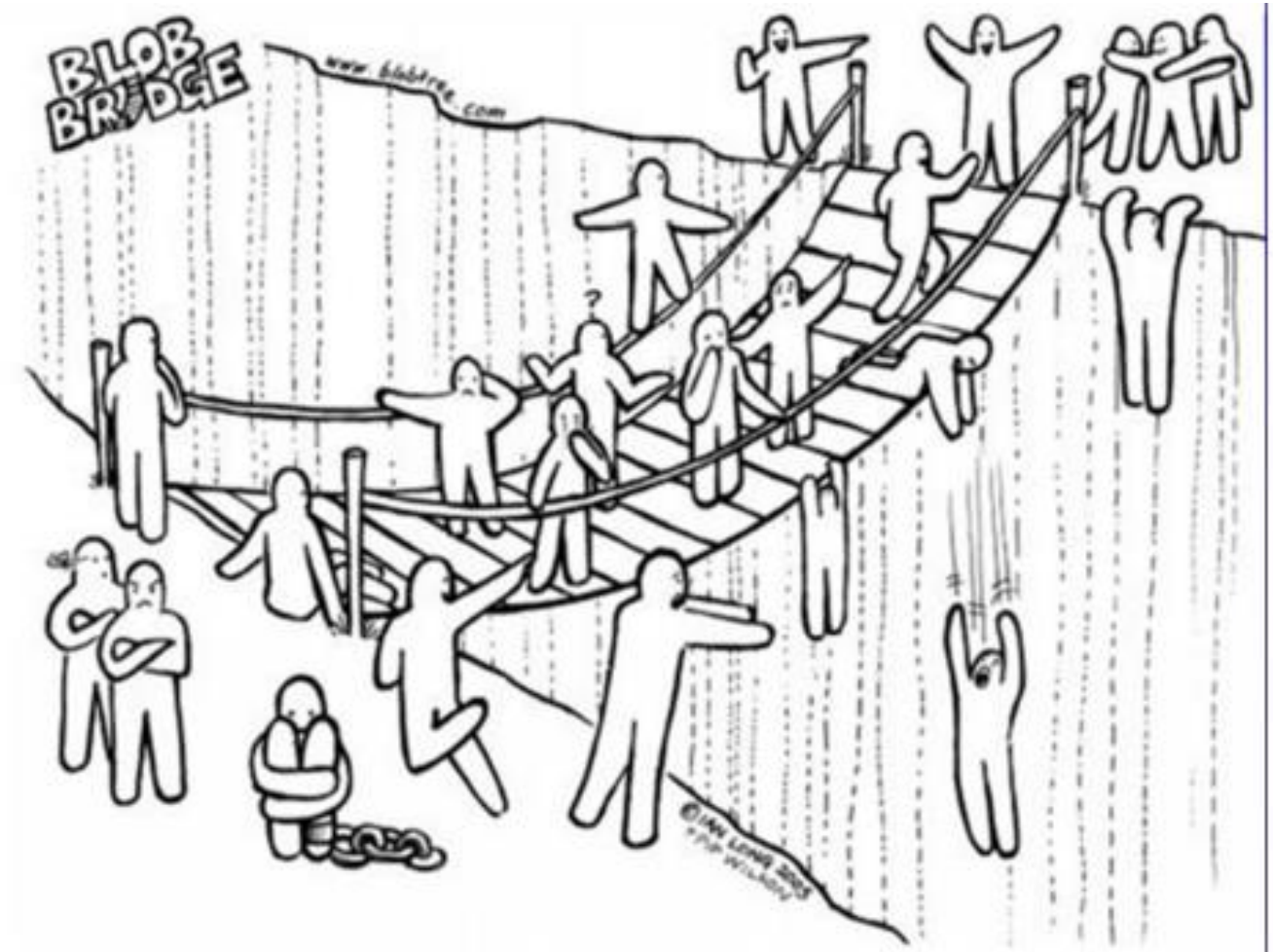
- Socialise
- Exercise
- Education
- Diet
- Sleep



What can I control? What is beyond my control?



How we look after ourselves is up to ourselves….and the people we live our lives with


BLOB BRIDGE
www.blobtree.com

Mind Full, or Mindful?

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet.” (Remen, 2006)

Self Care V Collective Care
We need to look after each other

- Self-care took off in the last decade.
- Can remove awareness of others

However….

- Our health and fates are linked to fellow human beings
- We need to create & sustain collective care.


IN A WORLD WHERE
YOU CAN BE ANYTHING
BE KIND
Mental health supports

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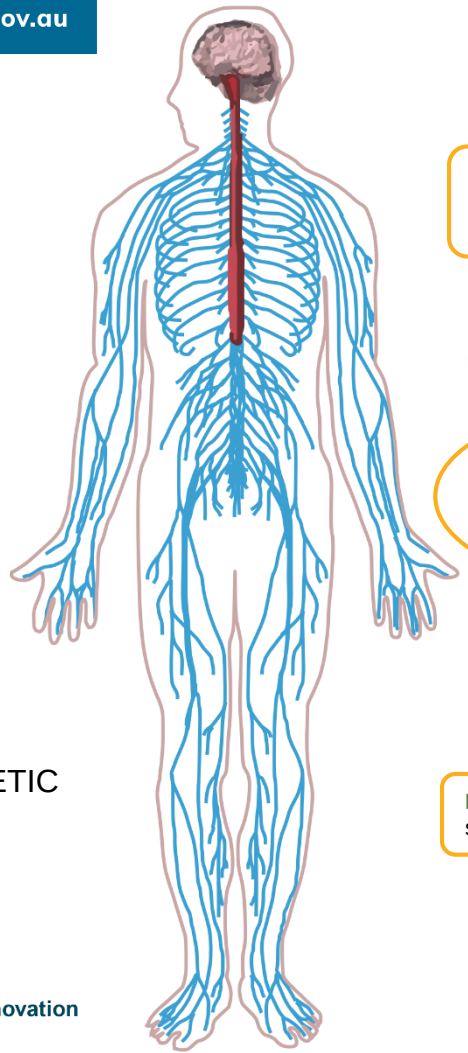
SOCIAL ENGAGEMENT SYSTEM

SOCIAL ENGAGEMENT SYSTEM:
Breathing, Heartbeat, Facial Expression, voice (2 functions – safe/not safe)

SYMPATHETIC SYSTEM:
Mobilisation of torso and limbs

PARASYMPATHETIC SYSTEM:
Immobilisation



NORMAL (SAFE)

Social connection: Soft voice, eye contact, soothing tone, engagement

MOBILISATION: Work, sport, social connection, intimacy, relationships

IMMOBILISATION: Rest, sleep, rejuvenation, relaxation

STRESSED (NOT SAFE)

NEUROCEPTION

Negotiation, appeasement, survival, oppression of others, denial, lying, passive aggression, manipulation, control

THREAT

DANGER

FIGHT

FLIGHT

NEUROCEPTION

LIFE THREAT

FREEZE
FAINT
DISSOCIATION
SHOCK

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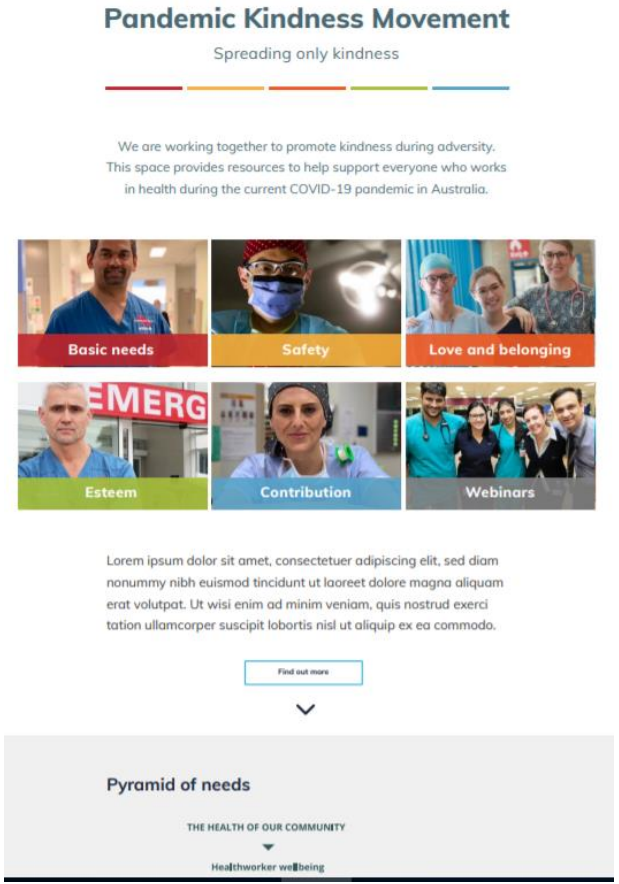
Trauma-informed kindness



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Thank you for joining us today, stay in tune for our second event
Trauma Informed Transformations: *Yarning for Change* (registrations open now!)

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