



The Journey Forward

**DISCUSSION PAPER:
TRAUMA AND SERVICE RESPONSE TO
TRAUMA.**

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This document will attempt to provide a brief summary of the literature related to the complex issue of trauma and how acute and crisis mental health services should respond. It represents the combined experience from the Acute and Crisis Workstream as part of the Journey forward for Capital and Coast DHB, Mental Health and Addictions Service Plan 2005-2010. Prior to the commencement of this document the following trauma issues were identified through a process mapping procedure.

Solution	Barrier To Over Come
<i>Use of Police</i> 6. Development of protocols within mental health services that promote decreased use of the Police.	Implied threat when Police are involved. Traumatic experience of the person who is unwell.
<i>Alternatives</i> 17 - 21. Alternatives to admission to acute inpatient units	Trauma associated with admission to inpatient services. Inpatient environment not helpful, frightening and traumatic.
<i>Responsive Services</i> 22. Develop trauma responsive treatment options	Past trauma not recognised or acknowledged. Past trauma including sexual abuse
<i>Resources</i> 32. The development of information resources that can be accessed in a variety of formats such as: web, mental health line, written. To provide people with information that can lead to choices e.g. peer services, social services, housing options, mental health promotion, assessment and treatment including medication, trauma and debriefing services.	



The Issue of Definition

Trauma and Traumatic experiences cover a wide range of diagnostic and clinical presentations. It is important to differentiate between these trauma presentations as there are different treatment implications.

Acute Trauma: This term is often used to relate to individuals who have experienced traumatic events recently (i.e. within 1 month). Individuals presenting with acute trauma reactions are likely to exhibit a reduced stress tolerance, appear confused, labile and could be experiencing transient psychosis. They may or may not go on to develop PTSD.

PTSD: This relates to the mental health difficulties that people may develop in response to one or more traumatic events such as deliberate acts of interpersonal violence, severe accidents, disasters or military action.

Complex/Chronic Trauma: This term is often used to relate to difficulties that arise out of extreme prolonged or repeated trauma such as repeated childhood sexual abuse or prolonged captivity involving torture.

Comorbidity: PTSD, Complex trauma and Acute Trauma can all present as individual difficulties or comorbidly with other mental health and addiction difficulties. Increasingly childhood adversity and traumatic experiences in childhood are being seen as a significant vulnerability factor in the later development of mental health difficulties. In addition disrupted attachments can be seen as very early trauma that sensitises an individual to further difficulties, this is often the case in relationships. This is important as it can help to explain individual sensitivities and highlights the importance of relationship issues in crisis and trauma.

Trauma and Acute Mental Health Services

People who are admitted to acute psychiatric wards especially if they are being admitted against their will are likely to find it frightening and distressing (Sainsbury Centre for Mental Health 1998). A more recent study by Frueh et al (2005) reported that high levels of potentially harmful experiences were reported by individuals with severe mental illness within acute psychiatric settings. These included being around frightening or violent patients, seclusion, restraint, takedowns and handcuffed transport. This combined with the research that suggests that individuals diagnosed with severe mental illness have high rates of lifetime trauma exposure and probable PTSD and or Complex trauma reactions These two issues make acute psychiatric inpatients a particularly vulnerable group in relation to trauma. Therefore Mental health services need to acknowledge, respond to and treat these two groups who present with trauma related difficulties.



Prevalence

The recent New Zealand Mental Health Survey (Te Rau Hinengaro 2006) reported prevalence rates for PTSD for the population of New Zealand as follows. No statistics are available for the prevalence of complex trauma presentations, so what is documented is likely to be an under estimation of the prevalence of all trauma presentations especially given the association of trauma and vulnerability to mental health difficulties.

Age	16-24	25-44	45-64	65+
12 Month Prevalence Rate %	2.4	3.5	3.2	1.7
Lifetime Prevalence Rate %	4.4	6.6	7.0	4.6

Gender	Male	Female
12 Month Prevalence Rate	1.6	4.2
Lifetime Prevalence Rate	3.7	8.1

While the distribution across the age ranges is not significantly different there is a clear difference in the prevalence rates between men and women with women being twice as likely to experience PTSD. This difference needs to be reflected in how services respond to trauma.

With regard to the severity of PTSD the New Zealand Mental Health Survey reports that the distribution of severity for PTSD is as follows:

Severe	Moderate	Mild
35.9%	36.9%	27.2%

With severity defined as a composite measure taking account of impairment associated with the specific diagnosis and the presence of bipolar 1 disorder, or substance dependence or suicide attempt in conjunction with any disorder.

What Works and What Doesn't?

Individual Treatments

Acute Trauma: This can be best described as “psychological first aid” and the general recommendations for interventions with acute trauma are as follows. To provide safety, support and information; ensure basic needs are being met; connection with social resources and general avoidance of exposure techniques.



PTSD: A recent meta-analysis of the PTSD literature (NICE 2005) suggests that trauma focused Cognitive Behavioural Therapy should be available and offered to PTSD sufferers. The duration of which should normally be 8 – 12 sessions when the PTSD results from a single event and there are no complicating factors such as comorbidity. People with comorbid difficulties are likely to need longer treatment.

Chronic/Complex PTSD: The evidence as to what works best for Complex/Chronic is less emphatic as this is a more complex issue that has been less well researched in terms of outcome studies. However recommendations are for a longer term therapy that incorporates CBT techniques with a working through of the relationship issues (as much complex trauma occurs within the context of attachment relationships) Briere (2002 & 2005) and Courtois (2004)

Debriefing: Interventions often referred to as “debriefing” such as crisis intervention and critical incident stress debriefing have been developed since the 1980’s to help deal with the immediate psychological aftermath of severe trauma. They have gained widespread initial popularity. These debriefing protocols were designed as an attempt to speed recovery before harmful stress reactions have had chance to impact on individuals’ lives. The NICE (2005) guidelines on PTSD indicate that there is little agreement on how best to deliver these interventions and it sites evidence that suggests that debriefing is at best ineffective but at worse has the potential to cause significant harm to those debriefed. In large scale disasters a process of screen and treat has been shown to be more effective.

Systemic and Organisational Responses – What does Trauma informed care look like?

Wells (2007) has provided helpful guidelines regarding what trauma informed care should involve within acute mental health services.

- Recognition of high prevalence of trauma within mental health services
- An individual’s life context / exposure is appreciated
- Mandatory screening for traumatic histories
- Power/control dynamics minimised
- Collaboration
- Address training needs of staff to improve knowledge and sensitivity
- Understands function of behaviour such as self harm, rage or repetition compulsion
- Include consumers perspectives in planning, including care planning and advance directives
- Psycho-education and alternative skills development
- Low/no seclusion and restraint
- Low rates of staff/consumer assaults and injury
- Recognition of primary and co-occurring trauma diagnoses, i.e. a diagnosis is not necessarily indicative of whether there is trauma present.

In addition to the above trauma informed care and services should



- Provide gender appropriate services acknowledging the higher prevalence rates of trauma for women. (links to mental health needs for women in acute and crisis mental health services)
- Provide easy access psychological therapies for trauma.
- Acknowledge, assess and respond to the different trauma presentations (Acute Trauma, PTSD and Complex Trauma)
- Acknowledge the role that the services play in the possible traumatisation of consumers and actively work to address this (by following the above guidelines).

Implications for Service Delivery – How can these principles be put into practice?

Capital and Coast DHB Mental Health and Addictions acute and crisis services need to acknowledge and respond to the variety of trauma presentations in the following ways. Though it is important to note that the service response should not be “one size fits all” more that a range of approaches is appropriate dependent on the individual need. Child and Adolescent services have not been the focus for this document however most if not all of the principles are true for Child and Adolescent services.

Role of Crisis Services: Is to provide containment for the crisis rather than escalating the distress this, within child and adolescent services the focus of this is more likely to be within the family system and additional family systems training etc may be appropriate.

Training & Workforce Development: To establish a good conceptual framework for understanding trauma, assessment and interventions together with being able to differentiate between different trauma presentations in order that appropriate treatment is offered. This would then allow trauma to be part of the core competencies for all mental health staff.

Improving Acute Psychiatric Inpatient Wards: In addition to workforce training and development, the physical environment of wards needs to be improved with better information, activities, reduction/no seclusion and restraint, zero tolerance to violence and aggression. Using the Star Wards model for improving Acute Psychiatric inpatient units.

Service Delivery: Acknowledgement of trauma in the variety of forms and provide evidence based treatments, self help material and information. There needs to be formal liaison with ACC with staff able to support people through the often difficult process of a sensitive or trauma related claim. ACC and the DHB need to have a shared understanding of trauma to facilitate easy access to trauma services.

Liaison with the Police: Provide information and education regarding trauma.

Disaster Planning: Within the disaster and emergency planning short, medium and long term planning to be able to address a significant proportion of the population who are likely to be acutely traumatised following a disaster, screen and treat those who are likely to be vulnerable to developing PTSD.

NEXT STEPS: Identifying systems and individuals involved in the Journey Forward to ensure trauma informed care is adopted i.e. training packages developed, liaison with external services occurs etc.



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