healing hurt people chicago

A Workshop for Medical Providers

TRAUMA-INFORMED CARE

NNHVIP National Network of Hospital-based Violence Intervention Programs

Session Overview

- Introduction to Healing Hurt People
- Overview of Violence in Chicago and Trauma
- Five Points of Trauma-informed Care
- Patient Stories

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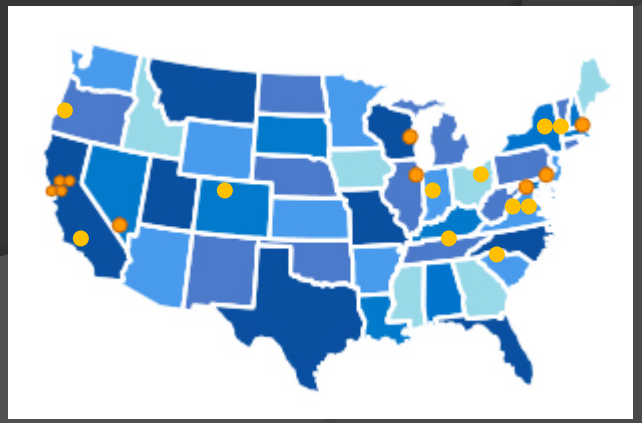
National Network of Hospital-based Violence Intervention Programs

- Violence is a preventable health-care issue
- Trauma centers and emergency rooms have a golden moment of opportunity to engage with a victim, promote healing and prevent re-injury



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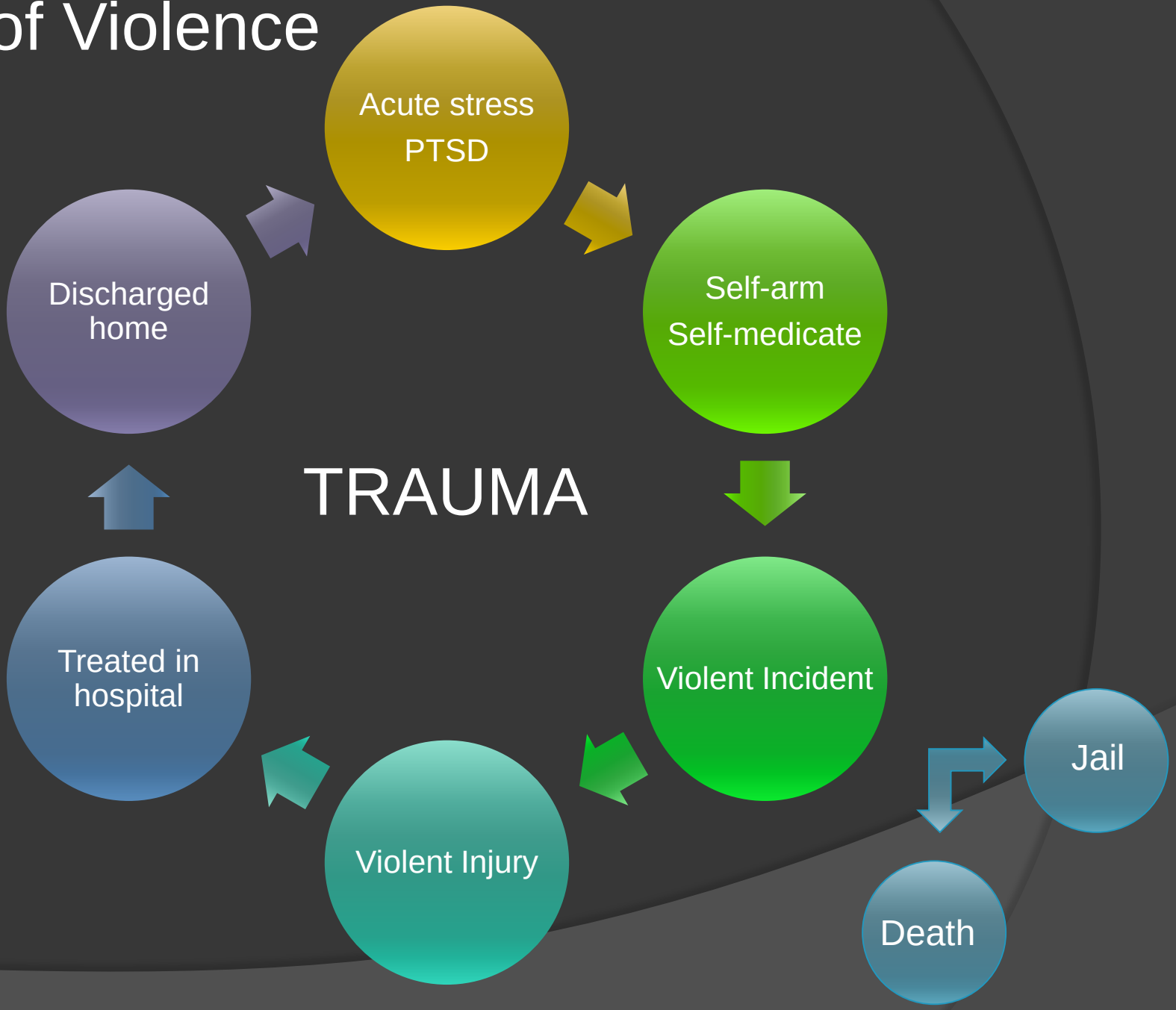
Healing Hurt People – Chicago

John H. Stroger and Comer Children's Hospitals

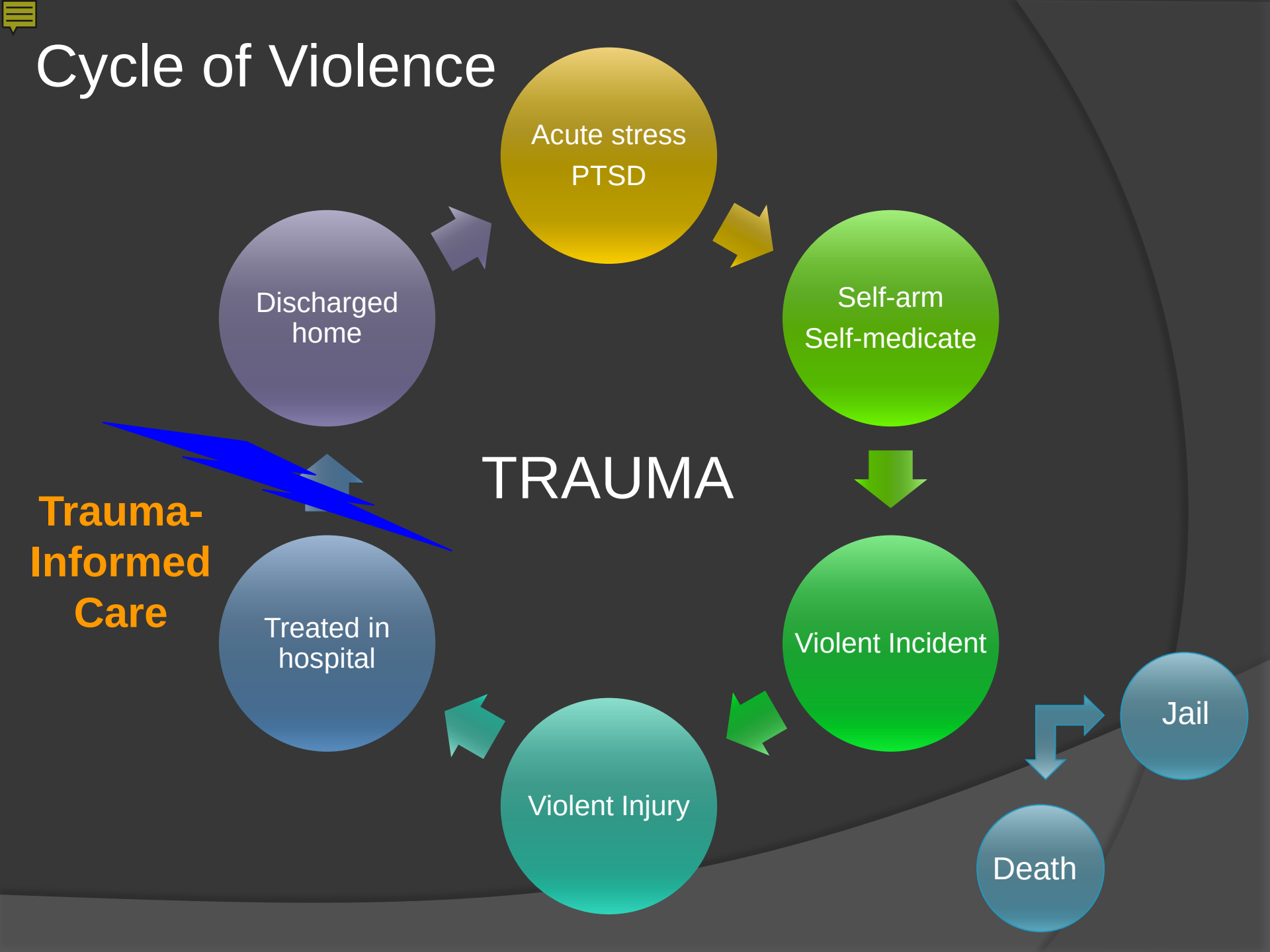
Replication of a model developed at
Drexel University School of Public Health
Center for Nonviolence and Social Justice

- Trauma-informed care for youth injured by violence
- Hospital-based referrals for early identification and engagement of youth and families injured by violence
- Take advantage of the "teachable moment" that accompanies violent injury
- Interrupt the cycle of violence by treating trauma-related emotional and behavioral dysregulation

Cycle of Violence



Cycle of Violence



Healing Hurt People

- Trauma Psychoeducation (S.E.L.F. Groups)
- Victims Compensation
- School (Homebound, re-nrollment, GED)
- Ongoing trauma-focused counseling
- Help getting to medical appointments
- Arrange durable medical equipment
- Safety planning
- Job training, housing/relocation needs

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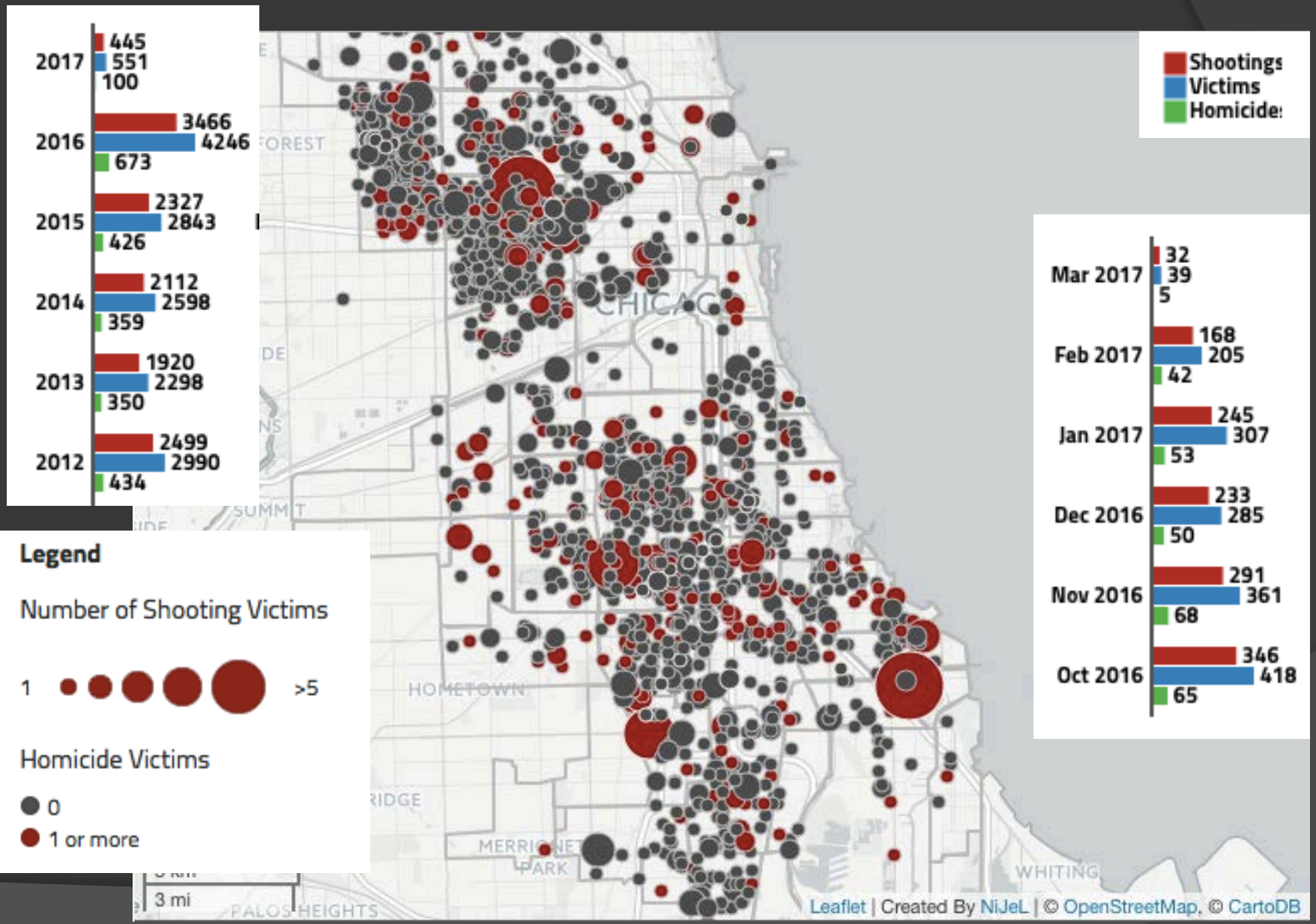
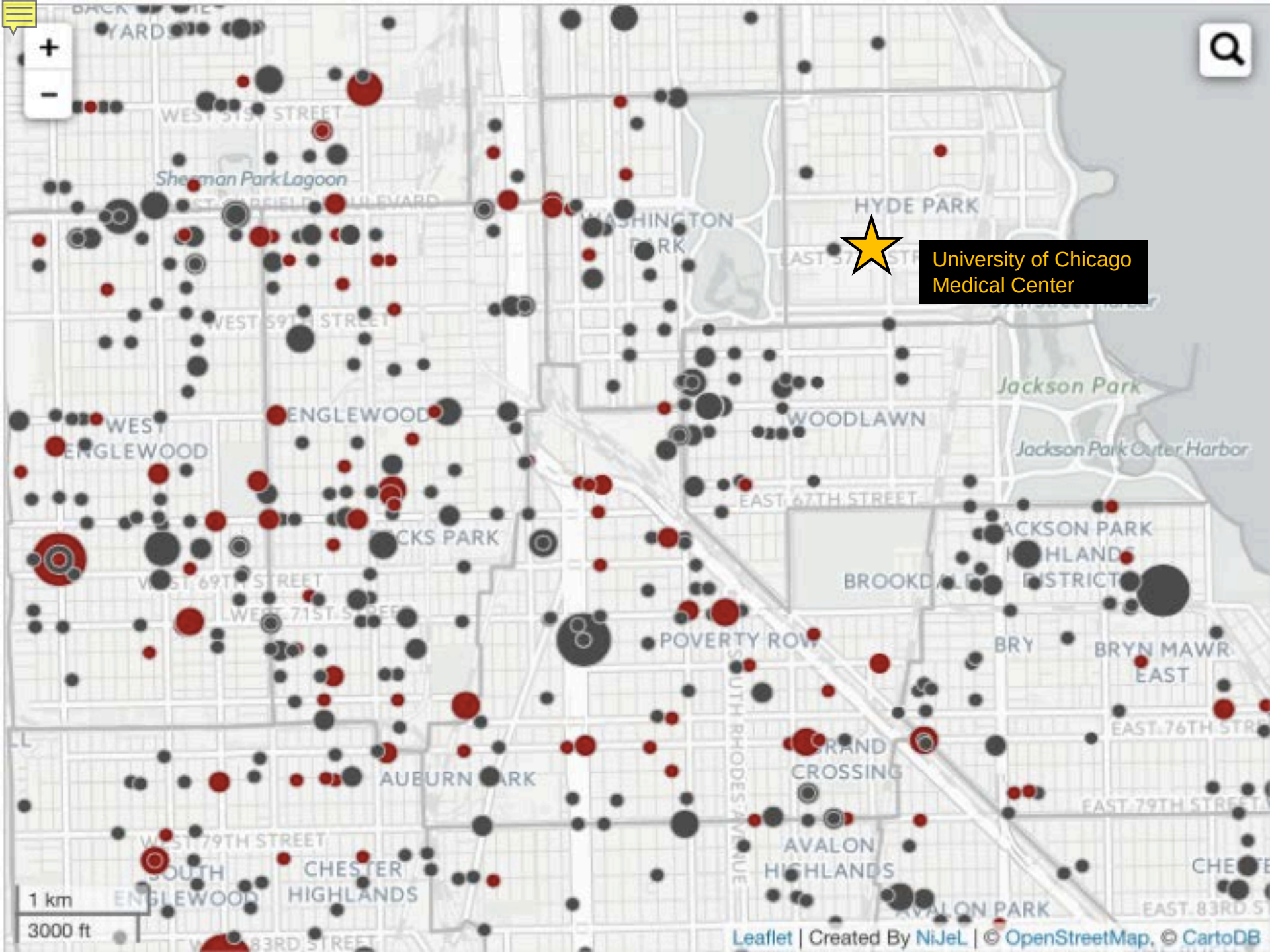
Violence in Chicago




University of Chicago Medical Center
HYDE PARK
WASHINGTON PARK
Sherman Park Lagoon
ENGLEWOOD
WEST ENGLEWOOD
WOODLAWN
Jackson Park
Jackson Park Outer Harbor
EAST 67TH STREET
WEST 69TH STREET
WEST 71ST STREET
POVERTY ROW
BRYN MAWR EAST
AUBURN PARK
GRAND CROSSING
AVALON HIGHLANDS
CHESTER HIGHLANDS
WEST 79TH STREET
EAST 79TH STREET
1 km
3000 ft
Leaflet | Created By NiJeL | © OpenStreetMap, © CartoDB

Violent Trauma in Different Forms

- Acute
  - Major trauma (GSW)
  - Minor injuries (assault)
- Chronic
  - long-standing injury
  - psychosomatic complaints
  - PTSD symptoms related to chief complaint
- Bystanders
  - Those who witness trauma
  - Relatives of those injured/killed

Posttraumatic Stress Disorder

- Re-experiencing
- Numbing
- Hypervigilance
- Avoidance

Key Developmental Capacities Affected by *Complex Trauma*

- Ability to modulate, tolerate, or recover from extreme affect states; capacity for self-soothing
- Regulation of bodily functions
- Capacity to know/describe emotions or bodily states
- Capacity to perceive threat, including reading of safety and danger cues; capacity for self-protection
- Ability to initiate or sustain goal-directed behavior
- Coherent self and identity
- Capacity to regulate empathic arousal

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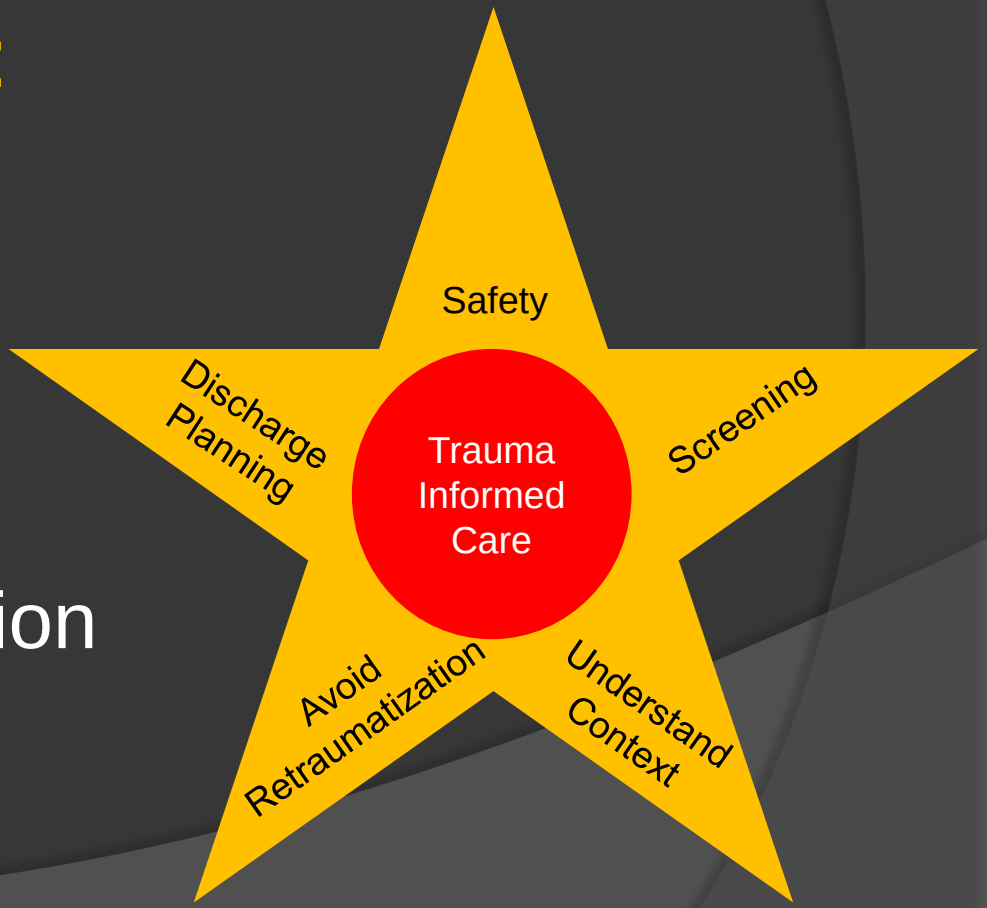
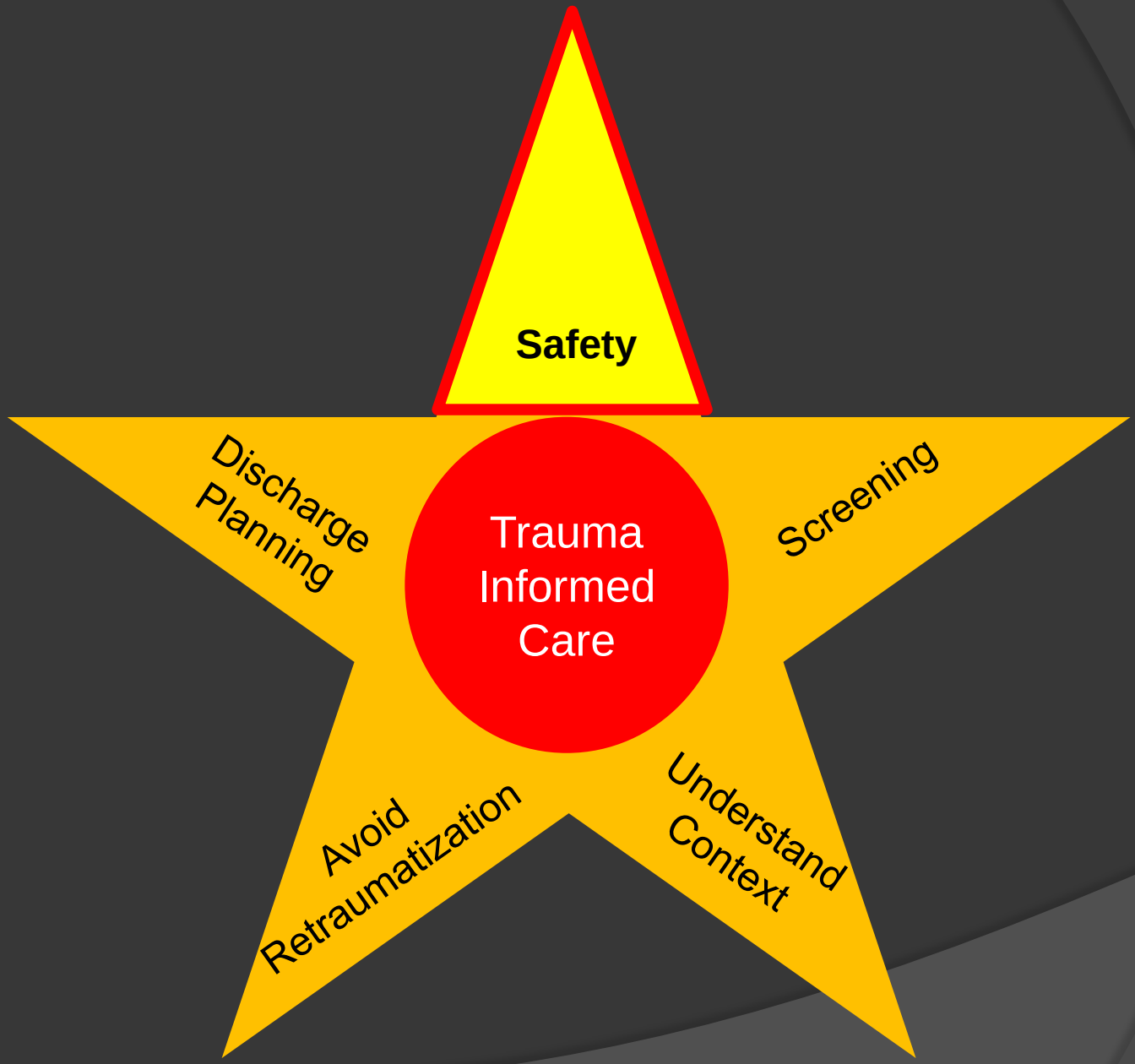
What Can You Do?

Five Points of Trauma-Informed Care for Medical Providers:

- Emphasize Safety
- Screen Patients
- Understand Context
- Avoid Retraumatization
- Discharge Planning




Safety
Screening
Understand Context
Avoid Retraumatization
Discharge Planning
Trauma Informed Care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Safety

- Hierarchy of needs: basic needs physiological (eating, sleeping), safety
- Recognize that a violent injury is the ultimate breach of sense of control, safety and autonomy
- Encounters with the healthcare system can possibly potentiate this OR can work to rebuild foundational basic needs

What can you do?

- Environmental safety
  - Safe, quiet places to wait are best
  - Orient patients to their surroundings
  - Readdress basic needs (food, water, sleep)
  - Coordinate with security regarding visitation

- Emotional safety
  - Respect and validate
  - Convey concern
  - Be consistent/predictable
  - Verbalize safety
  - Ensure privacy/patient anonymity if necessary

Simply being the excellent compassionate providers you are facilitates healing early on and is key for trauma-specific recovery.


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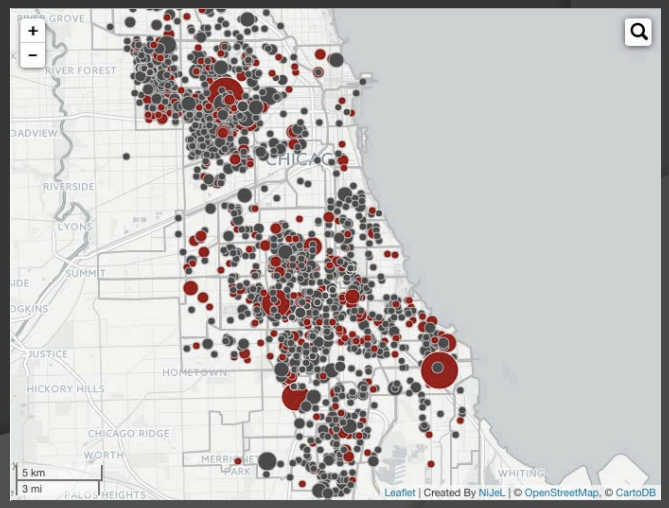
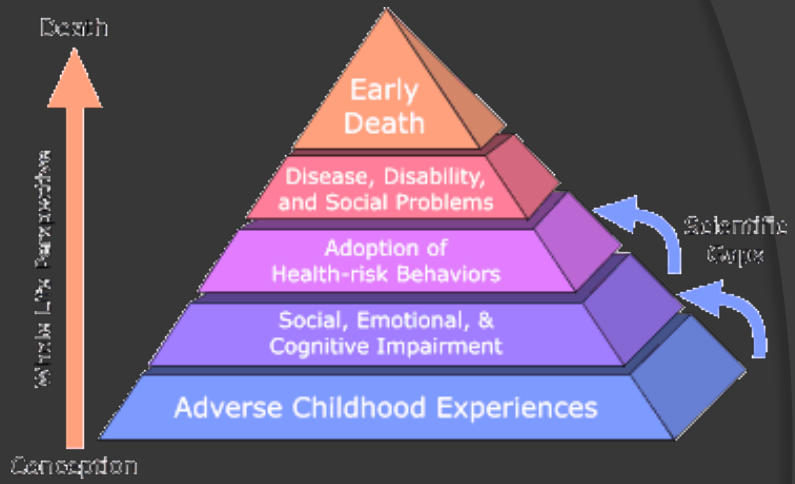
Screening for Underlying Trauma: Who to Screen

- Somatic complaints → medical workup negative
- PTSD symptoms, depression, sleep disturbance, affect distortion
- Unusual caregiver behavior
- Proximity to endemic violence
- Accumulation of ACEs…



Adverse Childhood Experiences (ACEs)

- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member



Screening for Complex Trauma: What to Ask

- Do you feel safe in your neighborhood/school?
- Have any of your friends/family been shot or killed?
- Has anything like this ever happened before?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Understand Context

Trauma…

- Causes mind/body dissociation
- Causes psychological dissociation
- Slows cognition
- Disrupts memory

A trauma-informed lens allows us to view difficult and confusing patient care situations differently…

Behavior	Context
Families who blame the patient	Overwhelming injustice, displaced anger
Patients who inconsistently pain report or affect does not match clinical judgment of pain	Disruption of the mind-body connection
Patients/families who don’t seem to appreciate the gravity of the situation	Dissociation/numbing
Patients/families who fixate on seemingly unimportant aspects of care	Dissociation/numbing
Patients/families who don’t follow up	Cognition disruption, depression, futility and disempowerment
Patients/families who don’t appear to pay attention to providers	Dissociation/numbing/cognition disruption
Patients/families who are upset that no one tells them anything despite many updates	Cognition disruption, memory impedance


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Triggers

What are triggers that can cause someone to re-experience trauma?

- Pain
- Lack of control
- Violation of personal space
- Exhaustion

What can you do?

- Healing interactions
  - Early and frequent Child Life involvement
  - Speak at eye level
  - Ask for permission to touch, intervene, visit, talk about the plan of care etc.
- Pain management
  - Early aggressive pain management then scale back as needed
  - Gauging a patient's pain in acute trauma is complicated by fear, numbing
  - Discordant affect
- Encourage choices where possible – patient choice of where lines go, when meds are given
- Assess sleep health (minimizing interruptions, psychiatry consult or melatonin etc.)
  - Nightmares?


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Planning for Discharge

- Primary care provider and sign-out
- Follow-up appointments (surgery, physical therapy etc.)
- Safety plan – enlist Trauma Intervention Specialist if possible
  - Retaliation?
  - Confrontation?
  - Suicidality?
- Easing back into daily life
  - Homebound schooling?
  - Home health services and equipment?
  - Wound care?

Does the family understand the discharge plan?

Is the discharge plan realistic?

Have practical questions been considered and addressed (e.g., transportation, access to care)?

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Case #1

- A 15 yo M presents to the Comer ER with an ankle injury. He states that he was walking down the street and fell. As he fell, he twisted his ankle. On exam, he appears somewhat withdrawn and is using his cell phone. His ankle is swollen but he has full range of motion and x-rays are negative.
- On further questioning, he states that he thought he heard a gunshot and abruptly threw himself to the ground. Brief review of his medical record reveals he was seen in the ER three months ago for evaluation after an assault.

Case #2

- A 17 yo F presents with chest pain. It has been occurring intermittently for the past several months but has been worsening, often awakening her from sleep. The pain is often accompanied by shortness of breath. History reveals no risk factors for pulmonary embolism, including oral contraceptive exposure, family history of clotting disorders or history of heart disease. An EKG shows sinus rhythm with a baseline heart rate of 86. When asked about how things are going at home, she becomes withdrawn and concentrates on her cell phone.
- Her mother addresses you and states that she hasn't been the same since her brother was murdered six months ago. She refuses to leave the house alone and often cries herself to sleep.

Case #3

- A 14 yo F presents with dysuria. Symptoms have been occurring for the past three days. She also reports new onset vaginal discharge. Her problem list includes sexual assault, pelvic inflammatory disease, bipolar disorder, assault by peers and homelessness. Her physical exam is concerning for pelvic inflammatory disease.

Case #4

- A 5 yo M is received as a trauma patient due to three gunshot wounds, two to the right chest and one to the abdomen. His GCS is 6 on arrival. He undergoes massive transfusion protocol blood product repletion, but unfortunately passes away shortly afterwards. His mother and his four older siblings arrive soon after.

Case #5

- A 15 yo M presents with a foreign object in his foot. On exam, he has a bullet protruding from his left heel. He states he was shot approximately 3 months ago and suffered two gunshot wounds. The bullet in his foot was not removed at his orthopedist's discretion, though now is ready to be removed. He would like to briefly hold the bullet before it is entered into evidence and photographs it.

Case #6

- A 7 yo F with arm injury presents with her parents. X-rays confirm fracture of the radial head. Her father paces anxiously in the hallway.