TRAUMA-INFORMED CARE BENEFITS SENIORS

Trauma and violence may occur at any point in and even *across* one's lifespan. Seniors may struggle with the effects of traumatic experiences that have occurred in the past, including during childhood, and those that have arisen more recently. The Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that "Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening…." Traumatic experiences have lasting adverse effects on one's functioning and well-being in multiple realms (physical, mental, emotional, social, and spiritual). For example, post-trauma responses may include confusion or cognitive decline, social withdrawal, and difficulty managing or "regulating" intense emotions.

Examples of trauma are transfer trauma (e.g., when no longer able to "age in place," when necessary to move from one's home); having lived through the Holocaust; having faced natural disasters; and having suffered from abuse *throughout* one's life. Additional examples of trauma include: adverse childhood experiences (e.g., emotional or physical abuse) with ramifications reverberating throughout adulthood and later life; elder abuse, including resident-to-resident abuse that may take place in nursing home settings; and <u>forced</u> relocations from current "housing" (e.g., nursing home closings). Certain challenges may come to the forefront later in life and can have traumatizing ramifications; e.g., deaths of spouses; onset of dementia or Alzheimer's Disease; chronic and debilitating physical illnesses; escalating reliance on caregivers.

Trauma-informed care (TIC) benefits seniors who have faced traumatic, life-changing experiences. TIC promotes maximization of resilience and sense of mastery over different aspects of one's life, overall well-being, self-empowerment, sense of control, and quality of life.

<u>What is Trauma-Informed Care</u>?

TIC reframes a basic question when clients/patients are approached. Rather than asking "what is wrong with you?," the question is "what happened to you?" Principles of TIC focus on "empowerment, voice and choice," "safety," "collaboration and mutuality," "peer support," and "trustworthiness and transparency" (SAMHSA). TIC providers recognize that past and current adversity influences how we act and react to stressors. They ground their therapeutic work in the knowledge that everyone has the capacity to heal and to develop/strengthen resilience (to be able to "bounce back").

Principles of TIC underscore voice, choice, and collaboration. Implementation of TIC necessitates a movement away from having mental health providers – including physician/psychiatrist providers -- be the only or final decision-makers about care, challenging a perceived or actual power differential between "experts" and clients/patients. Rather, TIC means that a "shared decision-making" approach is built into all *collaborative* contacts, promoting the active involvement and power of the client/patient in charting his/her recovery journey, and making decisions about the provision of care and assistance. Objectives when

providing TIC include: allowing trauma survivors to express their feelings, which are recognized as "normal" and make sense in light of circumstances; teaching seniors how to regulate intense emotions; helping them to develop strong and effective coping skills; and discussing how to maintain healthy social connections.

Federal Mandate about Provision of Trauma-Informed Care in Nursing Homes

The Centers for Medicare & Medicaid Services (CMS) require that nursing home facilities – ones that participate in Medicare and/or Medicaid programs -- provide TIC, effective November 2019. Care provision is to take into account residents' cultural differences, preferences and experiences as well as to prevent "re-traumatization." Trauma survivors' unique needs must be addressed. Implementation of this mandate necessitates staff training at all levels and for all disciplines; using person-centered, strengths-based rather than problem-based approaches; bringing in trauma experts or consultants when needed; identifying mechanisms for creating and maintaining a sense of safety; enhancing peer support programs; strengthening mental health interagency networks; and staff learning about residents' life "stories."

A must-read resource is "Implementing Trauma-Informed Care: A Guidebook," Resilience for All Ages (RFA), LeadingAge Maryland, 2019.

Trauma-Informed Community

A trauma-informed community is one in which individuals, families, organizations, and institutions dedicate themselves to being trauma-informed across-the-board in a concerted, collaborative effort, stopping the cycle of violence and harm.

The MHRB is committed to building a trauma-informed community, providing and/or facilitating trainings, offering information about trauma and TIC as a better care standard. Through relationships with aging organizations in the Older Adult Behavioral Health Coalition, information about trauma can be shared, specifying how TIC benefits seniors. Discussions take place about aging-related traumas, addressing unique needs for older trauma survivors who dwell in the community as well as for those who reside in institutional settings. As far as implementing TIC in locations where seniors dwell or congregate, where staff connect with older adults, the federal nursing home mandate is only the beginning of what might be possible. Ultimately, staff at all levels in multiple agencies/sites will need to learn about trauma, how to interact with individuals who have been traumatized, and what language should be used (e.g., how questions should be framed).

Closing Comments

For more information about trauma, adverse experiences, and TIC, visit the website for the MHRB (www.ashlandhrb.org). Review "Our Human Community," access the link to "Dealing with Effects of Trauma: A Self-Help Guide." View a video about adverse childhood experiences

and building a trauma-informed Ashland community (https://www.ashlandmhrb.org/ace-study). Contact David Ross, MHRB, if you have any questions (419-281-3139).

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