



INTERACTIVE CASE-
BASED SEMINAR:
MANAGING MENTAL
AND PHYSICAL
SEQUELAE OF COVID-19

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NOTES ABOUT THIS PRESENTATION

- This is one of a series of fictitious case-based presentations we created to rapidly respond to the emerging issues related to COVID-19 in mental health settings.
- The presentation is not intended to be a guideline and instead should be used as an interactive and dynamic exercise where clinicians contribute (via online discussion) to the clinical reasoning process.
- It was presented on 6th August 2020 and the information included was correct as of that date. If you are planning to use this presentation, please check the guideline links at the end to make sure the information is still up to date. We also advise you to check your local Trust guidelines and infection control policies.

INTRODUCTION

FRIDAY NIGHT

- You are the SHO working nights over a weekend covering the mental health wards, A&E and the acute hospital
- Around 4am you receive a call from the medical SHO “I think we have a patient who might need to be sectioned”
- Ms T is demanding to leave the ward and saying she can’t take it anymore, said to staff “you’re going to kill me” and refusing to speak to them anymore “Please just let me leave”

FRIDAY NIGHT

- Refusing to have vital signs checked. Last done earlier in the evening BP 115/60, pulse 100, SATS 95% off oxygen, afebrile, RR 18.
- Medical SHO has tried to offer her lorazepam, but she has refused
- Says he can't really assess her capacity – she's refusing to speak to him, she seems “psychotic”
- He says “I can't really deal with this right now, we've got someone unwell in the other bay, can you just come and see her?”
- **What is your approach?**

MS T: APPROACH

- Review notes, recent reviews
- What are her current medical issues?
- What is keeping her in hospital at this point?
- Are there family or friends who could offer support?
- Do we have reason to suspect she may lack capacity to consent to remain in hospital due to an impairment of mind or brain? Or be suffering from a mental illness?
 - Hypoxia
 - Paranoia
 - Delirium
 - Depression
 - Anxiety
- What are the risks?
- What might be going on?

MS T: MEDICAL NOTES

- 58 year old Black British woman
 - Brought to A&E 2/7 ago by ambulance with breathlessness
 - Ambulance called by volunteer who found her short of breath
 - Recent discharge from medical ward and ITU, treated for COVID-19 complicated by pneumonia, respiratory failure, AKI, requiring intubation for 5 days
 - A&E notes describe “poor historian” and “teary, anxious” “reluctant”
- Medical History
 - T2DM, Obesity, Hypertension, Hypercholesterolemia, Depression

MS T: MEDICAL NOTES

- **Psychiatric History**
 - Not on your mental health notes system, not known to psych liaison from previous ITU admission
 - GP notes say “depression” from 1990
- **Medication (on admission clerking)**
 - NKDA
 - Metformin 1g BD
 - Atorvastatin 20mg nocte
 - Ramipril 5mg daily
 - Cholecalciferol 4000IU daily
- **Social history**
 - Lives alone, teacher, currently on sick leave
 - Morning package of care after discharge and volunteers delivering shopping
 - Ex smoker, no alcohol, no drugs
 - Previous social work assessment prior to discharge last time mentions no official NOK and friend is looking after dog

MS T: MEDICAL NOTES

- Medical admission 30/5 – 28/6/20 with COVID-19
 - Complicated by ARDS, pneumonia, AKI
 - Required intubation and ventilation in ITU
 - Delirium noted in ITU discharge summary, given IV haloperidol & midazolam for paranoia & agitation x 3
 - Extubated after 5 days, stepped down to ward
 - AKI resolved
 - Discharged with 14 days prophylactic dose of rivaroxiban
- Since discharge:
 - Under community rehab who have noted ongoing issues with fatigue, poor sleep and exercise tolerance, queried low mood and were going to ask their psychologist to see

MS T: MEDICAL NOTES

- Progress on this admission:
 - In A&E Wells score PE: 9, Wells score DVT: 6, treated empirically with enoxaparin
 - Bloods on admission show eGFR 80, Cr 100 (baseline), Trop negative, coags NAD, Hb 110, WCC 7, Plt 170, CRP 12, D-dimer 1795
 - ECG sinus tachycardia
 - ABG: fIO₂ 21%, pH 7.48, PO₂ 8.8, PCO₂ 3.9, Bicarb 25
 - COVID swab in A&E negative
 - Required lorazepam for the CTPA and ABG – reported to be very anxious
 - Diagnosed with PE after CTPA yesterday showed multiple subsegmental PEs, bilateral atelectasis, resolving pneumonia

MS T: MEDICAL NOTES

- Seen on ward round this morning:
 - RR 20, pulse 100 reg, BP 110/60, SATS 94%, drops to 90% on exertion. Afebrile 36.5. BM 10.
 - For ongoing physio, review care package, aim discharge after weekend
 - Friend has called ward worried about Ms T's mental health

MS T

- When you arrive on the ward you don PPE
- The medical emergency team are in the bay next to Ms T's bed, curtains drawn, staff are rushing in and out
- You ask the nurse in charge if you can see Ms T in a side room and nurse finds you an empty bay
- You introduce yourself and she looks frightened and wary but agrees to come with you
- The nurses have managed to attach a SATs probe and check her blood pressure and she is flinching when the machine beeps. Her BP is 110/70, sats 94%, RR 22, pulse 110.

MS T

- You ask her how she is feeling and she looks stunned
- You say that you imagine she must be very frightened to be back here again after everything that has happened
- After a while she says that when the crash team came she thought they were coming for her
- She remembers little of her time in ITU but recalls when she couldn't breathe and they told her she needed a tube
- In ITU she recalls choking, falling, vivid images of knives coming at her, thinking that the nurses were trying to kill her, sense of her limbs being cut off
- Even after she left ITU she still thought that the nurses were trying to kill her but she didn't say anything and hoped she might just be able to leave hospital

MS T

- Since leaving hospital she can't sleep because of the images of knives which appear when she closes her eyes, is having nightmares when she does sleep
- Panic attacks almost daily
- When got home she wanted to forget everything to do with COVID but it's always on the news
- She feels exhausted all the time
- Friends calling her but she doesn't want to speak to them, feels disconnected
- Had hoped to start doing some work again but feels like her mind is broken, can't remember anything
- **What else would you like to ask?**

MS T

- What was her experience of hospital like?
- Mood
- Delusions vs flashbacks
- Further symptoms of re-experiencing, avoidance
- Dissociative symptoms (memory gaps/losing time/numb/detached)
- Coping strategies, supports
- Suicidality
- Psychiatric history
- (Personal history)
- Normalise distress and frightening experiences of delirium

MS T

- Feels numb, cut off and spaced out and then at other times guilty “I should be grateful but I feel broken”
- “It’s my fault I got so sick – I read about how obesity and diabetes were risk factors”
- “What good am I? They should have just let me die”
- Used to drink alcohol heavily but abstinent more than 20 years, has considered drinking again but “that will only make it worse”
- Cutting a few times age 17 “bad things going on at home, I don’t want to talk about it”, overdose aged 28, after miscarriage and leaving abusive marriage.
- Had 1 year of psychotherapy from charity organisation & support from women’s refuge after overdose and found this very helpful. No contact with MH services since.
- Lives alone, hasn’t had any romantic relationships, focussed on work, “not sure what I’ll do if I can’t work”

MS T: MSE

Appearance	Black woman, wearing hospital gown, tearful, poor eye contact but rapport improved as interview progressed. Hypervigilant, easily startled.
Speech	Normal rate, tone, and volume. Some word finding difficulties.
Mood & affect	Anxious, fearful, low mood, poor sleep.
Thoughts	Thought form linear, no FTD. Does not believe nurses really want to kill her, but feels frightened and on edge. Feels life is not worth living but doesn't have thoughts of harming herself. Sometimes wishes she had died or could fall asleep and not wake up.
Perceptions	Images of knives when closes her eyes, but is aware these are not real. No VH, AH. No IOR.
Cognition	Subjectively reports poor attention and concentration, does appear a bit distracted and hypervigilant. Recalls your name, orientated.
Insight	Partial – aware that her mind is playing tricks on her sometimes, but also has little hope for the future.

MS T: FORMULATION + DDX

MS T: FORMULATION + DDX

- 58 year old woman with history of possible early life trauma, survivor of intimate partner violence and pregnancy loss, who has experienced critical illness, associated with delirium and is now finding hospital environment terrifying and re-traumatising.
- PTSD (with or without psychosis)
- Complex PTSD
- Adjustment disorder
- Depressive disorder
- Anxiety disorder
- Delirium
- Psychosis

PICS: POST INTENSIVE CARE SYNDROME

Defined as new or worsening impairments in physical, cognitive or mental health which develop after a period of critical illness and persist beyond discharge.

- Cognitive impairment 30-80%
- Physical impairment 25-80%
- PTSD varying figures

A systematic review by Wade et al found that...

- Up to 27% of ITU survivors experience PTSD
- Depression can occur in up to 31%



Colbensen et al. Post Intensive Care Syndrome [link](#)



Wade et al. PTSD post ITU [link](#)

RISK FACTORS FOR POST-ITU PTSD

All PTSD:

- Prior trauma
- Lack of social support
- Psychiatric history
- Younger age
- Female gender



Wade et al.
PTSD post
ITU [link](#)



Youngner et
al. Predictors
of PTSD [link](#)



Brewin et al.
Meta-analysis
of risk factors
for PTSD [link](#)



Murray et al.
Cognitive
therapy for
PTSD post
ITU [link](#)

Post-ITU PTSD:

- Delusional memories of ITU
- Use of sedation
- ARDS and mechanical ventilation
- Awake paralysis
- Loss of control or restraint
- Communication problems
- Thirst, hunger, sleep deprivation, noise
- Experiences of traumatic events in ITU

POST-ITU PTSD: PHENOMENOLOGY

- In depth interviews with 17 patients with post-traumatic symptoms
 - 70% had hallucinatory/delusional intrusive memories, whilst 12% had factual memories, 18% unsure
- Can also experience intense emotions (fear, sadness, despair) or physical reaction (SOB, immobility)
 - Ehlers & Clark 2000 – “affect without recollection”/ or “the body keeps the score” (Van der Kolk, 2014)
 - Reminders can include smell of disinfectant, beeping, colour of sterile gloves, PPE



Wade et al.
PTSD post
ITU interview
study [link](#)



Murray et al.
Cognitive
therapy for
PTSD post
ITU [link](#)



“They want to kill me”

NY Times article [link](#)

“COVID-19 is a delirium factory”

The Atlantic article and documentary [link](#)

COVID RISK FACTORS FOR PTSD

I. High rates of delirium

- Delirium 5th most common symptom, occurring in 20% of patients with COVID
- Direct brain effects of COVID, inflammation, communication difficulties due to PPE, reduced face to face time due to PPE shortages and staff shortages
- Even higher rates of agitation and confusion in ITU
- Reports of needing more psychotropic medications to manage behavioural consequences



Khan et al. Delirium in patients with COVID pre-print [link](#)



Docherty et al. First 20133 patients [link](#)



Sanders et al. Hyperactive delirium in COVID-19 [link](#)



Kotfis et al. ITU delirium review [link](#)

COVID RISK FACTORS FOR PTSD

1. High rates of delirium
2. High rates of mechanical ventilation
3. Witnessing the death of others
 - Possibly higher in COVID ITU
 - Seeing other patients prone
4. Cumulative interacting risks
 - Adverse childhood experiences
 - Ethnicity
 - More severe illness



Murray et al. Cognitive therapy for PTSD post ITU [link](#)

BACK TO MS T...

- 58 year old single woman admitted with PE & DVT, following recent experience of critical illness secondary to COVID-19 complicated by delirium and ITU stay.
- Re-experiencing aspects of delirium, intrusive thoughts, nightmares, hypervigilance, panic attacks, mood fluctuating between anxious and numb, passive suicidal thoughts, struggling in hospital environment with multiple triggers.
- History of depression and anxiety, suggestion of trauma in early years, survivor of intimate partner violence.
- How can we help Ms T right now?

BACK TO MS T...

- She is feeling calmer after speaking to you
- Would still really like to go home, but understands that she probably needs to stay in hospital until she can get the help she needs
- Says she is exhausted and wants to sleep

THE WEEKEND

- You don't hear anything else about Ms T over the next couple of nights
- You look at her notes and see that she has spoken with the PLN the next two days and is doing ok, although sleep is still poor

THE FOLLOWING WEEK

- When you're back at work the following week you look Ms T's notes to see what has happened
- She's seen the liaison psychologist and psychiatrist
- Recounted to psychiatrist that she didn't ever want to come back to hospital - when she had first attended with breathlessness with COVID she had been dismissed as having anxiety
- She had collapsed in the car park and was brought back in and given oxygen
- She isn't in touch with any family – parents both deceased, only child
- Parents came to UK in the late 1950s from Barbados, father worked as a bus driver, mother secretary
- Recalls her father drinking, sometimes shouting
- Experienced racist bullying throughout school
- Mother died with vascular dementia a few years ago, father of AMI

THE FOLLOWING WEEK

- She disclosed to the psychologist that she was raped by her father's friend when she was 16, but was not believed when she told her family.
- She found therapy in her 20s helpful and is willing to consider it again, although is still unsure how she will ever get through covid.
- The psychiatrist has started her on sertraline, as she found this beneficial before when she was depressed. Also started some promethazine. She is feeling a little more hopeful but still low in mood.
- She is going to be discharged with BD package of care, help with cleaning, shopping.

When under threat, we are primed to find safety in attachments; to survive the pandemic, we must do the opposite.

- Pandemic mirrors trauma experience: inescapable nature and feelings of helplessness overwhelm existing defences.
- Threat of ill health, death, or loss of loved ones is at the heart of anxieties.
- This connects us to earlier anxieties: annihilation, disintegration, fragmentation, persecution.
- We see defences at individual and population level: splitting, projection.
- As ever, the body keeps the score.



COVID trauma response working group [link](#)



Stubley 2020. COVID-19 psychoanalytic and trauma perspective [link](#)

“Individual 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 and that has lasting adverse **effects** on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”



SAMHSA’s concepts of trauma and guidance for a trauma-informed approach [link](#)



Maltreatment

i.e. abuse or neglect



Violence & coercion

i.e. domestic abuse, gang membership, being a victim of crime



Adjustment

i.e. migration, asylum or ending relationships



Prejudice

i.e. LGBT+ prejudice, sexism, racism or disablism



Household or family adversity

i.e. substances misuse, intergenerational trauma destitution, or deprivation



Inhumane treatment

i.e. torture, forced imprisonment or institutionalisation



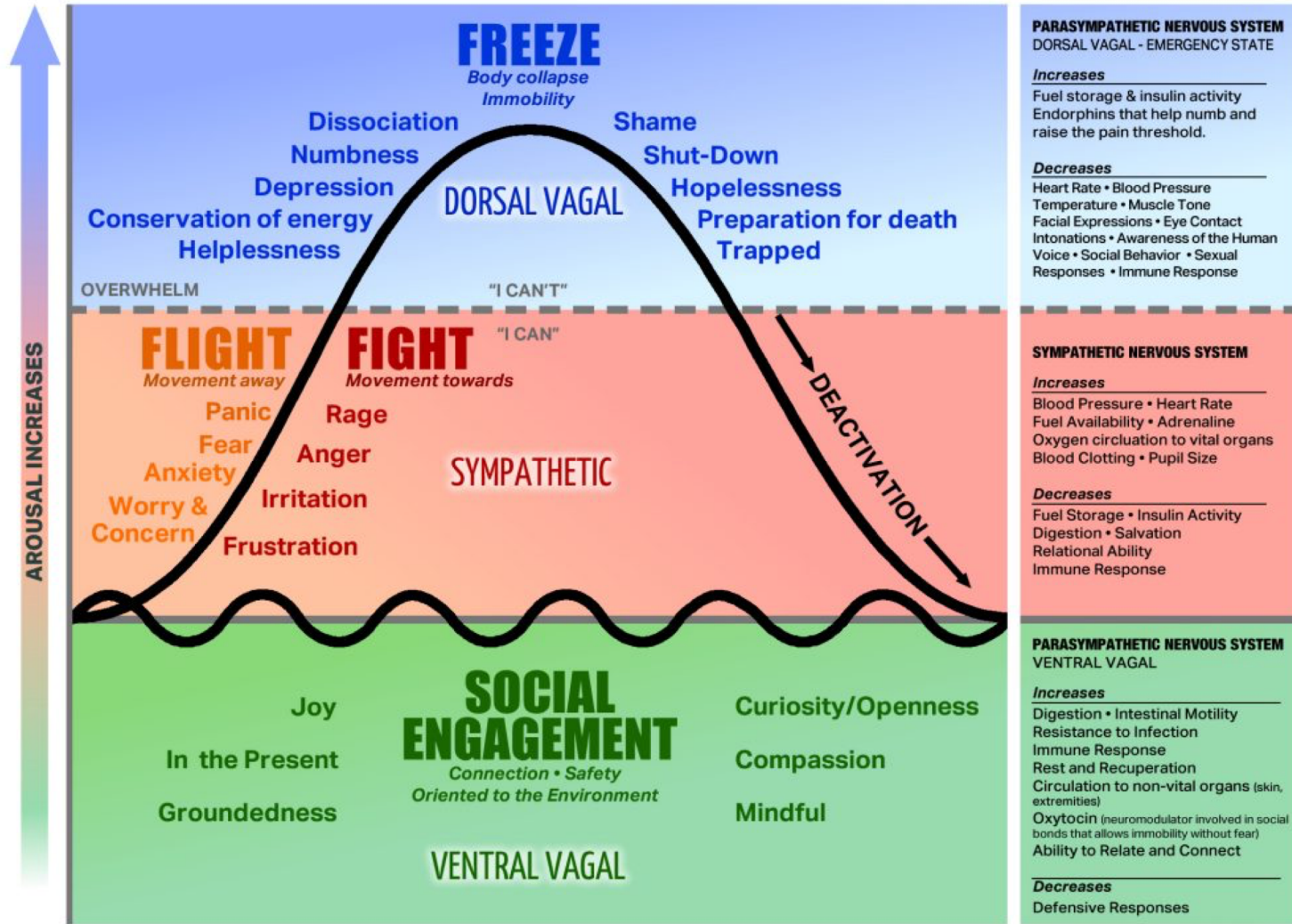
Adult responsibilities

i.e. being a young carer or involvement in child labour



Bereavement & survivorship

i.e. traumatic deaths, surviving an illness or accident



Adapted by Ruby Jo Walker from: Cheryl Sanders, Steve Hoskinson, Steven Porges and Peter Levine

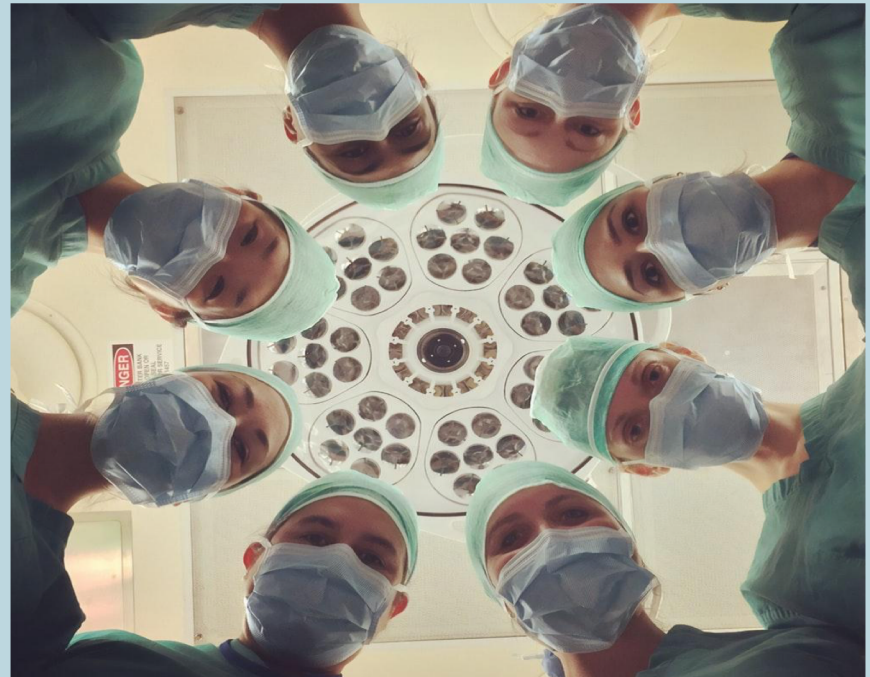
rubyjowalker.com

RECOGNISING TRAUMA

- Hypervigilance
- Shame
- Dissociation
- Coping and symptom control
- Frequent attending
- Never attending
- Attending only as an emergency
- Not attending screening
- Medically unexplained symptoms
- Poorly managed chronic conditions
- Multimorbidity
- Refusals of treatment

WHY MIGHT HEALTHCARE BE RETRAUMATISING?

- Power dynamics
- Invasive procedures
- Removal of clothing
- Physical touch
- Vulnerability
- Personal questions
- Blaming
- Lack of privacy
- Loss of control
- Requires trust in “authority” figures
- Previous discriminatory experiences



Raja et al. Trauma informed care in medicine [link](#)

TRAUMA-INFORMED APPROACHES TO COVID-19

Box 1: Psychological First Aid

Following a disaster, people have an instinctive need to give and receive support. The principles of Psychological First Aid, while lacking direct evidence for their effectiveness, are in line with what is known about trauma and, as such, can inform the ways we help one another (van Ommeren, Saxena & Saraceno, 2005; Bisson & Lewis, 2009; Bisson, 2014; Goldmann & Galea, 2014).

Psychological First Aid involves:

- Providing practical care and support, which does not intrude
- Assessing needs and concerns
- Helping people to address basic needs (for example, food and water, information)
- Listening to people, but not pressuring them to talk
- Comforting people and helping them to feel calm
- Helping people connect to information, services and social supports
- Protecting people from further harm.

(WHO, 2011)

For more information on Psychological First Aid, visit:

<https://www.apa.org/practice/programs/dmhi/psychological-first-aid/resources>



THE FOLLOWING WEEK

- You are attending a liaison psychiatry supervision group and decide to speak about Ms T
- Over the course of the discussion a number of questions emerge...

I. What are the longer term physical and mental health consequences for people who recover from COVID?

Mental health consequences

- Link between inflammation and depression
- Spanish flu survivors reported sleep disturbance, dizziness, difficulty coping (Lyons et al, 2020)
- Sample of 402 adults 1 month after COVID infection: self reported measures found 28% in range for PTSD, 31% for depression, 42% for anxiety, 20% for OC symptoms, and 40% for insomnia (Mazza et al, 2020)
- Setting, baseline inflammation, length of hospitalisation, gender and those with psychiatric history predicted outcomes
- SARS & MERS survivors
 - 19.3% fatigue
 - 10.5% depressed mood (Rogers et al, 2020)



Anxiety and depression in COVID-19 survivors, Mazza et al 2020 [link](#)



Neuropsychiatric presentations associated with coronavirus infections Rogers et al, 2020 [link](#)



Fallout from the COVID-19 pandemic, Lyons et al, 2020 [link](#)

I. What are the longer term physical and mental health consequences for people who recover from COVID?

Fatigue, cognition and Long-COVID

- Infection prior to onset of CFS commonly reported (Lyons et al, 202)
- Long-Covid experiences - Body Politic Covid-19 Slack patient led research and support group (2020)
- Stigma of fatigue, difficulties in returning to work
- Reports of ongoing low SATS, breathlessness, chest pain, tachycardia, fatigue, cognitive disturbances, fevers, lymphadenopathy, headaches, joint pain (Lokugamage et al, 2020)
- 15 (33%) of 45 patients with COVID-19 had a dysexecutive syndrome in one study of ITU patients (Helms et al 2020).



Patients' experiences of "longcovid" are missing, Lokugamage et al 2020 [link](#)



What Does COVID-19 Recovery Actually Look Like? Body-Politic 2020 [link](#)



Helms et al. Neurologic features post COVID-19 [link](#)



Message in a Bottle – Long Covid SOS [link](#)



Lyons et al. Fallout fom the COVID-19 pandemic [link](#)

1. What are the longer term physical and mental health consequences for people who recover from COVID?

- Psychological needs often overshadowed by focus on physical recovery
- Screen and treat programmes (IPAT)
- Multidisciplinary post-ITU clinic: with ITU diaries (variable availability)
- Grounding exercises and understanding triggers
- Education on delirium and post-ITU syndrome
- IAPT, ITU psychologist or rehab psychologist for brief supportive intervention*
- If symptoms persist, more intensive psychological intervention via psychotherapy service

2. What are the follow up options for Ms T?



COVID Trauma Response Group Guidance [link](#)



UK Patient Guide – Critical Illness, ITU & PTSD [link](#)



Wade et al. Detecting psychological morbidity after critical illness [link](#)

1. What are the longer term physical and mental health consequences for people who recover from COVID?



British Lung
Foundation &
Asthma UK
post-COVID
hub [link](#)



COVID Patient
telephone
befriending
service [link](#)

2. What are the follow up options for Ms T?



ICU Steps online
support group [link](#)



@LongCovidSOS
[link](#)

1. What are the longer term physical and mental health consequences for people who recover from COVID?
2. What are the follow up options for Ms T?
3. How is understanding trauma relevant to providing care for people on medical wards during COVID-19 and beyond?

The ACEs study

- Dose-response relationship between ACEs and ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.
- Later studies have found links to: cancer, HIV, obesity, headaches, depression, IV drug use, smoking alcohol use, chronic pain, premature mortality, “personality” disorders, PTSD, CPTSD, early sexual activity, violence (victim and perpetrator), poor diet, lifetime incarceration
- Need to consider wider context, mitigating factors, include other adversities too and move beyond perspectives embedded in European perspectives



Lacey and Minnis. 20 years on ACEs [link](#)



UCL Institute of Health Equity Document Allen & Donkin, 2015 [link](#)



Felitti et al. The ACE study [link](#)

1. What are the longer term physical and mental health consequences for people who recover from COVID?
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Pathways to poor health:

- Link between ACEs and coping strategies
- Link between ACEs and other social determinants of health
- Neurobiological, physiological, and genetic + epigenetic pathways
- Neural connectivity, imbalanced cortisol, hyperglycaemia, inflammation, premature ageing, shortened telomeres and epigenetic effects (Teicher et al 2016) (Yehuda et al, 2016)



Teicher et al, 2016 Enduring effects of trauma [link](#)



Yehuda et al, 2016 Intergenerational effects of Holocaust exposure [link](#)

1. What are the longer term physical and mental health consequences for people who recover from COVID?
2. What are the follow up options for Ms T?
3. How is understanding trauma relevant to providing care for people on medical wards during COVID-19 and beyond?

Racial trauma (impacts of racism)

- Institutionalised, personally mediated and internalised /internalisation of the inferiority complex
- Linked to other forms of intersectional oppression, micro-aggressions, collective and intergenerational experiences (including those of slavery, genocide, dislocation, colonisation)
- Can include threats of harm and injury, humiliation and shaming, witnessing racial trauma
- Need to consider the perpetuation of racism, discrimination and retraumatisation within mental health settings



Comas-Diaz et al.
Racial trauma [link](#)



Fanon. Black skin, white masks



Fernando. Institutional Racism in psychiatry and psychology [link](#)



Jones. Levels of racism; a theoretical framework [link](#)

RACISM & HEALTH

- Operates at 3 levels: institutionalised, personally-mediated and internalised
- Structural and institutional effects eg pre-term birth, access to medical care, poverty, immigration policy, inequalities in incarceration, police responses
- Unconscious bias
- Examples include differences in identification and management of AMI, pain relief, treatment of PTSD
- Black women are 5x more likely to die in the year after childbirth, Asian women 2x more likely across socioeconomic statuses
- Effect of discrimination on mental and objective outcomes in physical health eg BP, inflammation, allostatic load, shorter telomeres, cortisol, oxidative stress



Seng et al. Disparity in PTSD among African American women [link](#)



Williams et al. Racism and health [link](#)



MBRRACE Report [link](#)



Graham. Racial and ethnic differences in ACS [link](#)



Mende-Siedlecki et al. Contributions to racial bias in pain recognition [link](#)

COVID-19 & ETHNICITY

- OpenSAFELY study 10,000 COVID related deaths compared with population data (Williamson et al, 2020)
- Deaths associated with male gender, deprivation, older age, diabetes, severe asthma
- Black (1.48) and South Asian (1.44) people at higher risk even after adjustment for other factors
- PHE Report “Beyond the Data”
 - Less likely to seek care, NHS staff less likely to speak up about PPE
 - More likely to work in occupations with higher risk of exposure
 - Pandemic had exposed long standing health inequalities
 - Economic disadvantage strongly related to smoking, obesity, hypertension, lung conditions
 - Problems in identifying severe illness (eg: hypoxia)
 - Role of severe mental illness
 - Role of vitamin D?



GOV.UK “Beyond the Data” impact on BAME communities [link](#)



OpenSAFELY Study, Williamson et al, 2020 [link](#)

Medical Racism

History of poor treatment and discrimination may result in delay in seeking help;
Repeated experiences of discrimination;
Differences in responses to distress from staff;
Potential for diagnostic overshadowing if there is any mental disorder (*or female)

Post-hospital factors

Stigma, shame, and blame;
Pressure to return to work;
Poor societal understanding of recovery;
Post-viral syndromes, inflammation and depression;
Unstable financial and economic situation;
Access to culturally sensitive diagnostic process and therapy;
Secondary and collective trauma .

Ms T**Risk factors for ITU trauma**

More severe illness → increased risk of delirium;
Delirium → paranoia → isolation;
Reduced recognition of delirium during the pandemic;
Increased use of psychotropic medication;
Communication difficulties, isolation;
History of sexual trauma;
Previous mental illness.

Risk factors for COVID severity

Underlying health conditions including obesity, diabetes and respiratory disease;
Underlying inflammatory and immune changes.

TRAUMA-INFORMED HEALTH CARE

- *“In a trauma-informed mental health service, all staff – clinical and non-clinical – understand the impact of trauma on a person’s ability to survive in the present moment.... The critical roles of racism, sexism, homophobia, ageism, poverty and their intersectionalities are recognised.” Sweeney et al 2016*



Sweeney et al, 2016
Trauma-informed
mental health care [link](#)

SAMHSA GUIDE TO TRAUMA-INFORMED CARE APPROACHES

Realises

- **Realises** the widespread impact of trauma and understands potential paths for recovery

Recognises

- **Recognises** signs and symptoms of trauma in patients, families, staff, and others involved in the system

Responds

- **Responds** by fully integrating knowledge about trauma into policies, procedures and practices

Resists

- Seeks to actively **resist** re-traumatization

The first principle of recovery is empowerment of the survivor. She must be the author and arbiter of her own recovery. Others may offer advice, support, assistance, affection, and care, but not cure

Judith Herman

PRINCIPLES OF TRAUMA-INFORMED CARE

Patient empowerment: using individuals' strengths to empower them in the development of their treatment

Choice: informing patients regarding treatment options so they can choose the options they prefer

Collaboration: maximizing collaboration among health care staff, patients and their families in organizational and treatment planning

Safety: developing healthcare settings and activities that ensure patients' physical and emotional safety.

Trustworthiness: creating clear expectations with patients about what proposed treatments will entail, who will provide services and how it will be provided



SAMHSA guide [link](#)

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MS T: 2 WEEKS LATER

- Discharged with BD package of care plus support with shopping, cleaning, prompting with medication
- Ongoing rehab with community pulmonary rehab team
- Rehab psychologist providing interim support and considering referral to IAPT
- Remains on sick leave but is keeping in touch with colleagues and a graded return is planned
- Starting to Facetime friends again, has had a friend visit and brought dog, trying to watch TV, reading some poetry
- Has joined local mutual aid group and online support group for COVID ITU survivors

LEARNING POINTS

- Multiple neuropsychiatric sequelae after ITU admission, and reason to suspect the morbidity will be high after COVID-19
- Trauma (early life and in adult years) affects a person's health and their ability to receive medical care
- Structural and interpersonal discrimination affect people from BAME background in terms of risk of COVID and outcomes
- Medical care itself can be traumatising, especially in the context of critical illness and delirium
- Some of the supports which might have minimised this are less available
- Trauma-informed care can offer principles for supporting the survivors of trauma

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We are very grateful to Dr Paul Gilluley, Millie Smith, Sharmin Khonij, Neetu Klair & Dr Frank Röhrich

RESOURCES

- Ibram Kendi. How to be an anti-racist (2019)
- Judith Herman. Trauma and Recovery (1992)
- Bessel van der Kolk. The Body Keeps the Score (2014)
- Helen McKenna, Natalie Creary, James Nazroo. Kings Fund podcast: Covid-19, racism and the roots of health inequality [link](#)
- Nadine Burke-Harris: TED Talk: How childhood trauma affects health across a lifetime [link](#)
- David Williams. BMJ Podcast: Everyday discrimination is an independent predictor of mortality [link](#)
- Covid Trauma Response Working Group [link](#)
- ICU Steps: patient and professional resources [link](#)
- Slides from our previous ELFT Covid Cases webinars [link](#)

QUESTIONS AND CONTACTS

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