Case study detailing trauma-informed care provided to an adolescent in custody with a history of developmental trauma and Type-1 Diabetes

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Introduction

The present case study details the trauma-informed, multi-agency approach used when working with a young person in secure care with a history of developmental trauma and an existing physical health condition; Type 1 diabetes. This case study details the psychological assessment, formulation and intervention used; whilst also providing an insight in to the emphasis placed on multi-agency care planning relating to the wider physical health needs.

Methodology

The case study is presented through the Four R's (SAMSHA; 2014); realise, recognise, respond and resist re-traumatisation; being key assumptions in trauma informed care; whilst also drawing on key themes of collaboration and co-production. The case study centres around the care provided to an individual young person; aged 18 at time of discharge; whilst in custody with both a history of developmental trauma and co-existing physical health diagnosis. Through a psychological assessment rooted in Cognitive Behavioural Therapy, it was identified that our young person presented with symptomology related to that of developmental trauma. Furthermore a psychological formulation was co-produced with the young person in order to develop a shared understanding of strength and need.

The case study details both the direct and indirect interventions offered and the efficacy of such interventions in an environment focused on supporting a population of young people with a high prevalence of developmental trauma. With regards to direct clinical work, the case study details the psychological and physical health interventions offered, as well as highlighting key points in trauma-informed care of co-production and care planning. Psychoeducation, Dialectical Behaviour Therapy skills for emotion regulation and assessments of suitability for EMDR therapy, as well as continued physical health education around Diabetes are examples of the interventions offered. Furthermore, secure environments may be described as trauma-organised systems given the complexity of the population and the subsequent impact on staff wellbeing and care provided. Consideration is given in this case study to the necessity of working with the system in order to provide trauma informed care at all levels in order to ensure that frontline staff are knowledgeable of trauma and attachment, as well as supported emotionally. Verbal and written consent has been granted by the young person. Northamptonshire Healthcare Foundation Trust stipulates that no further research approval is required.

Realise	• System realises widespread impact pf trauma and understands potential paths for recovery
Recognise	• Recognise the signs and symptoms of trauma in clients, families, staff and others in the system
Respond	• Responds by fully integrating knowledge about trauma in to procedures and practices
Resist Re-traumatisation	• Seeks to actively resist re-traumatisation

Results

Interventions offered can be conceptualised as both direct intervention addressing both physical health needs and psychological support; as well as indirect work with the system to offered trauma-informed care system-wide.

Realise (the impact of trauma)

· Acknowledgement that witnessing such behaviours has emotional toll on frontline staff. Staff were supported to regulate their own emotions and work from a place of compassion and empathy through reflective practice and supervision.
· Realisation that diagnosis of Type-1 Diabetes in itself may be considered a traumatic experience. Work was done to support various staff groups to regard escalation in self-harm behaviours or aggression as a trauma response and demonstration of need

Recognise (trauma symptomology)

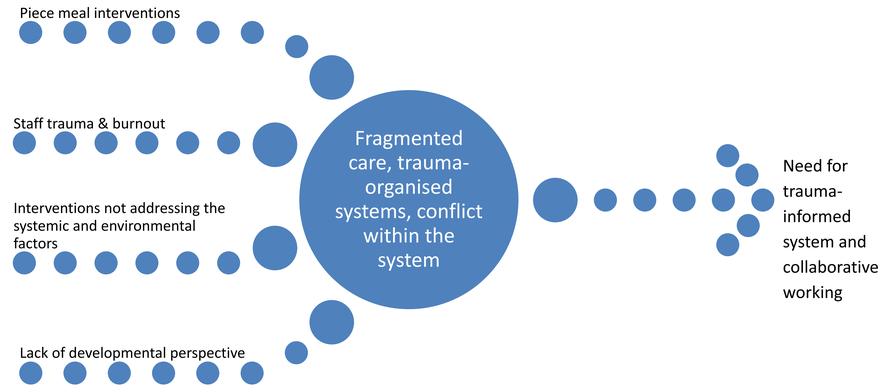
· Operational staff provided with training in trauma symptomology and attachment. Staff supported to recognise self-harm behaviour as care-eliciting behaviour in order to ensure physical safety, foster compassion and respond to emotional needs. Staff also offered education around Type-1 Diabetes.
· Direct intervention included a psychological assessment and co-developed formulation. The co-development of the formulation was regarded as particularly therapeutic for the young person, describing this as providing an insight and validation of distress experienced

Respond

· Establishing physical and psychological safety is fundamental in trauma recovery (Skuse, 2015). Staff are trained to respond to signs of distress and supported to formulate hidden needs.
· Flexibility in how interventions are offered. Every interaction has the potential to be harmful or helpful (Taylor et al, 2018); and thus regular check-ins with the young person, and boundaried informal conversations develop trusting relationships and feelings of being "kept in mind".
· Increased provision of psychological support with Dialectical Behaviour Therapy skills and psychoeducation being a key focus. Further assessment of suitability for Eye Movement Desensitisation and Reprocessing (EMDR) therapy also offered.
· Introduction of regular health education interventions to develop understanding of physical health diagnosis. This education was provided in the form of weekly video clinic appointments with Community Specialists, information booklets from appropriate sources and regular 1:1 sessions with Named Physical Health Nurse.

Resist Re-traumatisation

· There is a recognition that to continue to resist re-traumatisation whilst in secure care, a sense of safety and meaningful relationships must be achieved. Our young person reflects that high staff turnover due to burnout presented a barrier in developing relationships, and subsequent difficulties in experiencing safety through relationships.
· Our young person initially highlighted feelings of being "done to" with regards to care planning and resettlement plans. Increasing the young person's inclusion in Multi-disciplinary Team meetings as well as care planning increased sense of ownership of their care and "including my voice" was regarded as a positive of such meetings.
· Comprehensive resettlement planning with consideration to proximity to support for physical health needs, flexible community support and referrals for continued psychological support and EMDR therapy.
· In order to empower the young person to manage their own Diabetes, they were given training on monitoring blood sugars and Insulin administration - this is something that was discussed regularly both formally and informally to ensure correct and safe techniques were utilised.



Outcomes

- Initial challenges of engaging our young person with physical health interventions were recognised; described as feeling "done to" and not having input to care planning, targets or how successful engagement may be measured. With improved co-production of care planning with a new named nurse and continued health education, engagement in such plans significantly improved. Self-harming behaviours are also noted to have decreased in frequency when the young person felt at the centre of the care planning process.
- Young person describes feeling more able to manage Diabetes in regards to diet and insulin administration.
- The young person also requested an extended transition period in order to end therapeutic relationships safely with a meaningful handover to community professionals
- Positive feedback from Forensic Psychology team highlights the efficacy of Psychoeducation and Mindfulness interventions in order to increase suitability for EMDR therapy. Target and completion of assessment of suitability for EMDR therapy demonstrates efficacy of such interventions.
- Young person highlights continued reviewing of targets for both physical and psychological interventions, inclusion of their voice, a flexible approach in order to develop trusting relationships and psychoeducation for trauma as key successful aspects of interventions offered.
- Continued, although less frequent, self-harm behaviours demonstrate further need for emotion regulation skills and adaptive ways to elicit care from others.

Conclusions

- Highlighted need for collaboration between staff groups to recognise trauma symptomology and care-eliciting behaviour. Further collaboration recognised as a necessity to make individualised care plans that included input from healthcare, psychology, resettlement, education and operations. Such plans create a shared understanding of the young person's need and create a psychologically informed system focused on trauma recovery.

- Coproduction of care plans also recognised as a key feature of delivering trauma-informed care in with a young person in custody. Feedback received from the young person recognised a feeling of being "done to" when initial care plans were devised without the young person's input, and did not adequately meet physical and emotional needs. Improved co-production of a physical care plan for Type-1 Diabetes, along with targets and scheduled, consistent development, was noted to be a key aspect of engagement in such plans.

References

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