NHS
Health Education England

11:15am – 12:00pm – Keynote Speaker

Dr Filippo Varese

Senior Clinical Lecturer in Psychology & Clinical Psychologist, Director of the Complex Trauma and Resilience Research Unit (C-TRU)

Trauma informed care – implementation and evaluation

Greater Manchester Mental Health NHS Foundation Trust

The University of Manchester

C-TRU Complex Trauma and Resilience Research Unit

Trauma-informed care in mental health settings: Implementation and evaluation

Dr Filippo Varese

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C-TRU Director, Greater Manchester Mental Health NHS Foundation Trust

Annual NWPPN Conference

27th November 2018

Co-Directors and members of C-TRU

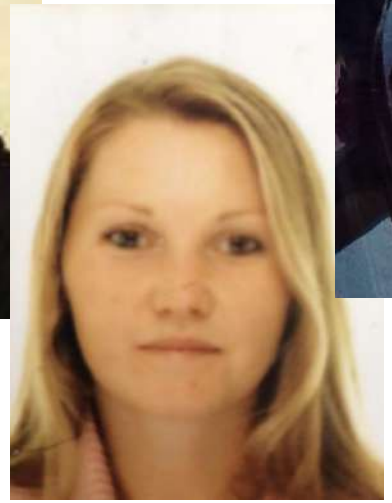
Sandra Bucci

Katherine Berry

Eleanor Longden

Richard Brown

Kim Cartwright



Kate Allsopp

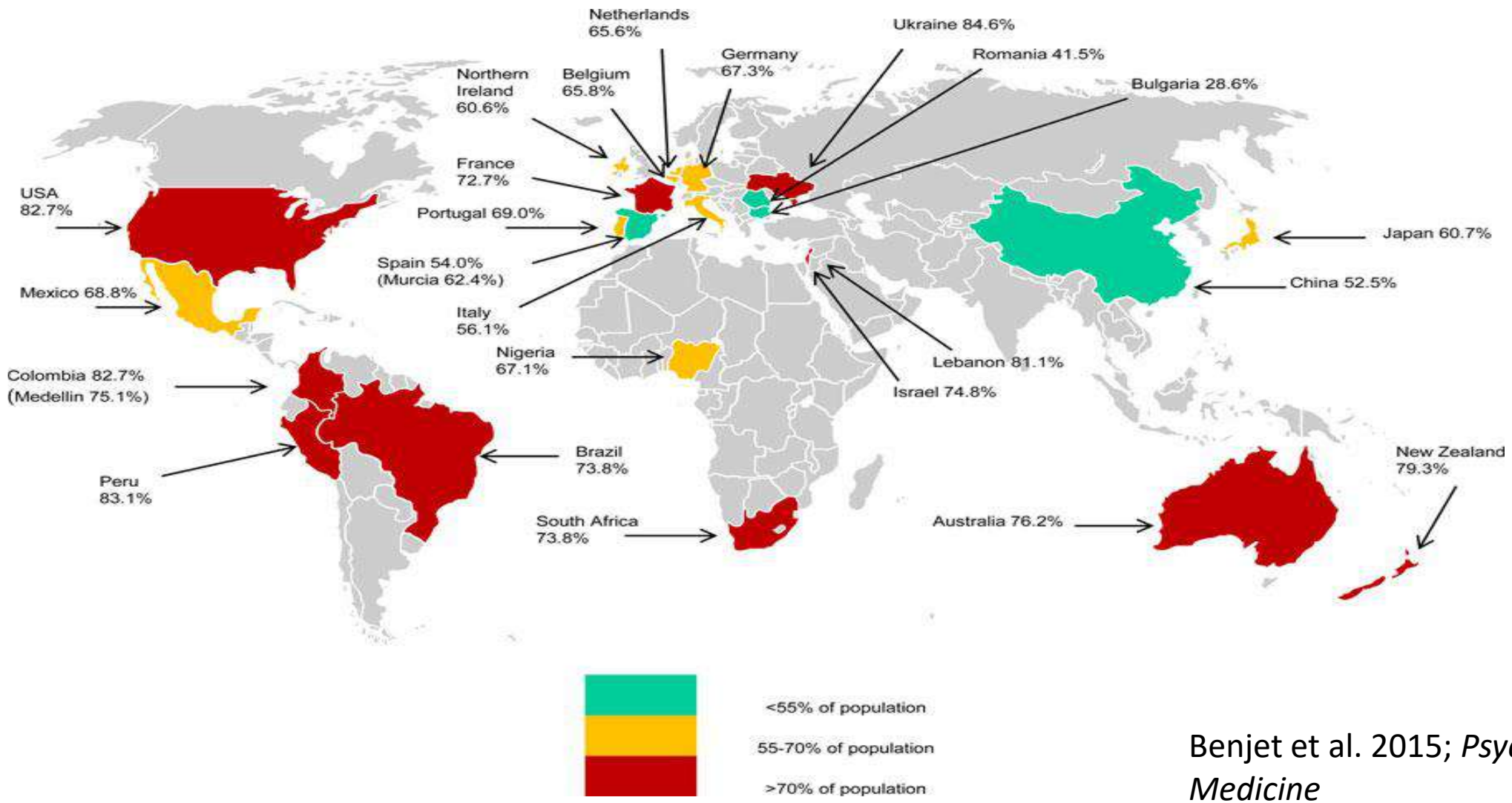
1) Overview of trauma in severe mental health difficulties

2) What is Trauma-Informed Care (TIC)

3) Highlights from a qualitative study with staff working in a UK mental health inpatient unit which attempted to implement TIC

How common are traumatic experiences?

How common are traumatic experiences?



Benjet et al. 2015; *Psychological Medicine*

How common are traumatic experiences?

English Adult Psychiatric Morbidity Survey 2014
(Fear et al. 2016)

- **Nationally representative survey with over 7500 respondents aged 16 or more interviewed in 2014 and 2015**

- **31.4% of people reported having experienced a major trauma at some point in their life (31.5% of men and 31.2% of women)**

Levels of trauma exposure are considerably greater in people who use mental health services than the general population…

Examples of the most “definitive” meta-analyses linking childhood adversities / trauma and subsequent risk of developing mental health difficulties	
Depression	Mandelli et al (2017)
Anxiety	Lindert et al. (2014)
Obsessive compulsive disorder	Miller & Brock (2017)
Suicidal behaviour	Zatti et al. (2017)
Non-suicidal self-harm	Liu et al. (2017)
Functional neurological (conversion) disorders / medically unexplained symptoms	Ludvig et al. (2018)
Dissociation	Vonderlin et al. (2018); Rafiq et al. (2018)
Eating disorders	Molendijk et al. (2017)
Substance misuse (illicit drugs, alcohol etc.)	Norman et al. (2012)
Psychosis	Varese et al. (2012)
Bipolar disorder	Palmier-Claus et al. (2016)
Borderline personality disorder	Porter et al. (under review)

Trauma and severe mental health difficulties

Childhood Adversities Increase the Risk of Psychosis: A Meta-analysis of Patient-Control, Prospective- and Cross-sectional Cohort Studies

Filippo Varese[†,1,2], Feikje Smeets[†,3], Marjan Drukker[3], Ritsaert Lieverse[3], Tineke L…
…hn Read[5], Jim van Os[*,3,4], and Richard P. Bentall[1]

Schizophrenia Bulletin

Relationship between childhood adversity and bipolar affective disorder: systematic review and meta-analysis

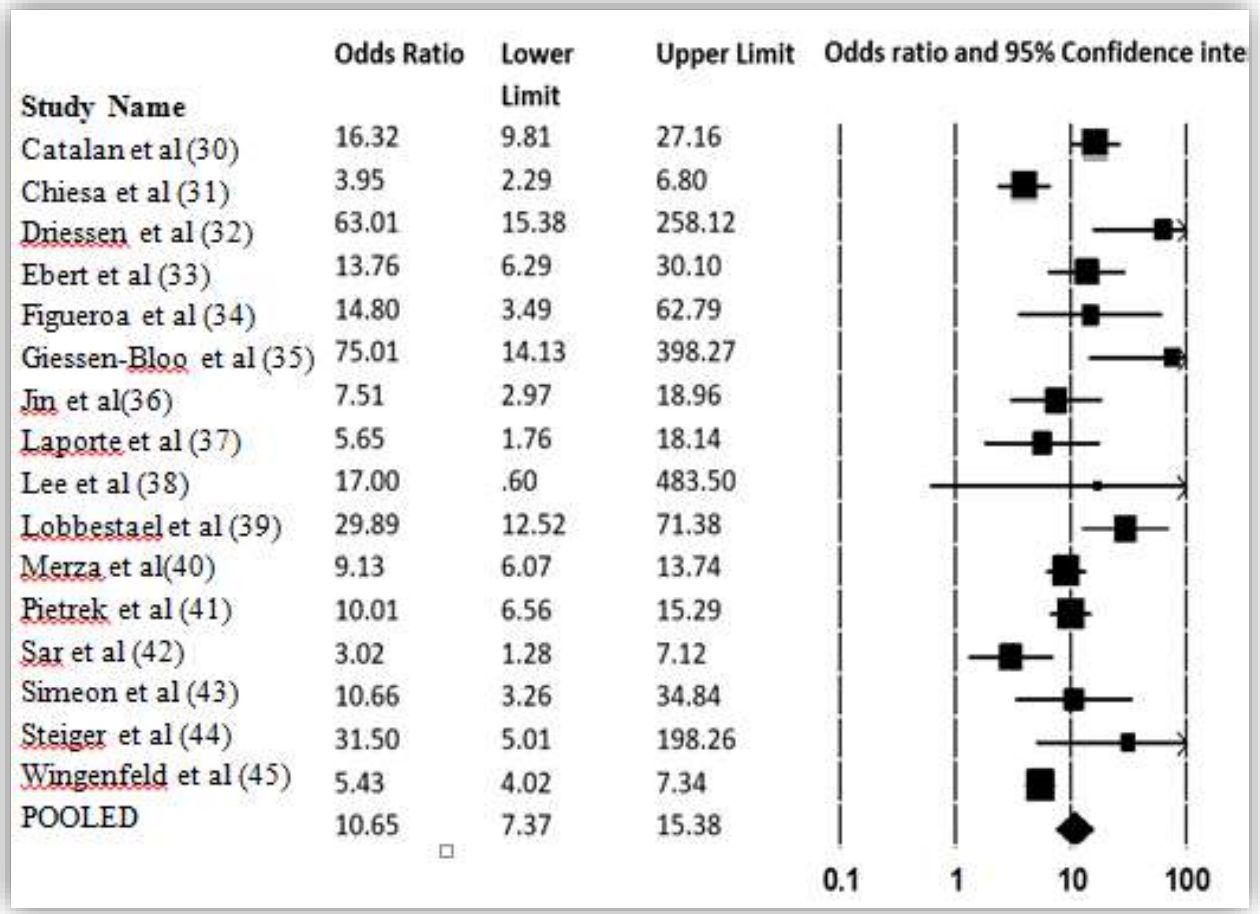
…l. E. Palmier-Claus, K. Berry, S. Bucci, W. Mansell and F. Varese

BJPsych The British Journal of Psychiatry

Childhood trauma in people who received borderline personality disorder diagnoses (Porter et al. *under review*)

Across the available literature (76 studies), people with BPD diagnosis are:

- **Over 10 times more likely to have experienced trauma than non-psychiatric controls;**
- **Over 14 times more likely to have experienced emotional abuse and 20 times more likely to have experienced emotional neglect**
- **Approx 3 times more likely to have a trauma history compared to other people with mental health difficulties**



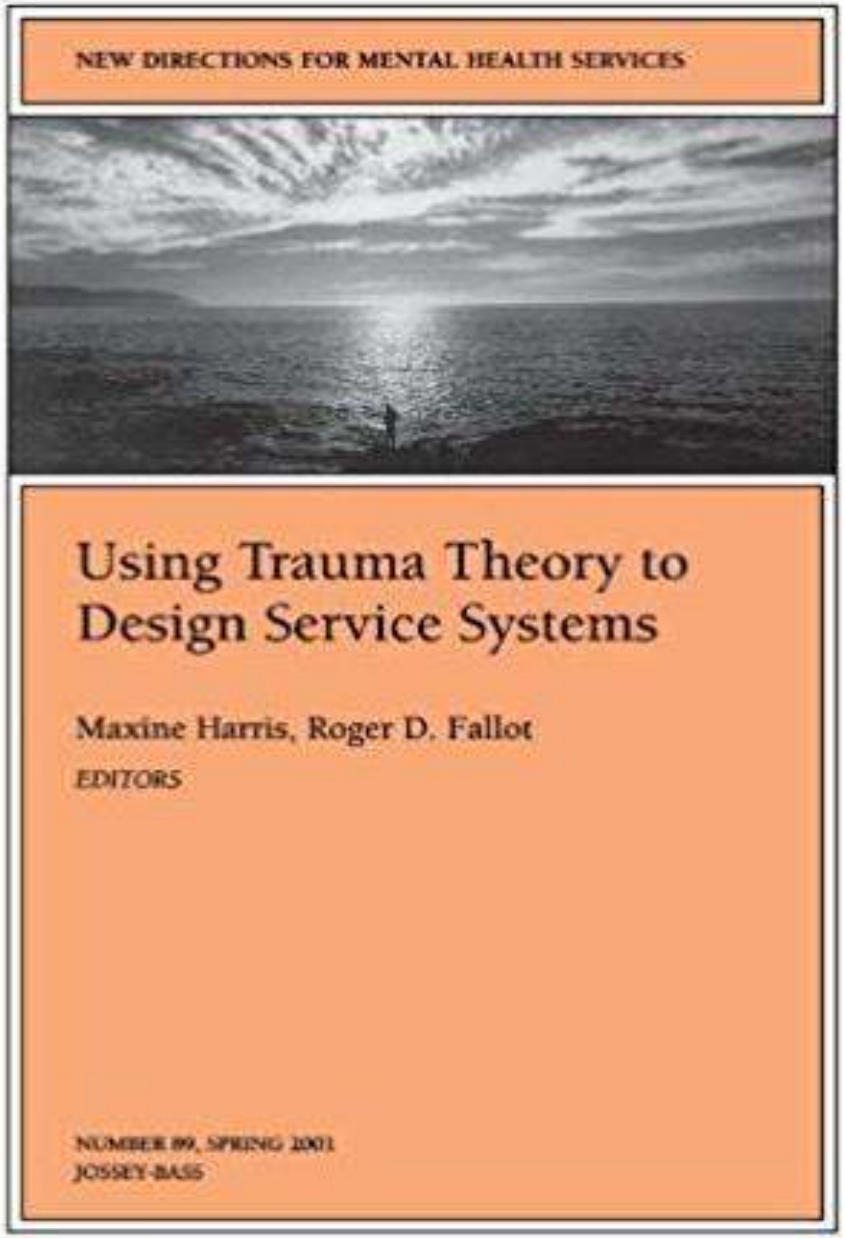
- **Service users are often exposed to potentially traumatic events / circumstances as a direct consequence of mental health difficulties or aspects of the treatment they receive:**

  - Hospitalisations
  - Frightening and sometimes terrifying “symptoms”
  - Coercive treatments
  - Loss of employment
  - Seclusion and restrain
  - Breakdowns in relationships and friendships
  - Side effects of medication
  - Risk of violent victimization and exploitation
  - Stigma

  … there is an accumulation of multiple, potentially traumatogenic and/or retraumatizing experiences that can aggravate existing mental health problems and thwart opportunities for long-term recovery

From "What's wrong with you?"...

...to "What happened to you?"



What is Trauma-Informed Care?

- The development of TIC can be traced to the USA and **Harris and Fallot (2001)** seminal text "Using Trauma Theory to Design Service Systems"

"…a system development model that is grounded in and directed by a complete understanding of how trauma exposure affects service user's neurological, biological, psychological and social development" ***Paterson, 2014***

Seeing mental health difficulties through the lens of trauma

- **TIC encourages systems to frame complex behaviour and mental health complains:**
- **They are NOT “ununderstandable” dysfunctional phenomena**
- **They are meaningful experiences that can be understood in terms of their function in helping survival and as a response to situational and relational triggers**

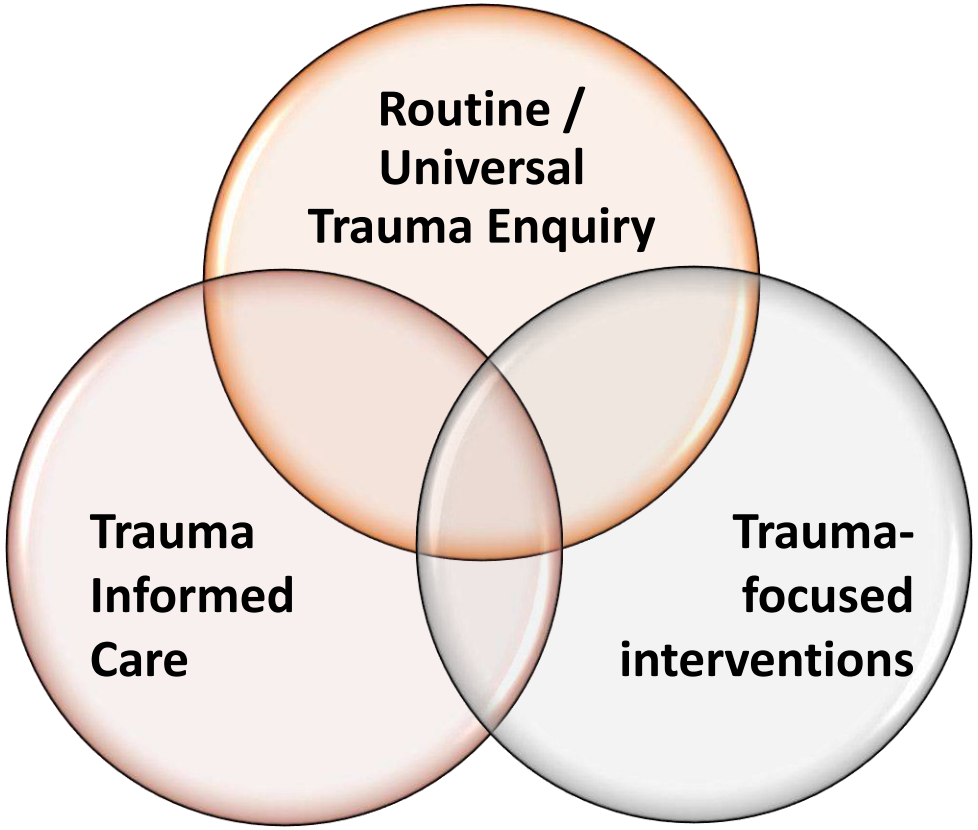
Trauma-Informed Care ≠ Trauma-Specific Care

- Common misconception that TIC is a trauma-focused intervention / a trauma-specific approach (i.e. directly treats trauma, its impact and associated distress)

- **TIC is a broader model of service delivery that CAN include trauma-specific components and interventions**

- **Most TIC proponents encourage universal trauma screening and assessment**

- **TIC employs a position of "universal precaution" (…treat all clients as if they have trauma)**



Common operating principles of TIC services

IMPLEMENTING TREATMENT PRACTICES THAT PRIORITISE SURVIVORS' NEEDS

1. Avoidance of practices that cause further disempowerment or re-traumatisation
2. Prioritise the promotion of a sense of safety
3. Adoption of holistic approaches
4. Educate clients about trauma and its impact
5. Help clients to identify triggers/cues
6. Encourage clients to develop self-soothing and coping skills
7. Trauma-focused or trauma-specific treatments may be used

Common operating principles of TIC services

CREATING OPTIMAL THERAPUTIC CONDITIONS

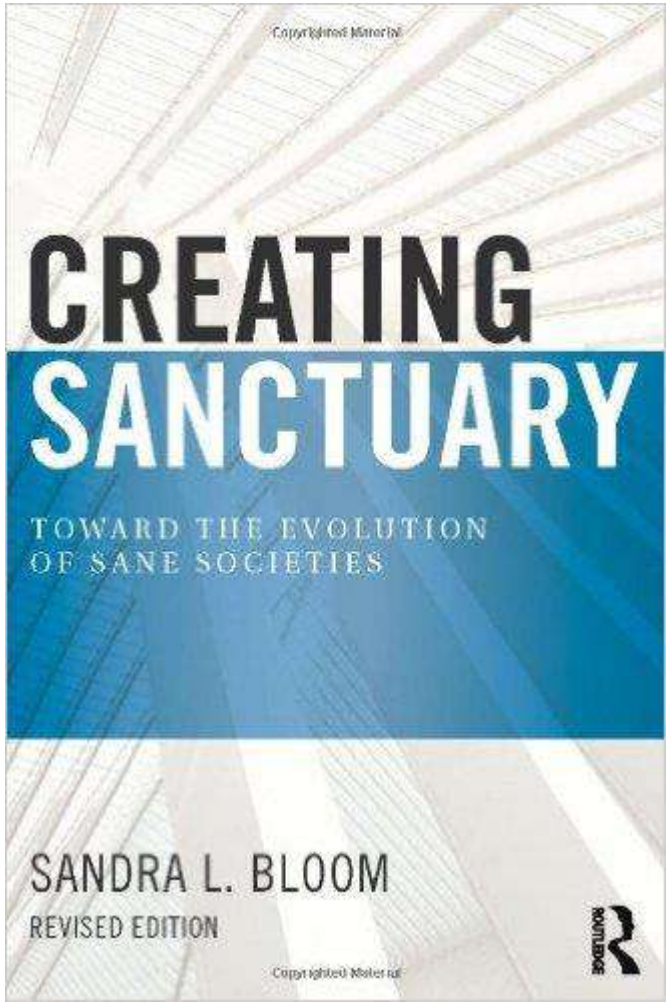
1. **Ensuring physically safe and calm therapeutic environments**
2. **Mutual decision-making and promotion of survivors' involvement**
3. **Being consistent in practice**

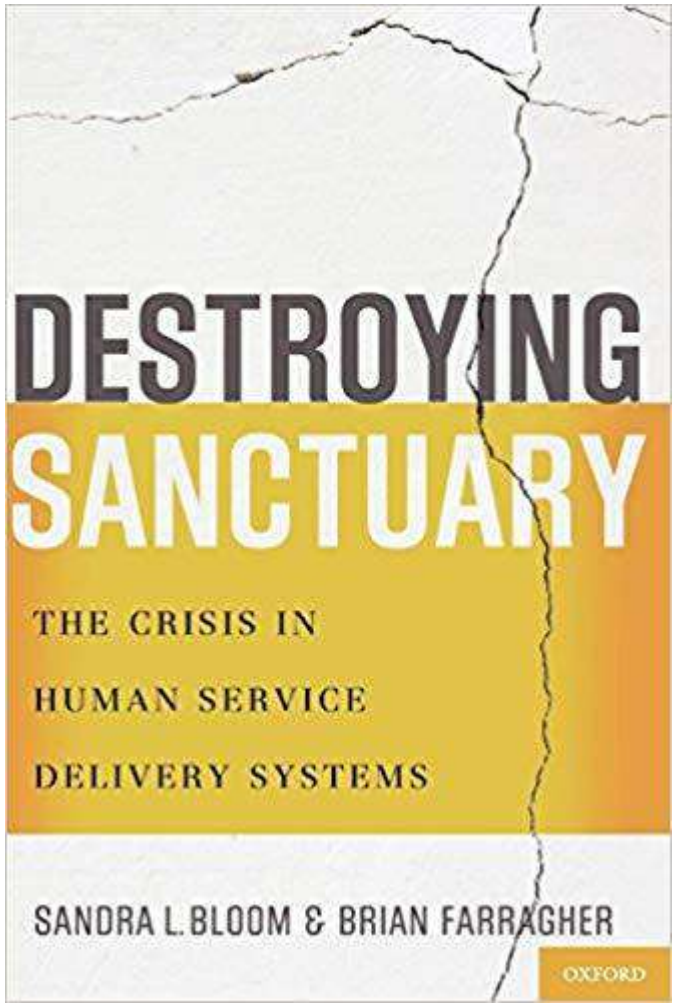
Common operating principles of TIC services

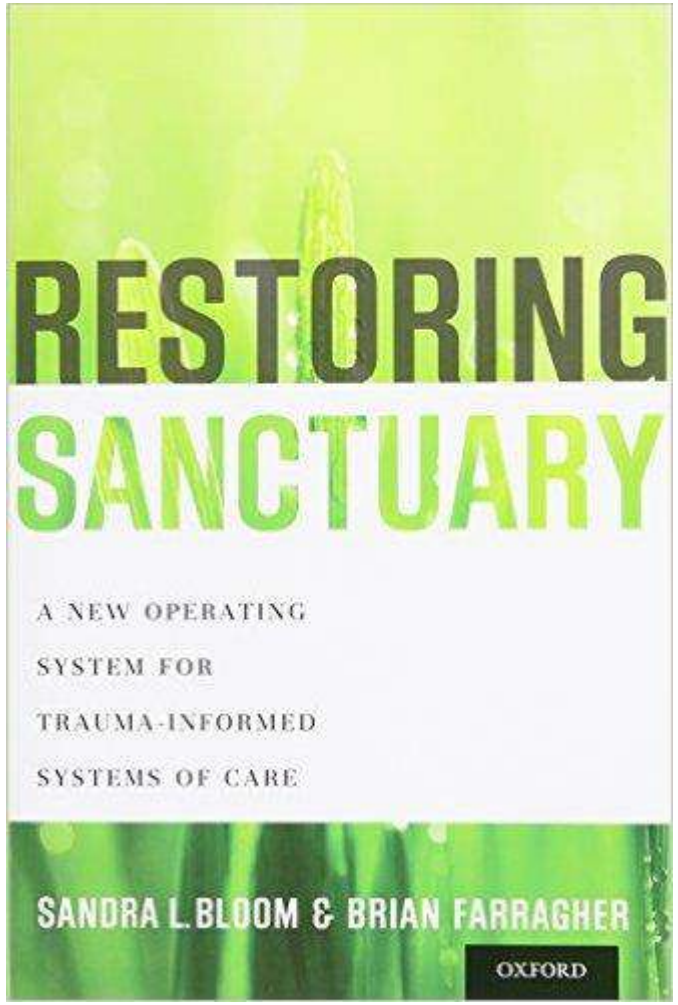
EDUCATE and SUPPORT STAFF

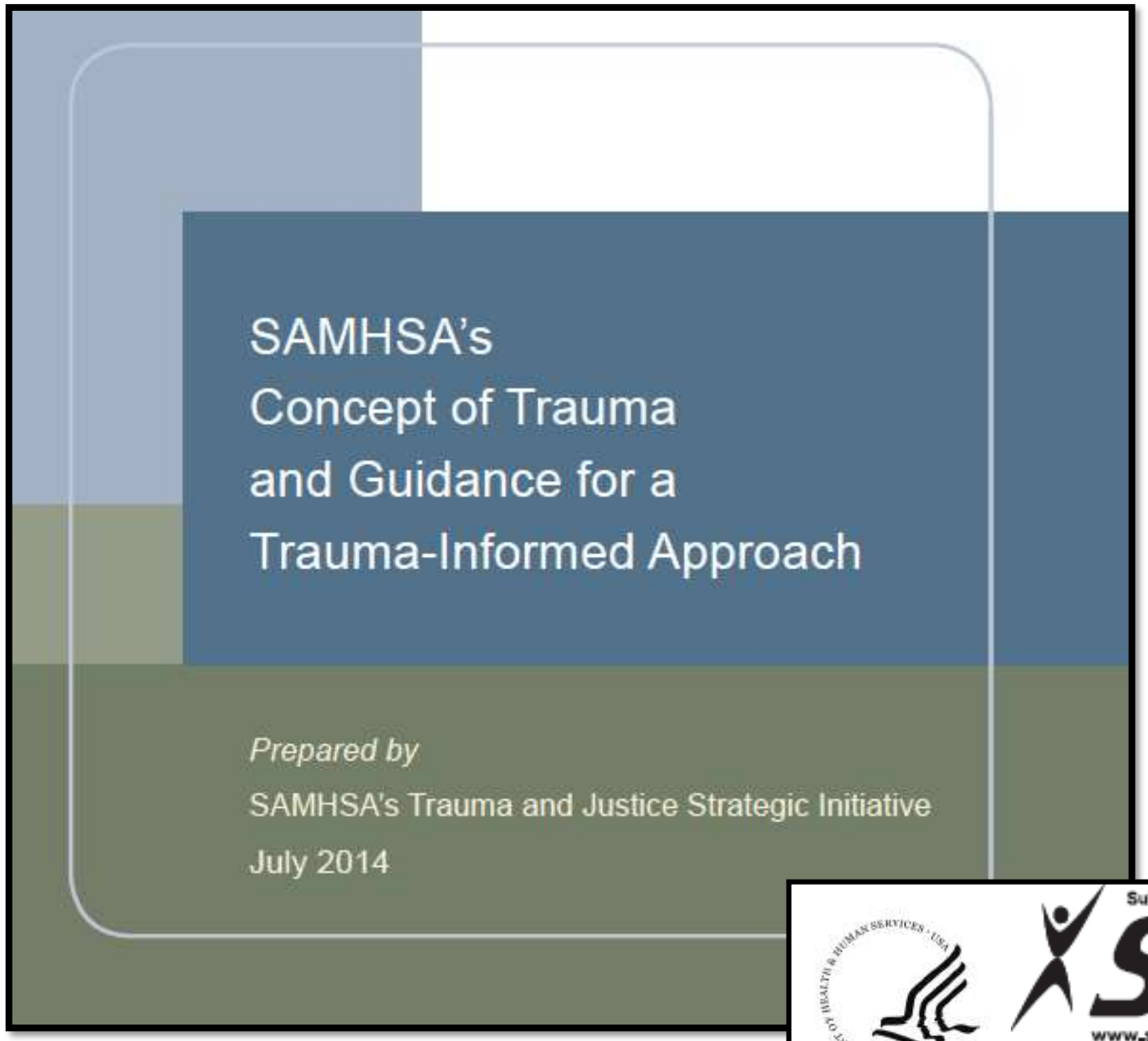
1. **Enable staff to understand mental health difficulties from a trauma perspective**
2. **Provide in-depth trauma education and training**
3. **Ongoing support from trauma-informed supervisors**
4. **Ensuring appropriate staff care to avoid burn-out and vicarious traumatization**

The Sanctuary model (Sandra Bloom)









US Department of Health and Human Services has included the implementation of trauma-informed approaches in mental health and substance misuse services amongst its strategic priorities (SAHMSA 2014)

asca
Adults Surviving Child Abuse

'THE LAST FRONTIER'

PRACTICE GUIDELINES FOR TREATMENT OF COMPLEX TRAUMA AND TRAUMA INFORMED CARE AND SERVICE DELIVERY

ADULTS SURVIVING CHILD ABUSE (ASCA)

Authors: Dr Cathy Kezelman and Dr Pam Stavropoulos

Funded by the Australian Government Department of Health and Ageing

Trauma and young people

Moving toward trauma-informed services and systems

PHOENIX AUSTRALIA | Centre for Posttraumatic Mental Health

Orygen
The National Centre of Excellence in Youth Mental Health

Increased interest in TIC in the UK (Sweeney et al. 2016)

Trauma-informed mental healthcare in the UK: what is it and how can we further its development?

Angela Sweeney, Sarah Clement, Beth Filson and Angela Kennedy

The authors' affiliations can be found at the end of this article.

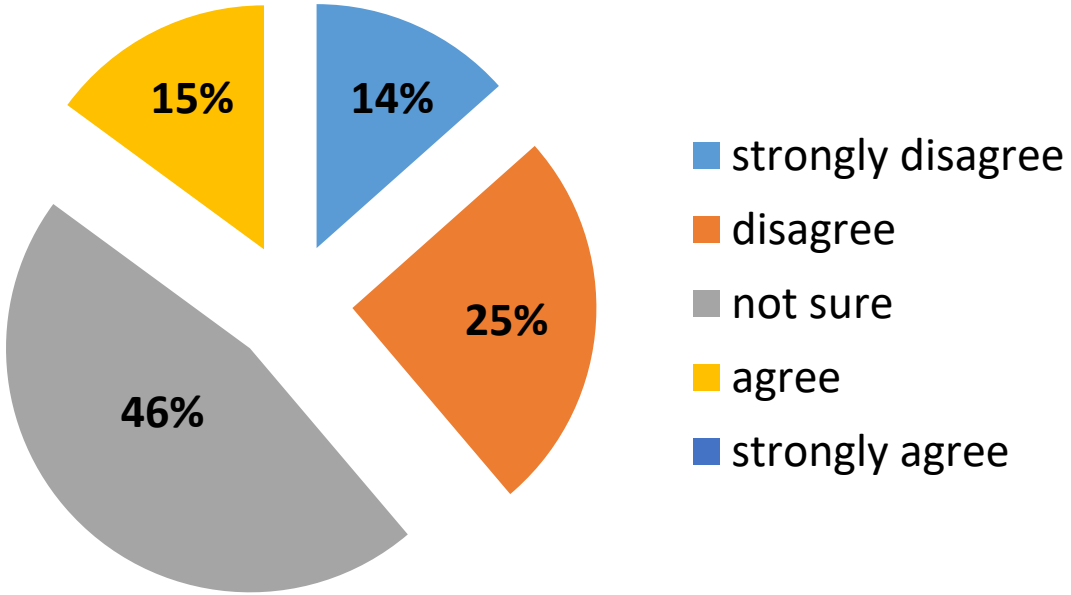
Abstract

Purpose – *The purpose of this paper is to describe and explain trauma-informed approaches (TIAs) to mental health. It outlines evidence on the link between trauma and mental health, explains the principles of TIAs and their application in mental health and explores the extent to which TIAs are impacting in the UK.*

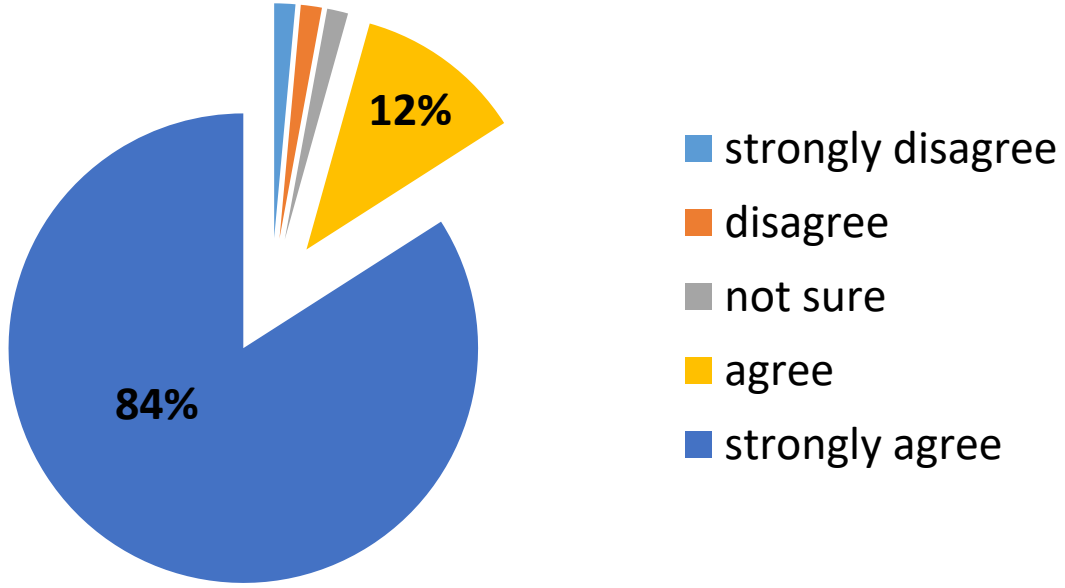
The first C-TRU and GMMH Psychological Forum conference

Views of (mostly psychology) NHS staff in the North West

Is your Trust "trauma-informed"?



Should your Trust do more to help services to become more trauma-informed?



Qualitative evaluation of TIC in a treatment and inpatient unit: The team

Poppy Harris – *Tees, Esk and Wear Valleys NHS Trust*

Dr Maria Haarmans - *Synergy Collaborative Centre on Inequalities in Severe Mental Health*

The setting

- Recently opened treatment & recovery inpatient unit for service users with severe mental health difficulties (mostly diagnoses of BPD)

- Aimed to comply fully with TIC principles:

I. Support service users in less restrictive ways (e.g. seclusion, over-reliance on medication for aggression, agitation and self-injury)

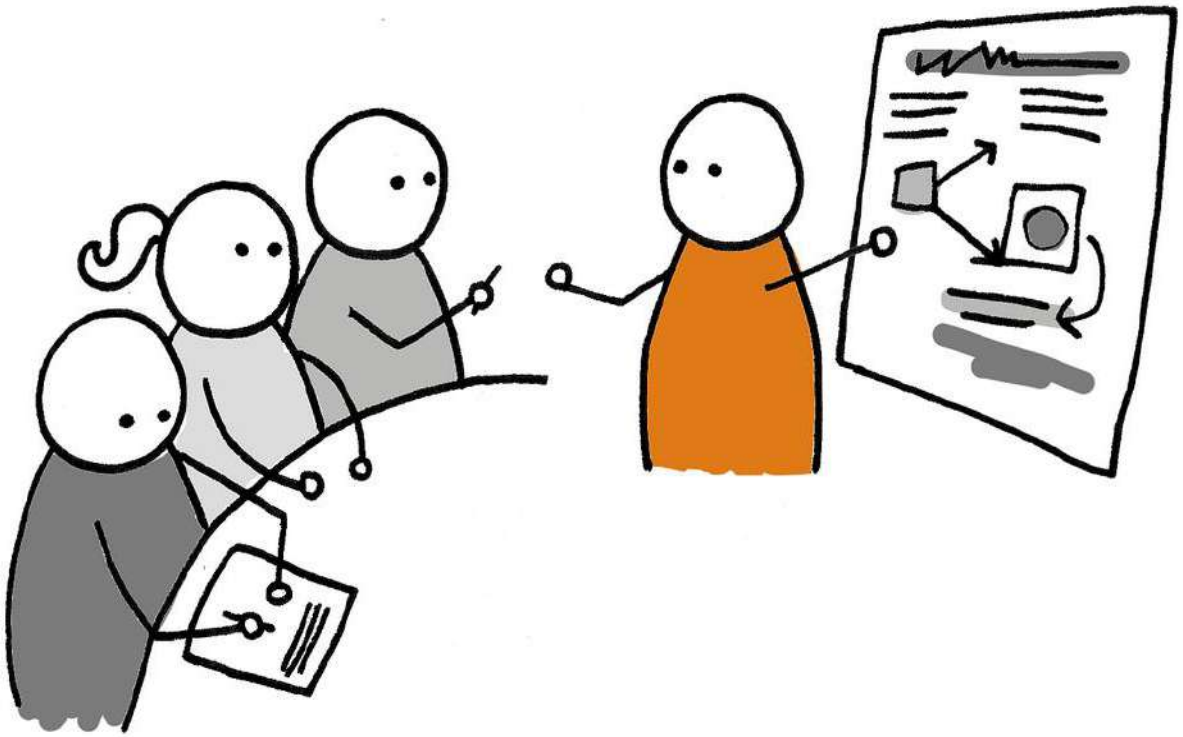
II. Improve service-user valued outcomes over time

III. Stabilised/reduced reliance on medications

IV. Improve community integration and independence

V. Reduce reliance on acute mental health services post-discharge

The training



- **Staff were purposely recruited to work on a trauma-informed inpatient unit**
- **3-days intensive training delivered by a TIC expert to provide staff with the conceptual and experiential foundations of TIC**
- **Attended by all permanent members of staff (not to agency staff)**

Bumpy start…

The service faced numerous organisational threats:

- **Difficulties in receiving commissioners' approvals and incongruences between hospital specifications and the needs of the service-users from a TIC perspective.**
- **Extensive restructuring, impacting on operational capacity and available resources**
- **Staff turnover - delays in recruiting new nurses and filling managerial positions.**
- **Key positions were covered by agency nurses or managers from other services within the organisation.**

The interviews

1. **To understand the barriers/challenges reported by healthcare staff regarding their attempt of embedding TIC in the unit**

2. **To understand the implications for future implementation of trauma-informed services in the UK.**

The participants

- **11 healthcare professionals who receive the TIC training and had worked at the unit for a minimum of 3 months**
- **Both current and former health professionals within the service**
- **Sampling reflected a range of professional disciplines, gender and current/former employment status at the unit**

Staff enthusiasm and initial training is not enough…

- **Participants spoke of their initial enthusiasm at the prospect of delivering innovative care that departed from the usual biomedical model approach**
- **Regarded the initial expert TIC training as empowering and inspiring**
- **Identified a range of organizational factors that thwarted the implementation of TIC…**
- *"Everyone was excited about this TIC model coming in, it was a new hospital where we could implement this new model and you know everyone was excited. But when it did started going a bit bumpy… you need support to get over it."* (P1)

1. Organizational ‘top down’ understanding and support
2. Consistent and stable staff team
3. Importance of ongoing training
4. Importance of staff care (clinical supervision and debriefing)
5. Ensure readiness before pressing ahead

1. ‘Top down’ understanding (and support) of TIC

- Participants spoke of the i**mportance of engaging with the top levels of management** within the organisation and service and that the **understanding of TIC and support from “very senior people” is essential** to its implementation

- Factors that prevented the longevity of TIC included:

1. General culture of the organisation, that remained ‘attached’ to a biomedical, restrictive and risk-averse way of working

2. Staff members in leadership positions failing to adopt ‘trauma lenses’ (service manager; psychiatrist) and drive implementation

1. ‘Top down’ understanding (and support) of TIC

“From an organisational perspective, there is an absolute need for a top down approach.”(P1)

“You need like-minded people leading it, and wanting to drive it; They [management] didn’t buy into it.” (P11)

“…If the person at the top of the pyramid, the psychiatrist, they guy who is making the decisions isn’t interested then it’s not a model that’s going to work is it […] definitely a TIC psychiatrist, that would have vastly helped.” (P5)

2. Consistent and stable staff team

- Participants spoke about the importance of **having an appropriately trained, consistent and stable team**

- Factors that contributed to difficulties in sustaining TIC included:

1. Lack of consistent manager, psychiatrists, and key staff members

2. Service relied heavily on (non TIC-trained) agency staff

2. Consistent and stable staff team

- *The problem is that we have had that much of a turnover in staff that most of them aren't even trauma-informed… I think everybody needs to be on board with it to know what and how it is working."* (P7)

- *They [agency staff] weren't trained in TIC. The residents were being held if they were hurting themselves…we were using medication to dampen people's emotions, we were, to me working in an old-fashioned medical model."* (P11)

3. Importance of ongoing training

- Participants highlighted the **importance of providing ongoing formal and informal TIC training opportunities**, and the need of ways to support staff and skill them further**.**

- *"I think the training was very good, I think it was very good, encouraging, very kind of empowering, but I think it stopped there. It needed to go on to something else next, that said right look, this is how it is implemented."* (P2)

4. Importance of staff care & support (supervision; debriefing)

- Proactive practices such as **clinical supervision and routine debriefing were seen as central to support staff's wellbeing and in turn implement TIC**

- Participants highlighted a pervasive lack of supervision/debriefing, causing:

1. Lack of a sense of "safety" and support
2. Extreme stress and burn-out in staff
3. Lack of confidence in implementing TIC
4. Reverting to "same old ways" of working

4. Importance of staff care & support (supervision; debriefing)

"If your staff team don't feel safe the residents certainly aren't" (P7).

"It reverts back to this model of right we will do your obs, we do your medication because that is all the staff can manage. Yeah so I think it's about allowing the staff to care for themselves so that they can then care for the patient, but yeah that is quite a lot of investment from a company." (P2)

5. Ensure readiness before pressing ahead

- **Introducing TIC too soon in a service might paradoxically work against its implementation**
- **Give the service the opportunity to resolve teething problems in operational procedures before introducing TIC**
- *"…ensure the fundamentals of high-quality service provision are in place, enabled systemically, and functioning well before attempting to embed an innovative model of care such as TIC…" (TIC trainer)*

The C-TRU Journal Club

[COMPLEX TRAUMA & RESILIENCE UNIT]

C-TRU Journal Club

1ST FRIDAY OF EVERY MONTH
1PM - 3PM
ROOM 2.30, ZOCHONIS

What is C-TRU?

C-TRU is a collaboration between Greater Manchester Mental Health NHS Foundation Trust and The University of Manchester. The unit aims to support research and innovation in the assessment and treatment of complex trauma-related presentations and the promotion of resilience across severe mental health difficulties.

Aims of C-TRU journal club:

- Stimulate debate, and improved understanding of new research and methodologies in the area of trauma and resilience
- Identify and discuss interesting findings in the area of trauma and resilience with the view of informing future research directions

For more information or queries, please contact:
carolina.campodonico@manchester.ac.uk **or**
rebecca.white@manchester.ac.uk

NHS Greater Manchester Mental Health NHS Foundation Trust

Thank you!

C-TRU

For more information about C-TRU or if you have any questions please get in touch: Filippo.Varese@manchester.ac.uk

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