GUIDANCE FOR THE HEALTH SECTOR

Creating ACE-informed places: Promoting a whole systems approach to tackling adverse childhood experiences in local communities

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INTRODUCTION

ACEs can have a negative impact on development in childhood which in turn can give rise to harmful behaviours, social issues and health problems in adulthood. There is growing research demonstrating that ACEs and wider adversity including poverty, discrimination, lack of economic opportunity and social connectedness can negatively affect lifelong mental and physical health.

Healthcare professionals are ideally placed to identify and support vulnerable children and families, and provide the links to wider support services. By looking through a trauma lens, recognising the signs and symptoms and realising the widespread impact it can have on an individual's life, healthcare professionals can develop a better understanding of the root causes of behaviour and provide the most appropriate care and support, particularly for those with mental health issues, among whom ACE exposure is more pervasive.

The purpose of this briefing is to explore how trauma-informed approaches have already been put into practice across the UK, share learning and reflections on the guiding principles for implementing such approaches and provide good practice examples.

ABOUT THIS PROJECT

The purpose of this project is to explore how trauma-informed approaches have been put into practice within the UK across four different sectors: education, health, housing and policing. This briefing is focused on health and is intended to support leaders and practitioners nationally and locally concerned with improving outcomes for children and their families who are at greater risk of experiencing physical or emotional harm and supporting those who have already experienced adversity/trauma. This briefing is specifically aimed at those who are relatively new to trauma-informed practice.

A total of 72 senior practitioners with experience of implementing trauma-informed practice have contributed to our briefings across all four sectors (see Appendix B for a full list). Through these conversations, we have gathered a range of insights into what good trauma-informed approaches and results look like. In Appendix A, we cover the benefits of a multi-agency approach and cite case studies of where this has been achieved successfully.

Feedback from interviewees and the outcomes we have seen across all four sectors indicate that trauma-informed approaches could have a profound impact on society when applied as part of a whole-system effort to tackle adverse-childhood experiences (ACEs) by engaging services across the life course. We hope this series inspires further interest in this area and that more services witness the levels of success our interviewees have achieved.

Understanding Trauma and ACEs

We all face emotionally challenging situations during our childhood and adolescence. It is a normal part of growing up. However, many children grow up in environments – or have experiences – that go beyond this and can have a traumatic and long-lasting impact on their development, health and life chances. All of us will know someone who has been affected by trauma.

The term Adverse Childhood Experiences (ACEs) was popularised following a landmark research study conducted by Kaiser Permanente and the Centres for Disease Control and Prevention between 1995 and 1997[1]. The study referred to a specific set of adverse experiences in childhood, which included various forms of abuse, neglect, witnessing or otherwise experiencing violence, having one's parents separate and living with parents who are affected by mental illness or addiction.

The ten markers of adversity identified in the original study were deliberately limited to direct harm and factors within the home. They therefore do not capture all forms of adversity experienced in childhood that might be expected to have a similar long-term impact on outcomes. Such circumstances include poverty, discrimination and prejudice, bereavement, bullying, community violence and gang membership. In addition to increasing the risk of ACEs, these negative circumstances contribute to poor outcomes independently of the original ten ACEs[2].

For the purpose of this briefing, the term 'ACEs' will be used to refer to the specific childhood events outlined in the original CDC-Kaiser Permanente study, while the term 'adversity' will be used more broadly to refer to potentially harmful experiences.

> "The concept of ACEs must not limit the conversation to the 10 experiences but open the door to discussions about all kinds of childhood adversity and their impact."

TRAUMA

Trauma occurs when an incident, series of incidents or persistent environment leaves a person feeling so threatened or overwhelmed it leaves a long-lasting impact.

Adverse Childhood Experinces (ACEs)

Highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity.

What kind of experiences are adverse?

Understanding Trauma and ACEs

Childhood adversity directly affects the young person and their environment, and can require significant social, emotional, neurobiological, psychological and/or behavioural adaptation.

The impact of trauma can span from childhood to adulthood, disrupting cognitive, social, emotional and behavioural development. Repeated exposure to traumatic experiences can result in toxic stress, a prolonged activation of stress responses in the body that can cause excessive physical and behavioural reactions[3]. Experiencing adversity in childhood can also create hyperarousal, which adversely changes a young person's ability to regulate their emotions, as well as hypoarousal[45]. Trauma overwhelms a person's resources for coping and impacts upon the person's sense of safety, ability to self-regulate, sense of self, perception of control and interpersonal relationships.

Being exposed to ACEs in childhood can increase the risk of developing health-harming behaviours including smoking, problematic alcohol use and illicit drug use.[67] These behaviours can lead to an increased risk of poor physical and mental health later in life (including cancer, heart disease, diabetes, depression and anxiety) and ultimately early death.[89] ACEs have also been linked to increased use of healthcare resources. For example, a recent study based on household surveys of adult resident in Wales and England found that exposure to multiple ACEs was associated with increased use of primary, emergency and in-patient care.[10]

Furthermore, adverse experiences in childhood are associated with negative social outcomes, such as low levels of education, poor employment prospects, deprivation and involvement in antisocial and criminal behaviour.[1112]

Adaptions are children and young people's attempts to:

1. **Survive** in their immediate environment (including family, peer group, schools and local community)

2. **Establish** a sense of control or safety

3. **Find** ways of mitigating or tolerating the adversity by using the environmental, social and psychological resources available to them

4. **Make** sense of their experiences

Resilience

However, not all children who experience trauma will have negative outcomes.

Whether adverse experiences lead to trauma is dependent on a range of factors wedded to the context of the situation, including how vulnerable the person perceives themselves to be at the time, whether they felt supported by others during the incident or aftermath, and how much control they believed they had over the proceedings.

One factor that plays a large part in the prevention of trauma, as well as the mitigation of its impact and a person's ability to heal from it, is emotional resilience. This describes a collection of qualities that enable a person to feel they are capable, in control and deserving regardless of what life throws at them. Like trauma, resilience is developed through life experiences, and is influenced by the support available to that person.

Throughout the life course, individuals can be supported and empowered to build resilience and develop the skills and attributes needed to face the challenges in front of them. Resilience can be enhanced by promoting protective factors including having a caring and supportive relationship with at least one adult, belonging to a united group or community, having the opportunity for work or activity that offers a sense of purpose, and having the skills to regulate your emotions and behaviours in order to overcome stressful circumstances.

Resilience is a dynamic process, rather than a fixed trait. It can increase or decrease depending on how available these resilience assets are in someone's current context. An individual is never too old

What are trauma-informed approaches?

To be trauma-informed is for a person to learn how trauma can be at the root of behaviour and to bring this understanding to the forefront of their work every day, conducting themselves in a manner that enables those who have experienced trauma to cope as best as possible with its impact. The thinking is often summarised as switching from saying "What's wrong with you?" to asking, "What happened to you?" Supporting staff wellbeing is also an essential part of embedding trauma-informed practice. This involves recognising that staff may have their own trauma and/or experience vicarious trauma through working with those affected by trauma.

Various terms are sometimes used to describe the degree to which a person has been trained in this approach. For instance, Scotland's National Trauma Training Framework begins with trauma-informed and escalates to trauma-skilled, trauma-enhanced and trauma-specialist. Terms such as trauma-aware are also sometimes used as a tier below trauma-informed. This briefing is largely focused on non-specialist practitioners who are trained to a trauma-informed level, though we will refer to lower or higher levels where relevant.

It advises that you follow the four R's:

- Realise the widespread impact of trauma and understand potential paths for recovery
- Recognise the signs and symptoms of trauma in clients, families, staff and others involved with the system
- Respond by fully integrating knowledge about trauma into policies, procedures and practices;
- seek to actively resist re-traumatisation of both service users and staff

What are trauma-informed approaches?

As many of this project's interviewees also advised, SAMHSA's framework recommends implementing this across the entirety of a service, including the following domains:

- **Governance, management and leadership** – the culture of an organisation and how leadership supports the adoption of a trauma-informed approach (eg by modelling it themselves)
- **Policy** –the written policies and protocols that can implement the recognition of trauma and promote recovery and wellbeing
- **Physical environment** – the creation of a physical environment which promotes a sense of safety amongst service users and staff and promotes collaboration
- **Engagement and involvement** – transparency and trust built with service users, as well as acknowledging the expertise of those with lived experience
- **Cross-sector collaboration** – strengthening connections with community providers and referral pathways
- **Screening, assessment, treatment services** – treatment plans which give power and choice to the service user and minimise feelings of shame and fear
- **Training and workforce development** – supporting staff emotionally (eg through peer support and supervision) as well as training and educating them on the impact of trauma and safe strategies to address it
- **Progress monitoring and quality assurance** – actively processing feedback from staff and service users and ensuring mechanisms for monitoring quality are in place
- **Financing** - appropriate funding for trauma-informed approaches (eg staff training on trauma and the establishment of peer support) and the creating of a safe environment
- **Evaluation** – appropriate methods of measuring/assessing the success of implementing trauma-informed approaches

SAMHSA's framework includes six principles for trauma-informed practice which encompass the following:

1. Safety
2. Trustworthiness & transparency
3. Peer support
4. Collaboration & mutuality
5. Empowerment, voice and choice
6. Understanding cultural, historical & gender issues

Though other frameworks don't contradict these, they sometimes add in, or exchange these for other complementary options, for instance practising care holistically, showing respect, being strengths-based, showing compassion and the importance of relationship-building, among others. Collectively, these principles can lead anyone to live a healthier, happier life regardless of whether they have experienced trauma, though the impact can be particularly beneficial for those who have.

Putting trauma informed approaches into practice

We interviewed professionals working in a range of health service roles to find out what putting trauma-informed approaches into practice means to them. Though it may not be the most appropriate term in each instance, to ensure consistency we've used the word "patient" whenever referring to the person the practitioner is working with. The key messages below are not listed in any particular order.

KEY MESSAGE 1:

Wherever appropriate, actively engage with patients on an emotional level, including building authentic, meaningful relationships where time permits. View these as a means to enable better communication with patients and, through this, as a contribution towards their healing process.

Invest time in relationship-building: Though the importance of a high-quality practitioner-patient relationship is widely appreciated already, it's worth emphasising here as relationship-building is a key aspect of trauma-informed practice that enhances your ability to implement all other elements. For instance, many interviewees felt that a strong relationship provided the ideal conditions within which to enquire into past adversities and talk about their impact.

Break down 'them and us' barriers: Springbank Ward, a specialist unit for patients with Borderline Personality Disorder (BPD), provides a good example of a service that has developed a communal atmosphere where staff and patients work together as a team. One interviewee said that people with BPD often carry the stigma of "revolving door patients", whereas Springbank sees them as people with lives to plan for and look forward to. The connections are so strong that the unit holds weekly sessions where ex-patients return to have tea with staff.

Animal-human relations can also have a calming effect: One example of an institute that has demonstrated this over many years is the State Hospital, a high-security forensic mental health hospital in Scotland. Its Garden and Animal Therapy Centre houses over 120 birds and animals that patients work alongside staff to feed, clean and play with. A senior charge nurse said animal-assisted activities are beneficial in developing a therapeutic relationship. She said they can divert patients from psychotic symptoms, improve their communication skills, give them a sense of responsibility and leave them feeling more motivated because of it. They can also help with emotional regulation, as she said patients appear calmer while working with them and report that it improves their feelings of well-being. She noted, however, that patients are assessed prior to being allowed in and that facilitation by skilled staff is still key. Contrary to some people's expectations, she hasn't come across a single incident of aggression towards the animals in 20 years of service.

KEY MESSAGE 2:

Routinely consider the far-reaching and diverse impact psychological trauma can have when seeking to unearth the root causes of presenting behaviour and symptoms. Allow patients to play an active role in this process, with an emphasis on a shared understanding.

Consider the importance of trauma for a wider range of symptoms: Research increasingly points to a vast range of health outcomes that are frequently either caused or influenced by trauma. A trauma-informed approach doesn't negate other possible causes, but does involve considering this as a possibility worth exploring for cases where you might otherwise have not done so. For example, one interviewee who works in NHS weight management said that whereas many programmes in their field focus on lifestyle changes, theirs focuses on historical and current adversities, as well as present emotional states. For them, it's about helping people negotiate what their body's telling them, whether to trust that and how to work with it. Because of this, their focus is not geared to weight loss, which can be re-traumatising, but to health improvements, helping patients with the concerns that lie behind their desire for weight loss, eg not to be judged.

Routinely explore the root causes of challenging or unusual behaviour with potential trauma in mind: Here we are not referring to formal processes (see Section on Routine Enquiry for ACEs), but to everyday interactions staff have with patients. Alongside being useful information-gathering exercises, these conversations can also be therapeutic experiences for the patients involved.

Allow patients to contribute to a shared understanding: One interviewee said the aim should be to listen to patients and build a shared understanding of complex difficulties with them, all of which also gives you a better chance of finding an effective solution. Others shared similar views, with one interviewee saying it's important to get patients' perspectives on the reasons behind their behaviour rather than dismissing them by saying "it's because they are mentally ill".

Share this knowledge with patients: An active effort to inform patients about trauma and its impact can lead to more effective self-help on their part. One interviewee cited the hypothetical example of a woman who is offered routine enquiry, recognises the significant adversity she faced as a child through it, realises that she doesn't want the same for her children and requests help to parent differently. She then feels more motivated to attend parenting classes than she would have been had she been prescribed them without the initial exchange having occurred.

Use language that's accessible to everyone: The relative simplicity of trauma-informed and ACEs frameworks can enable staff trained in them, to engage in basic discussions and decisions surrounding trauma that might have previously been the domain of specialists alone. This applies equally to staff being able to identify their own emotions, with one interviewee saying the training can help them recognise what they are ignoring or trying to shut down and when they themselves are in a triggered state.

Avoid deterministic applications of the ACEs framework: Though the ACEs framework has its benefits, it can create false impressions if it is applied as a deterministic tool. Be careful not to fall into traps such as, for instance, assuming that an adult with five ACEs must have issues of some kind. Instead, bear in mind the impact these ACEs may have had while recognising that wider factors, eg their levels of emotional resilience, will also have influenced this.

KEY MESSAGE 3:

With an understanding of psychological trauma and its impact in mind, review processes and practices to see whether they can be amended to improve patients' ability to feel comfortable discussing potentially traumatic experiences and to remain calm in general. This includes reviewing processes for responding to challenging behaviour, with an emphasis on de-escalation and the avoidance of re-traumatisation.

Enable patients to feel comfortable opening up about past adversities: This is partly about the practitioner actively asking questions about such adversities (which feedback from our interviewees and recent pilots shows either is not the case in many services or is only done to a limited extent), and also about ensuring they are delivered in a way that inspires trust. The latter is influenced not just by the way each interaction is conducted, but by the wider environment staff create at the service. Springbank Ward provides a good example of what a trauma-informed practice can look like in this respect, with one interviewee describing the culture as being hands-on, on first name terms with patients and with the consultant always at the end of the phone when staff need support.

Review how approaches could be adapted to help patients stay calm: Though this is standard practice for many health workers already, a greater understanding of trauma can enable staff to consider further factors they may not have done beforehand. One interviewee cited as an example, staff bearing potential triggers for sexual violence in mind when a woman attends for a smear, such as not forcing her legs apart or saying the words "just relax". Small, yet meaningful actions can also have a cumulative impact, including ones that are not directly trauma related. For instance, one interviewee cited staff bringing patients their medication in the morning alongside a cup of tea. The initiative Star Wards share similar ideas on how to improve the patient experience on wards.

Develop approaches towards challenging behaviour that emphasise de-escalation and avoid re-traumatisation: It is helpful to develop a better understanding of the roots of such behaviour so that it can be interpreted in a less provocative manner, for instance through realising that the anger deep down may not be aimed at you. This can calm the urge to react in a way that might escalate the situation, while providing staff with a language to interpret what lies behind the behaviour. It should also result in more frequent rejection of traditional responses that may cause someone to relive a traumatic experience, for instance by restraining someone's ability to move. One interviewee said that beginning with a dialogue about managing their thoughts and behaviour reduces the chances of restriction being necessary.

Apply this thinking to help staff remain calm too: This includes not just via supervision, but also group discussions, de-briefs and a general culture of reflection and support. One interviewee noted that being able to understand their internal emotions is a particular challenge for junior staff. Aside from the benefits a supportive atmosphere provides for staff well-being, it is also key to helping them remain calm with patients. Interviewees emphasised that staff members' listening skills are often better when their stress levels are low.

KEY MESSAGE 4:

Where appropriate, enable patients to have a greater sense of control over their care and health. This involves allowing them to feel respected and, where psychological trauma is relevant, appreciating how willing most are to discuss topics that may have previously been seen as too personal or otherwise undesirable.

Promote self-awareness and self-care among patients: Trauma-informed practice in this sense is not necessarily about trying to solve a person's trauma, or even getting them to disclose it, but about validating their experience and helping them understand it. One interviewee said it is also about reframing an intervention around how they can look after themselves.

Give patients a sense of control over their care and lives: One interviewee phrased this as "work[ing] alongside them, not telling them what to do". Sharing an understanding of how trauma may have affected them in their life can play a part in empowering patients to take their recovery into their own hands. By contrast, when discussing interventions for parents and families one interviewee said they believe many don't turn up because it was prescribed to them rather than them determining they needed it.

Provide patients with a sense of autonomy: Psychiatric consultant Dr Jorge Zimbron said when patients are treated as if they don't have capacity to make their own decisions, it can lead them to question their self-worth and sense of who they are. He has introduced a culture at Springbank Ward that has virtually ended restraints and coercive treatment, which can retraumatise patients, and left them free to decide whether they come or go. Glass items, usually replaced with plastic, are kept on-site so patients can learn how to use them safely. There are no rules, just a requirement to stick to the values of respect, recovery and safety. Dr Zimbron said around two-thirds of BPD patients will benefit from this greater autonomy and finish the programme. The rest may leave, for instance, because they do not want to be there or prefer a different style of treatment.

Appreciate patients' willingness to talk about these issues: Speaking about routine enquiry into ACEs, one interviewee said the only two complaints he can remember patients sharing about it referred to why it had taken so long for the service to ask them. Others said that fears over patients giving negative reactions when topics such as trauma are raised aren't realised in practice, though approaching the matter sensitively and allowing people the option not to disclose were strongly emphasised. One described the sense of relief some feel at having discussed it openly, saying it leaves them no longer feeling so alone.

KEY MESSAGE 5:

Develop a culture where mental health concerns among staff are widely understood and taken seriously. This includes prioritising early intervention and enabling staff to feel respected by colleagues and able to speak openly.

Actively promote a serious attitude towards mental health: This includes taking steps to improve staff members' mental health on a regular basis. One interviewee said much of this revolved around routinely reminding staff to look after themselves. To build a culture where this is taken seriously by everyone, it helps if each staff member has sought to recognise their own mental health needs as this can lead to them viewing such concerns as a higher priority than they might have been if left unaddressed.

Intervene early when staff begin to struggle: This involves being able to recognise the signs of deteriorating mental health and acting promptly before issues manifest to the point where the staff member can no longer cope. Supervision plays a part in this, as does a culture where staff actively pay attention to mental health on a regular basis and feel comfortable speaking out.

GP surgeries

A growing body of research shows an increasingly long list of symptoms, behaviours and conditions GPs encounter in patients where links to ACEs have been demonstrated. The Centre for Disease Control and Prevention (CDC) in the USA has produced a list of publications that demonstrate links to the following outcomes, among others:

- **Diseases:** Cancer, chronic lung disease, diabetes, ischemic heart disease, liver disease and sexually-transmitted diseases
- **Physical health problems:** Sleep disturbances, severe obesity, skeletal fractures and strokes
- **Mental health issues:** Behavioural problems, depression, hallucinations, high stress rates, suicide attempts and uncontrollable anger
- **Substance use, addiction and initiation:** Alcohol, drugs and smoking

Following the initial ACE study (1998), co-author Dr Vincent Felitti expanded the Review of Systems (ROS) and Past History questionnaire his staff used with patients at the Kaiser Permanente Department of Preventative Medicine in San Diego to include questions about potentially traumatising adversities such as combat experience, family members being murdered and suicide attempts. An independent analysis of 120,000 patient evaluations over two years found that doctor office visits dropped by 35% in the year subsequent to evaluation compared to the year before. Emergency Department visits and hospitalisations also decreased by 11% and 3% respectively.

Health visiting

For many health visitors, trauma-informed practice would not involve a complete transformation of their style of working, but instead an evolution of what they already do. Many are already expected to see each child within the context of their family and wider community, with an awareness of how certain conditions and experiences may affect parenting capacity. They ask about certain adversities (if not all) during the ante-natal period, as well as speak openly to parents about their experience of being parented and other personal matters. Closely related concepts, such as attachment theory, are already widely known and integrated. In some cases, similar processes have been around for a long time, though perhaps labelled in a different way.

So what does trauma-informed practice offer that is different, or otherwise enhanced? The following benefits raised during our interviews help to answer this question. We should note that there will be some health visiting practitioners or teams who already adhere to some, if not all, of these practices.

- Stronger emphasis on relationship-building and collaborative working: Informed by the science of resilience and attachment theory, it places an even stronger emphasis on the importance of trusting, authentic relationships as a means of enabling parents to feel supported and, where relevant, comfortable opening up about past or present adversities. This also feeds into a stronger focus on collaboratively reaching a shared understanding of their situation, as well as jointly constructing solutions to issues.

- Improved skills for stress regulation and behaviour management: It enables practitioners to deal more effectively with stressful situations and parents through better-informed self-care and the calming impact a greater understanding of the roots of challenging behaviour can bring. For instance, whenever the latter arises, they instinctively ask themselves 'what happened to make them act this way?' rather than 'what's wrong with them?'
- More likely to enquire into past experiences and their potential impact: The potential for current behaviours and circumstances to be rooted in past experiences, and how this may affect parenting styles if left unaddressed, is considered on a regular basis. This understanding is also applied when deciphering what signs to pick up on, what questions to ask and how to ask them. Crucially, it provides the confidence to do all of this.
- Greater understanding of emotional development: As well as expanding their knowledge around infant brain development and how to help parents build their own resilience, this also includes staff learning more about how parents' mental health concerns, as well as other personal and household issues, might affect their children.

Naturally, any improvements in staff capacity will make it easier for practitioners to adopt any or all of these approaches to a greater extent than they already do. If that's not possible, then trauma-informed practice and the knowledge that underpins it can enable staff to direct and focus the time they have more meaningfully for the parents they support.

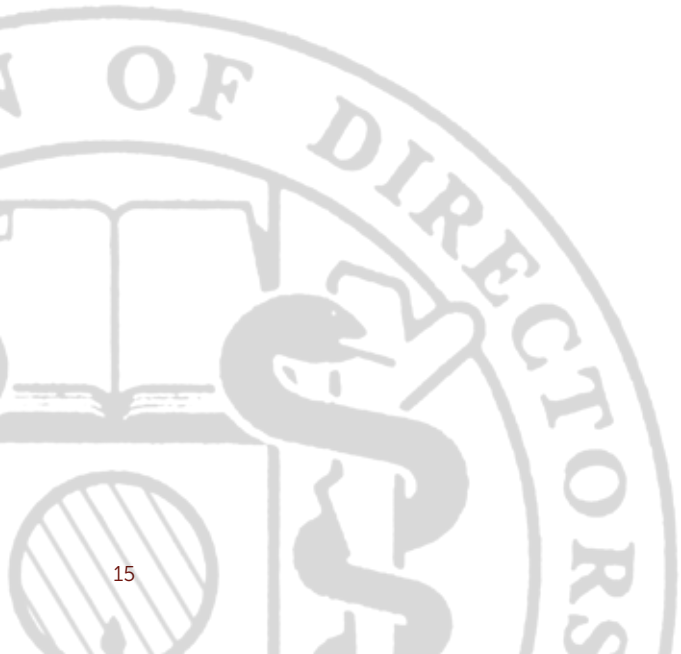
Accident and Emergency (A&E)

Accident and Emergency (A&E) wards witness a stream of patients every week who have experienced incidents or live in circumstances that have the potential to cause trauma, or otherwise exacerbate it. The same could be said for various other issues including poverty, housing problems, addiction and homelessness. Navigator, a scheme operating since 2015 that is run by Medics Against Violence alongside partners, including the Scottish Violence Reduction Unit, provides an example of what a trauma-informed initiative in this environment can look like.

Located at 7 hospitals across Scotland as of September 2020, each hospital has two 'navigators' who work in the emergency department most weekend evenings. These navigators approach people who have been affected by violence – including gang involvement, domestic abuse survivors and those who have self-harmed – at a moment when they're likely to be reflecting on what led them to this point and more open than usual to behavioural change, as well as the idea of receiving help to manage it. Visiting each patient numerous times, in the ward and outside of it, navigators don't aim to transform them overnight, but to build a connection and use that to gradually nudge them onto a more positive path. Seen as distinct from traditional authority figures such as the police and medical professionals – and therefore, to some, more trustworthy – they also help to diffuse challenging situations when they occur and to calm patients in crisis to allow for medical treatment to be provided.

When not at A&E departments, navigators continue to support patients in their community by attending to a range of complex social issues spanning housing problems, benefit claims, employment opportunities and help to address addiction or domestic abuse, using their connections with a wide range of external services when doing so. In one example, a navigator helped his recipient and his family move to a different part of the city to escape possible revenge attacks by gang rivals and accompanied him on his first visit to Alcoholics Anonymous. At other times, they are there to provide nothing more than company and a person to talk to. Their engagement can provide people who might otherwise feel trapped in their current situation and lifestyle with a route out that they may not have pursued of their own accord.

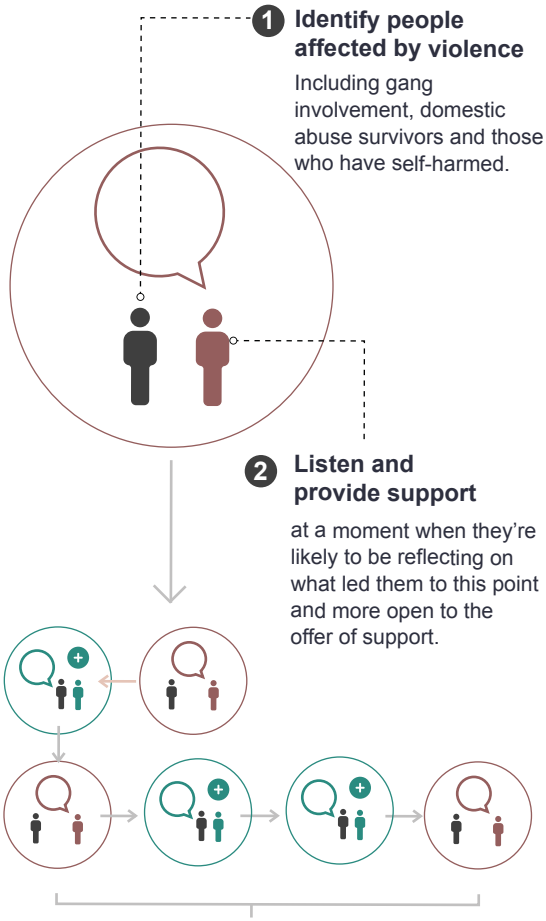
This emphasis on getting to the root of issues, treating people with respect, having hope for them, prioritising the establishment of meaningful relationships, building trust and, where possible, empathising with their situation closely reflects the principles that underpin trauma-informed practice. Through this supportive framework, the scheme had helped more than 2,500 people as of August 2020. Between 65% to 90% of patients engage with navigators, depending on the hospital, and research into 100 patients in Glasgow found that those who accepted support had 23% fewer emergency room visits in the 12 months following their meeting with a navigator compared to the year prior.



Case study: A&E Navigator Scheme

Navigators complement the work of medical staff by engaging with patients who have come into the Emergency Department and supporting them in the community on discharge to connect them with wider support services. They provide support for a wide range of issues including those related to alcohol and drug use, mental health, domestic abuse, homelessness, social isolation and debt.

How does it work?



1 Identify people affected by violence

Including gang involvement, domestic abuse survivors and those who have self-harmed.

2 Listen and provide support

at a moment when they're likely to be reflecting on what led them to this point and more open to the offer of support.

3 Continue to provide support on the ward and in the community

including facilitating links to a wide range of external services.

Who has it helped?

2,500 (as of August 2020)

of patients *helped* by navigators

65-95%

of patients *engage* with navigators

Reduced A&E visits

23%

fewer emergency room visits

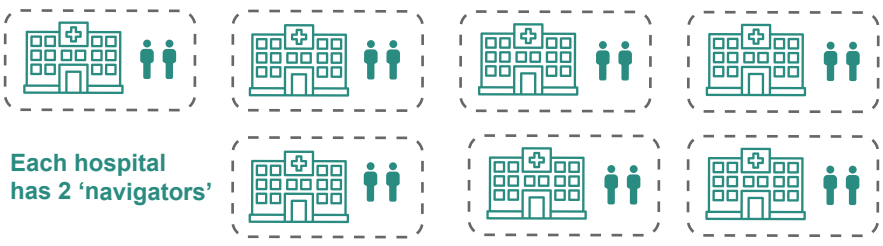
1 year after being introduced to a navigator

Based on 100 patients in Glasgow

Where does it take place?

7 hospitals

Across Scotland
(as of September 2020)



Each hospital has 2 'navigators'

Routine enquiry into ACEs

One area of trauma-informed practice that has generated a lot of interest – and contention – is routine enquiry into ACEs. This is the process by which professionals ask service users about adversity they may have experienced in childhood and how this adversity may impact on their lives now. We are using the term "routine enquiry" because it has become well-known, though we would clarify that the practice can be performed in a way that is not routine. Any enquiry about ACEs should be used to start a therapeutic conversation that considers what (if any) response or support will be required by the person, rather than as a form of problem categorisation.

Although there is a growing body of evidence of the potential positive impact of routine ACE enquiry, it is by no means conclusive. Further research is needed to develop the evidence base on enquiry of childhood adversity and evaluate whether it is safe, effective and acceptable to both patients and staff. Pilots are continuing to be conducted across the UK to develop the evidence base and share learning.

Though the practice can be applied in other services too, we have placed it in the health briefing in this series as we have seen it explored and used here more frequently than in any other sector. We spoke to people who have used, or overseen projects using, routine enquiry in GP surgeries, health visiting, addiction, sexual health, multi-sector projects and more, to seek insights into how the approach has been implemented and lessons learned. The following insights were shared with us by interviewees who have implemented routine enquiry:

- **Allow the option to not disclose:** Pushing for self-disclosure without consent can be damaging psychologically. One interviewee noted that whereas people sometimes say no the first time, they may open up later once the offer has been made.
- **Offer a follow-up conversation:** Include the option to discuss the matter further after filling in a form, with one interviewee describing this as the key outcome given the unreliability of ACE scores alone as diagnostic tools. Another said a more impersonal approach, eg "paper into a cardboard box", would feel unpleasant and risk re-traumatisation. The process can also lead to a stronger relationship with patients as the practitioner is sometimes the first person they've told this information to.
- **Ensure follow up support is available:** It should be used within the context of clear organisational plans about how this information will be used to support an individual or as part of a wider assessment.
- **Make clear why you are asking these questions:** One interviewee recommended telling patients these experiences are not uncommon; that everyone gets the opportunity to explore this as part of their assessment; and that other possibilities and strengths won't be ignored. This can be contextualised to the service, for instance by discussing links between trauma and high inflammation at a service for auto-immune conditions.

- **Train all staff at the service:** Appropriate training should be undertaken so that practitioners have the skills to respond appropriately to the information in a person-centred, trauma-informed way. One interviewee felt that training his whole team was a good decision as it gave the staff an insight into the person behind the difficult behaviour and their potential for rehabilitation.
- **Adapt the frequency to what is manageable:** For instance, a GP probably would not have the capacity to ask every patient and provide an adequate therapeutic response, so may take a targeted approach instead, for example only asking those with stress-related conditions.
- **Build upon an ongoing relationship:** Various interviewees mentioned the need for an ongoing relationship with the patient, with one project setting a minimum of six to eight continued visits before the enquiry is carried out. One interviewee felt the same about follow-up support, believing the lack of it may have a destabilising effect.
- **Ask patients of all genders:** One interviewee in sexual health said to make sure patients of all genders are asked, citing the example that men often do not get asked about sexual abuse and assault.

Parent-Child Psychological Support (PCPS): Giving children the best start in life

The relationships that babies form with caregivers during the first two years of post-natal life can provide them with an underlying sense of security and stability they can take into future relationships, known as a "secure attachment" style. However, due to the infant's vulnerability and the pliability of their brain during this stage of rapid development, they are also at greater risk of harmful impacts if they experience adversity during these 24 months. For good or bad, these experiences can have a profound impact on the child's later self-esteem, perception of others, stress responses, emotional impulses and relationship tendencies. PCPS aims to leave as many infants as possible in the "good" category by the time they reach their second birthday.

Having been implemented in Valencia and Dublin for a number of years – and now being introduced to the London Borough of Camden over the course of 2021-23 – this clinical-based, universal programme provides support to caregivers in bonding with their baby. It offers them the opportunity to attend an all-in-one centre six times between three and 18-months-old, following an introductory session at six to eight weeks. Where they overlap, these replace statutory health visitor visits. During these three-monthly sessions, the child's development is assessed, with supportive feedback provided to caregivers where beneficial and a referral system in place to signpost to additional services. Participation rates are usually high – in Dublin, they reached 72%. Cases requiring more support are discussed in monthly meetings to identify strategies and interventions. Each visit lasts 60-90 minutes and involves each family visiting the following 'stations':

Station A (admin): The service's first encounter with parent and baby, wherein they collect preparatory information to begin the process. Future sessions are also booked.

Station B (physical health): A health visitor carries out the processes that take place during their usual home visits, among them assessments for weight, height and nutrition, and discussions around immunisations.

Station C (caregiver-child interactions): With their permission, and as part of a developmental assessment, the caregiver plays with their child for a few minutes while the interaction is recorded for analysis. The child's progress on a number of measures (such as fine and gross motor skills, social and emotional development, speech and language) is assessed and used to help the parent to promote more optimum development. During the visit at 15 months, the Strange Situation protocol is used to determine the child's attachment style (secure, insecure avoidant, insecure ambivalent or disorganised).

Station D: Caregivers are given feedback on their child's developmental assessment, receiving tailored information about how to attune with their babies and communicate with them. They are also given the opportunity to discuss their own welfare, including how they feel, what concerns they have and whether there are any issues at home that may affect caregiver and baby.

Results: Assessments of a low socio-economic status (SES) sample of children under 18 months-old who had experienced PCPS (n=737) found 75% were securely attached and 6% had disorganised attachment. The former is associated with better outcomes in behaviour, language and cognitive development, whereas the latter is the most concerning of the four styles and one that overlaps frequently with abuse and/or neglect. In contrast, a comparable low SES sample (n=586) found rates at 48% and 25%, and a general population sample (n=2,104) at 62% and 15%, all respectively. 90% of children in PCPS are progressing in line with, or ahead of, global development expectations and 95% of parents fall outside the clinical range for stress when their child is 15 months. Improvements are also secured in parental sense of competence; with regards to intrusive, protective and sensitive behaviours; and in knowledge about child development.

Recommendations: Assess local willingness to reallocate resources from reactive services to primary prevention. Build support for this, armed with the economic case for prevention, and awareness of the severe short and long-term costs of insecure and disorganised attachment, whose consequences include (insecure attachment), higher risk of low self-esteem, lack of trust and affection in relationships, lack of self-control, pessimism, depression, alienation from others, hostility, aggression, antisocial behaviour and violence; (disorganised attachment) higher risk of mental illness, being taken into care, poor relationships, disruptive behaviour in pre-school and school, aggression and violence. Plan implementation carefully, taking full account of successful implementation elsewhere.
Next steps: The London Borough of Camden will continue its staged process of implementation. PCPS is also being discussed with a number of other areas across the UK. If you wish to find out more about the programme, contact George Hosking (WAVE Trust) at ghosking@wavetrust.org, or the developer Dr Angeles Cerezo (University of Valencia) at Angeles.Cerezo@uv.es.

Springbank Ward, Fulbourn Hospital: Providing choice and autonomy

Opened in May 2011, Springbank Ward (SW) is one of only two NHS personality disorder units across the UK. The 12-bed facility supports women, trans and non-binary with complex personality disorders, primarily Borderline Personality Disorder (BPD). Their patients are those who were unable to be supported within the community, acute wards or other specialist units in the private sector due to concerns over their safety (eg through self-harming), a common factor in referrals. Consultant psychiatrist Dr Jorge Zimbron said that trauma is present in around 80% of patients, often alongside historical mental health issues within the family. Though a specialist unit, the measures him and his team brought in provide lessons for many health services on the benefits of providing patients with greater autonomy, even under severe circumstances.

Prior to Dr Zimbron's arrival in 2015, SW pursued a strategy of 'risk containment'. They assumed patients lacked the capacity to make positive decisions and needed their lives controlled for their own safety. New incidents led to more rules being imposed over time. The ward was locked at night from 11pm, and rooms during daytime hours; items were restricted (eg metal cutlery); and personal searches conducted. Discipline was enforced on a punishment-reward basis – for instance, self-harm would lead to loss of privileges – and, when behaviour became seemingly unmanageable, physical restraint and/or rapid tranquilisation were not uncommon. Length of treatment was undefined, with most there for several years. Staff injuries were common, with high turnaround and vacancies, including in Dr Zimbron's position which saw 7 consultants in 4 years prior to him.

Dr Zimbron said that whereas terms like “patient-centred” and “shared decision-making” are often used in healthcare, they tend to go out the window once a crisis occurs. He wanted to work on the basis of “positive risk-taking”, where patients were assumed to retain capacity even under crisis, challenging a lot of the fears staff had in relation to the complexity of their conditions, potential patient suicidal tendencies, lawsuits, burnout and reputational risk. He believes there is no risk-free option, and that this approach would improve patient self-esteem and provide opportunities to feel in control of their lives, a key step towards recovery. Much of the same medication and therapies would still be provided, but in the context of shared decision-making with patients, who would co-produce the ward programme with staff, alongside an absent threat of seclusion and restraint. “It works better for people to learn how to maintain their own safety rather than you maintaining it for them, because you can’t control every variable”, Dr Zimbron said. Having secured the support of the Trust’s management, him and his team began implementing this approach in May 2015.

‘Positive risk-taking’ exchanged many of the previously rigid rules for a short list of key values, including respect (eg quiet if smoking at night), recovery (eg planned discharge within one year rather than an indefinite stay) and safety (still a priority, but with patients given more control over it, eg being allowed to use metal cutlery). Deviations from these values are immediately addressed during daily meetings and/or one-to-one time. If patients want to leave the ward, temporarily or permanently, they can as you “cannot force therapy on people with this diagnosis”. When given this option, patients rarely leave. If they do, they do so in a planned manner, rather than impulsively.
Around two-thirds finish the programme and benefit from it, whereas around one-third do not, sometimes because they do not want to stay or prefer a different environment (“it isn’t for everyone, but we haven’t made the problem worse by restraining them or making people dependant on us.”) Those who stay join a community environment, where relationships are strengthened through outings such as beach trips. Some ex-patients even return after discharge to meet staff over a cup of tea. Supervision and reflection for staff is prioritised too which, alongside away days and social events, helps to ensure their well-being is also supported.

Results: Compared to 2011-15, average incidents per month in 2015-2020 dropped 62% from 85 to 32. Numbers of incidents requiring physical intervention and rapid tranquilisation dropped from highs of 64 and 45 per year respectively in 2012-2015 to 3 and 0 in 2016, and 0 each in 2020 and 2021. Patients show improvements across a range of standardised treatment outcome measures (eg for anxiety levels) and average attendance at group meetings. By 2018, more than half of families and friends were ‘Extremely likely’ to recommend the service, compared to 5% under the previous model, and no patients were detained under the Mental Health Act or on any form of close observation. Staff injuries and vacancies are now much rarer, and staff morale is high.

Recommendations: Focus on improving relationships between staff and patients. Have a shared model of training, with everyone on the same page and all staff signed up to the approach. Ensure regular training and reflective practice is in place so that people have the confidence to follow the approach even when crises happen, which is when it's most likely to fall apart. Put aside time for team meetings to discuss persistent issues, rather than constantly falling back on firefighting. Have a flat team hierarchy where everyone plays an important role and ensure higher management are aware of and understand the treatment model.

Next steps: Dr Zimbron said they are hoping to eventually open up a house that offers the next step in a patient's progression after leaving SW. This would help to avoid problems post-discharge, such as being made homeless when an incident happens, as can occur in new supported accommodation environments with untrained staff.

Endnotes

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