Protected Learning Time (PLT) for Primary Care

Welcome

Dr Nigel Wells, Clinical Chair
NHS Vale of York Clinical Commissioning Group

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“When we care about people, we care less about the money, and when we care about money we care less about people.”

Margaret Heffernan,
Wilful blindness: Why We Ignore the Obvious at our Peril (2011)

Cutting edge medical breakthroughs for 2019:

Wireless brain sensors, Pharmacogenomics testing, A.I. healthcare.

However – have we looked earlier and closer?

"For every dollar spent on early child development you save $7 over the life course because children with better early child development are less likely to end up delinquent, involved in crime, unemployed and so on."

"Throwing young people on the scrap heap is a public health emergency."

Michael Marmot

Addressing Childhood Adversity in Professional Practice

… And why more of the same equals too little, too late

Dr Warren Larkin

Consultant Clinical Psychologist - Visiting Professor Sunderland University

Director – Warren Larkin Associates Ltd

wlarkin@warrenlarkinassociates.co.uk

@warren-larkin

www.warrenlarkinassociates.com

What are Adverse Childhood Experiences?

- Physical abuse
- Sexual Abuse
- Emotional Abuse
- Living with someone who abused drugs
- Living with someone who abused alcohol
- Exposure to domestic violence
- Living with someone who was incarcerated
- Living with someone with serious mental illness
- Parental loss through divorce, death or abandonment

Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0–7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$). Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

20 years asleep…but better late than never

- Adverse Childhood Experiences are unfortunately common yet rarely asked about in routine practice (Felitti et al.,1998; Read et al 2007, 2018; Ford, 2019)

- There is a strong and proportionate (dose-response) relationship between ACE and the risk of developing poor physical health, mental health and social outcomes (Skehan & Larkin, 2008; Kessler et al, 2010; Varese et al, 2013; Felitti & Anda, 2014.)

- ACEs increase the risk of adult onset chronic diseases, such as cancer and heart disease, as well as increasing the risk of mental illness, violence and becoming a victim of violence

- ACEs are associated with a large proportion of absenteeism from work, costs in health care, emergency response, mental health and criminal justice involvement

- **Preventing adversity in childhood and mitigating the impact, is potentially the biggest single opportunity we have to improve the health & wellbeing of future generations**

ACEs increase individuals' risk of developing health-harming behaviours

2
Times more likely to currently binge drink and have a poor diet

3
Times more likely to be a current smoker

5
Times more likely to have sex while under 16 years old

6
Times more likely to have had or caused an unplanned teenage pregnancy

7
Times more likely to have been involved in violence in the last year

11
Times more likely to have used heroin/crack or been incarcerated

Bellis MA, Hughes K, Leckenby N, Perkins C, Lowey H. National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. BMC Medicine 2014, 12:72

The impact of adversity

Brain science – (the neurobiology of toxic stress)

- Toxic stress adversely affects the structure and functioning of a child's developing brain

Health consequences

- Toxic stress caused by ACEs affects short- and long-term health, and can impact every part of the body, leading to autoimmune diseases, such as arthritis, as well as heart disease, breast cancer, lung cancer and a range of mental health problems.

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Over a 12 month period, compared to people with no ACEs, those with four or more ACEs were:

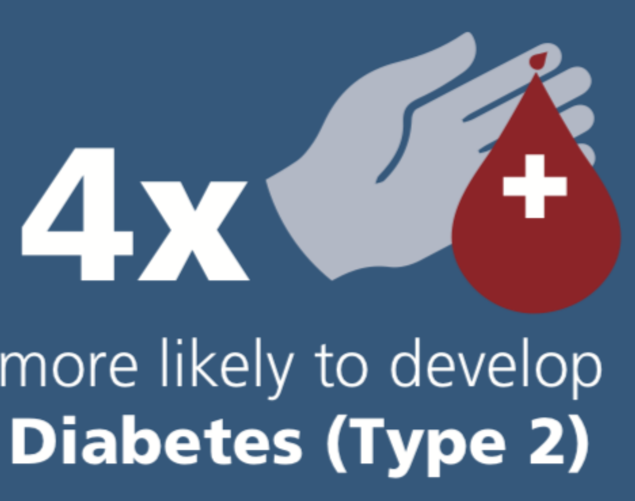
more likely to have frequently visited a GP**

more likely to have attended A&E

more likely to have stayed overnight in hospital

Up to the age of 69 years, those with four or more ACEs were 2x more likely than those with no ACEs to be diagnosed with a chronic disease*$

For specific diseases they were:



more likely to develop **Diabetes (Type 2)**

more likely to develop **Heart Disease**

more likely to develop a **Respiratory Disease**

Levels of health service use were higher in adults who experienced more ACEs*#

Adverse Childhood Experiences ACEs - The Life Course

DEATH

LIFE COURSE

BIRTH

Early Death

Non Communicable Disease, Disability, Social Problems, Low Productivity

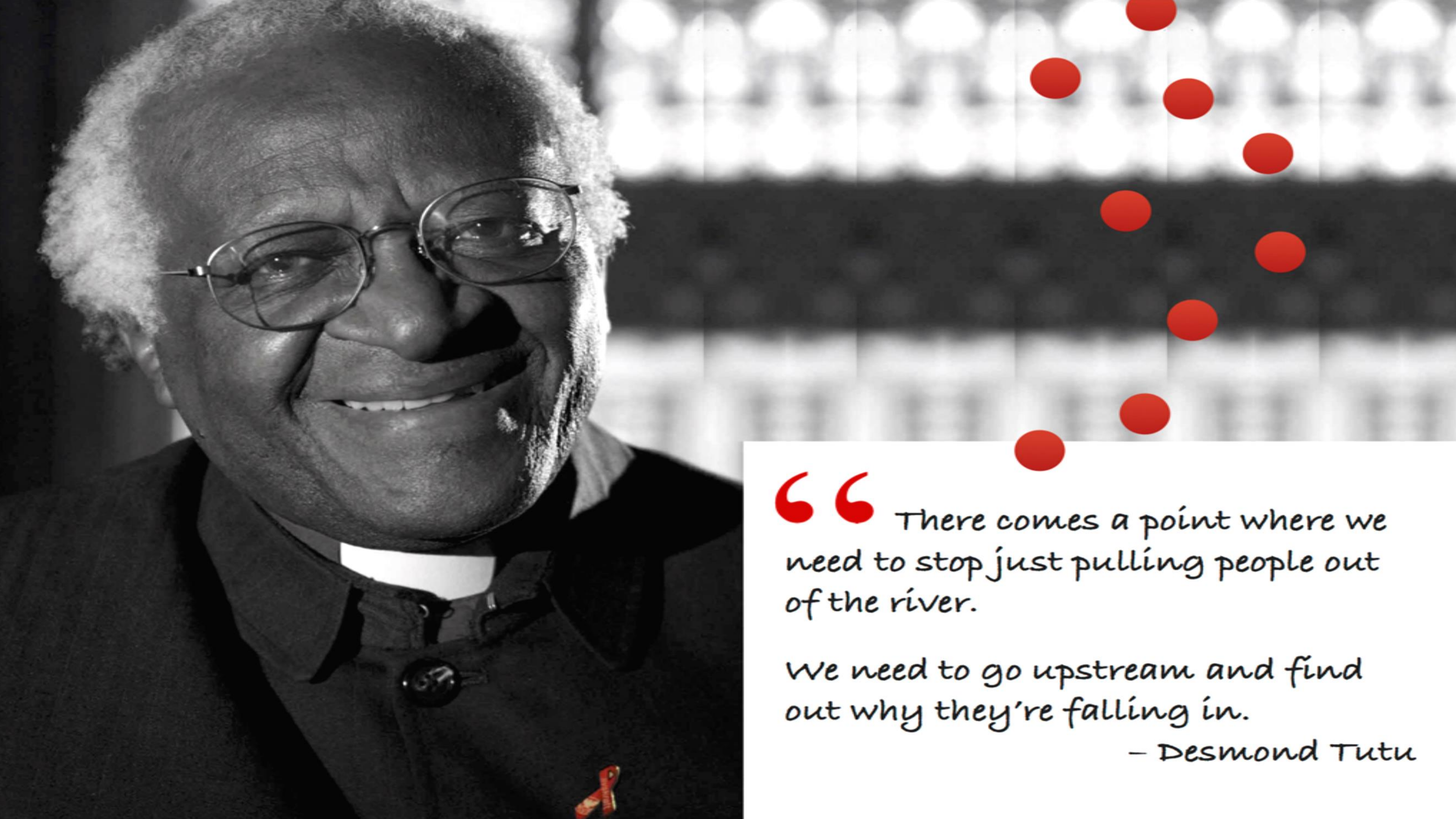
Adopt Health Harming Behavior's and Crime

Social, Emotional and Learning Problems

Disrupted Nervous, Hormonal and Immune Development

ACEs Adverse Childhood Experiences

Bellis 2016 Developed from Felitti et al. 1998


“ There comes a point where we need to stop just pulling people out of the river.
We need to go upstream and find out why they’re falling in.
– Desmond Tutu

Reframing Addiction

- "The solution to changing the illegal or unhealthy **ritualized compulsive comfort-seeking behaviour** of opioid addiction is to address a person's adverse childhood experiences (ACEs) individually and in group therapy; treat people with respect; provide medication assistance in the form of buprenorphine, (an opioid used to treat opioid addiction); and help them find a ritualized compulsive comfort-seeking behaviour that won't kill them or put them in jail."

- Dr. Daniel Sumrok, director of the Center for Addiction Sciences at the University of Tennessee

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Reframing Dis-ease & Health Harming Behaviours

- Drugs, food, sex, gambling, alcohol, smoking & violence are all ways of coping – self-soothing – comfort-seeking
- They provide short term relief from distress and pain
- The effect doesn’t last and they cause harm
- This impact is often intergenerational
- **Treating behaviours or ‘symptoms’ alone is not a solution**
- Removing a vulnerable person’s only means of coping!?
- **We need to help people link the past trauma/ pain to the here and now & find better coping strategies**

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Preventing ACEs in future generations could reduce levels of:

EARLY SEX
(before age 16)
By 33%

UNINTENDED TEENAGE PREGNANCY
(before age 16)
By 38%

SMOKING
(current)
By 16%

BINGE DRINKING
(current)
By 15%

CANNABIS USE
(lifetime)
By 33%

HEROIN/CRACK USE
(lifetime)
By 59%

VIOLENCE VICTIMISATION
(past year)
By 51%

VIOLENCE PERPETRATION
(past year)
By 52%

INCARCERATION
(lifetime)
By 53%

POOR DIET
(current; <2 fruit & veg portions daily)
By 14%

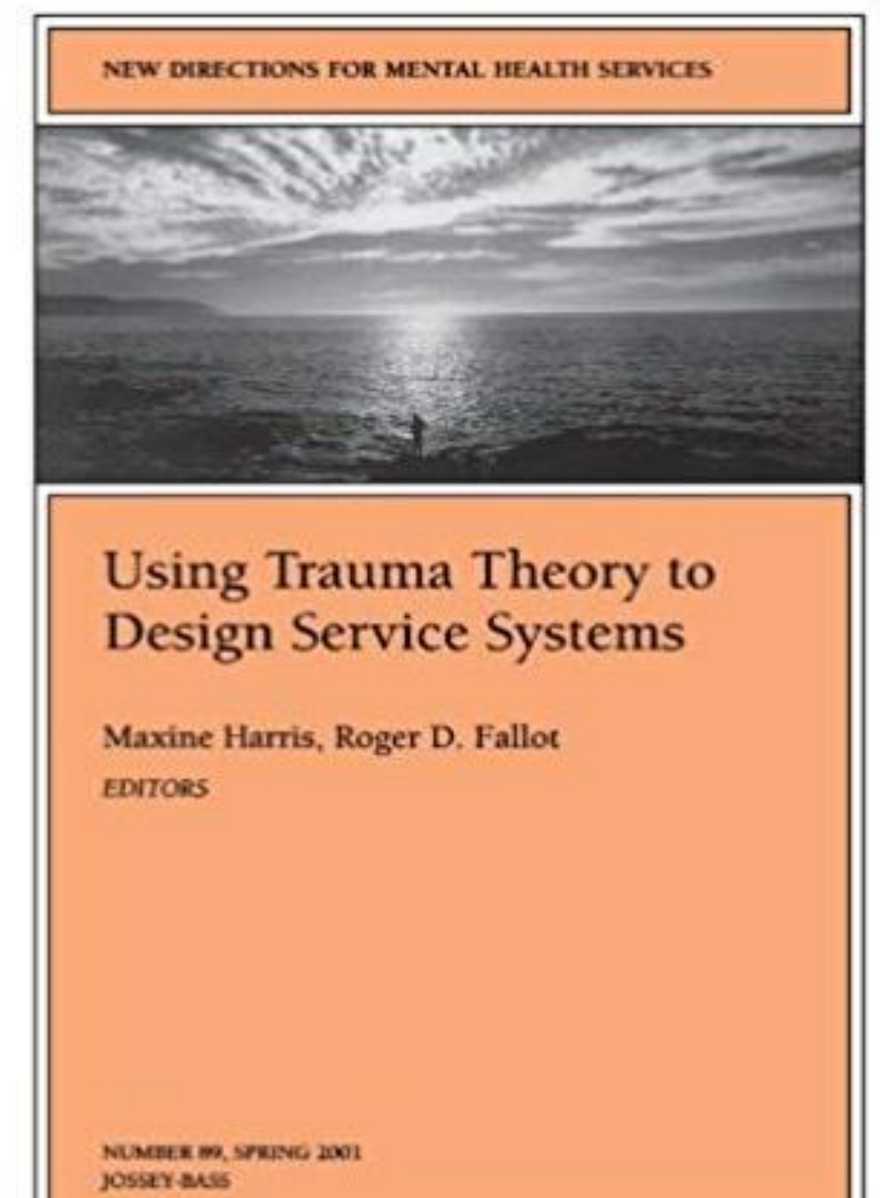
The English national ACE study interviewed nearly 4,000 people (aged 18-69 years) from across England in 2013. Around six in ten people, who were asked to participate, agreed and we are grateful to all those who freely gave their time. The study is published in BMC MEDICINE:

Bellis MA, Hughes K, Leckenby N, Perkins C, Lowey H.
National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England.

The urgent need for system change

- Services don't ask routinely about life experiences, including ACEs
- Treating the symptoms/ behaviours is expensive and ineffective for traumagenic difficulties
- The system reacts to diagnoses & labels
- Some labels can attract stigma
- Can lead to learned helplessness –

  "I have a lifelong illness, what's the point – there is nothing I can do, no-one will give me a break"
- Health, Social Care & Criminal Justice systems can not meet the growing demand & don't have the resources required
- There is an NHS workforce crisis and a worsening deficit in recruitment, retention, absenteeism and staff satisfaction
- We can't afford to keep doing the same things and expecting a different outcome



Credit: Filippo Varese

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***

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**

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Trauma-Informed Care/ Services (Adapted from Trauma informed Oregon Standards for Health Care 2015)

- Organisational Commitment and Endorsement
- Hiring and Onboarding Practices
- Systems Change and Monitoring progress
- Workforce Development
- Environment and Safety
- Care Delivery

The case for routine ACE enquiry

Waiting to be told doesn't work…

Victims of childhood abuse have been found to wait from between nine to sixteen years before disclosing trauma with many never disclosing

(Frenken & Van Stolk, 1990; Anderson, Martin, Mullen, Romans & Herbison, 1993; Read, McGregor, Coggan & Thomas, 2006

Read and Fraser (1998) found that 82% of psychiatric inpatients disclosed trauma when they were asked, compared to only 8% volunteering their disclosure without being asked.

Felitti & Anda (2014) report a 35% reduction in doctor's office visits and 11% reduction in ER visits in a cohort of 130,000 patients asked about ACEs as part of standard medical assessment in the Kaiser Health Plan

Why reduced service utilization?

- 'Slowly, we came to see that ***Asking***, initially by an inert mechanism, then followed up face-to-face in the exam room, coupled with ***Listening***, and implicitly ***Accepting*** that individual who had just shared his or her dark secrets is a powerful form of ***Doing***.'

- 'The economic implications of this 130,000-patient finding are clearly in the multi-billion-dollar range for Kaiser Permanente and other large venues like Medicaid or the VA System. Interestingly, there has been significant resistance in pursuing this.'

- Felitti V. J. (2019). Health Appraisal and the Adverse Childhood Experiences Study: National Implications for Health Care, Cost, and Utilization. *The Permanente journal*, *23*, 18–026. doi:10.7812/TPP/18-026

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Pilot study: 164 patients, a single appt with on-site psychiatrist as part of comprehensive health appraisal…

- ’A measurable benefit derived from this one-time diagnostic contact which provided a reduction in anxious utilization by commonly high-ultlizer patients who were helped to reconceptualize the nature of their somatic complaints from being disease-caused to being the result of problems in living.’
- ‘They also had the subtle but significant experience of sharing “shameful” secrets with someone they respected, and yet feeling implicitly accepted afterwards.’
- **51% reduction in their overall medical utilization the year following**
- Dr Vincent Felitti, 2018 personal communication with the author.

Keeping Secrets is part of the problem

- Keeping big secrets can be stressful
- Not sharing these with our closest others can interfere with our health.
- Including impaired immune function, cardio-vascular health and neurochemistry
- Suppressing emotions, thoughts and actions can increase the risk of a whole range of diseases
- “Confession” or disclosure can counter the effects of suppression and has been shown to lead to multiple health benefits
- Pennebaker and Smyth (2016)

THIRD EDITION

"Dr. Pennebaker has demonstrated that expressing emotions appears to protect the body against damaging internal stress and seems to have long-term health benefits."—*The New York Times*

Opening Up by Writing It Down

How Expressive Writing Improves Health and Eases Emotional Pain

James W. Pennebaker, PhD
Joshua M. Smyth, PhD

REACh – Key Findings (2015-2018)

- REACh training equips practitioners with the knowledge, confidence and skills to conduct routine enquiry, respond to disclosures and offer support to their clients.

- Routine Enquiry is feasible and acceptable to staff and service users across settings.

- Evaluations of the model have consistently found that it has **not** led to increased service demand

- It can lead to more informed and effective interventions which address the root causes of harmful attempts to cope e.g. substance misuse.

- It can help people to better understand the impact of ACEs on their health and wellbeing, which can motivate and empower them to make positive life changes for them and their families.

- Parents who participate in routine enquiry have reported that they have considered the impact of their childhood experiences in relation to their own children and their parenting.

- (Real Life Research 2015; McGee et al, 2015; Pearce et al, (in press); Simpson-Adkins et al (in review)

"It's not suddenly changed thirty odd years of a behaviour…and it hasn't undone all those experiences, but it has made them question now, what are my children going through...what ACEs am I putting in front of my children, and I think it's started that journey for them"

Public Health Wales REACh Evaluation 2018

- Asking about Adverse Childhood Experiences (ACEs) among adult general practice patients
- An initial exploration of the feasibility and acceptability of asking about a history of ACEs in a large multi-site GP practice in North West England.
- Findings explore practitioner experiences of delivery and potential impacts on patients.

What did patients say? (N=123)[e]

94% agreed that the ACE questions were understandable and clear

86% felt that their GP surgery was a suitable place to be asked about ACEs

84% thought it was important for health professionals to understand what happened in their childhood

70% said their appointment was improved because the GP/nurse understood their childhood better

87% agreed that providing information to a health professional about ACEs was acceptable

"The higher prevalence of both physical and mental health problems among adult general practice patients with ACEs highlights a clear need to respond to wider determinants and examine a more trauma-informed approach in primary care."

People with ≥2 ACEs[b] had higher levels of health problems

2.5x more likely to have **asthma**

3x more likely to be living with **multiple long-term conditions[c]**

3.5x more likely to have experienced **mental health problems**

For **67%** of patients with ACEs this was the **first time** they had told a professional about them

Having some resilience resources more than halved risks of current mental illness in those with 4+ ACEs

Childhood resilience resources

Percent with current mental illness

Childhood resilience[b]

Low 29%

High 14%

Trusted adult relationship

Never 28%

Always 19%

Regular sports participation

No 25%

Yes 19%

Adult resilience resources

Percent with current mental illness

Adult resilience[b]

Low 37%

High 13%

Perceived financial security

<1 month 35%

5+ years 11%

Community engagement[c]

No 23%

Yes 11%

Public Health Wales, 2018

Resilience building…

- **Resilience & emotional competence can be acquired at any stage & are protective**
- Trauma-focused therapies, E.g., TF-CBT, EMDR, bereavement counselling etc, effective and provide good return on investment
- Universal and targeted family support
- Exercise – especially with others
- Expressive writing
- Mindfulness meditation
- Dietary advice and education about nutrition
- Group/ peer activities – connectedness & relationship building
- Advice and education about the benefits of good quality sleep
- **Clinical Supervision for Staff**

TRANSFORMING PSYCHOLOGICAL TRAUMA:

A Knowledge and Skills Framework for the Scottish Workforce

in partnership with:

Click anywhere to continue...

CONTENTS

MINISTERIAL FOREWORD

REFERENCE GROUP MEMBERSHIP

INTRODUCTION

TRAUMA INFORMED PRACTICE LEVEL
Knowledge and skills required for all members of the Scottish Workforce.

TRAUMA SKILLED PRACTICE LEVEL
Knowledge and skills required for workers with direct and frequent contact with people who may be affected by trauma

TRAUMA ENHANCED PRACTICE LEVEL
Knowledge and skills for staff with regular and intense contact with people affected by trauma and who have a specific remit to respond by providing support, advocacy or specific psychological interventions to protocol, and/or staff with responsibility for directly managing care and/or services for those affected by trauma.

TRAUMA SPECIALIST PRACTICE LEVEL
Knowledge and skills for staff who have a remit to provide evidence-based interventions and treatment for those affected by trauma with complex needs.

RESOURCES AND REFERENCES

Trauma-Aware System Change (TASC) model

Increased Access to Intervention - Psycho-Social & Peer Support/ Therapies

Prevention - Trauma-Sensitive Schools, Antenatal, Parenting & Family Support

Governance - Single Integrated Transformation Board – Shared Goals & Vision

Commissioning - Driven Service & Culture Reform

Workforce – Personal and Professional Development

Community engagement and empowerment – messaging and asset building

The power of relationships – Ancient wisdom meets modern science…

- We now over-rely on medical technology and modern pharmacology
- Previously, healers had to rely on "placebo" effects …(Ross Buck)
- They had to inspire the patient's confidence in their own ability to get better.
- To be effective this relied on building a safe, trusting relationship, listening intently, and validating their subjective experience.
- Instead we now focus on illness and rarely ever gain insight into a patient's life, thinking and subjective experience.
- Quality of relationship is the best predictor of change in psychosocial interventions.

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What does this mean for the Vale of York?

1. Generate a sense of urgency for system-wide change

2. Long-term planning to make prevention, not cure, the new status quo

3. Engage, educate and co-produce with local communities

4. Commit to trauma informed care (TIC) & adopt practice standards

4. Evaluate routine ACE enquiry across settings

5. Invest in social prescribing & resilience building assets

6. Improving access and integration – holistic care

7. Supervision and training for the workforce in TI knowledge & skills

8. Go big on therapeutic alliance – it’s the relationship that heals…

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Thank you and questions

The rest of the afternoon…

Time	Session
3.00 pm	Workshop one (Rooms 1-11 upstairs)
4.00pm	Refreshments and networking
4.30pm	Workshop two (Rooms 1-11 upstairs)
5.30pm	Close

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