A Coordinated Service Network for Trauma Treatment and Related Services

A proposal for consideration

Background to this paper

This paper has been prepared at the invitation of the DHSSPS with a view to bringing forward ideas as to how the Department's investment in the Family Trauma Centre and the Northern Ireland Centre for Trauma & Transformation could be optimised. The proposals contained herein are based on the creation of a coordinated service network for trauma treatment and related services, the purpose of which would be to maximise the capacity of services working together, to identify, assess and treat trauma related disorders.

Where we have come from

Taken together, the SSI Report, *Living with the Trauma of the Troubles* (1998), the Victims Commissioner's Report*, We Will Remember Them* (1998) and the Good Friday Agreement (1998) represented a sea change in the recognition of the impact of the violence and of the willingness and intention to address such needs. Prior to that point, it was virtually impossible to formally and structurally address the impact of the on-going violence. The shift of context created by the ceasefires and the developing political talks made a seismic difference. Since the publication of the documents, progress has been made on a number of fronts and there has been a significant investment from Government and non-Government sources especially since 1998. Key developments have included:

- The establishment of the Victims Liaison Unit by the NIO in 1998 in response to the Victims Commissioner's Report;
- The establishment of the Northern Ireland Memorial Fund in 1998, again in response to the Victims Commissioner's Report;
- The establishment of the Victims Unit within the OFMDFM after the Assembly was first established (in June 2000) to represent the OFMDFM and to liase with external bodies etc.;
- A review of compensation arrangements;
- The development of services and funding streams;
- The establishment of the regional Family Trauma Centre;
- The development of a Strategy by the OFMDFM (*Reshape, Rebuild, Achieve* – April 2002),

- The formation of an Inter Departmental Working Group to coordinate the Assembly's Departments' work and responses in relation to those affected by the Troubles.
- Trauma Advisory Panels have been established in each of the four health and social services boards;
- A Report, *Counselling in Northern Ireland* (May 2002) has been issued by the SSI on foot of one of the recommendations made in *Living with the Trauma of the Troubles* (April 1998).
- The establishment of and three year funding for the Northern Ireland Centre for Trauma & Transformation

Prior to the Good Friday Agreement being finalised in April 1998, there had only been a handful of 'victims groups' representing, *inter alia*, members of police and army personnel, and a number of groups representing the perspective of those affected by state violence. Besides these, there was a handful of provider groups of which WAVE was the only with a regional remit to specifically address the impact of the Troubles related violence. Following the Good Friday Agreement the number of such groups grew significantly to the point where it is estimated that there are at present about 30 such groups (excluding ex-service organisations) and a wider circle of community development organisations with an interest to one degree or another in addressing aspects of the impacts of the Troubles. Whilst the three documents referred to above, represented a significant change, the development of strategy, policy and services in response to the recommendations has taken time to develop, and to date, has not encompassed all the recommendations of the Victims Commissioner's Report and the SSI report. The development of strategy has been somewhat distorted by a number of factors including:

1. The level of interest in the victims issue by political structures is substantially contingent upon political necessity.
2. To the extent that politics addresses the victim's issue, it is primarily seen as a political issue and not a service or even a reconciliation or peace building issue.
3. The considerable difficulties politicians have in discussing and reaching agreement upon victim's issues (including remembrance and justice) in the context of civil conflict and at times, widely different perspectives on the legitimacy of specific categories of victims.
4. The need for political consensus on policy, which at times perhaps inhibits progressive responses and service developments;
5. The difficulties (and perhaps impossibility) in recognising victims of the Troubles as a special subset of those with service needs (with special provision for accessing services etc.) in the context of equality and targeting social need policies;
6. The on-going challenge of embedding Troubles related victim's strategy into existing structures, policies, priorities and commissioning, and provider arrangements;
7. The competing positions, arguments and demands of the various services set up to address the consequences of violence or to represent victims;

8. In relation to some service areas, the absence of a clear evidence-base, which would inform, legitimise and shape service provision, and upon which strategy and policy could be based;
9. Problems created by the way Government responsibilities are organised including the split of responsibilities between the NIO and Assembly, and the difficulties in addressing what was often viewed as a political issue (i.e. the impact of the violence) into mainstream departmental activity.

As a consequence strategy and policy has not had time to evolve and mature fully because predominantly, movement and progress were linked to political necessity. Also, to some degree the movement that has taken place has been curtailed by the limitations placed upon it by what was politically achievable. Whilst the human consequences of the violence associated with the conflict are inherently and explicitly a consequence of that violence and the associated failure of politics, the level of political imperative about the victims issues has not yet quite matched the commitment given in the Good Friday Agreement, nor the level of political attention and imagination that has attended for example some of the key political mechanisms that have been developed to enable political progress.

This analysis might seem somewhat unfairly critical of politics and politicians. This is not intended. Rather, the analysis is intended to bring perspective and open up new possibilities and opportunities for addressing the concerns that lie at the heart of the issue. Further, the needs of those affected by the Troubles are well known to many involved in politics and experience demonstrates that politicians will support progressive policies, albeit policies that they can live with politically.

In relation to specialist trauma treatment services, much has been learned through the developments that have taken place to date. Clinically, the evidence base for the treatment of trauma related disorders has developed immensely, resulting in the CREST guidance on the treatment of PTSD in adults, (2003) and most recently in the publication of the NICE guidance on the treatment of PTSD in adults and children[1] (2005). Locally, the efforts by practitioners have led to key skills being developed and the evaluation of work done after the Omagh bombing, demonstrated the effectiveness of one of the new trauma focussed interventions.

There have been difficulties. These could be summarised as follows:

1. The new learning has not yet been picked up and mainstreamed structurally within the statutory services;
2. The relationship between the mainstream mental health services (statutory and non-statutory) and the role and work of the specialist

[1] There is a need for guidance to be developed in relation to for example, traumatic grief in children anxiety disorders resulting from trauma in children, childhood depression and other disorders resulting from the impact of severe trauma

trauma services has not matured to a point where maximum benefit can be derived from such a relationship;

3. Developments in the past were driven to one degree or another by political imperatives; practice and evidence based knowledge played a minimal part in such processes.
4. The lack of cogency between various streams of funding has led to a series of uncoordinated developments, and the lack of a common set of principles, values, standards and objectives has hindered the emergence comprehensive and consistent development of services.
5. There have been and continue to be competitiveness and less than optimum levels of interaction and cooperation amongst various players in the area of support for those affected by the Troubles.

Many of these problems are in the process of being addressed. For example the OFMDFM document, *Reshape, Rebuild Achieve*, offers a set of principles around which policy can further evolve. Also, the deficit of coordination has perversely led to the development of various approaches and solutions to similar problems, from which learning can be derived as to the best way forward.

Where we are now

So what is in place that we can draw upon? The recent publication of the NICE[2] guidance on the treatment of PTSD in adults and children (2005) is a key building block. Authoratively, it offers clarity on what does not work, what does work and leaves room for exploring new developments. This has implications for not just treatment, but for training, service design, the work and responsibilities or providers and commissioners-purchasers. It provides a compass against which services can be purchased in the future, and by which those already in place can revise their approaches and methods. Ultimately, it offers hope for those who suffer trauma related disorders that their needs are understood and can be treated effectively.

In terms of services, we have an array of trauma related services operating across Northern Ireland (and others outside NI which can contribute to meeting the needs of those affected by the Troubles). An overview of trauma-focussed services is provided in Appendix 1 (under development). Related to these services are the wider networks of victims support services, especially those aimed at providing services that assist people in accessing services providing information or supporting people in advance of during and after receiving specialist treatment services. Some of these are also able to offer psychological support services, for example, during periods of distress immediately following exposure to traumatic events.

[2] The National Institute for Clinical Excellence

Looking beyond Troubles related services, there are others that have been providing trauma support and treatment services in relation to experiences such sexual assault, rape, child abuse etc.

Finally the main statutory mental health services, for both children and adults have played a key role in addressing, perhaps mostly, the long term and more serious effects of traumatic experiences, providing both community based and in-hospital services. The degree to which the new approaches to trauma have been adopted and mainstreamed within mental health services is not clear, but seems to have happened in locations where clinicians and managers had an interest in or an opportunity to develop such services (e.g. the specialist trauma counselling service in the three Trusts in the SHSSB area; the primary link worker service with GPs in the NHSSB). Experience suggests that unless a person has developed a serious mental health condition, mental health teams do not have the capacity to address conditions such as post traumatic stress where it presents in a relatively less serious form and where the person seems to be coping. All such perspectives are relative however, and people suffering from trauma related disorders will in all probability want to argue the case that their experiences and needs warrant serious attention. Clinically we know that traumatic distress and disorders can have very serious outcomes (health, economic, social and relational) and there is a strong case for investing in earlier intervention. Further, experience suggests that specific trauma related conditions such as PTSD[3] are managed primarily through pharmacological interventions, although, as the NICE guidance states, increasingly specific trauma focussed psychotherapies are the treatments of choice. To the extent that this overview is correct, the degree to which mental health teams can adopt such interventions will depend upon the intention to address conditions other than those presently viewed as priority, and the degree to which evidence based trauma focussed interventions are adopted and integrated into the multi-professional milieus of teams and services. Resources, training and the refocusing of services would all seem to be essential components in the task of reorienting services to address trauma related needs, in the manner advocated by NICE.

The Northern Ireland Review of Mental Health & Learning Disability has produced a report on the future of adult mental health services (2005). This is clearly reinforcing the need for developments in psychotherapy. The Review is creating a framework for developments and investment in the future, which is in line with the latest thinking around the treatment and management of mental health services.

There are other factors at play. The primacy of patient safety and effective clinical services is a key objective of clinical and social care governance processes within the statutory health and social services. Increasingly, investments will be outcome focussed, and where interventions or arrangements

[3] post traumatic stress disorder

are shown to be harmful, or to place the public at risk, changes and improvements will be required, or methods and interventions ceased. Similarly, non-governmental funders are becoming increasingly anxious about their roles in securing effective and safe services.

Finally and related directly to our experience in Northern Ireland of conflict, but also to the recent NICE guidance on the management of the effects of disaster, the current concerns about the threats from terrorism, raise the need for services to be equipped to provide the most effective response whilst maintaining everyday services. Large-scale tragedies can produce great need, and demand great responses. More than in most areas it is vital that scarce resources are used effectively and efficiently, to support individuals, families and communities. As has happened in the wake of past major events, huge amounts of funding can be expended whilst we remain unclear as to what has been achieved.

A Vision of where we want to get to

Given our collective experiences the opportunity exists for us to put in place a comprehensive trauma service that will address need, effectively, at the earliest opportunity, increasingly based on research and offering high quality care and treatment. This can be done by making the best of current resources and arrangements and by ensuring that future investment follows a clear strategy. The aim is to develop and provide an evidence based and comprehensive trauma service, based around a network of interlinking services.

A user focus

For people affected by traumatic experiences, a trauma-focused service network should, in broad terms, have the following qualities:

1. **Improved information for the public and people likely to come into contact with members of the public who are exposed to and adversely affected by traumatic events**
2. **The earliest identification of trauma related needs**
3. **The most appropriate early responses**
4. **Speedy referrals to the relevant and identified services (within and beyond a trauma network)**
5. **Treatments to be provided where possible through mental health teams and related voluntary organisations**
6. **Access to specialist treatment for chronic and complex trauma related disorders**
7. **Where needed, psychosocial support in advance of, during and after treatments.**

Not all of these could be met in all places at present; rather this is a description of what a satisfactory service, in broad terms, might look like from the users' perspective.

Service Principles

The principles underpinning the services and a coordinating network would be as follows:

1. **Interventions should 'do no harm'**
2. **Services would be designed upon the best available knowledge of how to care for people exposed to traumatic events, and to treat people suffering from trauma related disorders**
3. **Services would be designed or required to achieve specific outcomes**
4. **There should be a focus upon prevention as well as intervening to address specific problems**
5. **Interventions should maximise individual and community recovery and competence**
6. **Services would be underpinned by minimum practice, service and organisational standards**
7. **Services and practice should be underpinned by evaluation**
8. **Where possible interventions should advance good relations**

Practice principles

The practice principles governing the working of therapists and service providers would be as follows:

1. **Person centred**
2. **Good and complementary assessment processes**
3. **Onward referral to more appropriate services**
4. **Trusting assessments of referring services that use complementary assessments**
5. **Common goals**
6. **Cooperation & partnership**
7. **Clarity about who is doing what**
8. **Progressive management of risk**
9. **Evaluation & audit; reflective practice**
10. **Supervision relevant to the level of work**
11. **Training; CPD relevant to the level of work**
12. **Appropriate registration and accreditation**
13. **Adherence to guidelines and policies**

A vision for services in 3-5 years

The vision is that within 3-5 years the following will be in place: -

1. **A regionally directed and managed system:**
    - **Set within a public health and well-being strategy**
    - **With clear standards across all levels of service**
    - **With protocols for referral**
    - **Complementary assessment processes**
    - **With menus of appropriate services**
    - **For Troubles and non-Troubles related trauma related disorders**
    - **With clearly defined pathways for accessing services pertinent to the persons need at the time it is required.**

2. **Specialist trauma treatment services:**
    - **Provided through a network (partially based in each HSS Board's area – partially regionally based)**
    - **That are *"… high quality, clinically effective*"**
    - **Differentiated (where necessary) for specialist groups**
    - **Delivered by statutory and non-statutory providers**
    - **Working as a regional system**
    - **In liaison with other specialist treatment services such as drug & alcohol addiction services**

3. **Mainstream service provision**
    - **Based around primary care, community mental health teams, education and other relevant services**
    - **Able to identify trauma related needs, and provide initial assessment and treatment responses and support**
    - **Able to refer to specialist services where required**

4. **Community based support services**
    - **Based chiefly around**
        - **Voluntary providers and self-help organisations**
        - **Statutory community health and social services**
    - **Able to identify trauma related needs, and provide initial information and advice responses and support**
    - **Able to refer to specialist services where required**

5. **Agreed funding processes and allocations**
    - **Through the identification of psychological trauma (and wider Troubles related) health and social care needs as a DHSSPS Priority for Action etc.**
    - **Priority for Action and other investments of a long term nature to be tied explicitly to the objectives of the Coordinated Service Network**
    - **Incorporation of non-Troubles related needs and services in the Coordinated Service Network**

- **Continuing commitment to supporting those affected by the violence associated with the Troubles as part of the post conflict and peace building effort**

A public health framework for addressing trauma related needs

We propose that the range of services directed at addressing trauma related needs could be described in the following terms.

Type and level of Service	Function
Wider community action and developmental initiatives	Aimed at addressing the social, economic and relationship problems of a divided and troubled community
Advice & Information Services	Could be specific to those affected by the Troubles or generic for those affected by violence and other traumas
Level 1 Befriending-membership services	E.g. where a person is a member of a specific group identified as having been specifically affected by the Troubles
Level 2 Befriending-support or non-trauma focused counselling services*	Where a person who has experienced specific problems requires support through difficult times, periods of treatment etc.
Primary & Community Care services*	Mainly family doctor and statutory community services based services
Community Mental Health Services	Secondary services which receive Troubles and non-Troubles related trauma referrals
Specialist trauma treatment services	To provide specialist treatments (for adults, children, families) to address specific complex trauma related needs; support other services; undertake research and contribute to training & development; support planning & policy

These services probably operate counselling services at one or both of two levels i.e.

1. Enabling the engaged person to live effectively, to achieve a higher of level of functioning and quality of well-being, or
2. Treating identified psychological or mental health related conditions[4].

If the task of addressing trauma related needs and illnesses is to be delivered in a coordinated manner a public health approach offers a means of identifying a range of tasks, summarised in part in the above table, that can be undertaken, as part of an overall strategy, by different types of groups and services, doing

[4] Standards and good practice for Counselling Services; To be published by the Fermanagh, Omagh & Strabane Local Strategic Partnerships in cooperation with the Sperrin Lakeland Health & Social Care Trust; Enniskillen, Omagh & Strabane; First published 2005

different but related things, at different points in the cycle of a person's needs. This runs from pre-trauma information, advice and education, through to specialist treatments for complex traumas. Such an approach has been used for example in making significant progress in Northern Ireland in relation to domestic violence over the past 20 years or so. The World Health Organisation, in its *World Report on Violence and Health* (2002) recognises that violence within relationships and communities is a health issue and builds a strategy on this foundation in the belief that a health response to violence will make the world a healthier and safer place to live. From this perspective, a health and well-being approach to on-going violence and the consequences of past violence could open up new avenues and means through which such problems could be addressed. This is clearly of relevance to Northern Ireland.

A trauma focussed coordinated service network (CSN)

There are four recognisable service groupings in the above Table, all of which have a part to play. They are:

1. Primary health and community services (mostly statutory services)
2. Secondary mental health services (mostly statutory with some voluntary and private inputs)
3. Trauma support and counselling services (provided mainly by the voluntary and community organisations)
4. Specialist trauma treatment services (both statutory and voluntary)

The service groupings need to be seen as a whole care system whose work in relation to trauma is governed by a common set of principles, values, standards and complementary objectives, as described above, and with a clear focus on what it is we are collectively trying to achieve. We would suggest that the common theme here is a public health, or in this context a '*special public health and well-being*' focus. The following proposals are based the concept of the managed clinical network[5].

To make progress (in relation to both Troubles and non-Troubles needs and services) we would suggest the following processes.

1. **A Regional Commissioning Support Committee**
   The formation of a Regional Commissioning Support Committee (RCSC) to provide guidance, support and set out expectations of

[5] Linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional and existing [organisational] boundaries to ensure equitable provision of high quality, clinically effective services

trauma related services. See Annex 1 for a more detailed description of the functions of the RCSC.

2. **Coordinating trauma support and counselling services; a role for the Trauma Advisory Panels**
In respect chiefly of trauma support and counselling services Trauma Advisory Panels would have a specific function of coordinating developments in service arrangements and service integration, under the guidance of the RCSB. Arrangements for linkages with the other service groups (as described above) would also be put in place. See Annex 2 for further discussion of the TAPs' roles.

3. **Guidance for the Health & Social Services**
In line with the RCSC's guidance the DHSSPS would set out its requirements and guidance for Boards and Trusts, and the Family Practitioner Services, developments with statutory mental health and primary care services. Service developments would be in line with the NIMH&LD Review. Arrangements for linkages with the other service groups (as described above) would also be put in place.

4. **Coordinating and developing specialist trauma treatments**
A forum of organisations specialising in the treatment of trauma (statutory and non-statutory) would be formed to agree, in line with the RCSC's guidance, referral networks and processes, to advance developments in treatments and to identify how best the collective skills and knowledge of specialist services could be maximised. Arrangements for linkages with the other service groups (as described above) would also be put in place. See Annex 3 for discussion and details of the functions of the forum.

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Annex 1

A Regional Commissioning Support Committee

A coordinated service network operating to agreed principles and values would assist with the development and coordination of this whole care system. We would suggest that to enable the network to function, at a regional level a commissioning support body, under the auspices primarily of the DHSSPS, would be in place to assist with long term planning and service integration. Its specific functions would be to:

- **Provide advice to Government, The Victims Commissioner (if in place), Governmental Departments, Boards & Trusts, other funders, training organisations etc.**
- **Provide the public with information about services, points of contact etc.**
- **Identify service and treatment standards (in conjunction with professional bodies, CREST, NICE etc.)**
- **Develop protocols for access to services and treatment**
- **Identify and specify training requirements and expectations**

- **Facilitate agencies in complying with the standards through training and publications**
- **Advise on investments in relation to trauma services from identified governmental funds**

We recognise that some of the above functions might be more pertinent to the role of the proposed Victims Commissioner. In the absence of a decision on the proposal to have a Commissioner, the functions are tied into the role of the proposed Regional Body, which in time could lose some of its functions if a Commission is created and if specific functions are deemed to be more appropriate to that office.

Annex 2

The Role of the TAPS in developing trauma support services

To ensure that there is integration of the specialist treatment services and the support services, (and in line with the OFMDFM Consultation paper that it would be necessary to "*establish a framework within which longer term planning could occur and to address the criticism that there should be greater coordination in the delivery of services*") the TAPs should put in place complementary arrangements to advance standards and coordination of trauma support and counselling services (including Troubles and non-Troubles related services). This would be a specific function of the TAPs (or whatever might replace them following the OFMDFM consultation) and would probably involve a subset of the membership of the TAPs.

The TAPs would undertake this work governed by the guidance being issued by the Regional Commissioning Support Committee, and would put in place arrangements to create linkages with the other service groups identified as part of the network.

Annex 3

A forum of organisations specialising in the treatment of trauma

Out of the above classification of trauma related services a distinction is drawn between those specialist trauma services using clinical-type treatments (pharmacology and psychotherapies) for serious trauma related disorders and other related on one hand, and services for addressing relationship and 'daily living' problems, or that provide social, practical and emotional support services for people affected by traumatic experiences.

The development of a coherent network of specialist treatment services is an essential building block of the wider public health approach to trauma related needs. At present services function largely independent of each other with no coherent practice approach. Further, the connections between the specialist treatment services, mainstream mental health services, other related voluntary and community based services, and self-help organisations could at best be described as inconsistent.

Specialist services have a specific function to play in the overall approach because they should have the function of connecting with their referring hinterlands, to explain what they have to offer, to offer support to referring services, and to provide assessment and treatment for individuals and families. Where a service deems itself not the most appropriate service, it should refer on to the most appropriate service.

Earlier the role of the Regional Commissioning Support Committee (RCSC) was described. This body should, if it became operational, provide guidance, support and set out expectations of trauma related services. To assist with the operationalisation of any guidance etc. issued by the RCSC, and to take forward the development of a regional network, a forum of organisations specialising in the treatment of trauma should be formed.

The **principal aims** of the forum would be

- To promote the development of quality and clinically effective services,
- To enhance and promote the competence of each service,
- To share and pool resources
- To facilitate access for individuals and families to the most appropriate services
- To forge service linkages with the other service groupings in the Network

The forum's **key tasks** would be as follows:

1. To share information about services
2. To put in place mechanisms and protocols for cross-referral
3. To work towards common or complementary assessment processes
4. To identify the more specialist services available in the network and to promote further specialisation where this is needed
5. To integrate regional, national and international guidance into practice
6. To advise the RCSC, Boards, Trusts etc. on issues such as standards, ethics, public information, practice and clinical matters, etc.
7. To determine how best specialist services could liaise and interface with trauma support and other services
8. To provide information to the public, other services about the specialist services
9. To explore and develop the capacity to provide training
10. To agree arrangements for registration and accreditation
11. To identify any issues that require to be addressed by the forum
12. To promote evaluation through research & audit existing and new developments in treatment

Establishing the forum

It is suggested that all organisations operating within Northern Ireland and which meet the following proposed criteria should participate in the forum.

The organisation or service:

1. Has a regional, sub-regional or Area Board (HSS) wide remit;
2. Is treating severe psychological trauma disorders (such as PTSD)
3. Is applying a trauma focussed evidence based intervention, or
   Is robustly evaluating (through clinical audit or research) its treatment approach(es)
4. Is ensuring its treatment services are subjected to regular and appropriate clinical supervision
5. Is providing services for the general public or for specific groups.

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Appendix 1

Troubles Specific trauma treatment services (under development)

Digest of References

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