

West Yorkshire Health & Care Partnership

Becoming a trauma-informed system by 2030

Reflections on the successes & challenges of implementation

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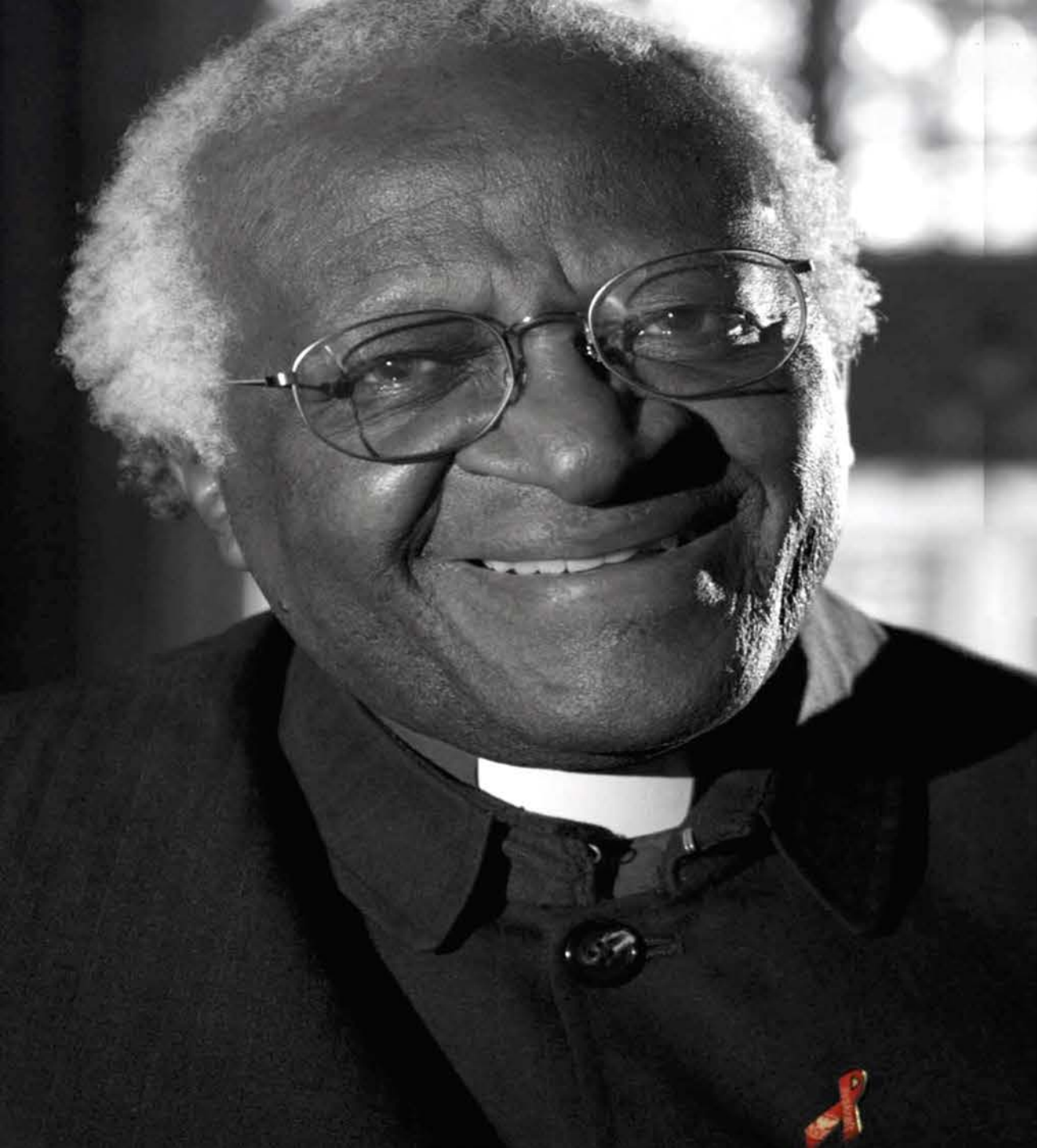
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Setting the Scene 2020-2022

- I have been acting as an expert advisor to the West Yorkshire Partnership ATR programme since 2020
- Supporting Emm & Carrie as a thinking partner
- I've met a lot of stakeholders, attended a lot of meetings and presented keynotes at launch events and conferences on ATR across WY partnership
- I have delivered numerous workshops on System Change, Trauma Informed Practice, Adversity, Resilience and Routine Enquiry
- I have been constantly impressed by the passion, expertise and ambition shown by colleagues in West Yorkshire





“ 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

Health & Financial Burden of Adverse Childhood Experiences in England & Wales

Open access

Original research

BMJ Open Health and financial burden of adverse childhood experiences in England and Wales: a combined primary data study of five surveys

Karen Hughes ^{1,2}, Kat Ford,³ Rajendra Kadel,¹ Catherine A Sharp,³ Mark A Bellis^{1,2}

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► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2019-036374>).

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ABSTRACT

Objective To estimate the health and financial burden of adverse childhood experiences (ACEs) in England and Wales.

Design The study combined data from five randomly stratified cross-sectional ACE studies. Population attributable fractions (PAFs) were calculated for major health risks and causes of ill health and applied to disability adjusted life years (DALYs), with financial costs estimated using a modified human capital method.

Setting Households in England and Wales.

Participants 15 285 residents aged 18–69.

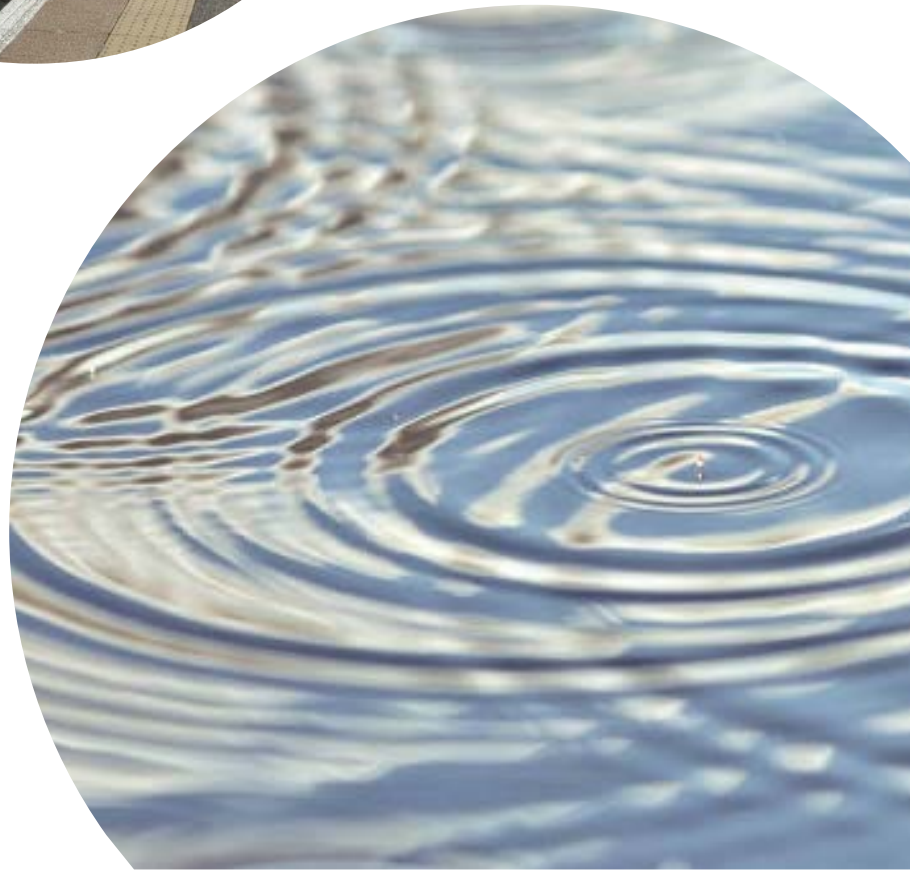
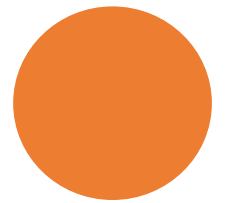
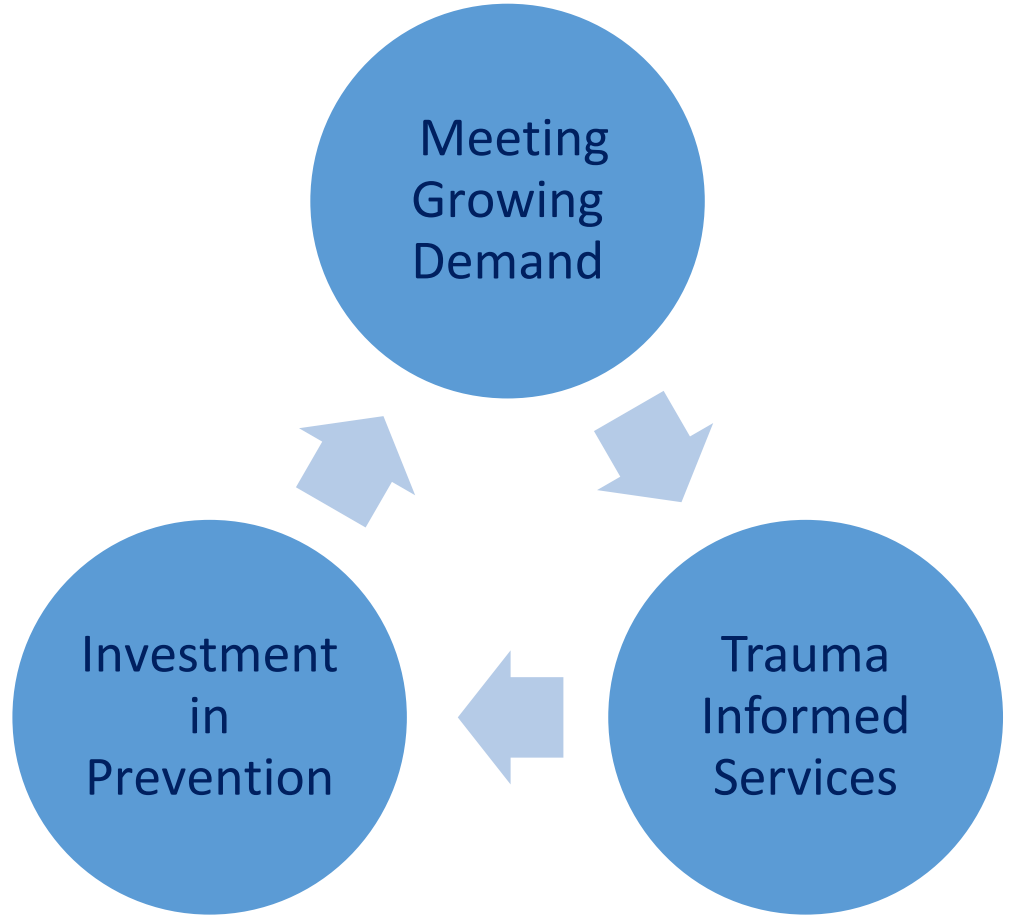
Outcome measures The outcome measures were PAFs for single (1 ACE) and multiple (2–3 and ≥4 ACEs) ACE exposure categories for four health risks (smoking, alcohol use, drug use, high body mass index) and nine causes of ill health (cancer, type 2 diabetes, heart disease, respiratory disease, stroke, violence, anxiety, depression, other mental illness); and annual estimated DALYs and financial costs attributable to ACEs.

Results Cumulative relationships were found between ACEs and risks of all outcomes. For health risks, PAFs for ACEs were highest for drug use (Wales 58.8%, England 52.6%), although ACE-attributable smoking had the highest estimated costs (England and Wales, £7.8 billion). For causes of ill health, PAFs for ACEs were highest for violence (Wales 48.9%, England 43.4%) and mental illness (ranging from 29.1% for anxiety in England to 49.7% for other mental

Strengths and limitations of this study

- Adverse childhood experiences (ACEs) are known to increase individuals' risks of poor health across the life course, yet the financial burden they impose on national economies is largely unmeasured.
- We combined primary data on ACEs and 13 health outcomes from five general population ACE surveys undertaken in England and Wales.
- For each outcome, we generated population attributable fractions for cumulative ACE exposure and applied these to disability adjusted life years, which in turn allowed calculation of financial burden of ACEs using a modified human capital approach.
- ACE data were retrospectively reported and may be affected by recall bias, while general household surveys by their nature are likely to exclude those that have suffered the greatest impact of ACEs (eg, homelessness, incarceration or premature death).
- Although many major health outcomes were included in the study, data are not yet available on all health outcomes potentially associated with ACEs and financial estimates are likely to be conservative.

behaviours and the development of mental and physical illness has burgeoned in recent



We need a public health approach preventing & addressing the impact of childhood adversity

- Multiple Public Health Organisations have reviewed the evidence for 'what works' and agree that in order to transform the health and wellbeing of future generations
- We can and must:
 - a) **Prevent** adverse childhood experiences (ACEs)
 - b) **Support** child and family wellbeing/ parenting
 - c) **Detect and mitigate** the impact of Trauma & Adversity
 - d) **Promote resilience** across the life course

NEW DIRECTIONS FOR MENTAL HEALTH SERVICES



Using Trauma Theory to Design Service Systems

Maxine Harris, Roger D. Falot

EDITORS

NUMBER 89, SPRING 2001
JOSSEY-BASS

The 4 R's – of Trauma Informed Care

- A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist** re-traumatization. (SAMHSA, 2014)


WARREN LARKIN
ASSOCIATES

What is Trauma Informed practice? #2

*“Trauma-informed practice is about the **democratisation and application of bio-psycho-social science, in human service settings and in society.**” Larkin, W. (2021)*

Public make informed choices

Services remove barriers

Relationship-driven practice

The Bio-Psycho-Social Model

- George Engel put forward this idea in 1977 as a holistic alternative to the dominant biomedical model that had dominated since the mid-20th century
- He felt the bio-medical model was narrow, reductionist and **ignored the patient's subjective experience**
- **Bio** (physiological pathology)
- **Psycho** (thoughts emotions and behaviours such as psychological distress, fear/avoidance beliefs, current coping methods and attributions)
- **Social** (socio-economical, socio-environmental, and cultural factors such as work issues, family circumstances and benefits/economics)

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*^{\$}

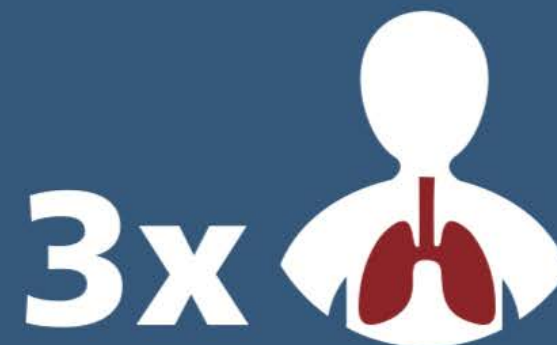
For specific diseases they were:



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*[#]

Examples of the most “definitive” meta-analyses linking childhood adversities / trauma and subsequent risk of developing mental health difficulties

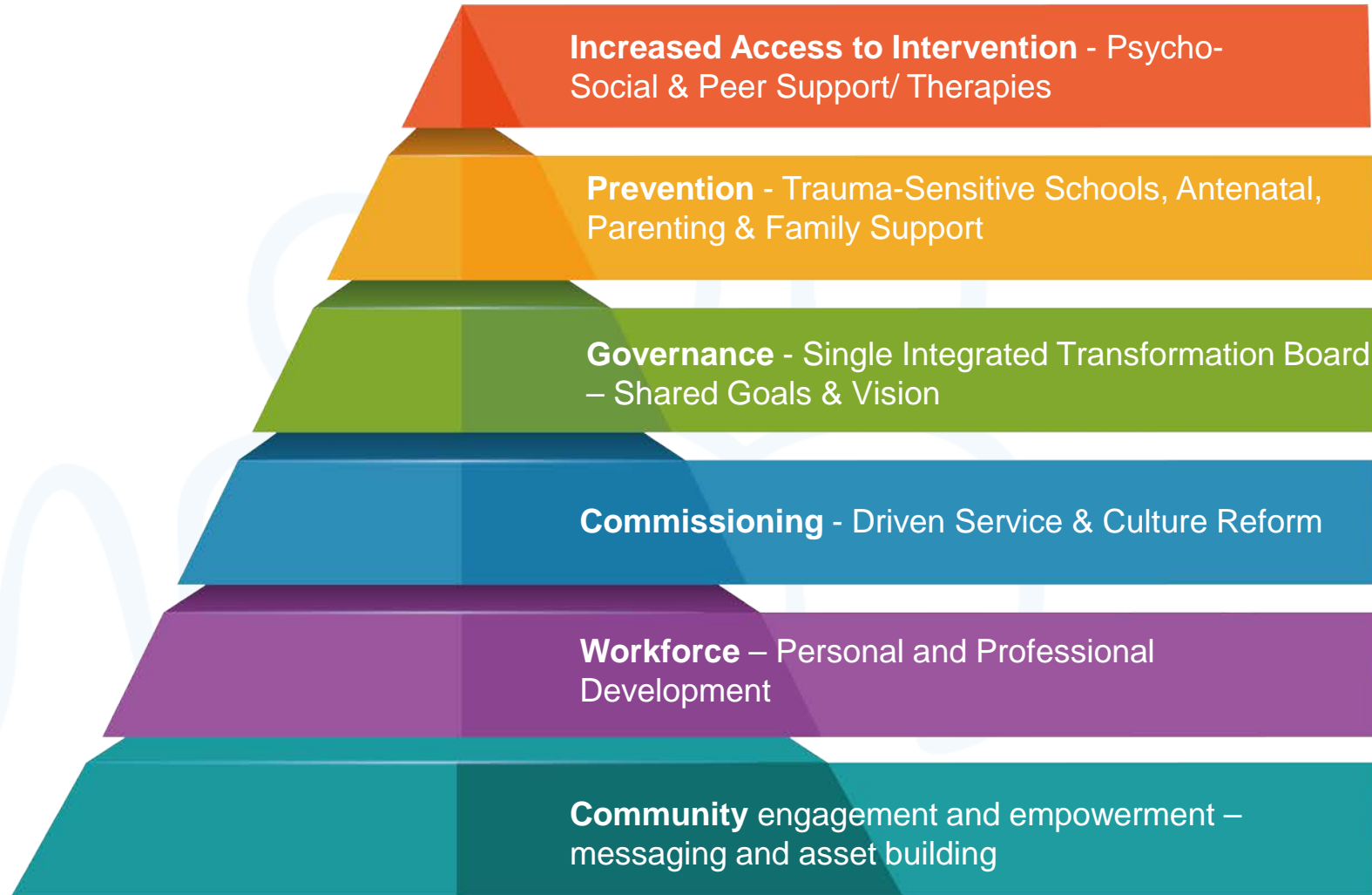
(Filippo Varese, 2018)

Depression	Mandelli et al (2017)
Anxiety	Lindert et al. (2014)
Obsessive compulsive disorder	Miller & Brock (2017)
Suicidal behaviour	Zatti et al. (2017)
Non-suicidal self-harm	Liu et al. (2017)
Functional neurological (conversion) disorders / medically unexplained symptoms	Ludvig et al. (2018)
Dissociation	Vonderlin et al. (2018); Rafiq et al. (2018)
Eating disorders	Molendijk et al. (2017)
Substance misuse (illicit drugs, alcohol etc.)	Norman et al. (2012)
Psychosis	Varese et al. (2012)
Bipolar disorder	Palmier-Claus et al. (2016)
Borderline personality disorder	Porter et al. (under review)

Childhood Trauma & Homelessness (Liu et al, 2021, The Lancet Public Health, Volume 6, Issue 11,

- 29 studies in the systematic review and 20 studies in the meta-analysis
- Emphasise the near **universality of ACEs in the homeless population**, as well as their association with poor outcomes in adulthood.
- **Lifetime prevalence was 89.8% for one or more ACEs and 53.9% for four or more ACEs among people experiencing homelessness.**
- in the general population, it is estimated that 38–39% have one ACE exposure and 3–5% have four or more
- **ACEs were consistently positively associated with suicidal risk, suicide attempts, major depressive disorder, problematic substance use, and adult victimisation among people experiencing homelessness.**

Trauma-Aware System Change (TASC) model



Workforce Approach – Key recommendations

1. Provide the entire multi-agency workforce with a foundational level of education and awareness of Trauma, Adversity, Resilience & Prevention (akin to safeguarding)
2. Develop a Knowledge & Skills framework so everyone has appropriate attitudes, level of knowledge and skills for the role they perform
3. Routine/ targeted enquiry training and support for appropriate roles/ settings
4. Workforce should have opportunity to address their own adversity, trauma & and get the help to do that
5. Operational managers, leaders and supervisors are supported as advocates, enablers and change agents
6. Trauma informed supervision & reflective practice for all front-line staff
7. Trauma informed practice standards/ organizational development plans
8. ATR Community of Practice – relationships, CPD, multi-agency reflection

Most Recently...

- I have been contributing to the work of the ATR Training Collaborative
- I've been given the opportunity to collaborate with Lisa Cherry and Dr Alicia
- My most recent assignment has been working with partner agencies to consult, adapt and co-produce sector specific content for the...
- 'Foundation Training in Adversity, Trauma and Resilience for Multi-Agency Colleagues in West Yorkshire'
- Working with Training Collaborative CotW to produce a Trauma Informed Knowledge and Skills Framework for West Yorkshire



REACH™ (Routine Enquiry about Adversity in Childhood) Model



Routine enquiry for history of adverse childhood experiences (ACEs) in the adult patient population in a general practice setting: A pathfinder study

Proof of concept – Feasibility and Preliminary Impact Evaluation

2018

Volume 5 (2019) 145-150

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Childhood adversity and trauma: experiences of professionals trained to routinely enquire about childhood adversity

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ARTICLE INFO

Keywords: Pathfinder; adverse childhood experiences; routine enquiry; Heliyon

ABSTRACT

Research indicates that adverse childhood experiences play a causal role in the development of poor health and social outcomes in adulthood. Despite this, research suggests that such experiences go undetected since clinicians are unlikely, and practitioners are unlikely to ask. A project was developed in which practitioners were trained to routinely enquire about adversity in their daily practice. Their pilot services took part that needed directly and indirectly with children and young people, many of whom were required to complete adverse experience questionnaires. The aim of the study was to assess an understanding of the experiences of these practitioners. Semi-structured interviews were conducted, and the data was analysed using thematic analysis. The emerging themes were: change in knowledge, perception and practice; the emotional impact of asking and responding to disclosure; confidence in asking and responding appropriately; making sense of the impact for clients; how and when to ask. Findings indicate that practitioners do not routinely enquire about adversity in their daily practice. It is recommended that practitioners receive continuous training and support to ensure they are confident to ask and respond to disclosure. Supportive supervision is recommended to ensure practitioners are confident to ask and respond to disclosure. Supportive supervision is recommended to ensure practitioners are confident to ask and respond to disclosure.

1. Introduction

Adverse childhood experiences (ACEs), along with related terms such as childhood trauma and maltreatment, refer to a range of negative childhood experiences. The World Health Organization defines child abuse and neglect as forms of physical and emotional abuse, neglect or exploitation that results in actual or potential harm to a child (Duckworth et al., 2005). ACEs may include, but are not limited to, physical, sexual and emotional abuse, including parental death or loss, neglect and poverty (Finkelhor et al., 1990).

The negative impact that ACEs have on health and social outcomes is now widely accepted. ACEs have been found to increase the risk of poor health behaviours including smoking, alcohol and substance misuse and severe obesity (Andersson and Tucker, 2009; Dohren et al., 2002; Dulcan et al., 2002; Ford et al., 1998; Ford et al., 2013). There is strong evidence that ACEs increase the risk of a range of chronic and life-threatening health conditions including cancer and pulmonary, liver and cardiac disease (Chen et al., 2008; Brown et al., 2012; Gung et al., 2004; Felitti et al., 2008).

Overwhelming evidence for the impact of ACEs on outcomes is established to also appear with mental health. Research and a has been estimated that in the absence of childhood adversity there would be a 23.9% reduction in mood disorders, 18% reduction in anxiety, 41.6% reduction of behavioural difficulties, 27% reduction of substance-related difficulties (Gunnell et al., 2015) and a 33% reduction in psychosis (Vostanis et al., 2013). ACEs have also been found, for example, to be associated with severity of hallucinations and delusions in people experiencing psychosis (Doherty et al., 2011), suicide attempts (Doherty et al., 2010), and risk of depression along with increased risk of relapse and poorer treatment response (Doherty et al., 2013).

To begin to reduce the impact of ACEs it is essential that we identify them early in a child's life, however, a major barrier to this early detection is the reluctance of the voluntary disclosure of adversity by people who are in contact with services. Research suggests that those who have experienced trauma and abuse are unlikely to spontaneously disclose them, particularly to services (Gunnell and Finkelhor, 2018). Vostanis et al. (2011) suggest that, since spontaneous disclosure is unlikely, it is essential that practitioners are trained to routinely enquire about adversity. Indeed, clinicians are encouraged to ask about trauma and adversity. Indeed,

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2403-4850/2019 Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).



Health Visitor Adverse Childhood Experience (ACE) Enquiry - Survey Report September 2020.

Centre for Early Child Development

Editorials

Addressing adverse childhood experiences: implications for professional practice

INTRODUCTION

It has been over 20 years since the publication of seminal research by Felitti and colleagues highlighting the powerful relationship between adverse childhood experiences (ACEs) and a wide range of health and wellbeing outcomes. Since the landmark ACE study was published, a compelling body of research has accumulated confirming the strong and proportionate relationship between experiences of childhood adversity and the manifestation of detrimental health and social outcomes later in life.¹ We have learnt that ACEs are relatively common and are amenable to detection. We have an evolving understanding of the neurodevelopmental links between adversity and poor mental and physical health outcomes. We have evidence that the negative effects of ACEs can be mitigated through psychosocial and resilience building interventions.² However, despite this growing awareness, it is not obvious that ACEs have yet been approached as a significant public health problem in the UK.

ACE enquiry is becoming more common in the UK primary care system and in paediatric medicine, with emerging evidence of significant human and financial benefit in the UK. There is a growing interest in routine or targeted ACE enquiry, with early indications that this might offer opportunities for GPs to alleviate suffering via therapeutic relationships. Nevertheless, it is still unclear how to best implement ACE enquiry in the UK. This editorial aims to explore some of the challenges and barriers related to implementing ACE enquiry in a UK primary care context.

WHAT ARE ADVERSE CHILDHOOD EXPERIENCES?

The ACEs concept most often refers to a list of ten categories of abuse, neglect, and household dysfunction, experienced before the age of 18 years. These are parental mental illness, parental substance misuse, parental attention, living with a parent or adult who is violent or abusive, parental divorce or separation, being exposed to domestic violence, experiencing emotional, sexual or physical abuse, and significant neglect.³

Of course, adverse life experiences are not confined to childhood and there are many adverse experiences and circumstances that can regularly impact a person's wellbeing.

Editorial

"Enquiring sensitively, with a questionnaire-based tool, when followed up with a compassionate response, is acceptable to patients and fosters insight into the social and psychological determinants of many presenting problems."

For example, we know that poverty is positively correlated with many of the ACEs on this list, including in an increasingly social cohesion and having high levels of crime and violence can have a similarly negative impact on emotional wellbeing and health outcomes.

UK national ACE studies⁴ reveal that around 25% of the UK population experience 3+ ACEs, with one in ten people experiencing 4+. At a population level, greater numbers of ACEs are associated with disproportionately increased risk of poor outcomes. Outcomes affected include educational and employment status, low mental wellbeing and life satisfaction, significantly increased risk of substance misuse, and increased risk of developing some of the leading biomedical causes of disease and death, such as cancer and heart disease. According to the Centers for Disease Control, ACE scores of 4+ has been found to reduce life expectancy by 20 years.⁵

RESEARCH

Having greater exposure to 'toxic stress' is term coined by the Harvard Centre on the Developing Child in childhood, such as witnessing violence or not having a consistent caregiver, is clearly not an optimal start in life. However, exposure to ACEs or toxic stress does not mean that a person's outcomes are set in stone.

The antidote to ACEs is 'resilience'. Resilience means having resources that can help a person cope and retain emotional and psychological balance in the face of adversity, such as being able to connect in a trusted adult, and can be acquired across the life course.⁶

In a recent study examining resilience and ACEs, people with 4+ ACEs who reported more childhood resilience assets were around two-thirds less likely to experience poor childhood health compared with people who had 4+ ACEs but no resilience assets.⁷

WE CAN'T KEEP DOING THE SAME THINGS AND EXPECT DIFFERENT OUTCOMES

ACE enquiry offers new opportunities by addressing the health impact of adversity by addressing the source of the distress. This is potentially significant as traditional approaches to helping patients experiencing the consequences of adversity often have low success. For example, commissioners of drug treatment services cite success rates as low as 10% in helping people get up their addiction to heroin in clinic setting.

WHAT IS REALISTIC IN PRIMARY CARE?

We should consider enquiring more frequently about ACEs.

Research suggests that disclosure of ACEs can positively impact recovery, promote resilience, and improve a person's perception of themselves. In contrast, keeping burdensome secrets, like childhood adversity or subsequent trauma, can be damaging to health and wellbeing.

Evidence suggests that if people are not asked directly, it can take many years for an adult to disclose a history of abuse.⁸ With disclosure, people can begin to create meaning through telling their story, which can help them to make sense of their experiences. This empowering experience can be a catalyst for meaningful change.

WHY ARE SERVICES NOT ALWAYS READY?

Disclosure of ACEs can often be reluctant to disclose voluntarily due in part to feelings of shame, guilt, and anxiety about their experience and the act or consequences of disclosure.⁹ Furthermore, health and social care practitioners often describe discomfort about the idea of having to ask people about childhood adversity and trauma, and worry about upsetting clients. In practice, such enquiries tend to take one hour or more and professionals have the opportunity to



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June 2020

Evaluation of a system wide approach to implementing routine enquiry about adversity in childhood (REACH) across Nottinghamshire (Interim report)

Zara Quigg, Rebecca Harrison, Nadia Butler, Charlotte Bigland, Hannah Timpson

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Contact: z.a.quigg@ljmu.ac.uk, ISBN 978-1-912210-83-1

Resilience building vs Treatment
















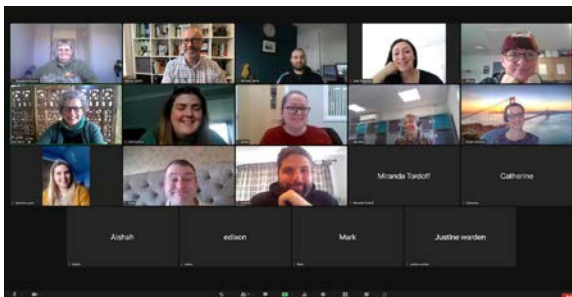
Source: www.acesaware.org/resources/



Click anywhere to continue...

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	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.	
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Adverse Childhood Experiences, Trauma and Resilience - A Foundation Course for West Yorkshire Police - Part 1

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Foundation Training –Why and How

- **Why** - Like Safeguarding knowledge– if you work with people, **you need to have an informed perspective** on Adversity, Trauma and Resilience
- **How** – We engaged with managers and workers from each sector to assess their needs and existing level of knowledge
- We shared an evidence-based and well evaluated foundation course with these focus groups and **generated sector specific content**, cases & adaptations

Foundation Training

- **Online** via Zoom or Teams
- **3-hour session** - interaction via discussion, group work, presentation, Q&A, case examples and reflection
- **West Yorkshire Police** - Response Officers
- **A&E staff** – Calderdale & Huddersfield Foundation Trust
- **Housing Sector** Organisations
- **Primary Care** – Calderdale Primary Care Networks
- **Armley Prison** – SMT and Officers
- **GP Trainees** – Wakefield

Foundation Training - What we learned...

- For many there was a varied level of baseline knowledge
- For some it was the first time they encountered these concepts and ideas
- The sessions had a powerful impact
- Some people went on to seek help for their own unresolved issues
- Supervision/ reflective practice varies from excellent to non-existent
- There was strong support for the principle of reflective, restorative & developmental supervision in the workplace becoming 'standard practice'
- Sector-specific & multi-disciplinary sessions have value

Foundation Training – sector specific issues

- Workers felt strongly that their managers and senior leaders should attend the training
- Workers are clearly being traumatised by the work they do and some operate in a culture where this is normalised or minimised
- This quote conveys the sentiment, *“if no-one is caring for us, how long are we going to be able to show care for the people we meet?”*
- High demand, time pressures, coupled with impersonal procedures - limits the opportunity for a person-centered approach
- Procedure and pace limit the potential for relationships and asking the right questions

Foundation Training– Police & Housing

- Approximately 600 members of police and housing staff have undertaken the trauma informed training.
- We received 110 post training evaluations and from those responses:
 - 79% of staff agreed or strongly agreed that ‘I think the training is relevant to my work and the people I serve’.
 - 76% of staff agreed or strongly agreed that ‘it is likely the training will influence my day-to-day practice/approach’.
 - 81% of staff agreed or strongly agreed that ‘other colleagues across agencies would benefit from attending this Adversity, Trauma & Resilience Awareness training course’.

Foundation Training – Housing

- Approximately 300 members of housing staff have undertaken the trauma informed training.
- We received 45 post training evaluations and from those responses:
 - 93% of staff agreed or strongly agreed that ‘I think the training is relevant to my work and the people I serve’.
 - 91% of staff agreed or strongly agreed that ‘it is likely the training will influence my day-to-day practice/approach’.
 - 96% of staff agreed or strongly agreed that ‘other colleagues across agencies would benefit from attending this Adversity, Trauma & Resilience Awareness training course’.

Feedback from the Foundation Training

- *“Today’s training session was very informative, powerful and well presented.”*
- *“I think the varied content was well balanced, with information, discussion and video, even though it was 3 hours on a Friday afternoon on a sensitive subject I was engaged throughout. There were things I could use with my Team to start discussion on this area.”*
- *“Thank you for the informative input, very interesting. Working as a patrol officer we do have significant powers and enter the appropriate homes of those during/post many ACE events in children's lives.”*
- *“An excellent session which massively increased my understanding.”*
- *“I found the course really interesting. Within the first 10 mins relating to the hierarchy of need helped me understand client’s behaviour and reactions a lot more. I think this has been really useful to show how to relate to and communicate with clients who may be experiencing trauma, which can get lost within a busy role sometimes.”*
- *“Found the training to be very thought provoking and insightful. I have never come across some of the issues and practices highlighted such as ACE’s and Traumatic informed practice, so this training has helped me improve my knowledge and understanding regarding these issues.”*

“I wished I had this training 29 years ago when I first joined the force, I have learned a lot of useful information, and it would be useful for leaders to attend the training too...”

For me there are 3 facets to the training that are helpful...

For me as Police Officer, the training provides insight to start to understand why people may behave in a certain way (both children and adults) that will inform a method of approach to assist as a communication strategy, in order to be able to respond there and then with incidents/individuals, provide initial support to achieve best evidence/victim care initially and signpost accordingly.

As a peer to be able to maybe identify and address colleague behaviour/attitude.

As a leader (very much as above) but to identify /staff welfare, performance, and attendance with a view to support.”

**Inspector Mark Chamberlain
Wakefield District Neighbourhood Patrol – Team 5**

Foundation Training...*Opportunities & Risks*

- **The experience was powerful; provoking personal and professional insights and shifts**
- **Three main implications:**
 - 1. Personal reflection and insight regarding own experience of adversity, trauma and resilience**
 - **Handled and supported well this leads to better supported resilient workers and teams ✓**
 - **Handled badly or without care, this could lead to re-traumatization and a more vulnerable workforce ✗**

Foundation Training...*Opportunities & Risks*

2. Workers embrace the values and principles of trauma informed practice & see opportunities for improvements/ express concern for out of date or incompatible policy or practice

- With a manager or supervisor who is modelling the values and principles of trauma informed practice they become champions, advocates and agents of change ✓
- Without such management support they become frustrated, feel disempowered and either *'fall in line'* or *'vote with their feet'* ✗

Foundation Training... *Opportunities & Risks*

3. Uptake has been fantastic – however, there are thousands of workers & leaders who need to access this crucial knowledge and education.

- We have developed some high-quality products ✓
- We have very high demand ✓ and a huge multi-agency workforce ✗
- We will develop the WY Partnership ATR Academy – to offer ATR Fellowships... ✓
- This will mean supporting Fellows to become trainers, advocates and change makers ✓
- We also want to build capacity by recruiting & training & coaching a group of ATR trainers to deliver high quality TIP training & practice development support across the Partnership ✓

Supervisors, Managers & Clinical/ Practice Leaders

- Let's assume we have successfully empowered the whole workforce to be informed & passionate agents of change...and to get help themselves if they need it...
- ...and we have board level support and long-term commitment from all partner organisations in West Yorkshire
- GREAT!!!
- Wait a minute, who is going to...



Supervisors, Managers & Leaders

- Create the conditions for change on the ground
- Model Trauma Informed values & support cultural change
- Provide permission
- Remove organizational barriers & assertively advocate (walk the tightrope)
- Encourage innovative solutions,
- Champion relationship-driven model (staff, customers, communities)
- Facilitate reflective practice / supervision
- Develop, coach and challenge
- Revise operational policy and procedure,
- Oversee a team or service progress against trauma informed practice standards

Relationships are our No 1. asset – the key to health, recovery and resilience

Society - Harvard Study of Adult Development - Relationship satisfaction was a better predictor of longevity & happiness, than social class, IQ, or genes.

Individual Recovery - “Strengthened relationships are a key resource in times of acute stress. Indeed, the perceived absence of supportive relationships is one of the strongest predictors of post-traumatic stress disorder” (Chris Brewin, 2000)

Therapeutic Relationships - Quality of the relationship is the most consistent predictor of change in psychosocial interventions. It’s the relationship that heals...

Organisational & System Imperative - If resilience and healing relies on relationships, then we must, “look after the people, that look after the people.”

Thank you...

- Please reach out if you want to discuss anything:
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