Title

The Rivers Centre in Scotland: An Attachment Based Service Model for People with Complex PTSD (CPTSD)

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Abstract

The Rivers Centre operated for nearly twenty years as a traditional specialist trauma service, delivering psychological therapies to an adult population affected by trauma. Embedded in a health and social care system whose characteristics were unhelpful for people with histories of insecure attachment experiences, the Rivers Centre aimed to find a different way of working and in January 2017 re-launched with a new model of service. The aim of this paper is to describe the new service model from an organisational perspective in the context of attachment theory. At the heart of the model is the premise that to be effective, a trauma service needs to provide people with an alternative model of attachment. Early signs from service audit data indicate that an attachment-based way of working can improve engagement, and can provide a supportive and responsive environment in which people can learn to recover.

The trauma landscape in Scotland

The Rivers Centre is a specialist trauma service in Scotland, serving the people of Lothian as part of the National Health Service (NHS). General mental health services in Scotland are provided by the NHS and the majority of services are accessed through General Practitioners (GPs). Services are organised around community-based primary care liaison teams, community mental health teams, and hospital psychiatry and psychology services. Specialist services, including specialist trauma services, are normally provided on a regional basis. Local government authorities are responsible for social care and support services in the community, and the voluntary and private sectors also provide an extensive range of services (Audit Scotland, 2009).

The provision of trauma care within this multi-sector landscape is very often fragmented, uncoordinated and unevenly distributed. GPs navigate a system characterised by multiple barriers and apparently arbitrary referral criteria (Watt, 2011), and children, adults, and older adults are treated by separate services based on age. In many cases referrers face service models that have long waits, opt-in systems and “two strikes and you’re out” discharge policies, whilst people seeking help for their psychological difficulties face a care system that can often seem inaccessible and unresponsive.

Recent years have witnessed the beginnings of a transformation in Scotland, however, as the Scottish Government has put trauma at the heart of its mental health policy. Beginning with a range of commitments detailed in their Mental Health Strategy (Scottish Government, 2012) the Government has taken a number of steps including the funding of an independent inquiry into historic child abuse (Scottish Child Abuse Inquiry, 2015); the production of the National Trauma Training Framework in partnership with NHS Education for Scotland (NHS Education for Scotland, 2017) and investment in a programme aimed at the prevention of adverse childhood experiences (Scottish Government, 2018).

The Rivers Centre

Within this landscape the Rivers Centre, named after the First World War psychiatrist WHR Rivers, operated for nearly twenty years as a traditional adult psychological therapies service. Based in the grounds of an Edinburgh psychiatric hospital, a multi-disciplinary team of clinicians treated adults affected by trauma using a care pathway that followed a traditional course: referrals were accepted from GPs or psychiatrists on the basis of strict inclusion criteria, and an "opt in" system was followed by an assessment appointment and placement on a waiting list for group-based or individual treatment in line with established guidelines (National Institute for Health and Clinical Excellence, 2005; Foa et al., 2010). Non-attendance and disengagement rates were high with 17% of people attending their assessment appointments and an average of 62% disengaging before they completed a group-based intervention. Psychological interventions were followed by discharge.

In 2012 service audit data indicated a shift in the profile of the Rivers Centre's population, with approximately two thirds of people reporting traumatic experiences in their childhood as well as adulthood. Analysis using the Scottish Index of Multiple Deprivation showed that less than 4% of people on the Rivers Centre caseload lived within the most deprived areas of Lothian and an examination of GP records revealed that the average time from adult index trauma to referral to the Rivers Centre was seven years. During this seven-year period people consulted their GPs an average of forty times and made frequent use of Accident & Emergency services, general mental health services, and support services across social care and the third sector. In the context of a national healthcare system where the total cost of mental health problems has been estimated at £10.7 billion (Scottish Parliament Information Centre, 2014), the impact of this seven-year help-seeking journey on human, health and social costs was likely to be substantial.

There were also indications that referrals to the Rivers Centre mirrored developments more broadly in society. Increases in the number of referrals appeared to correlate with high profile media reports of childhood sexual abuse allegations, and by 2016 childhood abuse had become the most common type of trauma experienced by people attending the Centre. Service audit data indicated an increase in the severity and complexity of clinical presentation (Karatzias et al., 2017). Increasingly, people were presenting with high levels of PTSD symptoms, little ability to regulate affect, and a pervasive negative view of self and others. Assessment of interpersonal relationship patterns (Bartholomew & Horowitz, 1991) suggested that "insecure fearful-avoidant" attachment was by far the most common style.

The traditional model of psychological therapy service utilised by the Rivers Centre for nearly two decades had become no longer fit for purpose and a period of data collection began with a view to developing a new model of service. A consultation process was initiated involving people attending the Centre and a third sector independent advocacy organisation was commissioned to identify service user priorities. A steering group was established of "experts by experience" to identify areas of focus, and this informed the development of questions for a series of service user focus groups and an electronic survey questionnaire which was sent to service users across Lothian. A report based on analysis of these data (CAPS, 2016) described people's experiences of accessing trauma care, and identified key themes, namely trust, safe and secure relationships, choice and accessibility.

The case for an attachment-based model of service

Similar themes have been identified in the attachment literature, where John Bowlby's pioneering work grounded functional and healthy lifelong development in the quality of the caregiver attachment relationship. Bowlby (1973) postulated that the consistent availability and responsiveness of the care-giver results in a "secure" attachment that enables an individual actively to seek out and secure appropriate support from significant others. In contrast,

inconsistent, unresponsive or abusive care-giving disrupts this process producing an “insecure” attachment, causing the infant to distrust or fear contact with the care-giver. Such early experiences with the caregiver become psychologically internalized as “internal working models” of future relationships and by the time the individual reaches adolescence, early interactions have become generalized interactional styles, driven by the internal working model. (Bowlby, 1982; Feeney, 2000).

The utility of attachment theory has long been recognized in the field of healthcare, not least because it has provided a framework for understanding the impact of traumatic experience on relationships with healthcare providers. Early traumatic experiences, it has been argued, can “ravage” the attachment system (Bloom, 2013) and produce expectations that relationships with care-givers in adulthood will be similar to those of the past in terms of a loss of power, choice, control and safety. A number of researchers have demonstrated the influence of insecure attachment patterns on relationships in a therapeutic context (Miller, 2008; Salmon & Young, 2009), and some have argued that healthcare systems themselves have the potential to re-traumatize due to their fundamental operating principles of coercion and control (Bloom and Farragher, 2010; Conners-Burrow et al., 2013).

As the full impact of attachment experiences has become apparent, there have been calls for services across the mental health system to become more sensitive and responsive, and to work in ways that do not reactivate past relational experiences. The rich body of work on trauma-informed care has pointed the way in this respect (Harris & Fallot, 2001), identifying themes of choice, collaboration, trust, empowerment and safety, and mapping a direction of travel for new models of service: “from fear to safety, from control to empowerment, and from abuse of power to accountability and transparency” (Sweeney & Taggart, 2018).

These themes from the attachment literature were drawn together with the results of the service user consultation to form the basis of a proposed redesign of the Rivers Centre. In 2016

the Scottish Government approved funding for this “test of concept” and the following year the Rivers Centre was re-launched as an attachment-based service.

An attachment-based model of trauma care

At the heart of the new model was the premise that to be effective, a trauma service needs to provide people with an alternative model of attachment. To do this, the Rivers Centre re-evaluated its fundamental organisational practices and policies through an attachment lens, reframing complex behaviours as a response to relational triggers. It prioritised the building of secure and trustworthy relationships above all else, basing its systems and practices on the following principles:

Accessibility

The Rivers Centre opened its doors in January 2017 as an “open access” service. Referrals were no longer required and people could seek help without the involvement of their doctor. Since opening on this basis, more than 2,000 people have self-referred, with an average of 89 new people attending each month. This contrasted with an average rate of 20 people referred by doctors each month under the old system.

Audit data for the period January 2017 to June 2018 indicated that 58% (n = 1160) of people were looking for help with the effects of childhood abuse (sexual, emotional, physical abuse or neglect) and 12% (n = 240) were seeking help with the effects of domestic violence. A total of 63% (n = 1260) of people identified themselves as female and 37% (n = 740) identified themselves as male. Three sub-populations were disproportionately represented; adults who had spent their childhood in care, people with a forensic history, and people on the autism spectrum. Analysis based on the Scottish Index of Multiple Deprivation showed that approximately 24% (n = 480) of people lived in the most deprived areas of Lothian. In terms of “time since index trauma”, approximately 6% (n = 120) of people had accessed help within 6 months of their index trauma.

A safe space

The Rivers Centre moved out of the Royal Edinburgh Hospital and embedded itself in the local community above a public library. The premises aimed to create a welcoming environment with a focus on safety, privacy and confidentiality. Opaque screening was placed on the windows and acoustic surfaces increased the sound-proofing of clinical interview areas. Furnishings were chosen for their non-institutional qualities and attention was paid to the selection of pictures, ambient music, and book titles. The large reception room was zoned to create seating clusters using high-backed curved-carcass chairs, lighting was kept subdued and pastel colour schemes were used. A small kitchen area added an atmosphere of domesticity and people were encouraged to prepare their own tea or coffee on arrival. Due to the lack of green space an "indoor garden" was created, funded by the Edinburgh and Lothians Health Foundation, and supported by expertise from the Royal Botanic Garden Edinburgh and a third sector horticultural project.

Control

The self-referral system at the Rivers Centre was designed to encourage people to control the timing of their access to services. An open access Advice Clinic operated four times a week, where people attended without the need for an appointment, at a time that suited them. The Advice Clinic was staffed by senior clinicians, ensuring that the first contact was with a "trauma expert." Informed by background data from NHS Lothian's electronic clinical record system, clinicians conducted a brief assessment of people's current difficulties and their context. An initial trauma-informed formulation was subsequently discussed, options were identified and next steps agreed. Recommended actions were confirmed by letter, copied with explicit consent to appropriate professionals, initiating a "person-centred" flow of communication.

Choice

By June 2019 approximately 1400 people had been seen at the Advice Clinic. As shown in figure 1, at the Clinic people chose their next step from a range of options, including the opportunity to come back for a full clinical assessment. Rates of attendance at full assessment appointments were high, with 90% of people attending their appointments compared to an 83% attendance rate under the old system. When a psychological intervention was the most appropriate next step, people were encouraged to choose from a range of options described in figure 2. Approximately 5% of people opted for a single individual psycho-education session. However, the most popular choices were group-based interventions, referred to as "courses" available as elements of a modular system, in order to create a sense of learning and personal growth. People seeking help with symptoms of PTSD most often chose the "Light Bulb Course", designed to harness peer support, introduce coping strategies and address avoidance behaviours. People whose presentation was dominated by negative self-concept most commonly chose the "Compassionate Resilience Course", designed to help develop a compassion-focused approach to difficulties (Gilbert, 2009; Lee & James, 2012). The "Toolkit Course" focused on affect regulation and was most often chosen by people who wished to develop a personalised set of coping strategies. Trauma-informed yoga and mindfulness courses were popular choices and people were also assisted to access a range of courses run by NHS Lothian's group service, including courses aimed at the treatment of anxiety and depression.

Figure 1 about here

Engagement in the courses was good compared to group therapy engagement under the old system, with an average of 64% completing their course. Progress was discussed at review appointments following completion of each course, where options were identified and next steps agreed. In some cases a further course was chosen. Others decided to consolidate

their skills independently, with long-term follow-up appointments available on request. If a first trial of an evidence-based psychological therapy was required on an individual basis, such as EMDR or Prolonged Exposure, people were linked to their local NHS community-based primary care liaison team. In particularly complex cases, or where previous psychological interventions had not been helpful, individual therapy was usually offered at the Rivers Centre.

Figure 2 about here

Self-efficacy and dose

It was made clear to people that they were in control of the pace and intensity of their engagement with the Rivers Centre, and that they were expected to increase or decrease this engagement as the nature and severity of their difficulties changed. To facilitate this, all courses were run on a rolling basis, providing people with the opportunity to titrate their exposure to course content. Individual treatment aimed to be similarly flexible and people were given as much control as possible over the frequency, duration and intensity of therapy sessions. The potential role of avoidance and denial were explicitly acknowledged in this context, however it was made clear that the responsibility of regulating dosage lay with each individual. Crucially, the Rivers Centre operated a policy of "no discharge" and people were encouraged to use services when they needed them, without a lengthy re-referral process.

Partnership working

The Rivers Centre was reconstituted as a "Public Social Partnership" (PSP), with NHS Lothian and the third sector forming a strategic partnership arrangement in order to work more closely together on service design and implementation. Twenty-five third sector organisations signed up as partners, greatly facilitating the ability of the service to respond to the wide range of need. The people attending the Rivers Centre were also considered to be its partners and the governance structure of the Centre was modified to reflect this. Focus groups, satisfaction

questionnaires, feedback boxes and a “happy-or-not” system also created a direct dialogue between the Centre and the people using its services.

Responsiveness

The Rivers Centre expanded its core staff team to include specialist link workers, employed and managed by its principle third sector partner, Carr Gomm. The role of the link workers was to focus on issues such as social isolation, housing, debt and unemployment, and by forming close ties with relevant services across Lothian they remained up-to-date with community-based resources, and were able to connect people to help in their local area.

Continuity

NHS Lothian’s specialist trauma team for children and young people co-located with the adult team at the Rivers Centre, and the upper age barrier of age 65 was removed in order to provide specialist trauma services across the lifespan. Clinicians who were previously working in separate services were able to offer support to different generations of family members and facilitate a more seamless transition of young people into adult services. Audit data indicated that people over the age of 65 now represented 1% (n = 20) of all self-referrals.

Monitoring and evaluation

An extensive range of socio-demographic and psychometric data were collected throughout the implementation of the new service model, however the analysis of this dataset has not yet been completed and the results are therefore not reported in this paper. The dataset included the International Trauma Questionnaire (Cloitre et al., 2018) in light of the introduction of “Complex PTSD” to the International Classification of Diseases (ICD) 11th Revision:

> “Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening

> or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning" (ICD-11, 2018).

Employing this definition, assessed by the International Trauma Questionnaire, the majority of people coming to the Rivers Centre met the full diagnostic criteria for Complex PTSD.

Lessons learned

The implementation of this "test of concept" has not been straightforward. The attachment-based service model was developed in the context of much scepticism regarding the potential for inappropriate use of services, the "opening of flood gates" and a new way of working that had not involved additional clinical staff. The use of services was found to be appropriate, however, by a population displaying high levels of morbidity and impairment, and there was no evidence of an increase in malingering or requests for benefit-related clinical reports. Concerns regarding the potential rise in self-referrals were justified and the adoption of an open access system demonstrated that when help is made accessible, people will access it. The response of the Rivers Centre clinicians was to learn to work differently, however, developing skills in matched care and making good use of links to partner organisations.

In the early months of establishing the new care pathway the clinicians also learned that high levels of self-referral needed to be met by high levels of expertise. Initially specialist link

workers were the first point of contact, but waiting times for clinical assessments quickly reached six months and people began to disengage because they felt that their needs had not been understood and their anxieties had not been contained. The pathway was consequently changed to frontload the clinical expertise and the Rivers Centre's most experienced clinicians were put at the front door.

It also became clear that the needs of people with Complex PTSD were multi-faceted and constantly changing. Recovery rarely followed a linear trajectory, but moved forwards and backwards before sustained progress was detected. The pace of recovery was also unpredictable, with slow progress, halts and leaps forward. People therefore needed the power to choose their own treatment path and regulate their own engagement. To provide this level of empowerment a multi-faceted, complex and flexible service model was required, and the dictates of protocol-driven interventions had to be constantly weighed against the individual's need to direct their own recovery.

Concerns had also been expressed about the degree to which a "culture of dependency" would be created by a service that did not discharge people. However, the Rivers Centre aimed to become a service that people could depend on. Misuse of the "no discharge" policy was rare in terms of inappropriate appointment requests and the great majority of people seemed keen to take responsibility for their own recovery. Benefits were also demonstrated in terms of the facilitation of engagement and reduction in the reported pressure on people to stay unwell in order to maintain support.

The future

The Rivers Centre attempted to become a better care-giver by providing an alternative model of attachment. In the coming years the service plans to enhance this model by focusing on keeping people well, with the offer of regular "psychological well-being clinics" and an

exploration of the factors that buffer people in the face of adversity. This will be informed by the systematic collection of data on benevolent, as well as adverse, childhood experiences.

In the meantime the benefits of adopting an attachment-based service model may be worth consideration not just by specialist trauma services, but by health and social care services more generally. Arguably the people who have attended the Rivers Centre are no different from large sections of the general population whose relationships are moulded by their early experiences. The wider population may also therefore benefit from services that can provide attachment security, along with a supportive and responsive environment in which to recover.

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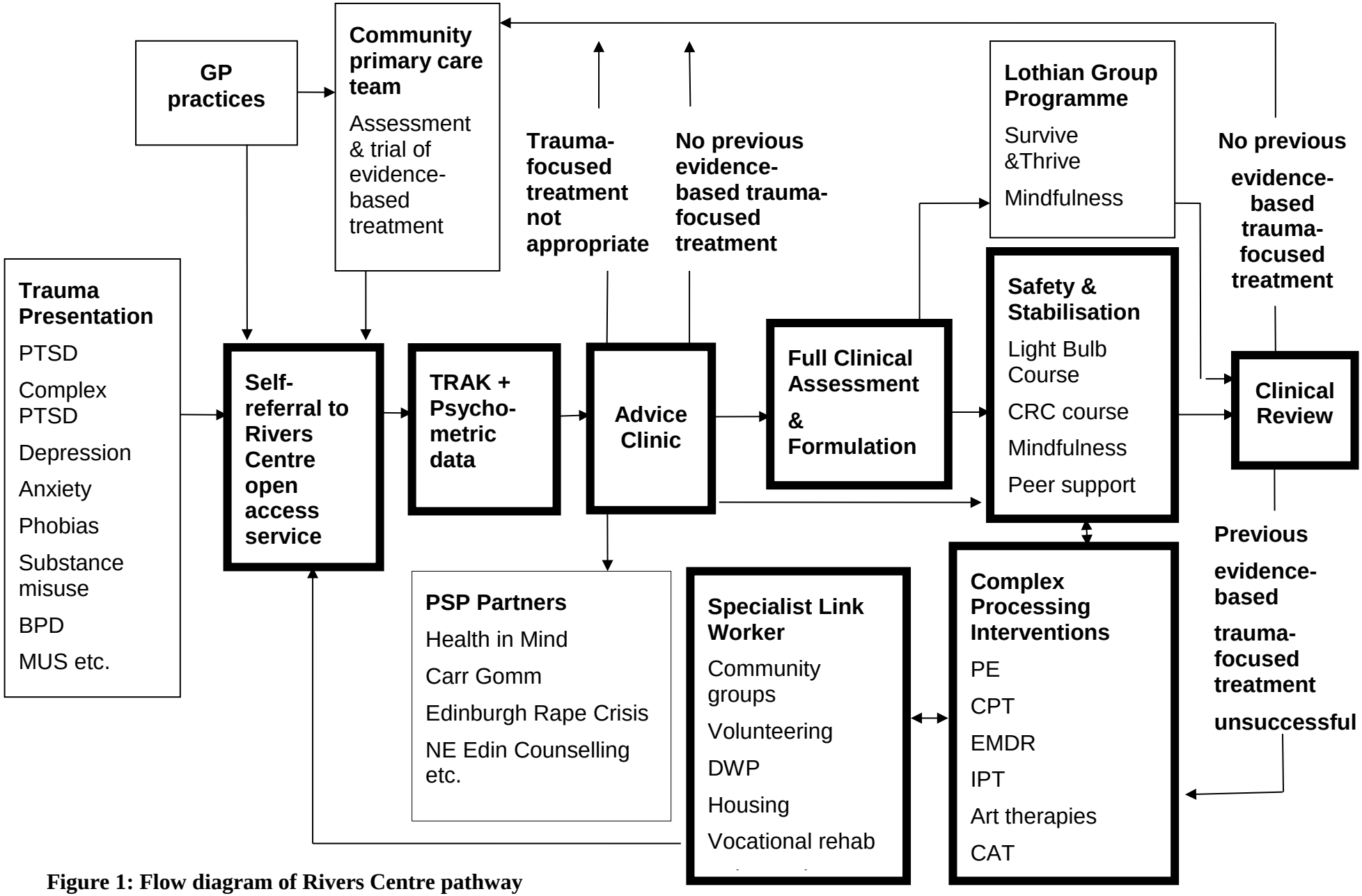

Figure 1: Flow diagram of Rivers Centre pathway

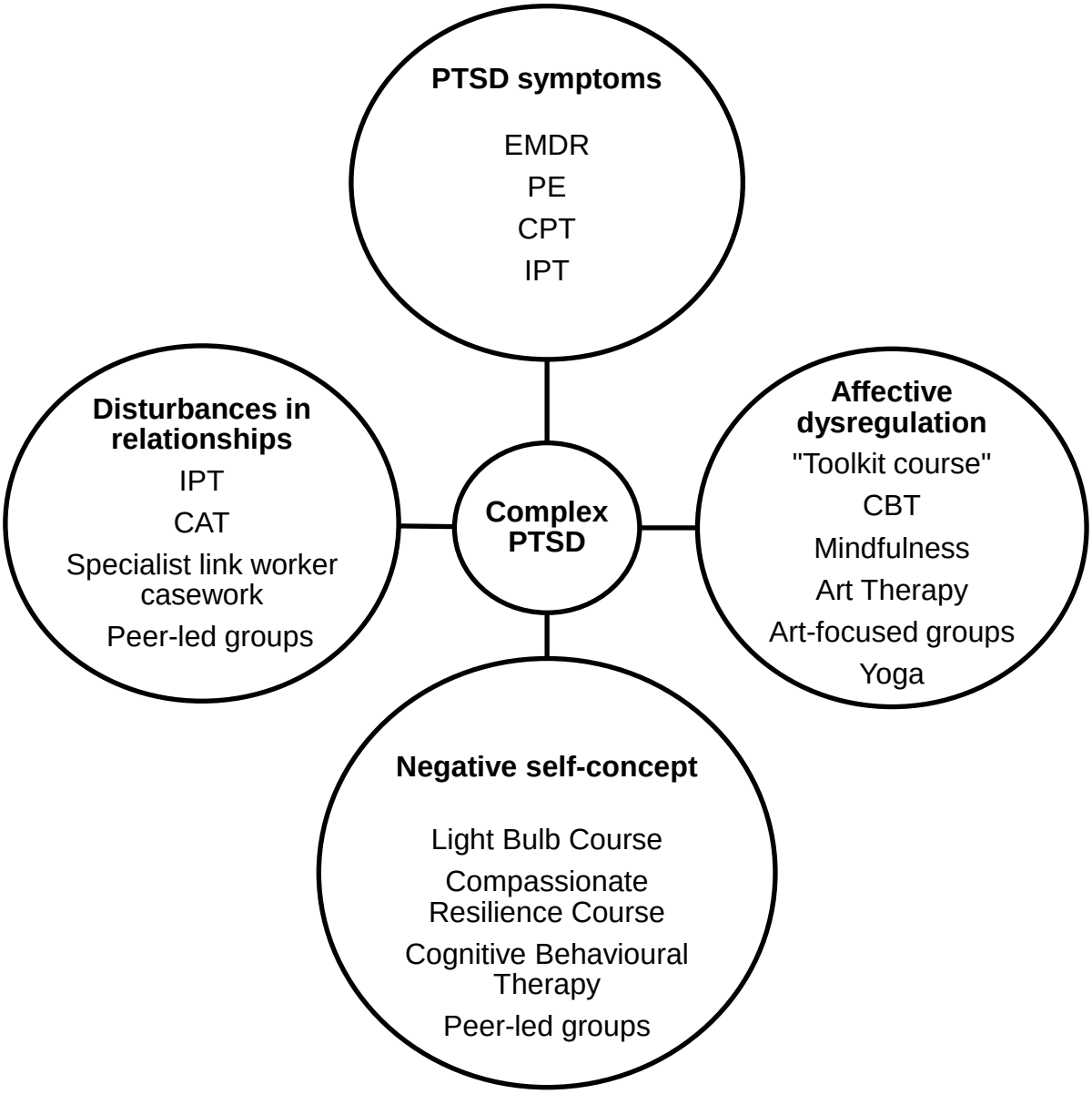

Figure 2: A modular system