NHS
Grenfell Health and Wellbeing Service

Trauma Therapies for Grenfell Survivors

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Grenfell

On 14th June 2017 many of us woke up to the news of a fire at Grenfell Tower. For some it was our local area, our place of work, where our neighbours lived, where our colleagues lived…it was home to many.

https://www.youtube.com/watch?v=8O1CcwYf79I

[0.17]

Many people witnessed the fire, which lasted for hours and resulted in mass fatalities. Confusion had arisen over the 'Stay Put' advice and the tragedy itself was linked by many to long standing concerns residents' had previously raised in relation to the building's fire safety standards.

1. The Grenfell Community

Compared to London overall:

- Slightly younger (more under-18s), but a mix of all ages
- 48-58% (vs 37%) born in another country, including Morocco, Spain, Somalia, Ethiopia, Portugal, Eritrea, other.
- A notable portion have prior traumas.
- More identify as Christian, Muslim, or with no religion
- More (55% vs 24%) in social housing
- Densely populated
- Kinship ties Vs 'family'
- A bit more with poorer physical & mental health and disabilities
- More difficulties with completing education and gainful employment

Most of these differences are even more marked when looking at just the Grenfell Tower & immediately surrounding area https://www.jsna.info/sites/default/files/Journey%20of%20Recovery%20Needs%20Assessment%20-%20Final.pdf *)

But Who lived there?

Trauma

Why Grenfell was a traumatic event…

"an event that involves actual or threatened death or serious injury; a threat to the physical health of self or others in which the person felt frightened, horrified, and helpless" (Regel & Joseph, 2010)

Resulting in PTSD when

- Symptoms persists for at least four weeks
- Onset normally with in six months of event
- "Enduring personality change after catastrophic experience"
- Idea of "Shattered Assumptions"

So Who Needs Therapy?

- Survivors – Tower residents
- Bereaved – Home and abroad
- Friends and family
- Neighbours and those living close to Grenfell Tower
- The wider North Kensington Community
- Helpers, volunteers, supporters - Dual roles and multiple identities

So What Did We Do?

2. Basic Needs and a Human Response

Hobfoll et al (2007): **5 essential elements of immediate and mid-term mass trauma intervention: empirical evidence.**

I. A sense of safety e.g. focus on the secure base: safe housing, stable caregivers; cognitive restructuring around unhelpful cognitions.

II. Calming e.g. large scale community outreach & psychoeducation; teaching self-regulation skills.

III. A sense of self and community efficacy involve survivors in development of services where possible; encourage use of community resources.

IV. Connectedness social support networks as a focus of assessment and treatment ; group work where appropriate.

V. Hope Help clients link in to services which will help them to rebuild their lives; Cognitive reappraisal of maladaptive beliefs (e.g. self-blame), build on strengths and positive coping.

- Maintaining a visible presence, listening, helping, monitoring.
- Core services mobilized to respond using existing and enhanced processes
  - Universal approach
  - Prioritization
- Early version of the outreach team
- Use of intelligence from Terrorist Attacks response
  - Comms - NHS trauma leaflet
  - Phased approach (Tower & bereaved, surrounding area, everyone else)
  - Frameworks e.g. Psychological First Aid
- Screening approach developed based on best practice
- Predictions about likely prevalence and resource requirements
- Large scale recruitment of trauma specialists and community members with relevant skills.
- Communication strategy - local and national

The Local Context

- London Incident Pathway (June 2017).
- Influx of Volunteers & 'Trauma Tourists'
- GOLD Command, British Red Cross and FLOs.
- Watchful Waiting (up to 4 wks)
- Psycho-education – leaflets, activities, hotel visits.
- Collaboration– Commissioning guidance, complimentary therapy provision in collaboration with RBKC Local Authority.
- Screen and treat programme.
- The visible burnt out shell of the Tower.
- Localised not dispersed population.

- **Rehousing Needs**

Large numbers of people lost their homes in the fire, while many others were unable to return to them. Approximately **373** individuals in **204** households required permanent rehousing. The number of households being rehoused is much higher than the number of households in the Tower and Walk previously. One reason for this is that some previously overcrowded, multigenerational households have been able to move into separate homes through the recovery housing policy.

And what about the children?

3. And What About the Children?

Aim: To deliver consistent evidenced based messages across the community

There are differences between children that depend on their developmental stage, for example, regarding the presentation of symptoms (Beer & De Roos, 2008). Information was provided to parents, caregivers, teachers , local CAMHS services and other adults in the community about how to talk to children about the fire.

After the event

Supporting children after a frightening event

This leaflet is designed to help adults to understand how children and young people might react to frightening events, and to give some ideas of what might help. Further copies are available from www.traumaticstress.org.uk

Reactions after a frightening event

Children and young people sometimes witness or are involved in things that they find very scary or stressful such as accidents, violence or terrorist attacks. As they try to understand what happened and "get their heads around it", the following reactions are common:

- Nightmares
- Memories or pictures of the event unexpectedly popping into the mind
- Feeling as if it is actually happening again
- Playing or drawing about the event time and time again

Memories of frightening events often start out as pictures and sounds that pop into people's heads when they don't want them to.

The memories may bring with them all the fear and distress that came with the original event.

What can be done to help?

Try and make things as normal as possible

Everyone feels safer when they know what to expect. A frightening event often makes

Screen & Treat

- Screening is an approach used when a large population is potentially at risk (in this case of Post-Traumatic Stress Disorder), to detect a condition, and see whether individuals may need more detailed assessments and treatment.
- NICE CG26: For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.
- The approach used post Grenfell, in a community, post disaster, rather than a dispersed population after a disaster like a terrorist attack, has not been done at this scale before in the UK (Public Health, JSNA 2018)
- Coding 'Grenfell-related) allowed the NHS to monitor changes in access between June-August 2017 e.g. those who had been displaced were still accessing their local GP .

Around 25–30% of people experiencing a traumatic event may go on to develop PTSD

Self Care Interventions

- **Stress management.**

  Breathing exercises, progressive muscle relaxation and cultural equivalents.

- **Strengthening of positive coping methods and social supports.**

  Build on the person's strengths and abilities.

- **Ask the person to identify people who give them emotional support.**

  Identify other people they trust, who they usually spend time with. Encourage the person to spend time with and also talk to trusted people if they want to.

- **Encourage resumption of social activities and normal routines as far as possible.**

  Try to eat and sleep well, exercise and relax. Everyday routines can be comforting.

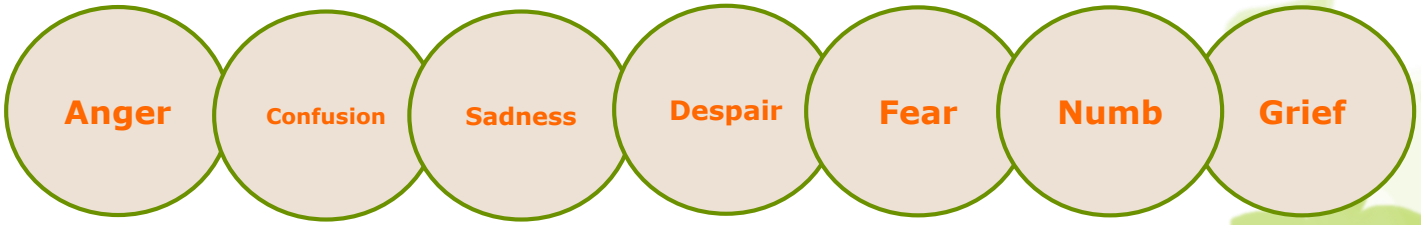
- **Alert the person that alcohol and drugs do not help recovery or sleep.**

  Heavy use of alcohol and drugs – including medicines bought without prescription at pharmacies – can lead to new health and social problems.

4. PTSD, Grief and a ‘Normal’ Human Reaction

- Complicated grief, no bodies returned, funeral rituals delayed.
- Coroner's briefings, media reports, interviews
- Long periods of waiting for news,
- Multiple losses (of people, material possessions, home, networks, safety and trust)
- Lack of stability and uncertainty over the future

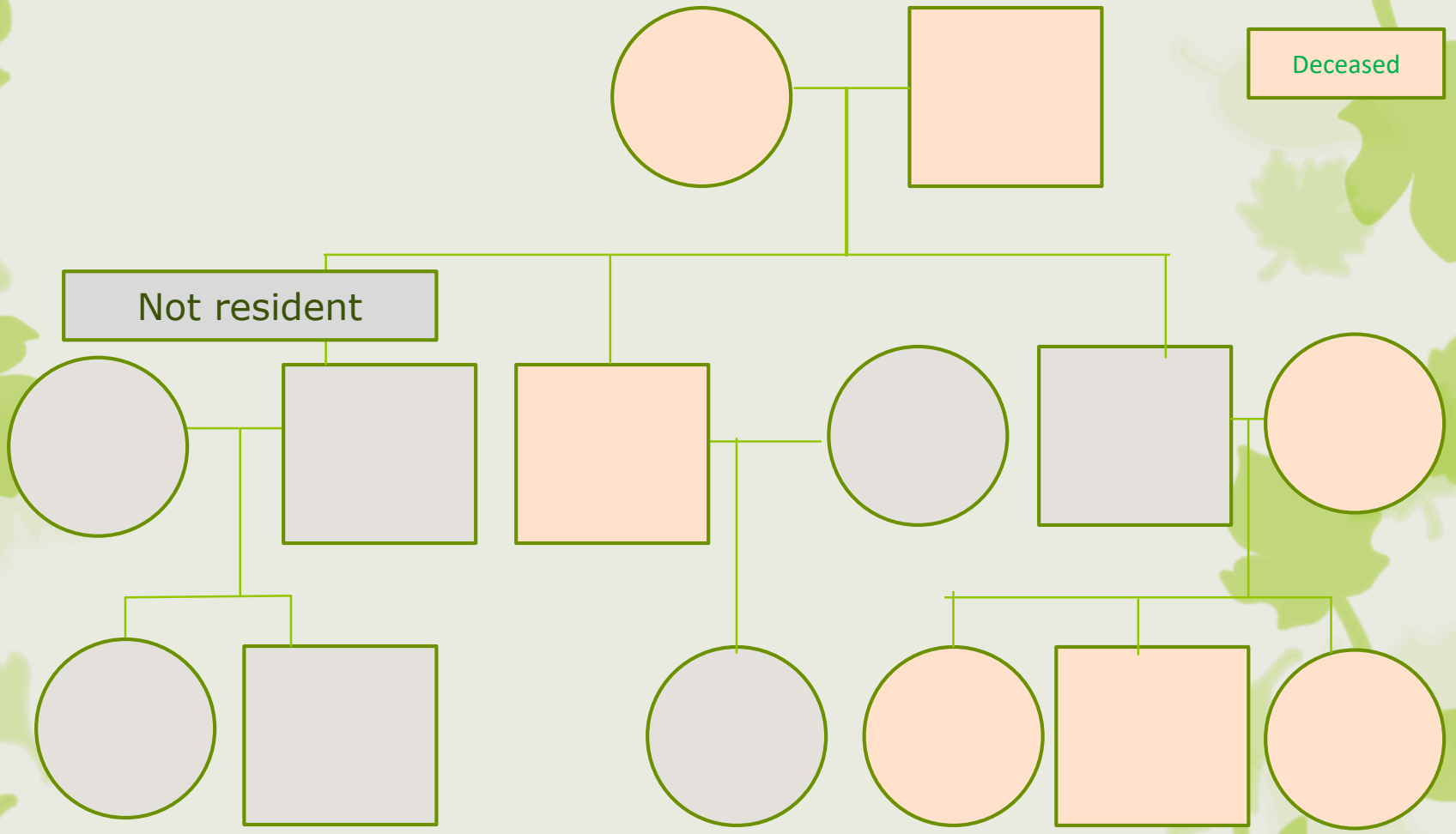
Who Can We Trust?



5. PTSD Symptoms

1. **Re-experiencing of the Trauma in the present**
   - Spontaneous intrusive memories of the traumatic event
   - Recurrent dreams related to the event; Flashbacks
   - Heightened reactions to related stimuli
   - Other intense or prolonged psychological distress
2. **Avoidance Symptoms including active avoidance of**
   - Distressing memories, thoughts, images or feelings
   - External reminder of the event
   - Use of drugs and alcohol to numb distress and blunt emotion
3. **Alteration in Arousal and Reactivity**
   - Aggressive, reckless or self-destructive behaviour
   - Sleep disturbance
   - Hypervigilance; Startle response
   - Autonomic hyperarousal; Bursts of panic and fear

The Impact on Families



6. GHWS: New Ways of Working

- Trauma Awareness Workshops
- Managing difficult conversations
- Clinical and reflective supervision
- Screening
- Treatment

- Assertive outreach - Visible presence Community screening
- Art Therapy
- Community Engagement Events
- Workshops and Psychoeducation
- Support e.g. at public inquiry, at memorial events, to engage in treatment, retrieval of belongings.
- Ministerial surgeries
- Street screening

- Visits to Grenfell Tower
- Trauma-focused CBT
- EMDR
- Bereavement Therapy
- Couples Therapy

- ✓ Flexibility (inc. time & location),
- ✓ Adaptable DNA policy,
- ✓ first time access by many groups (e.g. those >70yrs),
- ✓ Nimble response to community feedback.
- ✓ Culturally appropriate.

- Trauma-focused CBT
- EMDR, NET
- Family Therapy
- Under 5s Psychotherapy
- Teaching Recovery Techniques
- Community Engagement – link to local schools and youth service providers.
- School-based screening

Wounded Healers & Compassion Fatigue

- The impact of trauma on others
- Entering the work based on own experiences (of suffering) which inspires one to help others.
- Personal vulnerabilities can be addressed by examining motivations for helping, monitoring self-care and wellness
- Be mindful of projecting own experiences onto others
- Becoming a wounded healer can lead to compassion fatigue and burnout.
- Vicarious or secondary traumatisation is a process by which a professional's inner experience is negatively transformed through empathic engagement with clients' trauma material (Cunningham, 1999; McCann & Pearlman, 1990; Pearlman & MacIan, 1995).

7. Treatment

- All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]).
- Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.
- The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (e.g. 90 min).
- Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person
- Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.

NICE CG26

GHWS offers:

- **TF-CBT**
- **EMDR**
- **NET**
- **Family Models**
- **Teaching Recovery Techniques**
- **Couples Therapy**
- **Treatment of comorbid conditions (depression, anxiety, traumatic grief)**

Treatment Model

Prerequisite: Engagement and establishment of a therapeutic relationship

Phase 1: Stabilisation and Psychoeducation

- improving symptom management, self-soothing and addressing current life stressors to achieve safety and stability in the present.

Phase 2: Trauma Processing

- Trauma-focused work to process traumatic memories using Cognitive-Behavioural Therapy (CBT).

Phase 3: Reintegration, reconnection and recovery

- Re-establishing social and cultural bonds and enabling people to develop greater personal and interpersonal functioning.

TF-CBT – Trauma Focused Cognitive Behavioural Therapy

Components of therapy might include some or all of the following:

- **Grounding and stabilization.** Practising techniques to manage the overwhelming feelings PTSD brings using relaxation exercises, or other techniques to help stay grounded in the here-and-now.
- **Work with memories.** Approaching trauma memories in order to process them properly. This might involve talking through what happened, deliberately imagining the events, or writing or drawing about it. This is called memory processing and is done very carefully and deliberately in TF-CBT.
- **Work with beliefs.** Making sense of what happened. Sometimes events happen that are so catastrophic that we come to see ourselves and the world in a very negative way. Belief work in TF-CBT is about making sense of what you thought at the time of the trauma, and deciding what is a fair way to think about yourself and your situation now.
- **Reclaiming your life.** PTSD often has the effect of stealing people's lives: it is very common after trauma to start avoiding things which make you uncomfortable, but this can have the effect of shrinking your world. Effective therapy is about taking back the things that you used to enjoy, or building a new life that you can value.

‘Practice’

Phase 1– Stabilization

P – Psycho-education

R – Relaxation Skills

A – Affective Regulation Skills

C – Cognitive Processing Skills

Phase 2 – Trauma Narrative

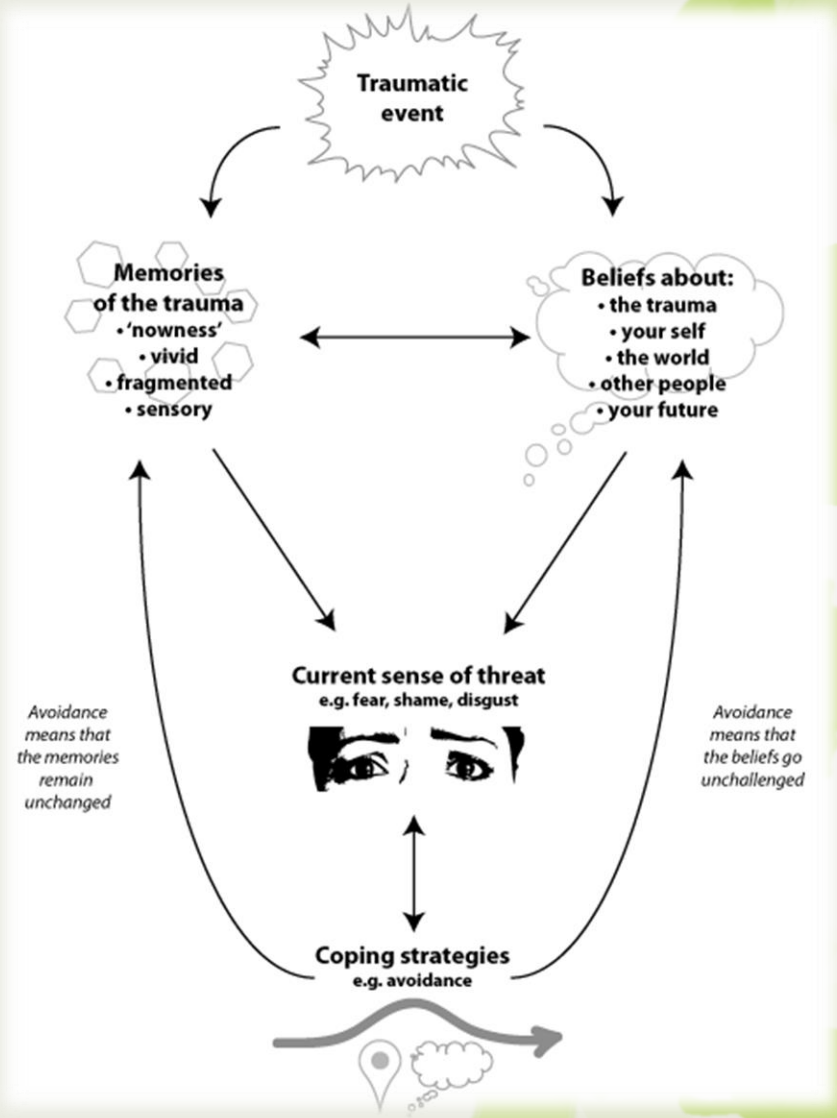
T – Trauma Narration and Processing

Phase 3– Integration & Consolidation

I – In Vivo Mastery of Trauma Reminders

C – Conjoint Child-Parent Sessions

E – Enhancing Safety



EMDR – Eye Movement, Desensitisation & Reprocessing

A powerful psychotherapy approach developed by Francine Shapiro (1987) to treat victims of trauma and a number of other conditions such as:

- Anxiety & Depression
- Dissociative Disorders
- Disturbing Memories/Thoughts
- Panic Attacks
- Personality Disorders
- Post Traumatic Stress Disorder
- Unresolved Grief

https://www.youtube.com/watch?v=hKrfH43srg8

Overview of EMDR Treatment

Helpful for people who present with *symptoms* as their main complaint (e.g. fatigue, poor concentration or a racing heartbeat, without conscious links to memories).

- **You are not required to tell your detailed story and the goal is not to relive past experiences**.
- During the processing phase, the goal is to stay in the present moment while also holding the memories or feelings of the past.

NET – Narrative Exposure Therapy

- The method of narrating the entire life story does not require the clients to select a single traumatic event from their trauma history. NET allows reflection on the person's entire life as a whole, fostering a sense of personal identity.
- Working through the biography highlights the recognition and meaning of interrelated emotional networks from experiences, facilitating integration and an understanding of schemas and behavioural patterns that evolved during development.
- Regaining of survivor's dignity and satisfaction of the need for acknowledgement as well as the explicit human rights orientation of 'testifying' distinguishes the approach. Additionally, the fact that the survivor receives a written biography as a result of the treatment has turned out to be a major incentive to complete treatment.
- The NET approach, has been modified to create a child-friendly, manual-based version termed **KIDNET** (Neuner, Catani, et al., 2008; Ruf, Schauer, Neuner, et al., 2008). Its efficacy is being tested in the current randomized, controlled study of traumatized refugee children aged 7 to 16 years living in the south of Germany.

GHWS Patient Data

Adult and Outreach (mid-October 2018)

Referrals received	Month Total	Cumulative
Adults	**72**	**2337**
Entering treatment (1st treatment)		
Adults	**41**	**1556**
Outreach	**15**	**709**
2nd Treat		
Adults	**40**	**1046**
Outreach	**8**	**231**
Completed treatment (after 2 treatments)		
Adults	**12**	**287**
Discharged for any other reason		
Adults	**55**	**1339**
Screenings		
Adults	**32**	**1113**
Outreach	**380**	**2392**

Children and Young People (mid-October 2018)

Referrals received	Month Total	Cumulative
CAMHS	**13**	**705**
Entering treatment (1st treatment)		
CAMHS (after assessment and 1 treat)	**13**	**271**
Completed treatment (after assessment and 1 treatment)		
CAMHS	**2**	**206**
Discharged for any other reason		
CAMHS	**8**	**168**
Screenings		
CAMHS	**15**	**489**

8. The Next Steps

- Health checks
- Future of the Tower
- Resettling into new homes
- The Public Inquiry
- Research collaboration – treatment efficacy, recovery rates, comorbidities, evaluation of innovative group based treatments, cultural adaptations…?
- JSNA: **Supporting the psychological wellbeing of the Grenfell impacted community over the coming years** will therefore rely on approaches which combine:
  - Promoting protective factors that support stability, particularly social connectedness, social support, employment and family functioning.
  - Supporting those with chronic PTSD and their symptoms to access treatment. Given the diversity of the community, this will rely on.
  - Innovative approaches to reach out to different populations as factors such as age, gender, language, ethnicity are all likely to be associated with different attitudes towards accessing treatment and support. A number of these are being developed and delivered in the community.
  - A diverse and personalised approach to treatment.
  - Work to tackle stigma associated with accessing mental health support.

Questions & Further Information?

Please contact a member of our team or email me directly.

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