DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study added to the Effectiveness Bank. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

"We have to put the fire out first before we start rebuilding the house": practitioners' experiences of supporting women with histories of substance use, interpersonal abuse and symptoms of post-traumatic stress disorder.

Bailey K., Trevillion K., Gilchrist G.

Addiction Research and Theory: 2019, p. 1–9.

Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Bailey at Karen.Bailey@kcl.ac.uk.

Within treatment systems that have tended to underestimate or overlook the importance of 'trauma-informed' practice, this study explores how practitioners in England respond to the needs of women with substance use problems, histories of abuse, and symptoms of post-traumatic stress disorder.

SUMMARY While it is common for women with substance use problems to have experienced physical, emotional or sexual abuse, and exhibit symptoms of post-traumatic stress disorder, there has been limited historical precedence for *trauma-informed* practice and *trauma-specific* substance use services. It was in this context that the featured study explored how practitioners in England have responded to women's support needs around trauma.

Trauma-informed practice is an organisational approach, based around five core principles: (1) trauma awareness; (2) safety; (3) trustworthiness; (4) choice and collaboration; and (5) building strengths and skills (free version of paper available).

Within the context of substance use treatment, trauma-informed practice provides practitioners with a framework to avoid re-traumatisation, promote physical safety, and use strengths-based interventions (eg, motivational interviewing). As trauma-informed practice is based on the assumption that experiences of interpersonal abuse are widespread, it doesn't rely on diagnoses of post-traumatic stress disorder or require women to disclose their trauma. UK substance use treatment guidelines promote trauma-informed practice as core business. However, little is known about its practical implementation in England.

Trauma-specific substance use interventions are focussed on treating trauma and substance use in an integrated manner through therapeutic interventions involving practitioners who have received specialist training in post-traumatic stress disorder and substance use. Experts agree (1 2 3) that the 'gold standard' for delivering such work is the staged treatment model:

1. safety and stabilisation (eg, building therapeutic relationships and education around substance use, interpersonal abuse, post-traumatic stress disorder, coping skills, and physical safety);
2. memory processing (eg, addressing traumatic memories);
3. reconnection and establishing future identity.

Until December 2018, guidance promoted a sequential model where substance use disorders were to be addressed first. While clinical guidance now advises against excluding patients with substance use problems, this may explain why specialist trauma-specific treatments remain inaccessible to the majority of those with current substance use problems.

To understand practitioners' experiences of supporting women with problems around substance use and interpersonal abuse, and symptoms of post-traumatic stress disorder, interviews were conducted with 14

Key points
From summary and commentary

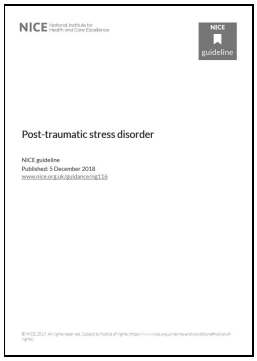
The featured study explored practitioners' experiences of supporting women with substance use problems, histories of interpersonal abuse, and symptoms of post-traumatic stress disorder.

There has been limited historical precedence for 'trauma-informed' practice, which provides practitioners with a framework to avoid re-traumatisation, promote physical safety, and build up the existing or inherent strengths in their clients.

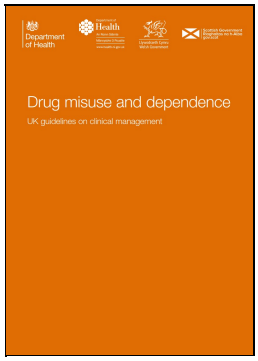
However, across a range of professional backgrounds and disciplines, this small group of practitioners emulated important components of trauma-informed practice and promoted a 'safety-first' approach reliant on multi-agency working.

practitioners from a range of clinical disciplines and service delivery models in England:

- Job title: clinical psychologists (7); service directors / managers (3); domestic violence / complex needs workers (2); counsellor (1); project manager (1).
- Sector: third-sector ‘not-for profit’ (11); National Health Service (2); community interest company (1).
- Area of specialism: substance use (6); domestic and sexual violence (5); criminal justice (2); substance use and child sexual abuse (1).



UK treatment guidelines on post-traumatic stress disorder



UK treatment guidelines on drug misuse and dependence

Main findings

Practitioners across different disciplines emulated important components of trauma-informed practice and promoted a ‘safety-first’ approach reliant on multi-agency working.

Philosophical approach

Regardless of their professional backgrounds, all practitioners eschewed the traditional medical model focussed on women’s deficits and pathology in favour of a strengths-based and relationship-based approach. Several spoke explicitly about the importance of reframing mental health symptoms and substance use as understandable responses to traumatic experiences, and focusing on women’s internal resources and resilience to manage the impacts of abuse. Rather than women being unable or unwilling to participate in treatment, some practitioners turned the focus to services currently being unable to address the challenges women face in accessing treatment.

Key components of trauma-informed practice were reflected in their own approaches, including supporting women’s agency by offering choice and flexibility. For many this approach was imperative to building strong therapeutic relationships.

Clinical practice

All practitioners used the language of ‘safety’ and ‘stabilisation’ to describe the core of their work – central concepts in the first phase of the staged trauma treatment model. Safety planning was conceived by many as an important first-line intervention preceding therapeutic work.

Several practitioners, qualified psychotherapists or psychologists, discussed using one-to-one trauma-specific treatments focussing on trauma disclosure (stage two of the staged treatment model). Treatment following the staged treatment model (each stage involving extensive preparation for the next, but the model being flexible enough to enable women to move forwards and backwards) was most commonly advanced by psychologists. However, all practitioners described core elements of their practice that were highly complementary with this approach.

The wider treatment system

All practitioners had considerable experience working with traumatised women, and had received training on the co-occurring issues. However, they identified systemic issues (ie, outside their personal clinical practice) that challenged their ability to deliver appropriate support. Several critiqued attempts by their own or other services for attempting to develop trauma-informed practice that was ‘tokenistic’, and expressed their frustrations at delivering trauma-specific interventions within an environment that had not fully embraced trauma-informed practice.

‘Putting out the fire’

Paramount to this study was the amount of practitioner time and effort required to support clients to establish physical safety due to the complex interplay of substance use with interpersonal abuse and symptoms of post-traumatic stress disorder.

Practitioners described women’s attempts to stay sober and women’s partners jeopardising their treatment attendance. Conscious that women may also be facing ongoing abuse, practitioners took the approach of trying to ‘put out the fire’, requiring an emphasis on risk management, advocacy and multi-agency working.

‘Putting out the fire’ also extended to internal safety; supporting women to manage emotional regulation, substance use cravings, and other post-traumatic stress disorder symptoms. Many of the interpersonal abuse and substance use services offered interventions to address the mind–body connection (such as mindfulness) as part of their standard service.

The authors’ conclusions

Despite limited historical precedence for trauma-informed practice and trauma-specific substance use services, practitioners in the featured study demonstrated practice closely aligned with these

approaches. In order to see integrated support for trauma and substance use problems extended across the UK, this will take organisational leadership and support from service commissioners and funders.

FINDINGS COMMENTARY The featured paper examined the delivery of *trauma-informed* practice and *trauma-specific* substance use services in England from the perspective of practitioners who were positioned to see the all too common experiences of physical, emotional and sexual abuse among women with substance use problems, and yet work within treatment systems that have traditionally not facilitated support for substance use problems alongside histories of trauma.

Building strong relationships with their clients/patients was important to practitioners, as was cultivating women's sense of agency. In doing so, some practitioners resisted the suggestion that women experiencing ongoing victimisation were less able to engage in treatment, or that non-attendance or compliance with treatment reflected a woman's lack of commitment or readiness for change. Instead the problem was redefined by practitioners around *services* not being set up to address the challenges women face in accessing treatment. In this respect, practitioners appeared comfortable taking a 'critical observer' role – critiquing the services and systems they worked within – while also taking on a role as 'advocate' for women, ensuring that women's experiences (for example, as different to men's) were not lost or misunderstood.

There was evidence that the philosophical approaches of this small group of practitioners were aligned with trauma-informed practice. Although they were not selected for interviews *because* they had favourable views about or experience of trauma-informed practice, they did all work specifically (though not necessarily exclusively) with women experiencing substance use problems, interpersonal abuse, and a wide range of symptoms of post-traumatic stress disorder. Overall, there was an eagerness to provide support that recognised the common thread of trauma running through women's lives and their substance use histories.

In the Netherlands five years earlier, an identically small sample of practitioners revealed that one of the barriers to implementing integrated treatment for people with substance use problems and post-traumatic stress disorder was that, despite being "well aware" of the link between exposure to trauma and substance use problems, practitioners were unaware of the high rate of exposure to trauma (and post-traumatic stress disorder) among their patients. This resulted in post-traumatic stress disorder *not* being considered a priority. Practitioners in the Netherlands also expressed the belief that talking about past traumas elicited craving and possible relapse, which led to them being overly cautious about approaching or even not approaching past trauma.

While neither this study nor the featured one claimed to reflect the level of knowledge in the wider workforces of the Netherlands or England, the contrast highlights the impact that experience and training can have on the way practitioners engage with clients who have a history of trauma. Those interviewed in the featured study arguably represented a 'best case scenario' where there was a high level of knowledge among practitioners, and consequently the challenge was framed as needing to move trauma-informed care from being a value or philosophy held by select practitioners to an organisational framework for delivering treatment and support. Elsewhere in the workforce there may be knowledge gaps or practitioner-level barriers to trauma-informed practice that this particular study was not designed to examine.

PRINCIPLES FOR TRAUMA-INFORMED CARE

Adapted from guidelines for UK clinicians providing treatment for people with substance use problems.

- Recognise the high rates of trauma exposure in the population.
- Promote awareness and understanding of trauma among patients and the workforce.
- Recognise trauma symptoms and behaviours as the individual's best attempts to adapt to and manage their experiences.
- Provide a treatment environment that promotes physical and emotional safety.
- Avoid inadvertently re-traumatising clients and patients.
- Prioritise trauma recovery as part of treatment goals.
- Support patients to make choices and take control of treatment decisions.
- Undertake routine screening for trauma experience and reactions.
- Explain the principles of trauma-informed care to patients, for example, by explaining why trauma-related questions are asked during the assessment.

Understanding post-traumatic stress disorder

Post-traumatic stress disorder is a type of anxiety disorder that can develop after someone experiences a traumatic situation (ie, something that is harmful or life-threatening). *Complex* post-traumatic stress disorder comes with additional symptoms and can develop among adults or children who have experienced repeated or prolonged traumatic events, such as violence,

neglect or abuse. This tends to be more severe if the traumatic events happened early in life, the trauma was caused by a parent or carer, the person experienced the trauma for a long time, the person was alone during the trauma, and there’s still contact with the person responsible for the trauma.

Substance use problems and post-traumatic stress disorder can overlap in a number of ways and for a number of reasons (1 2), including:
• trauma initiating the development of post-traumatic stress disorder and substance use problems;
• destructive or risky behaviour (such as drinking and drug use) stemming from post-traumatic stress disorder;
• drinking and drug-taking as a way to cope with trauma and symptoms of post-traumatic stress disorder;
• substance use making people vulnerable to, exposing them to, or increasing the likelihood of them experiencing further traumatic events.

Several types of integrated treatment have been developed for co-occurring post-traumatic stress disorder and substance use problems. Though their effectiveness is not described here, interventions include:
• ‘Seeking safety’ is a 25-session, manualised intervention, which provides education about the consequences of trauma, explores the links between trauma and substance use, and helps participants develop appropriate coping skills.
• The trauma recovery and empowerment model (TREM) was originally created for women, but has more recently been adapted for men (M-TREM). The intervention is typically conducted in 24–29 sessions and blends cognitive-behavioural therapy, with education, and teaching effective coping skills.
• Concurrent treatment of post-traumatic stress disorder and substance use problems using prolonged exposure (COPE) is delivered over 12 individual sessions, each lasting 90-mins and combines prolonged exposure and relapse prevention techniques.
• Addictions and trauma recovery integration (ATRIUM) is a 12-week integrated programme, which aims to help participants develop skills to actively stop negative automatic thoughts associated with re-experiencing symptoms and to develop more appropriate self-care and coping skills.
• Trauma affect regulation group education and therapy (TARGET) is a manualised, group-based intervention, which provides a framework for safely processing post-traumatic stress disorder and substance use problems without triggering psychological symptoms of avoidance, hypervigilance, dissociation, or compromising sobriety. The curriculum is completed in 10 or fewer sessions.
• Cognitive-behavioural therapy focuses on a variety of coping strategies to reduce symptoms of arousal and avoidance among people with post-traumatic stress disorder and substance use problems.

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