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The Perspectives Project

Discussions on psychological support and complex trauma pre-substance misuse treatment

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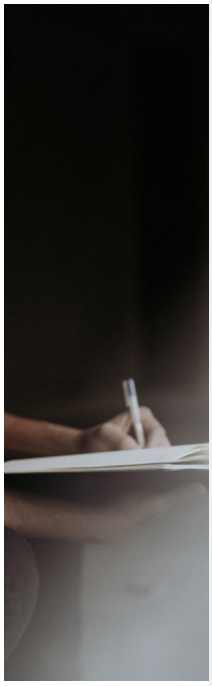

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About Fulfilling Lives

Fulfilling Lives South East Partnership works across Brighton & Hove and East Sussex and is one of 12 projects across England where National Lottery Community Fund investment is supporting people with complex needs.

The purpose of this initiative is to bring about lasting change in how services work with people with multiple and complex needs and we collaborate with partners to work towards this objective. We are committed to putting co-production into practice and value the voices of experience. We also recognise the value of trauma informed approaches in our work and the work of others.

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1. Introduction

This report summarises the findings from research into what good psychological support can look like for people who have co-existing mental ill-health and substance use, prior to them accessing formal substance misuse treatment. The research also addresses how complex trauma impacts on peoples' engagement with support and explores how services respond to trauma presentations. The aim of this work has been to listen and learn from those who work in organisations supporting clients with multiple complex needs ('MCN'), those providing or commissioning substance misuse services, mental health services, and others supporting these sectors.

In 2020 we interviewed 17 people working within this support system, bringing their perspectives on this subject together in this report. We have published the full interviews in a companion document that can be read alongside this summary.

CONTEXT

Our interest in this area comes from our commitment to supporting people with multiple and complex needs who have 'coexisting conditions' – mental ill health and substance misuse.

A recent snapshot of our client group highlighted how substance misuse and mental ill health are the most common problems for people on the Fulfilling Lives South East caseload (94% and 96% of the project's caseload respectively). There is a high degree of overlap between the two conditions, with 90% of beneficiaries experiencing both and there is a corresponding prevalence of complex trauma amongst beneficiaries; much of this linked to Adverse Childhood Experiences. [1]

A significant proportion of people with multiple and complex needs are effectively excluded from formal mental health assessment and treatment pathways due to presenting with behaviours resulting from complex trauma coupled with substance use.

Current clinical pathways often require an individual to address their substance use before mental health treatment can be provided. Unfortunately, the current substance misuse treatment system is often difficult to navigate for people with the most complex needs, especially when their mental health needs are considerable.

Given these barriers to accessing and engaging with formal treatment, how might we adapt to better support this disadvantaged group?

Our case work over the past six years has pointed towards the need for therapeutic support for complex trauma, to help build psychological resilience and stability, in order to make access to substance misuse treatment possible. When we published our 'Manifesto for Change' we set out an ambition to promote greater access to psychological support for all clients with complex trauma presentations to help them prepare for accessing formal treatment. However, we wanted to explore this further with those also working in this field, collecting a range of perspectives, to help spark debate on this subject and to see if ideas and reflections from contributors could point us in the direction of new ways of working to help better provide the support people with MCN need.

We hope readers will find connection and challenge in the conversations in this report and that this can contribute to the shape of future services and the ways in which we all work.

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2. Methodology

To gather our data, we conducted semi-structured interviews with 17 participants from across the UK. These took place July-October 2020. The participants occupied a range of clinical, strategic, project leadership and client-facing roles.

The transcribed interviews were then analysed using inductive thematic analysis, where interviews were reviewed and grouped into themes. This process was co-produced by members of our Systems Change and Service User Involvement teams and facilitated by the Research and Evaluation Officer for Fulfilling Lives South East.

The semi-structured interviews with contributors centred around a set of 7 questions that can be found in the Appendix.

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3. Learning from Conversations

The exploratory conversations we had on the topic of complex trauma and psychological support highlighted a range of important themes, as well as indicating areas of consensus between different professional groups. Our central findings have been summarised by theme to provide an overview of the discussions.

1 DEFINING COMPLEX TRAUMA

Most contributors commonly defined complex trauma as many traumatic occurrences compounding over time. Many answers cited childhood experiences, sometimes reflecting on how trauma can be replicated in a family through the generations.

> **'It's a whole series of overlapping issues which might go back to, often do go back to childhood. And it's clearly different for different people'**
>
> (Oliver, Collective Voice)

> **'Complex trauma for me would be a series of often interwoven traumatic events which affect how somebody sees themselves and how they behave and fundamentally affects how people relate to other people'**
>
> (Jan, Turning Point)

There was also a clear acknowledgement that trauma is an individual experience. When two people experience the same event, one person may develop trauma presentations, and the other may not. This was particularly emphasised by client-facing workers.

> **'Complex trauma isn't just about you witnessing things, it's about how it impacts on you'**
>
> (Iain, Fulfilling Lives)

Some also noted that the language around trauma and complex trauma could sometimes be too generally applied in their fields, which they believed was unhelpful to the conversation.

> **'A lack of rigour in any approach with vulnerable populations is a risk factor in mental health, getting hold of a concept, running with it and not really knowing what it means clinically, therapeutically, relationally and overusing it'**
>
> (Michelle, MEAM)

2 PRESENTATIONS OF COMPLEX TRAUMA

Contributors spoke of how complex trauma can present itself in a wide variety of ways. These presentations varied from heightened states of emotional arousal to dissociation and despondency. Some contributors highlighted psychological symptoms such as flashbacks and sleep disruption, whilst others talked about how experiences of attachment could impact relationships. Client-facing contributors, in particular, spoke of the strengths and assets their clients had adopted to endure the trauma they had experienced.

> **'Their emotions are heightened and unregulated so it's harder for them to respond to what's in front of them, so they are often responding from places of 'high' or 'low' and that in itself can result in things like aggressive outbursts'**
>
> (Giles, Fulfilling Lives)

> **'It is clients who have experienced not having their basic needs met as children and as teenagers for safety, for being understood, being listened to, to having their needs attended to. And then people can give up believing that they're ever going to get their needs met'**
>
> (Brian & Blyth, BHT Recovery Project)

The use of substances was felt to be a common, understandable way for individuals to manage overwhelming feelings arising from experiences of complex trauma. However, it was also acknowledged that substance misuse can exacerbate complex behaviours.

> **'People don't tend to be drug and alcohol addicted without there having been a reason for it. So quite often there's trauma that happens, drugs and alcohol can suppress the nightmares, the flashbacks…'**
>
> (Iain, Fulfilling Lives)

Many contributors recognised that the presentations of complex trauma are often at odds with expected behaviours within services. This was often thought to lead to people being excluded from services and gaining unhelpful labels.

> **'Their behaviours are often judged as challenging or difficult, instead of trying to understand what those behaviours mean or what people are trying to communicate'**
>
> (Colm, Social Interest Group)

3 BOUNDARIES AND DISCLOSURES

People with complex trauma will not always disclose their experiences in a controlled way, and their boundaries should be respected.

There was a clear consensus from contributors that workers should always respect client boundaries on disclosing traumatic events, and whether they would like to do any psychological work pre-treatment. Most contributors felt that in-depth psychological techniques were not appropriate until somebody had built a stable foundation.

> **'I feel it can be quite challenging and potentially dangerous to start lifting the lid on some of the more traumatic experiences that some of our clients have experienced'**
>
> (Giles, Fulfilling Lives)

> **'If somebody discloses something and says to you "but I don't want to talk about it again today" you need to respect that and you revisit it another time'**
>
> (Gemma, Fulfilling Lives)

At the pre-treatment stage, a focus on behavioural presentations was considered a priority over encouraging disclosures. Contributors who were clinical psychologists were most likely to share tools and practices around containing unsafe disclosures when people are in a pre-treatment stage of their journeys.

> **'There were times when [discussing specific trauma events] can actively be unhelpful. So, I'm very clear that this is about helping people to develop skills and ways of coping. It's not that you're asking them to tell their story and to talk actively about all those traumas'**
>
> (Celia, Sussex Partnership NHS Foundation Trust)

Contributors who worked in client-facing and project lead roles highlighted that often disclosures about traumatic events in the past or present frequently happen at client-facing worker level, and that those workers are often unprepared for such disclosures.

4 RISKS OF PRE-TREATMENT THERAPY

The implications of asking someone to share their trauma experiences before they are ready are serious. Many contributors shared concerns about the risks of embarking on therapy pre-treatment while some reflected that without more psychologically informed interventions people with complex needs would not get appropriate support.

Client-facing contributors in particular were clear that excessive use of substances and self-harm are potential consequences of formal psychological support going into too much depth about trauma experiences when a person has not yet received treatment for substance misuse.

> **'I saw people taking their life because certain things were opened up and they couldn't cope with it'**
>
> (Piercarla, Camden & Islington NHS Trust)

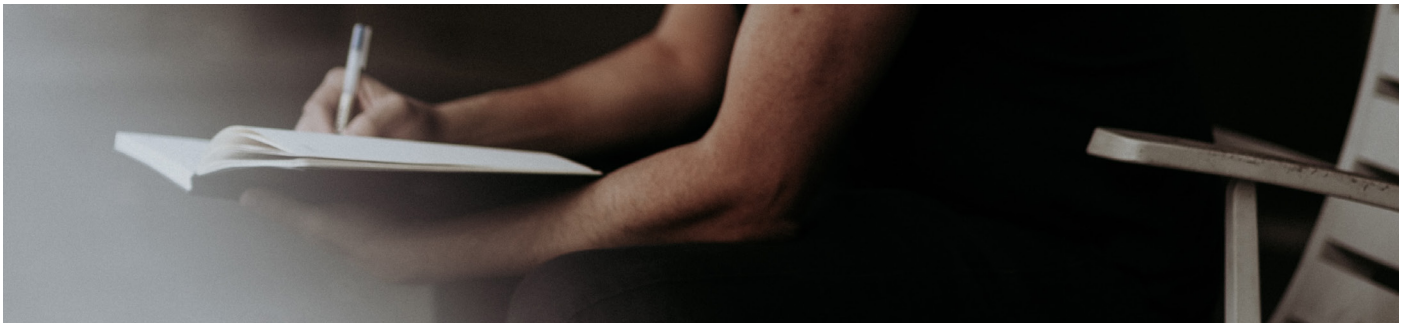
> **'I think the risks are that something will come up in those sessions and the client won't have anyone to talk with about it for another week. I think the client's capacity to hold difficult feelings that are evoked in counselling and therapy sessions is a risk of how that might play out behaviourally, in increased risk-taking behaviours, so increased substance misuse, maybe increased feelings of paranoia, maybe self-harming'**
>
> (Martin, Fulfilling Lives)

Strategic leads and clinical professionals were more likely to highlight that interventions were not likely to be effective for people in active addiction, because substance use after sessions had the potential to undo the hard work people were being asked to do in therapeutic spaces.

> **'Risks need to be Identified and monitored carefully from first contact. This is distinct from the more intensive intervention that constitutes psychological therapy. A common risk is disengaging from therapy, especially perhaps if this is being delivered remotely or online. An obviously serious risk is that of self-harm or suicide. PTSD and substance misuse both confer increased risks which are likely to be cumulative'**
>
> (Frank, Faculty of Addiction, Division of Clinical Psychology, British Psychological Society)

Some contributors also reflected that risk in people who have experienced complex trauma is often relative, and the risks of an intervention were to be balanced with wider risk factors at play for any individual.

> **'You can't do much worse than the situation these people are in and have experienced. Better to try doing things because you can't do much more damage than has already been done'**
>
> (Niamh, Public Health Calderdale MBC)



5 COLLABORATION AND CO-EXISTING CONDITIONS

By not working together, we are failing to meet the needs of people who have experienced complex trauma.

All contributors believe collaboration between support agencies is important, and all agree it is not happening in practice as well as it could.

> **'I fundamentally believe that joined up working should be an absolute minimum... Operational teams shouldn't be reliant on building good relationships with other agencies, collaboration needs to be built into service design'**
>
> (Michelle, MEAM)

> **'I think [working collaboratively is] absolutely key and it's our primary challenge. [...], I think we're a journey away from formal treatment interventions for most. When I say most, I mean, I'm looking at the more chaotic, complex needs'**
>
> (Niamh, Public Health Calderdale MBC)

Many contributors reflected on how some of the differences between substance misuse services and mental health services have built obstacles that slow down and hold back joint working and collaboration.

> **'There are professional divisions. It's not just that people decide, 'oh, I'm not going to cooperate' or 'I'm not going to...' People are trained differently. They work in different frameworks into different professional accreditations'**
>
> (Colm, Social Interest Group)

> **'I think the problem is the systems aren't set up to be able to cope with a lot of that joint working. So, things like consent and confidentiality, client records, systems, communication. I think we're too different in the sense that in substance misuse, we don't really use diagnosis apart from saying somebody is alcohol dependent or they're non-dependent. Whereas, in order to qualify for lots of CMHT's [Community Mental Health Team services], you have to have some kind of a diagnostic process'**
>
> (Jan, Turning Point)

All contributors reflected on the negative impact of services and systems not working as effectively as they can together to support this group of people.

> **'A lot of the people I worked with didn't have mental health involvement because they were poly substance users. My experience of working in this field with a mental health professional involved in the joint working is very limited'**
>
> (Karen, BACP Accredited Counsellor and Supervisor, UKRC Registered Independent Counsellor)

> **'I think we've lost our grip on the most vulnerable yet. And instead of giving them less, I think we need to give them more'**
>
> (Niamh, Public Health, Calderdale MBC)

'I've read stuff even from the 1970s that's saying we've really got to crack this issue. We're not doing good enough. And it's 40 years later, and we're still not doing good enough. I think people are being failed pretty substantially here'

(Oliver, Collective Voice)

Some contributors reflected further on the roles and responsibility of services when trying to support this client group and there were mixed views on who leads on paper and in practice.

'What we know is mental health services should hold the lead role. According to any kind of government advice and everything else. And it is a problem that that's not always something that happens'

(Celia, Sussex Partnership NHS Foundation Trust)

'No, it doesn't have to be [statutory mental health leading on joint working]. CGL and Fulfilling Lives have helped in finding those gaps in services. Adult Social Care, similar to statutory mental health services, sometimes struggle in acknowledging the multiple approaches needed for the complex cases'

(Alun, Sussex Partnership NHS Foundation Trust)

6 IMPROVING COLLABORATION

Collaboration can be improved and ideas for how this can happen were discussed.

An idea favoured by non-client facing contributors was for there to be joint key performance indicators and joint commissioning of both substance misuse and mental health services.

'I think there needs to be key performance indicators for substance misuse services and for mental health services. I think we should have to show evidence of that communication. Sometimes things only work or only happen if there's a KPI'

(Jan, Turning Point)

'I think there is a much bigger thing here about commissioning and how services are getting their money and how they're getting commissioned'

(Piercarla, Camden & Islington NHS Trust)

Some contributors reflected that dual diagnosis teams and co-location of workers has worked to improve collaboration.

'I think the way forward is experienced, well-trained and professional complex needs workers who are embedded within services and you can cross those divides or differences'

(Colm, Social Interest Group)

Most contributors reflected on how useful it can be to have clinical services/staff acting in a more consultative, advisory way to non-clinical practitioners, and for some, this is something that would be good to develop further. This included reflections on the role of psychologists within the support system.

'For me, as a psychologist, our task is to help people to understand how trauma affects people. And that's people on the desk in a busy service, in a needle exchange, in a pharmacy. I think it's working with people at every level to understand how trauma affects people, really. I think that's probably more powerful within a substance user service than being able to work through trauma with 20 clients across all the services that we've got'

(Jan, Turning Point)

'I would like to see all the services being used for their expertise. And that's why in substance misuse, there is a psychiatrist, there is a nurse'

(Karen, BACP Accredited Counsellor and Supervisor, UKRC Registered Independent Counsellor)

7 RELATIONAL MODELS

Qualifications and years of service do not automatically point to staff being able to build effective relationships; instead, relationship building skills were cited as being more important.

Throughout conversations, building strong, trusting relationships was referred to as a key element of working with this client group.

'I don't think these are difficult things that people are asking for. Essentially, they're wanting to be able to build trusting relationships with someone to have a sense of safety, both physically and psychologically, emotionally'

(Celia, Sussex Partnership NHS Foundation Trust)

'If you can get that meaningful relationship based on trust, non-judgement, all those skills that we know are invaluable, and probably are things that our clients haven't experienced through their life, they're the foundation and the building blocks to be able to move on to other aspects'

(Giles, Fulfilling Lives)

Some contributors also stressed the importance of building positive networks of peers, workers and others as a vehicle to support any therapeutic or rehab work.

'It's about having people that have lived it, that have had that substance misuse and alcohol history. Getting into the services and being able to influence from the inside by proving that there is hope if you get help'

(Giles, Fulfilling Lives)

'Again, that sense of the wider recovery community, being able to see people in a very different context that they had dealings within the past, now doing things again that they wouldn't have dreamt possible. And the hope and the inspiration that comes from that can't be underestimated'

(Brian & Blythe, BHT)

The behaviours and skills of staff were discussed by many contributors. The phrase 'being human' was repeated when referencing the most effective ways of building relationships with those who have coexisting conditions and have experienced complex traumas. Formal qualifications - and for some, length of service - were not necessarily indictors that a staff member would be able to build relationships well this group.

'You don't need to be a cognitive therapist or a psychologist or a trained counsellor to be trauma aware. You just need to be compassionate and humane. I think compassion is also an important kind of qualitative thing.... But obviously, it's a very human experience to be traumatised'

(Frank, Faculty of Addiction, Division of Clinical Psychology, British Psychological Society)

'Deeper listening, where you listen and read what's between the lines, is quite important. Because they're going to give out so many signals and clues just sitting down and having a relaxed conversation'

(Iain, Fulfilling Lives)

Many contributors referenced the value of strength-based approaches to build self-esteem within pre-treatment work, as well as taking an incremental approach to engagement and recovery. Timelines which may not always fit with existing service models or expectations.

'You've got to be realistic as well and things do take a long time. That can trip people up sometimes if they think "I need to give myself a couple of months and then it will all be sorted" '

(Gemma, Fulfilling Lives)

'He's still in that bedsit, he's still there, no evictions. He's a different character. And it might take another year for him to engage in drug treatment. It's important that we are realistic, celebrate incremental gains and recognizing those small achievements. And I think that's the other thing as well: realistic, incremental gains'

(Niamh, Public Health, Calderdale MBC)

8 SPECIFIC PSYCHOLOGICAL MODELS THAT CAN BE USED AT THIS STAGE WITH THIS GROUP

Psychodynamic approaches have mixed feedback largely from client-facing contributors and some shared how they felt these approaches were not appropriate for this group at a pre-treatment stage.

'I don't use psychodynamic techniques in working with people who are dependent on substances. And I much prefer more basic CBT techniques like grounding, breathing, mindfulness, those kinds of things that earth people and get them in touch with their surroundings rather than opening up internal stuff'

(Colm, Social Interest Group)

Trauma focused CBT is favoured by the NICE guidelines and by clinical psychologists who contributed but some felt it requires engagement and a level of stability.

'Trauma focused CBT is 8 to 12 sessions of, say, 90-minute sessions. That's actually quite large. That requires a big space of resource and commitment from the client'

(Frank, Faculty of Addiction, Division of Clinical Psychology, British Psychological Society)

'We did a small piece during our Fulfilling Lives programme on access to psychological therapies (primarily CBT). The learning from a very small cohort was that some people can engage in it whilst still using substances. We saw no increase risky behaviour in those that disengaged'

(Niamh, Public Health, Calderdale MBC)

Some contributors shared a view that emotional regulation models support 'fast to slow' thinking and can be helpful for this client group.[2]

'A lot of what we do involves helping clients to appreciate the difference between a reaction and a response, moving from the fast thinking to the slow thinking. It's a variety of different formats just helping people to kind of slow down their thinking long enough to allow themselves [...] to make a healthy choice'

(Brian & Blythe, BHT Recovery Project)

Most supported models of therapy that contributors shared as being helpful for this group, pre-treatment, target emotional regulation – addressing how trauma is presenting itself and not directly opening up to the trauma itself.

'Attachment theory, which is incredibly helpful for recognising all sorts of things, but particularly for understanding styles of engagement. So, rather than saying that a person is not engaging, we can understand what their style of engagement tells us about their attachment type'[3]

(Michelle, MEAM)

9 UNINTENDED CONSEQUENCES OF EXISTING SUPPORT SYSTEMS

Some contributors reflected how service spaces and institutions more generally can compound trauma.

'The referral was 16 pages, but we still didn't know what we needed to know, which was her traumas are triggered by institutions'

(Colm, Social Interest Group)

There was a strong feeling amongst contributors that retelling trauma stories has a psychological basis for perpetuating trauma, but, despite this, the system we work in asks people to do this regularly.

'If [telling their stories become] rehearsed, that's a really tough place for that person to be and can also make additional phase two of the trauma therapy harder. I'm doing some of that work and coaching them into another way of engaging with that memory'

(Celia, Sussex Partnership NHS Foundation Trust)

'You hear that from services users all the time. 'Why are you asking me all this again? I told somebody else that'. 'Yeah, but that was your doctor. That was your psychologist and I'm your substance misuse worker.' And then your social worker is going to do the same thing tomorrow'

(Colm, Social Interest Group)

Some contributors also reflected on the risk of services proving to be 'unreliable' in the eyes of the client, and how this can reinforce strongly held beliefs and reinforce behaviours.

> **'For many of our service users, it's like it's the starting position is 'I'm not going to trust you because you're going to let me down anyway at some point'**
>
> (Colm, Social Interest Group)

There was a recurring view that training and support for non-specialist staff could help systems to be less re-traumatising

> **'I think ...staff in services find it really difficult to understand what might drive somebody to act in the way that they do. People feel personally affected by somebody "kicking off" or being aggressive...And I think staff find that really hard to cope with. And I think often it's because of a lack of understanding of where that comes from. And you hear all this stuff thrown around about, manipulation, co-dependency, all that sort of stuff, labelling of people that we don't understand because they do stuff that we don't like or that we feel hurt by'**
>
> (Jan, Turning Point)

10 WHOLE SYSTEM PERSPECTIVES

Many contributors reflected on the broader systems at play and some felt that having partial organisational understanding of psychological models and trauma informed practices is not sufficient.

> **'If you want people to work in a trauma informed way, whole staff training is important, but it's a minor aspect of bringing about change. More importantly, you want to consider the broader system that everything else sits in. How well the organisation functions is key, is their house in order? Do they have the basic processes and procedures in place? Does the workforce have safe contracts and feel secure in their positions? Do they feel valued? Is the hierarchy of decision-making clear? Are they having line management supervision? If you don't have those kinds of fundamentals in order and you send operational teams on trauma training, it's just not going to cut it. The relational base they work from and how they're supported is absolutely part of it, that impacts how they then support the people they're working with'**
>
> (Michelle, MEAM)

Some contributors named how they felt there was not enough time built in for the client-facing support work and that this has a negative impact on the staff's ability to provide good psychologically informed support.

> **'Preparing people to access drug and alcohol services, there are lots of tools that can be used, but they need the time. So, if someone works for 35 hours a week, they need not to see more than 15 patients because then you can spend an hour with the patient, write the notes, and before that, you can prepare for a session. If a worker has a caseload of 60 -70 patients, you can't do that level of work'**
>
> (Piercarla, Camden & Islington NHS Trust)

When reflecting on the systems at play, some contributors shared concerns about the way services have been designed and felt more flexible models are needed to support this particular group who experience complex trauma.

'Most of our systems and structures and services are created in our own image and likeness in that we're mostly structured people who can go to appointments and have diaries and calendars and for many of our service users or people with complex trauma, life is not like that. It's not ordered in that way'

(Colm, Social Interest Group)

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4. Next steps and questions for the future

To build on the work of 2020, we would like to continue collaborating with partners nationally and locally in 2021. This will include:

- Bringing together and publishing views of people with lived experiences of coexisting conditions and complex trauma on the types of support that have helped them either access treatment or have helped them have greater emotional stability in their lives.
- Bringing together contributors, local commissioners and local services to discuss the perspectives shared in this report and consider together improved ways of working that we could implement locally.
- Continuing collaborations to trial new ideas for supporting people with complex trauma who have coexisting conditions to support them to help prepare for accessing formal treatments.

For Fulfilling Lives South East this project has sparked a number of questions to consider for 2021, including:

- To what extent do we all agree on where responsibility and resources sit in the system for supporting people with coexisting conditions and complex trauma presentations to stabilise and access support?
- How do we want services to respond to the behaviours of those who are affected by complex trauma?
- How might we better support staff within clinical and non-clinical services to nurture trusting and authentic relationships with people who are affected by complex trauma?
- What steps can we take to develop a support system that can better meet the needs of this group of people?

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5. Acknowledgements

We are thankful for the warm reception and interest people have shown in this project and this has given us confidence that these conversations are valuable, relevant and necessary. Special thanks goes to the team who interviewed contributors and analysed the wealth of feedback collected during these conversations – thank you to Aditi Bhonagiri, Alan Wallace, Ian Harrison and Kerry Dowding.

CONTRIBUTORS

The following people took part in one-to-one conversations with members of the Fulfilling Lives South East team to share their experiences, reflections and learning.

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6. Appendix: Questions discussed during one-to-one conversations

1. In your view how would you describe complex trauma?
2. Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?
3. Can you share any examples you have of where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?
4. Can you tell me about techniques or models you have used that have worked well in supporting someone with complex trauma prepare to access formal treatment?
5. To what extent do you think statutory mental health services and substance misuse services working together is important in aiding someone to access and complete formal substance misuse treatment?
6. In your experience of supporting people who have complex trauma, are there risks associated with someone receiving psychological support pre-treatment? And how might some of these risks be managed?
7. Is there anything else you would like to say around multiple complex needs and psychological support?

[1] Fulfilling Lives South East Partnership's Manifesto for Change

[2] 'Attachment theory' relates to how the parent-child relationship emerges and influences subsequent development and relational behaviours towards others

[3] Reference to psychologist Daniel Kahneman's 'Thinking Fast and Slow' book published in 2011

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