# The Perspectives Project: Interviews

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

February 2021

Fulfilling Lives
South East Partnership

COMMUNITY FUND

## 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.

**www.bht.org.uk/fulfilling-lives**

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## Introduction

The interviews presented here explore 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. People in this group are often affected by complex trauma and can face barriers to accessing formal treatment.

The aim of this work has been to gather the perspectives on this complex issue from a range of professionals. We spoke with those who work in organisations supporting clients with multiple complex needs ('MCN'), those providing or commissioning substance misuse services, mental health services, and other related services.

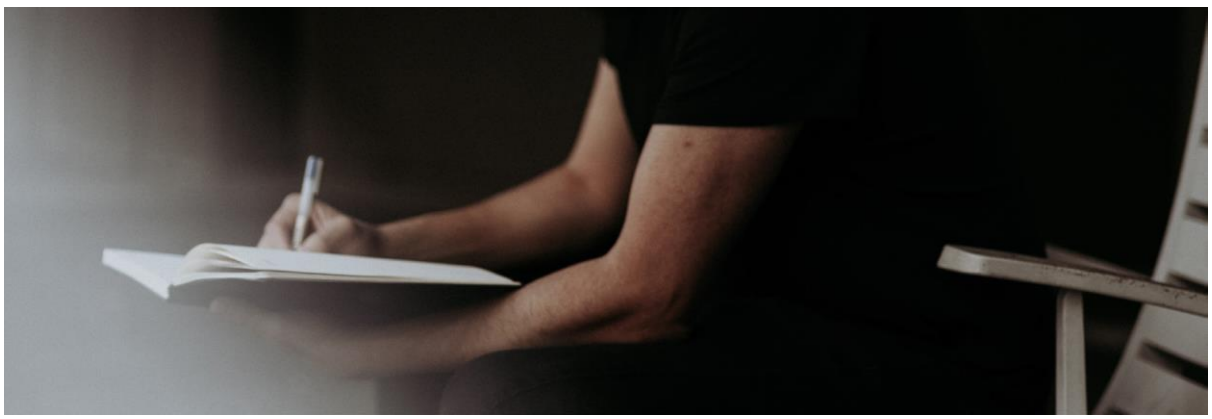
We have published a summary of the themes that emerged in these interviews in a **companion report** that can be read alongside these interview transcripts.

## Interviews

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 transcripts published here have been edited and approved by the contributors. A couple of participants requested that their interview transcripts should not be included, however their anonymised contributions were still used to inform the summary report.

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.



## Alun Stere-Jones

Mental Health Specialist Nurse, Sussex Partnership NHS Foundation Trust, Rough Sleepers Initiative East Sussex

*I have been working in mental health for 15 years. Working mainly in urgent care (crisis, liaison and street triage) before working with rough sleepers. Prior to that, I worked in a substance misuse clinic in Camden and as a general nurse at UCLH. I trained as a general nurse in Liverpool and mental health nurse in London.*

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## *"I think it's the trust, building that trust."*

***QUESTION 1: In your view, how would you describe complex trauma?***

Complex trauma is something we support quite a lot of clients within our job. It's layers and layers of different traumas over the years from when they were a child to when they were in relationships; situations they've ended up in and it just builds on top of the other until it gets to the stage where it's really difficult to get someone focused. You've got the complex side of it where it's not just a one-off trauma. And obviously they've been in services and sometimes they feel they've not been supported by statutory services. So, then it adds another layer, and often they don't feel able to move forward.

***Would you be able to explain how you think complex trauma presents itself? The kind of behaviour that people who have complex trauma exhibit.***

Often the engagements can be quite difficult. First of all, just to explain, before working in this role, I used to work in A&E liaison. And it's almost the opposite presentation in my current role. In A&E liaison, people would turn up in A&E in crisis. Whereas, this client group, often they avoid statutory services, lacking trust in help and support. They struggle to get to the right service because they've felt abandoned by services before and they just find it really difficult moving forward.

***And as a mental health worker, what difficulties does that throw up for you in trying to provide support to someone with a complex trauma background?***

I think it's the trust, building that trust. It's important that the client is seeing you as a person rather than the service, that you're not representing some huge business that they've been to before: Being a person and you're going out to them. There are a few obstructions along the way, especially if they're under the influence of substances. A lot of clients are used to services saying 'no, no, no, we can't work with you whilst you're intoxicated'. I say, well, you can work with them [clients], you just have to change your way of working. And by doing that, you build that trust. They see you as a person rather than a list of reasons why they can't work with you. I think it's quite important to go on their terms. A lot of people will happily see you, but they don't want to see the Mental Health Trust. It's getting that balance and building on that to engage with the right support, which takes time.

*"A lot of clients are used to services saying 'no, no, no, we can't work with you whilst you're intoxicated'. I say, well, you can work with them [clients] you just have to change your way of working. And by doing that, you build that trust."*

***QUESTION 2: Can you Explain to me how psychological support for someone experiencing complex trauma might help in preparing or setting the ground for someone to access formal substance misuse treatment?***

I think at that really early stage, it's almost not involving the substances as a subject. You're focusing on the actual trauma and current needs rather than saying, 'well, if you stopped using substances, then services can be offered'. Although often substances are a huge part of their coping with trauma (understandably), but also focusing on what is it that they want is often more beneficial? There is no point pushing somebody into services when they're not ready for another few months. I think by doing it in a more flexible way, you'll get a better response from the clients to then be able to work closely with them, again start building their trust, that human side of it.

***So, you're really saying that you're waiting for people? The door is open, but it's up to people to walk through it themselves.***

I think most people accept that, they're more likely to then move forward. No one likes to be told what to do, do they? I think that's true of our client group as well because they've been told they have to do this, and they have to do that to move forward. Where, if we're working with them, when they're ready and hopefully they will have met you prior, you're not going away, the support isn't going away. So, they can engage whenever they're ready to do it.

***I guess in some respect, people pushing away, people who have maybe been in controlling or coercive relationships, there's an element of empowerment there.***

Yes, and it's more powerful than anything. It's again, very similar to the psychologically informed environments ('PIE'), it's that similar kind of way of working, that you're there to support. The psychological approach is there from day-to-day in a less formal way, which is quite important as well. People need to feel safe don't they before they move forward to the next step.

***I think it's interesting the steps you take, so that's not a set process. That's a skill as a worker, as someone who has a deep knowledge of working with people with complex needs. It's your intuitive call to go at what pace you think that individual needs to go at?***

I think that's difficult within statutory services because there's almost this expectation of where you're heading towards. One of my biggest issues is that people have to fit into the service where there can be a lack of that flexibility. I think it's quite important for people, that there is flexibility and by taking the pressure off you'll get a better outcome.

***QUESTION 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

I suppose you know about the Housing First Model. What it's meant to be is that we go at the pace of the clients, which is difficult in a two-year project because of time constraints. But with a lot of clients, it's actually getting them into an accommodation, their own home, before sometimes even mentioning if they want any services. I think it's really important; it gives that kind of stability for them before moving forward. What I keep telling the clients is that 'this is your home; this is your safe place'. If they begin to feel safe there, then they can come out of that survival mode and begin to then think about everything. This can be traumatic for them and impact their mood/anxiety. I think it also gives them an opportunity to think of what it is that they want from life? There have been some really positive outcomes from some clients. They know what they want. They know what they need to aim for. I think they just have to be somewhere safe first before they can even think of that. I think its stability and also that openness as well, that the services are there whenever they're ready.

***Do you think that the Housing First model acts as an element of psychological support, as a stabilizing affect?***

Definitely. And I think it's that reassurance for them, knowing that there are people out there that are not just there for the first three months and then they're going to leave; they're there for as long as needed. I think having, especially for us in East Sussex, the MDT [Multi-Disciplinary Team] accessible – the mental health nurse, physical health nurse, social services, the substance misuse service as well and obviously housing – and it's the Housing First team and clients having access to them as needed. Then they're able then to feel stable before they can move forward.

***The agencies that you were just referencing, are they all linked into the RSI?***

Yes, that's one aspect of the team basically. It's one staff member from each statutory service. From my point of view, I have a few core clients I would see weekly and then there's other clients that dip in and dip out whenever they are in crisis or whenever they want/need to see me. It's not, if they don't engage, they get discharged, we will still be there for the person whenever they need it. When a crisis arises, the support is there, ready. When you've got somebody on their doorstep already with prior engagement with them rather than having to refer to the GP and the layers and layers of referrals. And one of the big things we wanted as well, we wanted to avoid people just repeating themselves all the time with multiple assessments. And I think it's really important with this client group, and especially with the trauma as well, that they are able to explain once knowing that people have some understanding of what's happened in the past and how it's impacted on the person.

***Is the idea being that you're navigating people through services quicker and with less disruption and re-traumatizing?***

Yes. From the mental health side, I would refer people straight into mental health services or other services which need to be appropriate and realistic. There's no point setting up somebody to fail by throwing them into services when you know they're not going to engage, or they don't want to engage; there's no point. You might as well just work with them until there's something specific they want to do or feel confident enough to engage with services.

***QUESTION 4: Can you tell me about any examples you have of where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

I went on a course last year with Homeless Link on Solution Focused Therapy. And to be honest, that was most rewarding course I've been on in many years. It's really effective and helpful, especially when clients feel that they are getting stuck. It's sometimes good to just re-group and think from the start and consider what is it that they want from seeing me? There's no point me going with an agenda, it needs to be coming from them mostly. Then to support the client, it's the engagement that's the main thing. Being there, being flexible. I think again it's building that trust and building that relationship with somebody. When the time is right, we can access substance misuse treatment at a less rigid pace.

For a couple of clients, they've been quite keen on getting specific therapy. They want Cognitive Behavioural Therapy (CBT), they want Dialectical Behaviour Therapy (DBT) and they want it now. Where realistically, if we're throwing them into specific therapy services it would need to be that they are off or not using substances and in a stable place for a few months beforehand, which is understandable for some therapy. It's not often realistic in cases. But to keep that momentum going, for a lot of clients, self-guided material can be useful while linking in substance misuse colleagues. We often use some self-guided psychological approaches and linking it into the substance misuse, so they are getting some kind of CBT, DBT input, but it's more self-guided, which helps people acknowledge the link. I make it clear to them from the beginning that I am not a therapist; I'm a nurse. Again, maybe that's good as well, so the pressure's off. It's not expecting too much from me and I'm not expecting too much from them. Just kind of a learning curve for both of us.

*"I think at that really early stage, it's almost not involving the substances as a subject. You're focusing on the actual trauma or need rather than saying, 'well, if you stopped using this, then everything will be fine."*

***And in terms of your role now, being seconded into the RSI, are there examples of clients who are coming into that project who are, for example, receiving implicitly or explicitly Solution Focused Therapy that you're referring to and then entering into substance misuse treatment, is there examples of that? Or is it too early in the project to know that yet?***

There are certain cases, especially when they've moved on from temporary accommodation to their own accommodation. It's the pride in keeping their place and they want to address issues. 'What's the next step'? And I think there's an opportunity then to introduce the ideas. But obviously, yes, this takes time. As part of the RSI we've got the substance misuse clinician working with us. So that would be as easy as them coming with me one day and then just building a relationship with them about different options. It's less formal.

***That's interesting. How long are you into the RSI contract?***

We started 2018 in November so almost two years now. I'm hoping it's going to continue. We'll see.

***And are there any other techniques or models that you use in your day to day work?***

What I'm trying to do is focus on the assessment side otherwise I end up with a massive caseload, not being able to move anywhere. I think it's the CBT and DBT engagement, Solution Focused Therapy and trying to keep it as simple as possible, I think.

***It sounds like what you're saying is, and, you would be echoing what a lot of people have said in these conversations we're having, is that there's an authenticity which is very important.***

Yes, I think it is.

***About people feeling you're genuine and you're not going to tell them what to do. It's like you're there as a safety net if they need it and to help them forward when they feel they're ready to do that?***

I think that's quite important. It's working with them, and kind of working alongside them. And it makes our job easier as well then. I think there's that human element there as well. It can often be cases you've supported in crisis and respecting they will only want to see you in crisis, but they know you're there. Over time the trust to engage will develop. If they feel safe, and respected, this will then grow. And I think it's important that we work on that and gain that respect, from them and them from us.

***QUESTION 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?***

It's hugely important. It's a different way of working for the mental health services, I think. And I think that's going to be the biggest obstacle. If people want it, if workers want this to happen, they will do it. But I think there will be difficulties as well. They've tried it, they're doing quite well in Hastings and the dual diagnosis approach. The services accept referrals from one another which is really good.

They're doing joint assessments on people. But it's been slow to catch on in Eastbourne.

***Right. I think they do have a similar meeting though in Eastbourne, don't they?***

They have the forum meetings but the whole joint assessment or the referral in from the CGL [the local substance use support service] to the assessment treatment I'm not aware that is happening. They have to go through the GPs. There's that obstacle there. I believe it's to do with how it's commissioned and GPs being involved in the referral process. But I think if they can develop the links, if both sides can have realistic expectations from each other, I think that would be a huge, huge achievement. It's accepting that both {substance use and mental health support needs] are there and there are certain pieces of work you can do even if somebody is still using substances, there are different approaches that people can do.

***Can you elaborate a little bit on what you think the difference is? What makes mental health and substance services, apart from the surface obvious stuff, what makes them markedly different in how they approach this type of client? Is it governance? Is it procedures and policies? Is it a cultural thing?***

I think it's a cultural thing, services not fully understanding the other role and expertise. Also acknowledging both interact. Mental health workers can work with people using substances and substance services using their skills with mental health. But it is difficult because there is a gap there. While there are differences, combining both is very difficult, but very similar skills.

***And is there quite a lot of buy in from the mental health side of things into working this approach?***

*"I think it's just getting that investment from services I suppose, statutory services. That they're recognizing it not as a separate issue."*

There has definitely been a huge improvement, but I think its people getting the value of it and wanting to do joined up work. There is a lot of specialist services now, the personality disorder service, Thinking Well, and rehab teams, RSI, but I suppose it's getting the clinicians to work closer. Biggest buy in has been the expansion and the attendances in the dual diagnosis forum, with members for various teams (acute, urgent and community mental health teams) attending the meetings, as well as all the other non-statutory services across the boards involved. It's a different approach I suppose. It would be good to get more clinicians in the meetings.

***That's interesting and what is the sticking point in Eastbourne? It's a little bit behind Hastings in terms of the establishment of that forum isn't it?***

The forum is more established in Hastings, but Eastbourne is now catching up with the approach. The referrals from CGL to the Assessment Treatment Service (ATS) I think is still an issue, but hopefully we can learn from the Hastings approach. Both towns are different, partly due to how it's commissioned and also historical relationships and the towns themselves being very different.

***QUESTION 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?***

It all depends on how much and how deep the psychological support would be beforehand. Again, I'm a firm believer in keeping it simple, keeping it just in that engagement side. I think building those relationship early, and just engaging would reduce the risks as well as people having some awareness or insight into future psychological support available. I think it's about managing expectations from us to the clients and, the clients back to us. They don't want to feel that they've failed. Otherwise, it just goes around in circles again. I think it's just generalised engagement with people. And again, it's re-enforcing having that safe place for them, it is more difficult when somebody is on the street to do any kind of psychological work. But you can still do something, even if it's the basic just catching up general discussion about mental health and engaging just in conversation with them if that's all they want at that stage. We [Rough Sleepers Initiative] are getting two community support workers starting in about a month who will focus on the psychosocial/psychological approaches, so I think they'll make a big difference as well. And a lot of work there would be that pre-therapy, general engagement, and managing symptoms.

***Is there a clinical psychologist in the RSI team?***

We're advertising at the moment. The clinical psychologist will help partly, with introducing the PIE idea to the assessment unit but I think it's also to focus on the complex trauma of people as well. I think it's a huge, huge shift.

***QUESTION 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I think it's just getting that investment from services I suppose, statutory services. That they're recognising it not as a separate issue and feeding this down to the clinicians, not just the community, but also the urgent care and inpatients. It's the mix of the mental health side, but it's also a whole complex substance misuse issue, behavioural issues and everything. They've done quite well in the last few years with developing the Thinking Well service for the personality disorder. But that's just one part of the complex issues. I think moving forward and accepting that people do have multiple complex needs that can't be separated that easily and hence need a multi professional joint working approach. I think if we manage that then it would be a huge impact.

***And do you think statutory mental health are naturally the lead on joint working with this client group?***

No, it doesn't have to be. 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.

For further information about the work of the Rough Sleepers Initiative in East Sussex, please visit:

https://www.lewes-eastbourne.gov.uk/housing/help-for-people-sleeping-rough/#:~:text=Rough%20Sleepers%20Initiative&text=Hastings%20Borough%20Council%20and%20Eastbourne,the%20most%20entrenched%20rough%20sleepers

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## Blythe Crawford & Brian Sudway

Blythe is BHT Addiction Services Manager
Brian is BHT Recovery Project Manager

*Blythe Crawford trained as a drama therapist and worked as a hospital drama therapist for two years. She qualified as a counsellor at Birkbeck College, University of London and has also trained in Hakomi psychotherapy. She managed two mental health day centres in London and has worked for Brighton Housing Trust since moving to Brighton in 1991, managing BHT Addiction Services for the past 12 years.*

*Brian Sudway has been working with BHT Addiction Services since 1999 and previously spent 10 years in education in West Sussex. His qualifications include a Postgraduate Certificate in Education and a diploma in Integrative Counselling from the Wealden College of Counselling and Psychotherapy. He is a member of the Federation of Drug and Alcohol Professionals.*

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***"I do think, without a doubt, there would be more positive outcomes for clients who have suffered unspeakable trauma if there was better preparation before entering treatment."***

***Question 1: In your view how would you describe complex trauma?***

**Blythe:** Most clients in our service have experienced such severe and layered trauma in their childhood, that over time they have become stuck in self-sabotaging survival defences – extreme fight, flight and freeze responses to life and perceived threat. For many, this has caused the downward spiral that led to their addiction. The numbing of self that heroin and other drugs give, is what many of our clients with complex trauma say they craved.

Their early experience of what felt like life threatening trauma was life changing – and progressively made the connection with their sense of self, needs, thoughts, memories, and feelings, too painful.

I would describe complex trauma as this entrenched and extreme dissociation – an extreme discomfort and difficulty in attuning to, and expressing, basic human needs or engaging with life in a way that gets needs met. The self-destructive behaviour that results from this loss is at a deep level - a loss of hope and trust in others, a belief that nothing will ever go right for them again, that they can never make any positive changes in their lives, that it will never be safe to engage with life in a 'normal way' - and often an intense underlying anger . For many of our clients, this has been their life for decades, and the dissociation from trauma has led to mental health problems and chaotic lifestyles, alongside addiction, that mirror their trauma. Some of the life stories we hear from people are almost beyond belief. The trauma they have experienced – often inflicted on them by their own parents, makes their defences, addiction, and sometimes challenging behaviour, understandable.

**Brian:** Some clients who access our service are almost of a 'second-generation complex trauma', having grown up in households where the parents are people who suffered serious addiction problems and neglect and chaos themselves as children. So, there is a multigenerational aspect here as well.

**Blythe:** Several clients have told us they had their first injection of heroin from a parent. I struggled to believe this when I first heard it. A lot of clients have parents who are in addiction. The chaos in a home with a using parent is in itself very traumatic for a child and is often where their pattern of trauma begins - to have parent/s who are substance affected, and often unable to attune to your needs or keep you safe, can be very frightening.

Our understanding of complex trauma is through working with clients who often have experienced the most severe sexual and physical abuse but also the trauma of neglect - not having their basic needs met as children and as teenagers - for safety, to be understood, listened to, have their needs responded to, being cared for and loved. At some point they then bail out - give up 'the unbearable hope' of ever getting their needs met as it's too painful. They dissociate from their needs, from themselves and from other people to a very significant degree and then, as teenagers/adults, many feel that the only way their needs will be met is to steal something, to 'duck and dive', to 'fix themselves' with drugs - and those ways leave them marginalised and excluded in so many ways, with some finding their 'belonging' with the using/homeless street culture.

Heroin is the most effective drug to block out memories, block out emotional pain, and that's why most of our clients with complex trauma have used it. We do get to see wonderful hope and recovery in our job too - clients who have been using heroin for decades achieving abstinence from all drugs and alcohol and becoming

caring, wonderful human beings – good parents, responsible and caring people who can attend to their own needs and also care for others. All the staff in our service are in recovery from addiction and/or trauma.

For some of our clients who are stuck in negative thinking and behaviour and resistant to changing this, I think it requires really creative approaches, which we're always trying to develop. It's often not the first or second time in rehab that works. Some clients need the process of having treatment, getting a taste for it and then coming back again with a little more hope, and learning more. I think the whole experience of learning to make life enhancing change is not easy for clients with complex trauma - many have such long held defences against absorbing and building on positive, supportive learning. Their whole cognitive apparatus has been impacted by trauma. To think about what you need and what other people need, to be able to make good choices; these are things that we can take for granted if we've not experienced severe trauma. The most damaging legacy of severe trauma is that it's hard to think clearly about what you and others need. And hopefully that's one of the things we teach in the programme; to reclaim the capacity for thinking and making good choices, and just slowing that process down. To "sit with" what you're feeling. And allow the learning to be slow and gentle. We also try to make the learning in our recovery programme as enjoyable and fun as possible - of course it isn't always possible, but if the learning is too grim and difficult too much of the time, clients are more likely to abandon or sabotage treatment.

**Brian:** Learning, in the context of the treatment programme, is very much about allowing yourself to be open to feedback from your peers and from staff. And, in order to do that, it requires a degree of vulnerability, which most of our clients associate with being abused and being taken advantage of. I think one of the strengths of the lengthy programme with our service is that clients do get the opportunity to try these things out, realise that it's ok for them to make mistakes, and allowing the staff occasionally to make mistakes as well.

**Blythe:** And hearing staff apologise for mistakes is something new for most of our clients. They have usually had caregivers who never apologised for harm done to them. So, if we make a mistake, we just say we're really sorry and you can see in the client's face that this is very healing for them.

**Brian:** We log formal complaints, of which we've had none in the last couple of years, but we also make a point of logging every single informal complaint. It could be a grumble that someone has about a group, or something else that happened. Regardless of how small the issue seems to be, we will always make a note of it and respond to it within 24 hours. And so, clients at both projects know

that we take seriously the service that we're trying to provide and that we want to design it to fit their needs. A lot of the significant changes that have happened in our treatment programme over the years have been suggestions from clients.

**Blythe:** When things go wrong, and they're always going to go wrong at times in a community with a significant number of people with complex trauma history - the mistakes are part of the learning. Having said that, it's 12-step treatment, and if a client uses drugs/alcohol while on this programme we do have to evict that client for the safety of other peers in the project. And that's really difficult and challenging because it allows no room for making mistakes on that issue; and for clients who have been using drugs/alcohol for a long time and haven't yet learned the skills they need to manage their triggers - their skills often don't match their motivation. We have to hope that they will learn from their mistake and return to treatment to learn more. That's where some pre-treatment preparation would be valuable - because clients have to hit the ground running with the challenges of early treatment - even if they are very motivated, their old negative thinking and behaviour patterns can derail them. Clients who have severe trauma histories can make mistakes that prevent them getting past the first hurdle in treatment. So, preparation is needed to make it more likely that they've learned for instance, better impulse control – so they're more prepared for that first hurdle. By the time clients have been here for a month or two, they're more able to cope with the triggers, and have learned strategies to manage these, but those first few weeks can be fraught for clients coming in with complex trauma histories.

*The difficulty is that sometimes clients who have had severe trauma can make mistakes that prevent them getting past the first hurdle. So, preparation is needed to make it more likely that they've learned for instance, better impulse control - so they're more prepared for that first hurdle. By the time clients have been here for a month or two, they're more able to cope with the triggers, and have learned strategies to manage these, but those first few weeks can be fraught for clients coming in with complex*

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

**Brian:** Psychological support in terms of counselling and other psychological interventions are of limited value if people are using and drinking chaotically.

Rather than going along to receive a parcel of psychological support, it can be of more help if they have an ongoing connection with somebody who, once they've started in treatment, can act as a bit of a bridge and come in and see them. It's not a psychological intervention as such, but that's the kind of thing that I think helps.

And also transport, getting along to 12 step fellowship meetings before they actually come into treatment, so that they have some experience of that before they come in. It's a requirement of the programme at the Recovery Project that all clients attend a minimum of four meetings of one or more of the Anonymous Fellowships - NA or AA or CA -in order to have that grounding before they enter the service. And it's that continued connection, which is still available after a client has left treatment, that connection with the wider recovery community in Brighton and Hove. It provides a really helpful safety net for people once they leave the relatively high level of support in our project. They still have sponsors, they've worked the first five steps of the programme, they are linked into meetings that they go to regularly. So that's an ongoing set of relationships and connectivity. And that's, again, not traditional "psychological support", but it is a vital aspect of recovery.

***I really like that you've brought in the peer support element to accessing treatment where being guided by someone who's already a fellow of the program is a lot more essential. Does the project jointly work with any front-line mental health workers who are providing these sort of psychological interventions?***

**Brian:** Clients are still under the umbrella of their CGL care coordinator. So that's a key ongoing relationship. We quite often have CGL workers visit the project and check in with their clients, and we very much encourage staff to do that. A number of our clients have also suffered from eating disorders and we have engaged in joined up working with the eating disorder unit.

**Blythe:** Sometimes mental health workers are not connected with our clients because there's still that issue that if the client is under addiction services then, until the addiction has been dealt with, they don't get a mental health worker. But occasionally, mental health workers are linked to clients and do visit them here. We also work closely with children's social services as quite a lot of our clients are parents with a children's social worker involved. It's an important part of the work the client does with their keyworker in that small window when a client who is also a parent, comes into treatment - to give them the best possible chance of getting their recovery while also supporting them to have ongoing contact with their

children while in treatment, and the best possible chance of being a good parent for their child/children.

All our volunteers achieved their recovery with our service, and we often ask them to give some extra support to a client who is struggling, choosing a volunteer with similar life experience whenever possible. For instance, if a female client has experienced domestic violence, we would try to link her with a female volunteer who is in recovery and who has experience of finding a positive way through that issue, who will take that client out for coffee, and give her identification, support and hope. Many clients have had significant contact with St Mungo's and Equinox before starting treatment with us, and that contact often continues in treatment, which has been helpful. Also, if things go wrong and the client is evicted or abandons treatment, they have got the continuity of support from that worker to ensure that client is safe at a vulnerable time, and hopefully to encourage them to try treatment again.

***Question 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?***

**Brian:** Not really is the short answer. As Blythe mentioned, sometimes people leave our project, have a period of time away, and subsequently come back; and that previous treatment experience is a resource for them when they start. But in terms of formal psychological services I don't think I have any specific examples.

**Blythe:** Clients get support from their CGL care coordinator before coming here, and/or from services like St Mungo's who often provide practical support, get them along to the drop ins at our project, and can also be a go-to person to carry hope and belief alongside the client that treatment really is possible for them; but no formal pre-treatment psychological support has been available thus far. That is something that we are interested in though.

**Blythe:** When clients are in treatment, they have a structured programme of support. We have a varied programme of therapeutic and recovery focused groups and a weekly community meeting - working towards a healthy community culture here is the main focus and challenge of our work.

We run specific groups, teaching skills and strategies for the kind of behaviour which can be problematic in treatment, and recovery skills. The Detox Support Project will usually hold a group on a behaviour/recovery issue that has presented itself that week. So, for example, if there's been a lot of anger playing out, we get

the group on board to do some learning around that issue – how to change old patterns of anger for new healthier ones that support recovery.

In therapeutic work we use CBT alongside our 12-step model, and also other therapeutic interventions – trauma sensitive meditation, for instance, or drama to teach psychosocial skills. We teach clients who are very dissociated how to be more present – to help them activate strategies they are learning when risks and challenges happen in real time. Often a client will say something like "it just never occurred to me that I could say no - I didn't realise there was a risk happening there". Bringing creativity and fun into the groups has really helped to engage clients in learning who've had a negative experience of learning in school, related to their neglect and trauma. People often tell us that they remembered what they learned in a particular group that was drama, and fun-focused, and that they put what they learned into practise many months later.

*'I think 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. And again, it's a variety of different formats, just helping people to slow down their thinking long enough to allow themselves to be in 'Adult' long enough to make a*

That's one of the best things for us about this job - when clients actually use a strategy that they have learned here to keep their recovery safe. It might be something as simple as giving them an image during a group that sticks in their mind. So, with the learning, we often use these creative tools – and sometimes humour, or just sitting on a bench in the courtyard and having an informal chat with a client. You're just trying to give them an experience of being present with what they're feeling, and for that to be safe. So, it's using the opportunities, not just in a group or keywork, but also the informal human to human moments - having a cup of coffee with a client, chatting about nothing in particular, and they're quite lovely those moments. I think clients really value them. They have an experience of us just being there for them in a way that's meaningful and normal, and many have not had that with their own parents or anyone for a long time.

**Brian:** I think 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. And again, it's a variety of different formats, just helping people to slow down their thinking long enough to allow themselves to be in 'Adult' long enough to make a healthy choice.

**Blythe:** One of the things that's really powerful is positive feedback - to show people that you've seen a positive change they have made, even if it's really small; to say, 'I noticed how you responded there - normally that would have been a trigger for you to get angry or walk out and you didn't, you stayed with it, and you responded in a really helpful way. And that's real progress - a really hopeful sign', and you can see the client taking that feedback in like it had real meaning for them. Sometimes we use feedback on body language in the learning too. We had a young man with us who was hunched over; he was only 24, but his upper body was hunched over like an old man. There was nothing physically wrong with him but his embodied defences from early trauma were painfully visible. So, at some point in his treatment - in a way that was gentle and not shaming - we encouraged him to practice what it felt like to open his chest up a little bit and to practise this; and by the end of his treatment he was standing up completely straight. We were able to say - 'You look so much happier' or 'You look more relaxed' and he smiled and knew what we meant.

***Question 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?***

**Brian:** I think it's limited in terms of pre-treatment. We have had a few clients in the past who have come in and really struggled with their mental health to the extent that they were unable to engage with therapeutic groups or meetings. We then found some difficulty in the referral pathway to mental health support, or other residential support services, for those clients who feel they have got all they can out of the service we provide, or whose behaviour while at the project is making it very difficult for other residents to feel able to stay. We have found that it can be a very time-consuming and stressful process for the client to access mental health support at this point - and during that time of waiting, the client does need to move on to a more appropriate service, but it can be a very challenging time for all concerned waiting for that support while still in treatment.

**Blythe:** We're not a 24/7 staffed service. We do have staff available on-call should a client have a significant decline in their mental health, and we also have cover staff available at the Detox Support Project on evenings and weekends, but not overnight. So, it's important that we make a good judgment call about the support needs and risks of clients when a client has a dual diagnosis, to ensure the support we can offer is high enough for them, as our programme can be challenging at times. We do often get very good outcomes for clients with a dual diagnosis.

**Brian:** We do have access to dual diagnosis nurses at CGL. And if we have any concerns, we can get in touch with them. I think the other thing that would be helpful would be faster access to mental health reviews when clients stop using alcohol or their drug of choice. Sometimes the use of alcohol or other drugs can mask an underlying mental health condition, which can become more apparent once the drug/alcohol is no longer being used. And it's really important that those clients are able to rapidly access mental health support. They can do that to a certain extent through their GP. But it is limited, so that would be something that we would find helpful.

***Question 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?***

**Blythe:** In terms of pre-treatment, it would very much depend on the kind of psychological support they're receiving. I don't think you can do in-depth trauma work with people who are in active addiction before they come into treatment – I feel they need to be stabilised in their recovery before therapeutic work of that nature. What would be very helpful for clients at the pre-treatment stage is trauma-sensitive preparation - getting clients used to being in groups and sharing their feelings, hopes and fears about treatment, and learning/practising strategies for some aspects of treatment they might find difficult. Maybe psycho-social skills-based work around the very issues that would be problematic for them in the early stages of treatment, with a trauma-sensitive approach so that it would be along the lines that you've heard us talking about, with the learning as enjoyable and as safe an experience as possible, but also preparing them to tolerate coming out their comfort zone and defences a little. The risks in providing pre-treatment psychological support to clients with complex trauma are that if they are still using drugs/alcohol at that point, the therapeutic work may not be effective and could trigger negative behaviour and beliefs about themselves and their ability to cope with treatment. However, there is potential for pre -treatment support to better prepare clients who have complex trauma for the challenges of treatment, so that they have a better chance of a positive outcome. Clients with complex trauma usually have a lot of shame about the lifestyle they've lived, people they've hurt, things they've done to get their drugs - and parents feel guilty about their children and not having cared for them properly. I think a lot of the pre-treatment work could help people to believe that they can do it, that they can work towards and achieve recovery.

Something we've heard many clients with complex trauma say is 'treatment is not for people like me'. Some really don't think they can do it. And so, I think a lot of

the pre -treatment work needs to ensure that it focuses on helping people feel hope and to believe that 'people like them' can do it. I think some people just need an extra bit of support to look at the thinking they have about themselves. Strength-based training, looking at the resources that they do have and building on those, so that when they enter treatment they've done work on impulse control, work on anger management, and a lot of work on hope and certainly on motivation. Training up volunteers who have been through trauma themselves and who have succeeded.

***Question7: Is there anything else you would like to say around multiple complex needs and psychological support?***

Many clients with extremely traumatic life stories, who didn't believe that they could do it, have achieved recovery with our service. It has been wonderful to witness them reclaim their sense of self and a positive connection with the world around them, and then go on to help others in the project with similar life histories. We are very aware of that percentage who really do need that something more to give them a better chance. I do think, without a doubt, that there would be more positive outcomes for clients who are suffering, who have suffered unspeakable trauma, if there was better preparation before entering treatment.

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## Dr Celia Lesquerre

Consultant Clinical Psychologist
Professional Lead for Psychology and Psychological Therapies, Eastbourne, Hailsham and Seaford ATS, Sussex Partnership NHS Foundation Trust

*Dr Celia Lesquerre is a Consultant Clinical Psychologist and has worked in Sussex Partnership NHS Foundation Trust for over ten years. At the time of this interview, in addition to the post referred to above, Celia was also seconded to YMCA DownsLink Group as their Head of Clinical Development, with a remit to develop their organisation as Trauma Informed. She was also working in the Specialist Sussex Partnership Trust-Wide Complex Trauma Service.*

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## *"We must speak with integrity, not making it sound like this is an easy thing to happen. We also must appreciate how hard that will be for some individuals."*

***Question 1: In your view how would you describe complex trauma?***

I think this is an important question and one that people might get confused about. My understanding of the term is that it's referring to the sorts of experiences somebody might have had in their lives. What we're referring to are multiple traumas that might have gone on over a number of years and it could be different sorts of traumas or traumatic experiences, or it could be one thing that repeats over a number of years.

So often we're thinking about early developmental traumas, but not exclusively. It could be traumatic experiences like childhood sexual abuse or physical abuse. It could be growing up in environments where you feel very unsafe; witnessing or being on the receiving end of domestic abuse and domestic violence. But it doesn't have to sit within childhood experiences either. Some people might have a relatively trauma free childhood, but they could grow up and find themselves in a domestic violence type situation or something of that nature. And that could also be thought of as a complex, traumatic experience. What we're not talking about here, is single event traumas. And for me, I would also be distinguishing this from complex PTSD, which is a diagnosable condition, increasingly now that's coming into ICD 11. So, I think sometimes complex trauma, certainly in mental

health services, the term can get misused. I don't think people always confidently know what it is that we're talking about. So sometimes just because somebody has a history of complex trauma doesn't mean that they'll have significant mental health difficulties now and in the present. So, again, depending on the experiences they've then gone on and had in life, they might be functioning and doing really well. And so, I think that's important as well.

***What does it look like and how have you seen complex trauma present itself?***

I think that's where we're getting into this tricky distinction between complex trauma and complex PTSD. I wouldn't say complex trauma particularly looks like anything clear in the present now. This could be very different for different people. Some people may have experienced complex trauma but will now be functioning incredibly well and to others, it may not be evident that they have a traumatic past. If somebody is experiencing PTSD or complex PTSD, that might look like certain things. I guess what we know is if people have grown up experiencing a lot of complex trauma or even experienced that as an adult; they may or may not present with symptoms of PTSD within that broad spectrum. So, PTSD is another kind of umbrella term. Complex PTSD is a smaller subset of that. So those people are likely to struggle with or have difficulties with relationships. They may struggle to trust other people, they might be a bit wary of you, kind of suspicious. They're not going to instantly open up and share everything that they've been through with you. They may be avoidant of certain things. They may be kind of easily startled. They might experience difficulties with intrusive memories, have flashbacks, all these sorts of things. But these things end up being potentially diagnosable. So normally when we're talking about complex trauma, it's another word for these sorts of type two traumas. Not the single incident traumas, but either the same sort of trauma that happens over a number of times and over a number of weeks, months or years. Or multiple single event traumas, different things that could happen.

***What difficulties does complex trauma present in trying to provide support?***

Where we're thinking about complex trauma and certainly working within mental health services. I think some of the challenges are just because somebody has this history doesn't mean automatically that they'll be appropriate for mental health services. That is some of the discussions we have internally at a trauma working group meeting within our Trust.

We are talking often about people with these very significant and traumatized histories who can end up falling between gaps in services. If they aren't experiencing significant symptoms of PTSD or complex PTSD or depression or

psychosis or personality disorder, they may or may not be appropriate to be seen by secondary care mental health services. And so, the people that are most vulnerable to that are probably pretty resilient, given what they've been through and who find a way to manage day to day.

We know they've got this awful past that I'm sure they would benefit from working on and talking through and finding different ways to manage that. But unless they're presenting certainly in my service, I'm thinking about Eastbourne, for example, we would be thinking about what is the mental health difficulty that this person is presenting with now in this moment? Somebody who has a history of complex trauma could well present with a multitude of mental health problems. It could be PTSD, complex PTSD, depression, a personality disorder, psychosis; it could be anything. So that's the bit that we end up paying more attention to. And then, I guess, the risk there in mental health services is sometimes we get a bit too focused on the symptoms and some people are then very poor at asking about or thinking about what's happened to you in your life, which obviously helps to contextualize why somebody might be depressed or why somebody might hear voices that might represent the voices of those in the past or things like that.

### *Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?*

I think there's something about what I would call phase one approaches. By that I mean, there's something about safety: Is this person safe from current traumatic experiences? That would be one of the first things to ensure as much as that is possible. Then, I'd be wanting to share with them some ideas about what sorts of things can happen if you've experienced a lot of trauma in your life. So that their symptoms or the things they might be struggling with in the moment can be thought of as understandable responses to awful things that have happened, many of which shouldn't have happened.

And so, there's a way that they can begin to understand about the brain, the way we respond naturally to traumatic experiences like fight, freeze responses, any of those sorts of things. And helping them understand that maybe their drinking or substance misuse difficulties have stemmed out of perhaps a desire to block stuff out, to try to forget about what's happened to them. You're already beginning to help them understand how this might have been helpful or productive ways of coping when they felt like there were no other options. We're wanting to begin to help them see that there may be other ways of coping and learning to manage with the distress they might be experiencing. We're focusing on building up those

coping skills and other resources. Because if we don't have those, the chances of somebody stopping some of those things that they found helpful in the past is unlikely to work or to last.

***That sounds like quite authentic conversations.***

Yes, and where we're really appreciating the difficulties that they faced and that we're not blaming or shaming somebody for finding a way that works for them to help them get through each day. Most people, I don't think want to be drunk most of the time. They may do if it's better than having to deal with intrusive memories of traumatic experiences. If they could get rid of those memories of traumatic experiences, they might not feel the need to drink or take substances. I think psychological support is recognizing somebody's caution or fears about letting go of using substances. They may well have tried in the past and found it hasn't worked. But we must be authentic, sincere. We must speak with integrity, not making it sound like this is an easy thing to happen. We also must appreciate how hard that will be for some individuals.

***Question 3: Can you tell me about any examples you have of where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

I remember working with this client, he hadn't received any psychoeducation and had, I would say, been quite badly let down by services. And came to me because of a complaint that had already been raised. Rather than send him off to see somebody else to do the psychoeducation aspect of the work and then come to see me for the clinical part of the work and so on, I just did the work.

With this person, the risk was he used a lot of substances. And, I needed to have quite a frank, open and honest and authentic conversation with him around the fact that if he were to come to a session when he's under the influence of something, or even if he were to leave straight away afterwards and use substances, the likelihood of him benefiting from the work that we were doing would be very slim. But what I wasn't saying is go off and work on your addiction and then come back to me. I suppose it was sort of trying to find a way of helping skill him up in other ways and recognizing that he did have other strengths, and things that he could draw from. In order that he felt able to reduce the amount of substances that he was using to get to this kind of window of tolerance before and after sessions.

But I was not asking for abstinence either. We would work, to begin with, with a 24-hour rule before and after sessions. We later expanded that to 48 hours. And actually, this person in particular did end up making a decision to come off substances with the support of other services working with him at the same time. And did successfully at that point. I don't know what's happened since, but he had managed to come off substances that he was using.

But there is this need to approach it in that way, to help people find alternatives and substitute other ways of coping, otherwise they will continue to naturally turn to, whatever substance it might be for them.

***When you speak about psychoeducation and psychosocial, who do you see as best placed to offer that support? Is it across the board? So, are we talking about non-specialist frontline workers her?***

Can be. So, if I think about my YMCA role, for example, just recently what I've been doing is providing a lot of training around trauma informed care. The YMCA across Sussex is a big organisation. I focus specifically at the moment on our housing staff. So, where support workers, managers, whoever, even linking to rents teams and others, so that they've got enough understanding of what might be going on in someone's life. I want to help them understand about the prevalence of trauma. Allowing them to become a bit curious about what might have gone on in people's lives and, then highlighting to them, this is the way the brain works.

This might be why somebody kicks off with you. Or why somebody has retreated or withdrawn to their room. That's not somebody you can think 'phew, that's one less person I have to worry about,' that's somebody you might be needing to be a bit more proactive with in terms of how you draw them out and engage them. And so I'd be talking to them about these kind of key principles of supporting somebody to feel safe, to develop trust, to feel like they have some kind of control over their lives and that they're collaborating with staff around that, in order that they feel more empowered to make these sort of better life choices.

But I share with them information about the brain. I talk about a hand model of the brain so that they can even use this way of talking to the people that they're trying to support. So I showed them videos, clips from the Internet that if they're not feeling confident enough yet to have these conversations for themselves, they could watch these videos with the person that they're trying to support and they can kind of work it out together.

We talk about the window of tolerance and how somebody might become overwhelmed, hyper activated or hypo activated and what they can do to help

somebody come back into that window and again, to get away from language that leaves people feeling they're in the wrong. They're to blame. They should know better. They should be over this by now or whatever else. So, I think other people are so well placed to provide this work, and I'll say to them, me as a psychologist, I might see somebody for an hour or an hour and a half a week. You were there with them after those sessions where we might have done some really tough work or, you're with them when they heard a door slam in the building or something like that. And it's created this sort of startled response, and they're now overwhelmed and feeling terrified. So, it's then about how do they support these people to come back into that window of tolerance? And I'd be encouraging workers to talk with them about the window of tolerance and like I say, if that's through watching a video together and learning about that together, then great.

### *Question 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?*

I tend to think about a phase-based approach to treatment, but that doesn't mean it's a nice linear process. Like phase one, phase two, phase three. But Judith Herman would have spoken about this phase-based approach to treatment. These days we try to draw it out as a bit of a triangle because it's this idea of you can move between these different phases and often you need to keep coming back to different things at different times.

Phase one is more about that psychoeducation. The first thing actually is about safety. If somebody is still in an unsafe situation, if there is ongoing domestic violence, if there's ongoing rapes or whatever the trauma might be, our priority is to do whatever we can to get that person safe. So that's part of phase one. The other part is then about trying to stabilize and manage those sorts of symptoms that they're experiencing, whatever they might be. If somebody is really depressed, we might be wanting to work with them to feel less depressed. If somebody is experiencing PTSD we might be wanting them to have that understanding. So that would always involve psycho-education, some explanation of things. And so that's the bit I'll come back to. If we're talking about a trauma-focused intervention, either for PTSD or complex PTSD, if somebody has a history of complex trauma, it's more likely that they'll fall into that subset with complex PTSD. That's where they have these intrusive symptoms in relation to multiple traumas. The reason they might have PTSD as opposed to complex PTSD, is because there might only be one of the multiple traumas that they struggle with in particular. In some ways, then you just focus in on that one trauma, because

that's the one causing them the difficulties in their day to day life. Yes, they've had all these other traumas.

It doesn't mean you have to focus on all of those in the phase two parts of the process. Phase two is where you would need an evidence-based psychological intervention. Currently NICE would be recommending trauma focus CBT (Cognitive Behavioural Therapy) or EMDR (Eye Movement Desensitisation and Reprocessing) as the main key areas. And that's where you actually spend time either talking about or thinking about the specific traumatic memory. There would be some sort of retelling of that in the session, remembering of that. When you get in touch with the emotional experience, the thoughts that come to mind and you're actively working to shift the way they think and feel about themselves in relation to this thing that happened in the past. And that's often the big part of that role in helping to make it feel like it's now distanced and not a present thing. And that's why the phase three is the future focused re-engaging with life work.

I think people understand why the phase one work in providing psychoeducational support is so important. If people can't stay within that window of tolerance when they're having to remember what they've been through, they're not going to be able to do that part of the work easily. They'll become overwhelmed and you'll need to build strategies, in phase one, to help them manage and contain that. We have this expression of "one foot in the present, and one foot in the past". If somebody is two feet in the present: 'Yeah, blah blah this happened to me, etc, etc,' in a very disconnected, detached way, they're not likely to shift the way they think and feel about themselves in relation to the trauma. Equally, if somebody is two feet in the past, essentially having a flashback of what happened in the past, they're back there, they're not feeling like they're here with you in the room so they can't do that work. In that initial phase one, which I think is the work that would be really valuable in preparing people for either substance misuse work or mental health work. It's understanding how the brain responds when we're experiencing a traumatic event, how those very survival-based techniques take over that need to just survive this moment.

*"The initial phase one, which I think is the work that would be really valuable in preparing people for either substance misuse or mental health work. It's understanding how the brain responds when we're experiencing a traumatic event, how those very survival-based techniques take over that need to just survive this moment."*

If that's through running away, if that's through fighting my way out of this, if that's through just shutting down completely, then that's what I'm going to do. And, also a lot of people will feel intense shame, if they found that they froze or didn't do

something, they might easily think, 'why didn't I act? I should have done that.' And so, by explaining the way the brain works and explaining why fragments of memories might intrude is often quite helpful. It's then moving into this place of 'yeah, these awful things happen to me. Sometimes they do have this impact on me in the day-to-day. But there are other things I can do about that. I can ground myself, orient myself to the present. If I'm hyper activated, I can do these things to calm, to sooth. If I become hypo activated, I can do these things to prep myself up, to kind of feel like I've got a bit more energy, I'm a bit more connected again to my body and so on.'

***So, it isn't a case of going through in triangular process from phase one to three. Phase one would be a time where someone with that preparatory work, on an individual basis, could begin think about potentially going into treatment if they wanted to?***

Absolutely, so if I think about my YMCA work, I'm absolutely clear with workers, you're not the person to be doing phase 2. I want to emphasize there are some people that we've worked with where we've provided that phase one, that ability to understand and make sense of what's going on for them. That ability to know, to anticipate triggers and think about how I prepare for that, to anticipate nightmares and think how I prepare for that, if and when they happen, to know what to do when they happen. And they might say, actually I don't want to talk about what happened to me. I don't want to go into phase two of this work. I don't want to be actively remembering. I've now got strategies I can use to manage this and that's enough. That's great. It allows them to move on, they already feel understood, even if they've not had to go into the detail of what happened to them. And they might just want to get into living life. So, it doesn't have to be absolutely that they then get referred even to mental health services for that phase 2 bit of the work.

***Just so I'm connecting dots here, phase 1 doesn't necessarily have to be led by someone like yourself, a psychologist?***

It could be happening essentially with friends and family. In our mental health teams, we're trying to make sure all staff are trained to do it. So, yes, a psychologist can do it. But given that there's a small number of psychologists who are able to offer phase 2 to work, it's better that our time is normally spent doing that bit of the work and some of the preparation has happened elsewhere. It could be in the charitable sector that that's happening. As I say, it could be that we do some of that work with friends and family and then they can support the person as well. And certainly, our nurses, our social workers, our occupational therapists and so on. A lot of what we're talking about is, I think hopefully makes intuitive

sense, and if it makes intuitive sense, it's easier to then explain it. I don't think it should be kept in the realm of psychology. For example, part of my other role in the YMCA is to ensure good clinical governance around all of the work that we're doing to make sure that people have the training and the skills to be able to provide what they're doing, to ensure that those staff are also supported and supervised and, have their own space to go to and take concerns or issues to. That there are safeguarding processes in place, especially with this kind of work, because we are talking or finding out about things that have happened in the past.

***Question 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?***

I do think it's crucial and this comes up time and time again in our serious incident type reviews and especially, unfortunately, where somebody might have taken their own life or died. We recognize that these are significant problems, but it is a complex issue. And so often what tends to happen is in mental health services, in statutory services, you might get people saying that someone was turning up drunk or under the influence of substances.

And it is true that we can't do any meaningful work with somebody if they're turning up under those circumstances. But on the other hand, if you simply say, OK, go off to substance misuse services and find a way to come off different substances. They say, well, how or why would I do that? Because this is maybe preventing me from having one flashback or another after another, or kind of intrusion after intrusion. Or feeling really overwhelmed by the things that have happened to me or feeling kind of hopeless about things. I'd rather just feel nothing or feel high or just pass out from whatever's going on. What people require is a meaningful way out of a situation where they feel well supported. Some conversations, for example, I might have had with people where I know they might drink a lot or something like that. I might be having a conversation about this with them ahead of the phase 2 work, which is often very challenging work.

*"Some services will be much stricter around abstinence and things like that. I don't think that's helpful. I think it's just too easy to say, you need to stop using these things and then you can come back to us. It ignores all the complexity of what's going on and why that might be a struggle for somebody."*

This is the phase where we're saying, we want you to actively remember what happened. To talk about that. Or think about that. I'll explain to the person we want you to have the best shot at this. This is not easy work that we're asking you to do. If you do leave here and go and get blind drunk afterwards, chances are you'll have undone any work that we might have done within the session. You're going to do this really hard thing with me and then you're going to try and block it out, and you're not going to benefit from it.

So, let's try to work together in these ways so that you can find a way to tolerate this really difficult phase of the work. And you feel that you've built up these skills and competencies to be able to do that. As I say, some services will be much stricter around abstinence and things like that. I don't think that's helpful. I think it's just too easy to say, you need to stop using these things and then you can come back to us. It ignores all the complexity of what's going on and why that might be a struggle for somebody.

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. And it's tricky because, we also have to work with somebody in terms of when they're ready to, actively and meaningfully engage with both services. And again, it's understandable, especially if people have tried things before. That services might think, well, they say they'll engage and then they don't engage. But that's where some of the trauma informed principles become so important because we're really actively collaborating with somebody, giving them a sense of choice and control over what steps they do, what works for them, to empower them to be able to embark on this journey. And, potentially drastically turn their life around. But it requires a lot from them, but they can't do it on their own either. Many can actually. But they shouldn't be expected to. I see it as a multidisciplinary kind of need, between both mental health and substance misuses services, that we're all paying attention to.

***Question 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?***

If people start drifting into talking too much about the content of the traumas that they've experienced, that can be very overwhelming for people in a number of

different ways. Particularly if a worker is not appropriately trained and confident to manage this kind of conversation and disclosure. If the client is not in a place to be feeling ready to talk about their experiences. It can just simply in the moment leave them, if they're having a flashback, not knowing where they are, who they're with, those sorts of things, and that could be very frightening for them and will activate the brain again to think I need to escape from this trauma. I think that it's risky in the sense of somebody might then just want to go off after that and take substances and/or drink excessively. And of course, then we know the risks associated with doing that.

Or it might be that they're left feeling very frightened and could want to then self-harm or end their lives or those sorts of things as well. I think where the focus is around helping develop those skills, it's a really sensitive area. I would often say if somebody is now wanting to tell you a bit about what's happened to them. That suggests that they're building up a trusting relationship with you, which is good, and is to be valued and it's just such a positive thing.

*"I would often say if somebody is now wanting to tell you a bit about what's happened to them. That suggests that their building up a trusting relationship with you, which is good, and is to be valued and it's just such a positive thing."*

If then when they start talking about things, they're becoming overwhelmed, then I think it works both ways. It might overwhelm the worker. The worker might now be hearing awful details about what somebody's been through. And so that has a potential impact on the worker, they might think, 'I'm out of my depth. I don't know what to do.' So that can also feel difficult. So, there's a way of just really respectfully saying, 'no'. I think you could even reflect on the trust in the relationship that clients been able to share something. You could say, *I'm really pleased that you felt able to talk to me about this. I wonder if you're now reaching a point where you would find it helpful to talk to somebody about the things that you've been through. I'm here. And I will always try to support you in these sorts of ways that fit within the realms of my role. But it may be that I can support you to access some additional help where you can then talk more about what's happened to you.* Because that's where there is a clear evidence base about how you unpack those conversations, what works and what can make things harder. But, just encouraging somebody to talk about their traumatic history, it is potentially problematic.

Now, having said that, some people who have a complex trauma history, but who can stay within that window of tolerance when they're talking about things that might be absolutely fine. It might be what they need. So, what we're looking for is when people become distressed and overwhelmed when they start to talk about

it. I might ask somebody, could you say in a word or a sentence or two - certainly, no more than that -a little bit about what you've been through? And I'll have coached them up to that point. Some people might instantly display a fearful response, the deer in the headlights. And at that point I'll say, 'I can see by your response that that might be something that would be really hard for you to do. Remember, I said at the beginning if there are any questions you don't want to answer, you don't have to answer them. How about we move on? Would you prefer that we move on?' And they often say 'yes please.' But they've told me so much already. I'm not then thinking nothing happened to them because they didn't tell me. Absolutely something's happened to them. And they are rightly cautious about opening up about that.

***And this is a phase two set of questions you're referring to? If that was a non-specialist frontline worker, is that something you would be recommending someone to ask if you have that relationship with the client?***

With training. I say that because if we think about trauma informed care, we know that if we're not asking about a history of trauma, people won't necessarily spontaneously tell us. There is a recommendation that we should be asking people about whether or not they've experienced trauma in their lives. But there are very sensitive ways in which that should be approached. And it's also important that workers know what to do, where to signpost people, or to be able to think about what needs to happen and when. Sometimes when people have then disclosed something it of course increases risk. Which is why the initial phase one around safety is really important.

All too often, even as a psychologist in a mental health team, some of the pressures in these areas, we don't always have the resources and the ability to have multiple staff members working with an individual. But we also, I think, end up having to be quite cautious in an assessment and treatment service around the psychological interventions in phase two, because we're not necessarily able to do long term work with people. And that's the reality, the NHS just doesn't have the resources to be able to do that. So, we have to be really thoughtful, we might not be resolving every single trauma that a client's ever been through. We would be focusing on the ones that leave them feeling most distressed, if we can resolve these ones that have the most impact, it will also have the most impact in terms of resolving some of that. Whereas in the Trust Wide complex trauma service that I also work in, we deliberately call it complex trauma service as opposed to complex PTSD services or something like that. Because we recognize people might have multiple and different diagnoses and we don't want to rule people out because they have the wrong diagnosis for our service. So, in that service, we can see people for longer.

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

It's not uncommon that people with a history of complex trauma, might have multiple physical health needs. If we think about the adverse childhood experiences study, we know that people are much more vulnerable to having a number of physical health complications. It's not uncommon for me in the complex trauma service to be liaising with physical health teams about the fact this person needs an MRI scan, for example. And if that's likely to also be a traumatic experience because the client doesn't like being touched. I'll either be empowering the client I'm working with to have those conversations or I'll be on the phone to those physical healthcare teams to talk them through what they can do to help somebody through a situation like that. Or a medical examination or something along those lines. It is just about the importance of trauma informed care, wherever you are. And thinking about those five key principles: 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. And to be offered control and choice and to be collaborated with around that process rather than just being told this is what they're going to do. To then feel empowered to make a choice in the decision that's right for them. And sometimes it's giving them that information that they take away and it's respected if now isn't the right time. But you've already planted a seed and it might be that they can then come back at a later point and feel like, 'I'm ready now and I've got the supports in place to be able to do it.'

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## Colm Keegan

Director, Innovation and Impact, Social Interest Group who deliver social and health care services through their subsidiary charities SIG Penrose, SIG Equinox and SIG Investments

*Colm has worked for the Social Interest Group for almost 5 years and currently leads on Service User Involvement and Psychologically Informed Environments. Colm has worked in the Voluntary Sector and the NHS for over 30 in both Development and Operations, mostly in Substance Misuse and Mental Health Services.*

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### *"I think it's ultimately about staff training and staff competency to understand the nature of trauma."*

***QUESTION 1: In your view, how would you describe complex trauma?***

I would describe complex trauma in the context of adverse childhood experiences, most likely a continuing series of overwhelming events that cause distress, and lead to specific responses and defences to cope with that distress. Complex trauma is different to a one-off traumatic event, like a bereavement or a redundancy or some dreadful thing that can be overwhelming. The person has experienced and continues, or has, over an extended period of their life, experienced a different range of traumatic events. I think probably complex in that it would be difficult to define or difficult to get to the root of or to understand exactly the nature of the trauma and the defence mechanisms, because there's so much going on.

***And when you say defence mechanisms, are you referring to the kind of behavioural traits, behaviours in how complex trauma can present itself?***

I'm thinking in the context of many of our service users across the Social Interest Group with whom I am familiar. 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, and so often the defence mechanisms are about - attack first or, create a problem before a problem starts, if that makes sense? For many of our service users, it's like the starting position is 'I'm not going to trust you because you're going to let me down anyway at some point, so, let's

get this over with.' I'm caricaturing here a bit, but I think service users can think 'let's cut to the chase here, I'm going to behave so badly that you're going to chuck me out. So, let's go for it. Let's see how far we can push this'. I think that's a service user's defence against a feeling of, that 'you're going to reject me, you're going to let me down at some point, everybody else has, so why would things be any different?' I guess that's what I mean by defences, but then there's lots of different ones. Many of our service users become quite withdrawn, and that's been, quite difficult during COVID because much of our work is trying to help them to come out of that withdrawn place and participate. I've heard from service users saying, 'Well, actually, I'm helping my country by staying indoors and isolating, so I'm doing something positive here.' And that's true, there's a truth in that. It's not just about the behaviours that are perceived as challenging or difficult. I think, withdrawing is another defence mechanism that many of our staff struggle with from our service users, so they'll say so-and-so is not motivated or he doesn't want whatever. So, a judgment is made around that, I think.

*"...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. So, for many of our service users or people with complex trauma life is not like that..."*

***I guess that speaks to some of the difficulties that complex trauma can present in trying to provide support.***

Yes, 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. So, for many of our service users or people with complex trauma life is not like that. It's not ordered in that way. The services don't always bend and shape themselves to suit the people they are there to support.

***QUESTION 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal services?***

In a previous role, when I was counselling, mostly people with alcohol dependency before they would engage with treatment. I think how we can help is providing some kind of consistency in a trustworthy relationship where there is consistency and empathy - somewhere to contain people's anxiety as a preparation for treatment. Once a person enters into substance misuse treatment and we're asking them to take away the substance or to reduce the substance or be abstinent from the substance, then all the trauma is going to emerge and all the

things that the substance has masked and medicated will rise to the surface. So, there's an opportunity, I think, in psychological therapy for preparing for that, providing some kind of a container for anxieties and helping people to reshape a bit their internal world and resolve internal conflicts.

I come from a psychodynamic background so that informs my thinking. Trauma creates unresolved internal problems which we often don't understand or recognize or can name. They could be preverbal from being a baby or whatever. It's not possible to rationalize them always or even put words around them or even thoughts. Psychological therapy is, I think quite an essential component of entering into treatment; before, during and after I would argue. But beforehand it's certainly about creating some kind of a safe space and a container for whatever might emerge during the treatment.

***QUESTION 3: Can you tell me about any examples you have of where phycological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

***I'm thinking more widely around what happens within the Social Interest Group and whether there are examples of how services operate or how you've seen particular workers work.***

Across the Social Interest Group, we are working to embed a Psychologically Informed Approach, using the thinking that informs Compassion Focussed Therapy. More and more, we are recognising how trauma has played such a significant role in peoples' development and how they respond to what's happening around them.

For example, we have a residential Detox Facility in London and we find that it is very important that Service Users are prepared for the treatment programme. As we face the risk of creating a kind of systemic traumatic situation where what we are trying to achieve could itself trigger a traumatic response. Through reflective practice and training in trauma informed care, the staff are continuously learning about adverse childhood experiences and how to relate to Service Users empathically.

We are very aware that, as someone detoxes from alcohol or any substance, there is a likelihood that underlying trauma masked by that substance will emerge. We have to consider whether or not the kind of treatment we provide is appropriate and consider the risks within a framework of trauma informed care. It is very

important for our staff to develop their skills and knowledge in this area so that we can assess and manage the potential risks.

I think there's a gap in services around being trauma informed and understanding the nature of that. I suppose for me, it's a bit of the medical model, if you want to be better, this is what you have to do rather than how can we help you to engage with this? And so, we want to develop our Detox service so that it can become a centre of excellence around trauma informed care. I think it's ultimately about staff training and staff competency to understand the nature of trauma.

There are real challenges – some of them related to the physical structure of our buildings that are difficult to make less institutional, but we can make them so much more trauma informed. I think back when I was in community services, when I was managing community drug and alcohol services in London and I think back to our reception area. People would come into a place where there's somebody behind a reception with a big, almost bulletproof glass partition. It was inevitable that somebody was going to pick up the chairs in reception and chuck them at the glass. That was going to happen. You have freestanding chairs and you have a big glass partition. Somebody is going to smash that. What we did was we took away the glass, took away a wall as well behind reception so that it was a bit like BBC News. There was somebody on reception, but then there were people working at desks behind. It was all open and people come into a much more open place. And then if a situation did escalate, those people were aware of what was happening, and it reduced the number of incidents significantly. So, there's something about the physical space, which I think is hugely, hugely important.

I'm a great believer in some of the smaller things, like how you gain entry to a building, what the appearance of the building looks like, that people should know in advance what they're coming to. Strangely enough, COVID has helped in this because we've started to do things like making videos for people to see the environment in advance. This is what your room will look like. This is what the building looks like. And it's actually preparing people in ahead of time. It's not always possible to make a building beautiful, but we can show there are people there who will care about you and good things will happen to you there. And you can actually see it in video form. So, lots about preparation and attending to the small details. Well, what is it like to arrive at this place, whether it's a community service or a residential service? What happens when you get there? How do you get in if you arrive in an intoxicated state? All these things matter hugely.

***QUESTION 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?***

As I said my background is psychodynamic. When I've worked with alcohol dependent people, I've used that to inform myself, but I don't use psychodynamic techniques in working with people who are dependent on substances. I much prefer very kind of basic Cognitive Behavioural Therapy (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. I might inform myself and be thinking there is a deep attachment issue or whatever, but unless the person wants to go there, I wouldn't go there. I do think there's a need to be cautious in psychological therapies before treatment, in not being tempted to open everything up. In fact, I would see it as almost the opposite. Containing things, grounding things. A lot of reassurance. And although it's not the nature of counselling formally to explain things, there's a need to explain the process of treatment and what will happen to a person physically and emotionally, what to expect, what their body is going to do, what the brain is going to do, the importance of what they eat and drink and exercise and, all those things. So very much about grounding techniques and things like diet journals (I'm a great believer in journals), and talking about what money people spent on substances, things like weight, physical health, and understanding the kind of relationship between the substance and physical and mental health. I wouldn't go in there and try and expose the trauma or even try to name it. I think that's the work for extensive residential rehab later. So, keep it very grounded, attached to reality. And then obviously, if a person opens up deeper stuff, and I did encounter that quite a lot when I used to work with people in alcohol treatment, they could very quickly get into the underlying trauma, and I used to feel my job was to not close it down but contain it and bring it back to a grounded place.

*"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."*

***QUESTION 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?***

It's kind of been the refrain of my working life, really, and the frustration of my working life is the separation of those things and how people fall between them. I've been around long enough to see the development of dual diagnosis workers and teams and then the dismantling of those teams and then

the need to put them back in place. I've seen it go around the circle, go around a couple of times at least. When I worked in community services the only place people with personality disorder could get support was in the substance misuse service. So, there was a perverse incentive to use substances which was so unhelpful. We were promoting a system that was actually encouraging people to use substances so that they would get some kind of support. And then a relatively small group of people then were using a disproportionately large amount of the resources of the service, so say in a service that had 800 clients, we had about 20 people diagnosed as having a personality disorder. And that was all because the mental health services were in one place, and substance misuse in another place and never did those parts really cross. And the perennial problem that somehow people can't engage with mental health services if you're using substances and vice versa.

***Are there examples in Equinox/SIG services, or London Boroughs, where your substance misuse services engage well with mental health, is there examples or pockets where you think it has worked well?***

I think there are some. There is a growing trend, again, towards what we tend to call complex needs workers or what I would have known as dual diagnosis workers. Like in Wandsworth, for example, there used to be a whole team of nurses who were dual diagnosis workers and then that whole layer was removed, so we lost a lot of expertise, but it's gradually coming back. I'm thinking of one of our newest services in Hammersmith and Fulham where we put in a complex needs' worker, or a dual diagnosis worker, to be a link between the residents in the service and substance misuse and mental health services. There was a risk that would make our bid less competitive because of the cost, but the commissioners responded positively and you can see the difference in that service to other supported accommodation services who don't have that worker who's able to engage with both mental health services and the substance misuse at the same time with an understanding of both, and then support the residents to engage with both services and advocate on their behalf. I think that model really, really works.

And, thinking back to Brighton and the women's service we set up. I remember the complexity of the women there. I'm thinking of one woman, particularly, the personality disorder service wouldn't work with her because she's using substances, substance misuse services couldn't work with her because she had personality disorder, mental health services couldn't work with her because she had a personality disorder and she was using substances. And it's like 'who's going to do something here?' I've spent a lot of time being very frustrated about that. 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. I think I've always had a great belief that for substance misuse services, there's a need to understand and be able to speak the language of mental health services and vice versa. Because they are very different cultures and different approaches. And, there are professional differences. It's not just that people decide, 'oh, I'm not going to cooperate'. People are trained differently. They work in different frameworks, to different professional accreditations and so on. It's about overcoming those differences, really. I'm a great believer in the complex needs workers and bringing the different services together. I don't need to tell you the issues of mental health services. There are just some great workers, but it's under-resourced and that's the world we live in.

I think I have detected this change. Hammersmith and Fulham being a good example. And it's happening in Croydon as well and Enfield, which is another new service we recently set up where, although we didn't put it in the bid, we're now in negotiation with the commissioners to bring in a psychologist and occupational therapist. We have to be clearer about what we do, that we are providing the safe space, the enabling environment, that will enable this person to engage with your services. We're not here to replace or replicate mental health services. So, it's keeping that balance. While I'm a great believer in bringing in an in-house psychologist, occupational therapist, complex needs worker; there is always that danger then that the statutory services will go 'well, you've got all this covered, that's great'. It's about seeing what it's there for, as the bridge into statutory services, we're not going to replace them.

***Which requires quite a lot of buy in from both sides.***

I agree, absolutely. In terms of good practice across Equinox and Penrose, I see very positive signs in Hammersmith and Fulham, in Croydon, in Enfield. I'm sure there's others as well, but they're the ones I'm most directly involved in and I've seen a shift in more recent times to invest more in some of these services, to ultimately save money for the statutory services. And that's fine, we are not here to replace them but to enable our service users to get the best from them. If we can support people in a way that keeps them out of hospital or keeps them from relapsing, that will enhance their lives, as well as saving costs for the NHS in an increasingly challenging time.

***QUESTION 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?***

For me the risk is about triggering trauma and going in too deep. And if people are not professional enough to recognize that we don't need to know what the trauma is to be able to work with it because the person themselves might not know what it is. I'm a great believer in the curious facilitator approach that we try and understand what triggers things, whether it's smells, sounds, places, people, colours, whatever. But we don't need to know everything. And I've seen and I've supervised and worked with counsellors who would say 'oh I really wanted to get to the bottom of this and know...' and I say, 'why do you need to know that?' You don't need to do that and there is a danger of too much, too soon. So, I think they're the risks. And I've been thinking a lot recently about systemic trauma or systems-induced trauma, and certainly, the way I was trained in terms of assessments were so intrusive. We had to know every single thing. And I look back in horror at that now. And I think, why did we need to know every single thing? Because things you need to know, it's helpful to know. I think as you go along, you learn. When I was a practitioner, I never did an assessment in one session, I would take up to six sessions to assess somebody because I could find out without interrogating and pick up what I needed to learn. I think there's a huge risk in the way we assess people and repeatedly assess people over and over again. And 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. You know, I really get quite cross about that. I think there's a lot of risk in trying to do too much too soon and get too much information.

*"I've been around long enough to see the development of dual diagnosis workers and teams and then the dismantling of those teams and then the need to put them back in place."*

***It's part of a wider picture, isn't it? What you're looking for is that first one, two hours when you come through the front door.***

Absolutely. And you don't need to know every single thing. There are things you need to know, of course, and certainly, in a medical setting, like a residential detox, there are medical things we do need to know because somebody could die. We're talking life and death stuff here. So, you do need to check their blood pressure and do blood tests and all those things. Yes, because that's a medical intervention, but that's very specific to a medical intervention. If it's a community service and it's not a medical intervention, that's quite different. I think the risks are around triggering trauma and trying to do too much too soon are very real.

***QUESTION 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I've referred to it a few times, it is about the flexibility of services. I'm a great believer in structure, that there has to be a structure. Sometimes for our services in the Social Interest Group, we're helping them to create some kind of a structure. However, most of our services are built around a medical intervention model, which is, if you want help, you turn up at three o'clock on Tuesday, because that's when the doctor or nurse is free. And that's the bottom line. It happened to me recently trying to make a doctor's appointment. Every time they offered me a date, I kept saying, 'well, I'm working'. And the receptionist got quite cross with me and said, 'look, if you want this, you come at this time'. And I thought, I know that. But I also have a job to do. And I'm reasonably organized. So, for people who don't have that kind of structure, I think our services need to be more flexible and understand the nature of being chaotic. Not having an internal structure. Not having an understanding that two o'clock on Tuesday at this place is a thing. For me, for many of our service users, that's not a thing, it doesn't mean anything. I can say it 100 times. I can write it in a letter, doesn't mean anything. And that's not a judgment on them. It's just not part of their life.

I know that we have to have structure and you can't have staff just sitting around and hopefully somebody will turn up. But it's just about being flexible around that and understanding the nature of life and all of its complexities.

I think how we create services that don't write people off in that way is important. If somebody doesn't turn up for their appointments or can't turn up to the appointments, how do we facilitate that? Can we make the service more flexible? Can we have a support worker help them? I would always make the plea it's just about understanding the nature of trauma and what that means really, and why people behave in certain ways and what that's trying to communicate. I'd like everybody to do trauma informed care training. It would begin to provide some solutions for workers I think, in the way that we promote safeguarding for everybody, we should be promoting trauma informed thinking and responses.

I get concerned sometimes about what I see as a growing culture of exclusion – the signs that say, "abuse will not be tolerated". I do understand and agree that no-one should have to tolerate abuse, but I wonder if we are creating a kind of environment that escalates or triggers traumatic responses. I've been in places where I've thought if I show even the slightest sign of impatience here, I'm in trouble. That can be difficult to manage for many of our service users.

***I think trauma informed care training, if anything, it gives someone a really interesting insight into who might be in front of you.***

Absolutely. Yes. And I think for administrative staff, reception staff, often those people don't get that kind of insight. I did some trauma informed work with our HR team the other week, and it was really eye-opening for me because I was really apprehensive. I thought, 'they're not going to get this, it's not going to mean anything for them.' But we focused on their relationships with people inside and outside the organisation and how COVID has had an impact on them. They sometimes get impatient responses and wonder what they have done to upset people when they are trying to help them. So, we reflected on how frontline staff are recruiting new teams with a very tight deadline and having to do it remotely in a pandemic. Everyone is having to adapt their processes. But the HR team was struggling too, and they would say 'Why are people cross with us? We're trying really hard'. And when we talked about vicarious trauma and the work that our frontline staff do, we were able to reflect on what is happening and how stressful it is working in a pandemic. So now I'm doing the same thing with the finance team. It's been really, really interesting for me because I've been so focused on trauma for service users on the front line and now, I'm learning so much from our central support services.

***That sounds like a good angle. A good approach to take with central services in making it relatable.***

I do believe people understand trauma and adverse childhood experiences and they're usually open to reflecting on their own and other peoples' experiences. Ultimately, whatever role we have, we are working together to support our service users to live happier, healthier lives.

For further information about the work of the Social Interest Group, please visit: https://socialinterestgroup.org.uk/

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## **Dr Frank Ryan** C Psychol AFBPsS

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***"There needs to be good liaison and communication between specialist substance misuse services and specialist mental health services. However, it is also important to develop pathways to enable service users to migrate from the substance misuse service network to specialist help with trauma or emotional difficulties."***

***Question 1: In your view how would you describe complex trauma?***

Complex post-traumatic stress (CPTSD) trauma stems from experiencing multiple traumatic events, often from an early age. These experiences can be coercive or invasive and include abuse by parents, carers or peers. People who experience these often develop problems with substance misuse possibly with the aim of using substances to regulate the negative emotions associated with complex trauma. The emotional difficulties can persist long after the traumatic experience may have ended. This contrasts with the more traditional view of PTSD which pivots around a single dramatic incident such as a violent assault or a "near death" experience. Common indicators across the PTSD spectrum include re-experiencing the episode, for example through flashbacks, dreams or rumination; unexpected or unwanted emotional arousal, for example panic attacks or feelings

of depression; and avoidance, for example avoiding intimate relationships or revisiting situations or places associated with the trauma. These can all be addressed psychologically, for example by encouraging the person to re-experience the trauma in a safe place, teaching emotional regulation skills, or enabling the person to overcome avoidance. Collectively this approach is known as emotional reprocessing therapy, a form of cognitive behavioural therapy (CBT).

In the context of substance misuse, it is important to dissociate substance use from the management of the emotional distress linked to trauma. As long as the traumatised individual has access to mood-altering substances to numb the emotion there is no opportunity to learn how to manage emotions in a more sustainable way. Substances can be used as a form of emotional numbing or avoidance which enables PTSD to persist. Another caveat is that if there is current poorly controlled or high- risk substance misuse, harm reduction (including abstinence) needs to be sought in advance of psychological therapy for PTSD.

*"Cognitive behavioural strategies can be effective because they can teach someone about what happens in PTSD. Behavioural therapy, for example, can help the person deal with the intrusive thoughts by teaching them to be mindful and accept those thoughts as something that happened in the past and is now no longer a threat."*

Cognitive behavioural strategies can be effective because they can teach someone about what happens in PTSD. Behavioural therapy, for example, can help the person deal with the intrusive thoughts by teaching them to be mindful and accept those thoughts as something that happened in the past and is now no longer a threat. However, triggers in the present can activate trauma related memories and emotions. The person is encouraged to believe "they're just thoughts, it's a thought I'm having, not a thought that's taking me over." You change the person's relationship with their thoughts, and you teach people acceptance strategies.

Complex PTSD can be a more difficult process to address because it can be more subtle or pervasive. Complex PTSD comes from a situation where, say, a child is systematically bullied and or sexually abused and/or undermined or emotionally bullied or continually invalidated, say, by a parent or hostile family member. The child is not being physically assaulted or threatened every day, but they're just continually undermined and told that this is normal, they are the problem. This is like the "gaslighting" phenomenon where people begin to question their own sanity. Even years later this can lead to difficulties controlling emotions, feeling hostile and distrustful towards the world, feeling empty or hopeless. These experiences can act as barriers to engaging in substance misuse treatment. The

offer of a better life post-detoxification is viewed through a distrustful lens. If your life's narrative was defined by coercion or betrayal, why should things ever get better?

### *Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?*

I think nurturing the workforce so that a) they're "trauma- aware" and b) understand that a lot of the people who come their way will have experienced trauma is important here. For example, even mild criticism for say, missing an appointment (even implied criticism) can be an emotive trigger for a person with PTSD. This can lead to disengagement and a poor outcome.

The key term is 'invalidation'. The experience of PTSD-C is often one of being devalued and one's experience discounted: The victim of coercion or abuse is told that it is their behaviour that is at fault. Effective therapy can reverse this by a process of validation. Being listened to empathetically is a validating or authenticating experience. This can prove to be therapeutic in itself.

When dealing with complex trauma it is important to ensure that there is a robust system of support and supervision for staff. If a given worker is hearing personal tales of trauma on a daily basis it can prove overwhelming. This can lead to an ultimate failure in compassion or even the phenomenon known as burnout. Managers and senior staff need to be aware of this. Regular supervision and a supportive team atmosphere are essential.

### *Question 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?*

Cognitive behavioural therapy is recommended in NICE guidelines. This applies a range of therapeutic techniques to teach the individual how to manage intense emotions and overcome the behavioural avoidance that often contributes to the persistence of PTSD. In the context of substance misuse, it is important to work towards abstinence or stable substance use before any psychological treatment is embarked on. Because at the initiation of therapy emotions can often be evoked, there is an increased risk that the individual will reach out for their drug of choice.

***Question 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?***

Typically, I was the only psychologist in the alcohol or drug team. I was therefore able to offer more intensive psychological therapy such as CBT for PTSD. This more integrated model works for many but there is also a need to have clear pathways for individuals to navigate through to more specialist mental health services. For example, for somebody who has spent six months working on their substance misuse and progressed well it is often appropriate for them to move on in the treatment system to access specialist mental health services. Conversely, workers in mental health settings need to be able to screen for and assess substance misuse difficulties. Left unrecognised, these can be a significant barrier to progressing with treatment. There needs to be good liaison and communication between specialist substance misuse services and specialist mental health services. However, it is also important to develop pathways to enable service users to migrate from the substance misuse service network to specialist help with trauma or emotional difficulties. It is also important to have pathways to move an individual towards psychological therapy with specialist trauma teams.

*"When dealing with complex trauma it is important to ensure that there is a robust system of support and supervision for staff. If a given worker is hearing personal tales of trauma on a daily basis it can prove overwhelming."*

***Question 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?***

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. Indicators here include expressions of hopelessness or feeling trapped in one's situation. From a CBT point of view these can be viewed as *beliefs* which can then be modified. For example, feelings of hopelessness can be deconstructed into beliefs that "*things will never get better for me*". The individual can be helped to re-evaluate this and consider a future post therapy where things do indeed improve. The revised belief could be "*I've made the effort to get help and now things could really get better for me*". Motivational enhancement is important here and a key stage of the therapeutic journey. Service users can be encouraged

to identify the benefits of sustained change. This can enable them to re-evaluate the more immediate perceived - or misperceived - benefits of substance misuse.

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## Gemma Harfleet

Specialist Women's Worker, Fulfilling Lives South East Partnership

*Gemma has worked in the substance misuse and homeless field for the past 12 years. In her current role, Gemma, supports women with complex needs including trauma, and is passionate about this client group being treated and supported in a way that meets their needs. Gemma is part of Fulfilling Lives' client-facing delivery team and delivers training around improving support for survivors of domestic abuse and repeat removal of children.*

***"We need to be careful not to shame people if the plan doesn't work, people with trauma history can have strong feelings that they are not good enough. An experience like this can stop someone accessing support again, just being mindful of this and working with strengths can help avoid this."***

***Question 1: In your view how would you describe complex trauma? What does it look like and how have you seen complex trauma present itself?***

*"I think if you've got a good understanding of trauma and you're able to engage people in conversations which aren't easy, then I don't think it matters what title you have. It's about the relationship that is built and who people feel trust and safety with."*

My understanding is that it's more than a one-off event. So, if something has been going on for a long time, such as neglect, domestic abuse, childhood abuse, homelessness. It puts people into survival mode and the use of maladaptive coping skills to navigate the world. It's really confusing for people to make sense of trauma and it leads to a loss of identity, low self-worth, self-blaming and destructive behaviour. Also, struggling with trust, building relationships, and ability to feel safe.

I have worked with both men and women and do notice a gender difference in how people express trauma symptoms, such as anger, that society makes more acceptable. For example, women are more likely to self-harm and internalise anger unlike men. People with CPTSD struggle to regulate emotions, for example hyper-arousal, maybe shouting, pushing people away, very erratic. To hypo-aroused, switched off, disconnected with people, dissociative. Both are a way of

surviving when feeling overwhelmed or under threat. People with complex trauma are living with flashbacks, constant feelings of being overwhelmed, night terrors, hyper-vigilance, anxiety and fear. Making change a struggle for people.

***Is change for your clients difficult because they've learnt these behaviours in order to have that survival mode?***

Yes, it's a very self-protective mode and it would have been something that a lot of people learnt very young. When we're looking at attachment styles people with CPTSD have typically lacked a safe and nurturing environment and a care giver. They don't trust that they can be dependent on someone or themselves to get needs met which affects how they connect with others, there's a real relational disconnect with people and not feeling the same as others.

***What difficulties does complex trauma present in trying to provide support?***

I think trust is the main barrier, it's hard for clients to let somebody in when they've only experienced abuse or negative relationships. So, it takes a really long time to build trust and something that is really nurtured. As workers we're aware of that, we need to always be very sensitive around trust, not assume that just because I wear a badge, you're going to give me trust. We really work with where people are at. And there's lots of ways of building trust and it often starts with working with where they are at and being consistent.

***Is that often just practical stuff?***

It really does start with the practical. I support someone who people haven't been able to work with for years because she's become so shut down with people and is described as a non-engager. She's very shut down and scared to talk and connect. So, I started shopping with her, every week we went food shopping and then during the walk around the shop she started disclosing the abuse she experienced from her partner. By showing I was useful and consistent she could trust enough to open up but only whilst doing a task as this feels less intense for her.

**That must be very satisfying for yourself?**

Yes, because it helps me understand her and working with her communication style has helped me explain to other services how to work with her as she was very misunderstood and mis-represented. Creating safety for her was key to her being able to open up and now we do things that she enjoys, such as colouring so she feels safe to talk. Understanding that she has a traumatic past and often

dissociates when feeling overwhelmed means, I can work with keeping her feeling safe to engage.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

Trust is a barrier for people, we are asking for them to trust in treatment and recovery. People are scared of being on methadone or Subutex because that's a dependency and that means someone is in control, that power dynamic makes it difficult to work with. Substance misuse has also been a coping skill to manage trauma symptoms, recovery is asking someone to be able to sit with the emotions they are avoiding.

We're asking people to engage in a service that may not meet their needs, or they have bad experiences with, such as feeling misunderstood or banned from. Trauma is not always recognised as part of addiction and without this people remain in the cycle. For people with complex trauma there needs to be some gentle work around trust and allowing themselves to receive support before making a plan for recovery. A good understanding around impact of trauma and attachment can really help people engage in support as it avoids people feeling overwhelmed and creates safety that they can trust.

***It sounds like you do a lot of preparation with the rehab itself?***

Yes definitely, it's about helping people to communicate emotions and how to communicate with others. In rehab they will be detoxing off the substances they use to numb and avoid emotions so teaching people to sit with this is crucial. I have seen many people leave rehab due to not feeling able to manage the trauma symptoms that return, such as flashbacks. Preparation work can help people understand what to expect and how to manage symptoms.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Some of the women I support find it very triggering to attend the local drug and alcohol service as it is very male dominated. They are afraid of ex-partners or perpetrators being in the building which they can't control, and they feel very on edge. Those with avoidant attachment can really struggle as they don't like to rely

on others or a service, so often avoid appointments which can lead to restrictions on treatment.

*"For people with complex trauma there needs to be some gentle work around trust and allowing themselves to receive support before making a plan for recovery."*

Being able to understand this for a client I was supporting meant I was able to advocate for them to attend in a way she felt safe and manageable with her substance misuse worker. We only made afternoon appointments as she sleeps during the day and not at night as this helps her feel safer. I supported her to appointments and where possible we met in the community jointly so she could build trust with her substance misuse worker. This has helped her remain in treatment, where previously she didn't feel able to. Once people feel able to engage with us, we can advocate for them to get their needs met, which may need to be creative and outside the normal treatment plan. Helping people feel they deserve recovery and to help them achieve this is a big part of the job we do. Trauma is often seen as negative behaviours instead of the amazing survival skills it has taken to survive. The brain has worked exactly as it's designed to, they are not broken.

***So presumably you're doing a lot of psychological support with your client? So, If I'm your client and I've been unsuccessful in previous attempts and it might not be top of my agenda to go back – you're kind of plotting a path for someone to be able to successfully re-access the treatment* service?**

I would be looking at what were the barriers before, what didn't work, what would it look like if you could do it? How close can we get it to that? It can be trial and error and understanding core beliefs, that can also be the barrier to success. We need to be careful not to shame people if the plan doesn't work, people with trauma history can have strong feelings that they are not good enough. An experience like this can stop someone accessing support again, just being mindful of this and working with strengths can help avoid this.

***Question 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?***

I'm not a counsellor and can only use the tools that are safe to use with clients. I use the window of tolerance to help clients and workers to understand what emotion the behaviour is showing. I use visual tools to help explain the impact trauma has on mind and body, this helps people make sense of trauma. We

discuss what safety means to them and how they feel safe, this is important for people to be able to regulate emotions and feel calm and able to learn and connect with others.

By helping people understand trauma they then have a choice about how they respond and allow a pause before reacting to avoid the negative cycle they have been trapped in. It supports people to see that they can have control in their life when the trauma made them feel so powerless. There is something powerful in knowing that there is nothing wrong with you, but your body did what it needed to survive. This can be the first step in the healing process. We make calm boxes with people that include pictures, smells and objects that help you feel positive and calm. Self-care is a big part of recovery and something that both trauma and addiction take away.

Working with trauma is messy and can take a lifetime to heal from. Psychoeducation is the start; support staff need to be patient and avoid rescuing. We ask clients how they want us to respond and write this in support plans to avoid re-traumatising. We also explore grounding techniques and tips around managing flashbacks and nightmares.

***The grounding technique must be very empowering for someone to begin to have that self-reflection on themselves and understanding that the trauma, like you say, I'm not flawed but use it for their advantage***.

As a worker it's really lovely when you start hearing them say back what you've taught them and identify the patterns and symptoms. When we understand what is happening, we can communicate this with others to avoid conflict and work on ways to change behaviour and challenge negative self-talk. Support is about helping empower people and trust in their own resilience.

***So, someone identifying trauma behaviour or something that triggers a trauma response, presumably, that does begin to build resilience?***

Yes, because they then have a few things in their toolbox to manage symptoms. It's about teaching people to create safety when they haven't always felt it. The women I work with have a lot of compassion and empathy for others and little for themselves. By working with what they already have and guiding them to offer themselves this same compassion and empathy. We can remind them that they are survivors and no longer powerless.

***Question 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?***

It's absolutely essential. People experience trauma often before and during addiction with little support to understand the impact of this. It can feel like a battle to access any psychological or mental health support whilst in addiction. People often use substances to manage trauma symptoms, so people need support before detox, so they have tools to maintain recovery and stay alive.

***Do you currently have any clients that are supported by statutory mental health as well as accessing substance misuse services?***

Not really. We have a huge battle advocating for clients to access psychoeducational support as it doesn't exist in a pathway. This is why I have sought more training and a desire to fill the gap and injustice of the therapy offered on the NHS. Services are starting to change language and I hear trauma informed practice used more but there is still a lot that needs to be done.

***Do you have anyone on your caseload at the moment, who you have referred unsuccessfully to mental health services?***

Yes, lots of them. One of them had two years of therapy with Nicki [Nicki Taylor, psychotherapist working with Fulfilling Lives' clients] before she left Fulfilling Lives. Myself and Nicki made the referral to the mental health services, the client wanted to do some group work and she also wanted to continue the counselling and she was refused on the basis the psychiatrists thought she needed to wait a year before finishing with Nicki and having a new counsellor. We're going to start looking into private counselling for her. This is someone who has never asked for help before coming onto Fulfilling Lives caseload and has disclosed childhood trauma. The client is motivated, is able to sit and reflect on emotion and now has tools to help her regulate. It's frustrating that someone who has never met her made this decision. The Wellbeing service in Brighton is not set up to work with trauma so people are often in limbo.

*"Taking things at the client's pace and respecting when they don't want to talk about things and their reasons."*

***In your view, in terms of someone preparing to access formal treatment or already in it, is it always necessary for a statutory mental health service to be involved? Or is the psychological support being done by frontline workers such as yourself equally beneficial and having the same impact?***

I think if you've got a good understanding of trauma and you're able to engage people in conversations which aren't easy, then I don't think it matters what title you have. It's about the relationship that is built and who people feel trust and safety with. Working with trauma needs a team approach.

***Do you know of any other services in Brighton that offer the same kind of psychological support as Fulfilling Lives does? Frontline workers that you liaise with day-to do?***

We've got Dr Tara O'Neil sitting in a lot of the housing and safeguarding meetings and she comes from psychological perspective and is helping frontline staff understand behaviour more and respond better to it. I think Rise workers show a very good understanding of trauma and the impact on the person. There is a network of front-line workers in the city that are advocating for more trauma support and we share resources and good people to speak to, we have to find allies in services.

***Question 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?***

Being mindful that people are in a safe place to talk and not too substance affected and managing expectations on you. Taking things at the client's pace and respecting when they don't want to talk about things and their reasons. If people are homeless this could be more harmful as they don't have a safe environment, however this can be part of advocating for people to be housed in appropriate accommodation to be able to start this work. In my experience, when I revisited a disclosure, clients are usually quite surprised that I remembered. This shows that you are listening without judgement and builds trust.

***And that's a way of managing risk as well?***

Yes, it's important to know that sometimes we see really obvious risks and that might not be what the client feels is the most important risk and understanding that. For some people the risk of losing a relationship is worse than the abuse they experience in relationship. Without understanding what is important to them you will struggle to connect and engage the client in the support on offer.

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I'm a big believer in psychological support. I see how it works and I think trauma can sometimes get minimised and, people need to understand how exhausting it is for somebody living with complex trauma. I would like to see people with complex needs be shown more compassion and understanding. There is also the staff working with this trauma that need to receive good training and supervision. It's hard to keep listening and supporting trauma survivors and we need good self-care to protect ourselves (workers) from the impact.

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## Giles James

Multiple Complex Needs Worker,
Fulfilling Lives South East Partnership

*Giles is a Multiple Complex Needs worker in Eastbourne. He provides support for clients who have issues around their mental health, substance misuse, offending and homelessness. In carrying out this work, Giles also identifies gaps and issues with current service provision and links with the wider project and systems change team to try and influence positive change for those with complex needs. He is particularly interested in the health inequalities and criminal justice barriers faced by his client group.*

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***"It's relationship based I think and grounded in trust, grounded in a belief in when relationships rupture, we can heal them, so, you're modelling best practice, you're modelling how things could be different. We don't just close clients because they have a particular outburst."***

***Question 1: In your view how would you describe complex trauma? What does it look like and how have you seen complex trauma present itself?***

It's a good question. The key word there is complex, because a lot of people appear with trauma, but complex trauma is an exposure to multiple traumatic events not just a one off. It's usually rooted in adverse childhood experiences, so things like physical abuse, sexual abuse, maybe witnessing domestic abuse, neglectful or inconsistent care from primary care givers at a really young age. It disrupts many aspects of a child's development, and their formation of sense of self is missing so they have no real concept of who they are. They struggle to form healthy attachments. I think some of my clients struggle to regulate their emotions, and they can cause conflict, and often they act from an emotional response rather than a rational response, and their emotions are heightened and unregulated so it's harder for them to respond to what's in front of them. This can result in aggressive outbursts, so your client is deemed as problematic and high risk, and then they face a lot of judgement and stigma around that behaviour as opposed to understanding that trauma is what's underpinning it.

So yes, emotional regulation, angry outbursts, obviously I think some destructive behaviours such as substance misuse, self-harm, and quite interestingly females - not in a gender-stereotypical way but because the numbers are far greater – domestic abuse relationships that probably stem from traumatic experiences as well.

***Can you give me a sense of who you work with?***

Yeah, out of eight, seven are men. I've only got one female on my caseload and I've only ever had one female on my caseload. Interestingly, she's made the most progress out of all my clients and has probably been one of the most chaotic as well. The male-worker/female-client dynamic is interesting because I think often gender specific are needed and definitely beneficial whereby perpetrators may have been male, but similarly, harnessing healthy positive relationships with a male can be beneficial, so I've really enjoyed the dynamic with me and her. I've enjoyed being able to show her a different side of men; that men can be trusted.

***What difficulties does complex trauma present in trying to provide support?***

When their emotions are heightened, sometimes you're walking on egg shells and it's hard to get a message across because they are not coming from the same place, they are used to having to have their defences up or be guarded or feeling under attack or feeling threatened. So therefore, it's about trying to bring their emotions down before you can get a message across. There are occasions where clients are unable to hear simple messages so, everything takes a lot longer with this client group sometimes to ensure that messages have been received, other services don't have that time.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

*"I think some of my clients struggle to regulate their emotions, and they can cause conflict, and often they act from an emotional response rather than a rational response, and their emotions are heightened and unregulated so it's harder for them to respond to what's in front of them."*

I've just interpreted psychological support in my own way, but it's about preparing them mentally and providing them with support which means they can better understand their own thinking and behaviour. In doing so you might be able to unblock previous self-imposed barriers that they've put up to avoid having to access treatment. They might have automatic negative thinking again from that place, they've created a picture for themselves. By unpicking that from a psychological perspective you can get them to better understand why they've missed seven or eight assessments previously, and how that's impacted on their lives. Somebody said that what's important with this client group at times is just to be humanely present. I thought at the time it sounds a bit washy, but it does make sense just to be walking alongside them and help them to get a bit of insight into their thinking and behaviour. Part of that "humanely present" for me is relationship-based practice, which I think features as a psychological approach to support. It's just about gaining a sense of trust, bearing in mind you could be the first person that this client has trusted for a long time, given their experiences of trauma.

***What might this look like? What steps would take place in this preparation?***

Their lives are so in the moment, it's very hard to formulate a plan and stick to a linear progression plan to get to an end goal. It just varies from person to person.

***Are there steps you take?***

As a professional you have a plan, but I guess it's about trying to get that client to come alongside. If they're not in the space to address issues, it's about rolling with their resistance. It's about building that relationship based on trust whereby they go "oh hang on, he's not just going to badger me to get into drug treatment or talk about my drinking. I can have a chat to him on the park bench while I'm still drinking" but it's quite subtle, slow, and it creates their own ambivalence.

It's about you as a professional holding a plan about what needs to be addressed but then working in partnership with the client on time scales.

There are some real practical things, like if somebody has missed three assessments, "oh they're always offering me a 9 o'clock in the morning assessment and I can't physically get up", and a drug service might go "well if you really want drug treatment you'll make the effort to get up" but actually that's not trauma informed or person centred, "well okay what time would work for you?" You can try some small practical steps to change it rather than write people off, and there have been times where we've done that. But that's more than just about changing the time that's showing the person you're respecting them and you're hearing them and you're listening to what matters to them.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Everything we've discussed really about understanding their trauma, understanding how that's driving their behaviours, trying to get them to slow down, to stop operating from an emotionally heightened place and be more pragmatic with their approaches, to then implementing the practical things like we're in a position whereby we can physically accompany clients to appointments.

***You were talking about the woman you support, you talked about she probably had the biggest impact. Is there something in there that you'd like to talk about?***

It's relationship based I think and grounded in trust, grounded in a belief in when relationships rupture, we can heal them, so you're modelling best practice, you're modelling how things could be different. We don't just close clients because they have a particular outburst.

It doesn't feel like it's anything profound, I think it's going at her pace and it's the same for any of my clients really. My approach is, I can't fix people, I can't do things for people, and I have no expectations of my client group. That's kind of my baseline. I'm not saying whether that's right or wrong, but I just feel that for me, there's no pressure. You're there to provide them with opportunities and options, and then if, as and when they decide to take you up on those offers that's when you kick into action and you're there to support them and it's about checking in with them.

I always feel that my role in a client's life is minimal. You're just there when the client's ready is how I feel. Kind of like a safety net, you're holding them, you're

ready to act when they feel ready to act, rather than forcing them to participate because that's just not going to work you know. The evidence is their life, and the chaos they're in, they've probably experienced people trying to tell them what to do, and it hasn't worked because they're not at that point.

***Question 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?***

One client, every time he presented at the drug & alcohol service or appointments with me, there were significant violent threats of violence, delusional thinking, paranoid behaviour which would always result in a safeguarding or a police call. Every appointment he was saying stuff that we have to act on, even though it was just him venting which blocked him from engaging meaningfully at all, so we just did some real simple breathing techniques. I'm not a mindfulness expert at all, so just trying to slow his heart rate down in those moments. He would get agitated and we would then focus on the breathing to allow him to start to regulate some of that emotion. That kind of work with him meant that we weren't calling the police, we weren't raising safeguarding, he was able to engage with his drug & alcohol worker. It was about showing him that I was ok with an emotional release and that I wasn't going to be afraid, but about how he can just express that anger differently and more healthily.

Motivational interviewing/cycle of change feels like a key tool I use – I'm also aware that my background is drug and alcohol so it's probably a residue of it carrying into my practice now from then, but it feels useful for our clients whereby motivation levels do wane, and it's kind of tied in with the cycle of change. Do I need to talk about that, would that be helpful at all?

*"...we would then focus on the breathing to allow him to start to regulate some of that emotion. That kind of work with him meant that we weren't calling the police, we weren't raising safeguarding, he was able to engage with his drug & alcohol worker."*

It's applied across the board really in substance misuse but could probably be put into any element of your life. It works around a state of pre-contemplation, so you're not even thinking about change. Contemplation you might be thinking about change, then action so you start doing stuff to facilitate that change, and then you maintain that change and then you kind of leave the circle and, then the whole diagram is you can kind of enter and re-enter at different points on that cycle.

A lot of our clients are pre-contemplative when they come to us. It's about creating their ambivalence, creating their desire to want to change, highlight to them important aspects within their life where it's impacting. So motivational interviewing, the cycle of change and mindfulness are kind of the three main things. And I guess just finally, more recently we've been on AMBIT training. My approach to work fits within that model without really knowing that what I was doing was AMBIT based if that makes sense. So, doing things together, not "jumping in the pond" you know like they have all these different tools and terms, so if somebody's in chaos don't join them and be a bit kind of removed. So, it's a bit similar to what I've described really. But that feels like quite a useful tool to use with clients. And a lot of the AMBIT work is about reducing emotional responses, so getting a bit more emotional regulation to be able to have an adult to adult conversation. It feels like a really important approach and one I probably need to practice a bit more with clients as and when it's appropriate.

***Do you know of any other techniques and models you haven't used but think could be valuable?***

Nothing I can think of. I mean I'm sure there are loads and I feel like I get some good results with clients, not always. But not because I'm trained in this or I've got this kind of model, it's an inherent belief and passion in wanting people to have a better life. That works as best as it possibly can for them that I carry within myself. Which I know sounds cheesy but there's something in what you carry and what you hold as a person and being able to form meaningful relationships and have that belief without applying pressure. I mean, you can't learn that I guess is what I'm saying. There's something about our job where, you know, yes it's a vocation and yes I could be educated and qualified up to the hilt but knowing stuff on paper is quite different to actually the practical application of it I guess is what I'm trying to say. That's not to say that there aren't great clinical psychologists and everybody

out there, it doesn't necessarily equate to being able to engage with clients with MCN. Does that make sense?

***Question 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?***

It's essential, and I think for far too long dual diagnosis has been a real barrier for our client group, and it's not new it's been around for years. I think there's two prongs, the mental health side of things will bear the brunt, but similarly, having worked in the drug and alcohol treatment side of things, there's something in equipping drug and alcohol workers to feel more confident in understanding and addressing mental health as well. Because a lot of it, I'm not a mental health nurse, but my clients are quite chaotic and psychotic at times but through various training and just feeling a bit more confident myself you're able to provide a low level of support. Mental health needs to be more accommodating to referrals, but treatment providers also need more training to feel better able to manage some of the mental health issues themselves as well. So, it's done in partnership, it's not all on the mental health teams. I think there's a place for drug workers to be trained. But clearly, you're not going to have many successful completions or people sustaining recovery where either your substance misuse or your mental health is going unchecked or unsupported, it's just not going to be sustainable.

***Do you have any examples or any views on how they do jointly work?***

In East Sussex we have a dual diagnosis forum, they have a protocol between Sussex Partnership Foundation Trust that provide the mental health services and CGL STAR, the drug and alcohol services, around jointly managing clients with dual diagnosis. I haven't got a huge amount of "I've done it, I've seen how it works" but I know on paper it's there, there's local agreements in place. And from what I've seen and how it is managed, it is beneficial.

***Question 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?***

Personally, I feel it can be quite challenging and potentially dangerous to start lifting the lid on some of the traumatic experiences that some of our clients have experienced. For example, offering them therapy around their childhood abuse, when for example they may be homeless, or at risk of losing their accommodation, or they have no benefits. So, if they're in a state of chaos, I do feel that offering psychological support needs to be done really carefully as there is no safe space for them to feel contained. We had a great lady called Nicki who

was on hand, she was a nurse, and highly skilled practitioner when it came to counselling techniques and various approaches to offer psychological support, and in East Sussex we put a couple of people forward. One did equine therapy and that was ok, but the other clients didn't feel ready. They didn't feel secure in themselves and in their own set up to then want to push on to that next stage of accessing psychological support.

***Some of these risks that you mentioned, are there ways of mitigating these?***

It's interesting. With some clients it becomes that last bit of the jigsaw. You do all the practical support around getting them engaged with the services, sorting out accommodation, getting their benefits in place etc, none of that is straightforward, so you get to that place whereby their basic needs are being met. So, you've got a stable place to operate from, the next bit would be to access something around the trauma, and that's the bit that I probably get quite stuck on in fairness. I guess it's the deeper, darkest thing that's been driving their life and that is a scary, scary thing to have to face. But yeah it feels like this missing piece for me with some of my clients. You get them to a certain stage; you try and say why don't we look at counselling around what happened, and you know it just seems to never take off. From a worker's point of view, you can discuss the trauma informally but accessing something more formal I think is a bit trickier.

*"I think sometimes we can over complicate things. You know our clients' lives are complicated and their experiences are shocking. For me it does feel that I try to simplify things and I come back to relationship-based practice."*

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I think sometimes we can over complicate things. You know our clients' lives are complicated and their experiences are shocking. For me it does feel that I try to simplify things and I come back to relationship-based practice. But I think if you can get that meaningful relationship based on trust, non-judgemental, all those skills that we know are invaluable, and probably are things that our clients haven't experienced through their life, then they're like the foundation and the building blocks to be able to kind of move on to other aspects I think. There's something about respecting somebody's rights not to want to engage in something. Non-engagement becomes them taking control, I guess is what I'm saying. But then often we see that as problematic. We go oh they don't want to engage or they're difficult to engage, they're hard to reach. But maybe that person's just exerting

their own right to say I don't want that right now, and that's quite empowering in itself to be able to say no.

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## Iain Boyle

Specialist Complex Needs Worker,
Fulfilling Lives South East Partnership

*This chapter of my life started after experiencing my own mental health challenges, being diagnosed with Complex PTSD in 2011, and then finding the systems that were supposed to help and support me being so difficult to navigate. I challenged the way I was being treated and highlighted barriers.*

**LinkedIn:** Iain Boyle | LinkedIn

*I went to university and in 2015, gained a BA (hons) degree. I volunteered at the university and in my local community, with the hope of preventing others being treated how I had been.*

*I started working for Fulfilling Lives in January 2019 after leaving Sussex Partnership Foundation Trust, where I had been employed as a Peer Support Worker and a Peer Trainer with Sussex Recovery College.*

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***"For me that's important, our clients have so many knockbacks in life, my job is to get them to experience one good experience with a professional. If we can do that, then we can help them."***

### Question 1: In your view how would you describe complex trauma?

This is a subject very close to my heart. I am somebody that's got a diagnosis of PTSD and I run a group for veterans with PTSD, from the military and the blue light services.

Complex trauma is experiencing trauma many times, quite often over a period of time, as opposed to trauma of a car accident, which happens once. Service personnel, when they're on operational duties, the current situation with care home staff and nurses in very unpleasant situations [Covid-19], they are experiencing trauma every day. They don't have to go in and see death every day, but they go in and they have the fear of their own death. So complex trauma isn't

just about witnessing things, it's about how it impacts on you. That fear of dying every day you go to work increases the level of complex trauma.

Often complex trauma doesn't present at the time. You may have had a period of five years where you've experienced lots of trauma, complex trauma tends to come later in life normally when something happens in your life, so a relationship breakdown, loss of job, physical health issues – and then complex trauma presents. And that can be PTSD; there's different ways PTSD can present, so that could be flashbacks, nightmares, inability to sleep, irritability. Personality disorders are quite often a result of complex multiple traumas early on in life. There's a lot of methods to assess early on, one way is to use TRIM (Trauma Risk Management), it was designed by the military to deal with troops if they've been involved in a heavy fire fight or they've lost comrades and they're TRIM(ed) at the time. They're made aware of their trauma at that moment. Rather than it being something that they bury down inside, and it comes back later, they're dealing with it then. The research results from it – it's been going about 20 years – so far are showing that the prevalence of PTSD in the service personnel that undertook TRIM at the time, has reduced dramatically. There are ways of avoiding complex trauma, and that's to get the person to deal with the trauma at the time and acknowledge they were traumatised.

***This is from your experience with working – being in the army – and working with the veterans? Do you use a lot of these methods with the clients you support?***

I do, yes. This COVID situation has really shone a light on complex trauma. When I've had discussions with some of my clients that are flaunting the social distancing and social isolation rules, they say "I'm not scared to die cos I've lived with this. I've seen my mates die over the years, I've lost tons of friends, and I know every time I inject, or I take a massive hit of something there's a chance I'm not going to survive this. So, death doesn't matter." That's complex trauma. Not having a fear of dying, isn't because you're really brave and you can hack it, it's because you've had so many traumas in your life, one more is unimportant. We see this a lot in our clients, and quite often it's that thing of "*I don't matter, it doesn't matter what happens to me cos I've lost tons of friends and I could die tomorrow. So, what's the point?*" Also, people don't tend to be drug and alcohol addicted without there having been a reason for it. Quite often

*"It could be as simple as, someone struggles to go out their front door, so you'll get them to open their front door and they'll stand inside, and you'll stand outside and just have a conversation with them. And then maybe next time encourage them to be on the doorstep and have a conversation with you."*

there's trauma that happens, drugs and alcohol can suppress the nightmares, the flashbacks. You drink, or you use until you pass out or you're numbed. I think that many of our clients, if they'd been helped earlier on in life, or earlier on in their journey of substance or alcohol addiction, then we could have better results. Getting them younger is the important bit.

***What difficulties does complex trauma present in trying to provide support?***

There is that sense of hopelessness, and there is that sense of lack of value in themselves, and because of that we find quite a lot of our clients have no self-respect. You'll see street drinkers and you'll think: why don't they just hide away, why are they out there shouting and screaming? It's because they don't care anymore what people think. Quite often that's a result of the trauma they've experienced, and when you're trying to say to someone "let's get you into therapy, let's get you to see a psychiatrist" and they've had so many knockbacks in the past. Because services say, *"nah we can't help you because we can't medicate you because you're using, or you're drinking".* So, clients think – well I've been knocked back so many times in the past.

I had a great example with a client – sadly he passed away – but he was a heavy drinker and occasional heroin user, and his blood pressure was a bit of an issue. So, I was trying to encourage him to go to the GP. It took ages and ages, and eventually I got him to the GP with the help of St John's Ambulance Homeless Team and he was pleasantly surprised because he went in and the receptionist didn't talk to him like he'd been spoken to previously – "what do you want? Get out". The receptionist said, "how can we help you?". He saw a nurse who took his blood pressure, she was so concerned she got him to see a GP instantly, and then that nurse and that GP, they took control of his care. So, subsequently, every time he had an appointment it was those two that treated him. Every time he went in the receptionist said "*hiya, how you doing? Take a seat, they'll be with you in a minute"*. He said at first it felt like everyone was looking at him, but then he began to feel he had a right to be there. It's purely because he was being treated civilly by the staff. For me that's important, our clients have so many knockbacks in life, my job is to get them to experience one good experience with a professional. If we can do that, then we can help them. The problem is getting to that point because they've been knocked back so many times. Our job is to gain their trust quickly. We normally get involved because all the other services are not sure what to do with them.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

Unfortunately quite often getting someone psychological support while they're still using substances is very challenging, because psychologists like people to be abstinent, and the standard practice that we're getting from Sussex Partnership – the mental health trust – is they want people to be abstinent for 12 weeks before they see them. What you're asking someone to do is give up their safety blanket for 12 weeks, be left alone, before they can then get any form of counselling. So, It's something – just before lockdown – we were trying to have conversations with psychologists about. There are interventions that can be used, like myself I'm a Behaviour Activation and Graded Exposure therapist, which is the B part, the behaviour part, of CBT (Cognitive Behavioural Therapy). I use that, not in a formal way, I use elements of it now, but when I worked for the NHS trust it was quite a formal way of approaching things. It would be getting people prepared for psychological interventions. Getting them used to the language and filling out the forms and just being prepared to be in that space for psychological support. Psychologists tend to want you to go to them rather than them come to you. So, it's about saying to the client, we will meet at a particular place, and through graded exposure, it's getting them used to taking those steps and feeling comfortable and realising its safe.

***What might this look like? What steps would take place in this preparation?***

It could be as simple as, someone struggles to go out their front door, so you'll get them to open their front door and they'll stand inside, and you'll stand outside and just have a conversation with them. And then maybe next time encourage them to be on the doorstep and have a conversation with you. It could be catching a bus somewhere. The first thing I'd do is find out what bus route they want and get a timetable and give it to them. They would look at the times of the buses, and then we'd figure out where the bus stop was, and we'd build up towards getting them to the bus stop. It might be just watching people getting on and off the bus a few times and then walking back home. And then it might be getting on the bus, talking to the driver and then getting back off. The next step might be paying for their ticket or using their bus pass and going one stop, with me or whoever their support worker is sat with them, and then you build it up until they can do the journey without support. A way I used to do it was to meet the client, at the bus stop, they'd get on the bus, I'd follow in my car. I'd drive behind the bus, meet them at the other end, and then they'd get back on the bus and go home. We'd do that till they're comfortable. So, it's breaking everything down into bitesize little chunks.

***I just want to understand, when you say substance misuse treatment, you mean somewhere to get rehabilitated, is that just getting detoxed? Is that rehab?***

There are different levels. You tend to find that people go for a short detox, quite often now in the community, and then they will go, if it's suitable for them, into a rehabilitation centre where they will do more of the psychoeducational side behind remaining abstinent. Whereas a detox is literally stopping you from using, quite often through a chemical means. And then psychological interventions are more about going into a mental health setting, sitting down with a psychologist and having therapy or counselling.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

I've got one person that's currently in prison, and he's always refused to engage with CGL. More psychoeducational side rather than psychological because he never really got to that point. It was more about helping him to understand that methadone can help him while he's in prison. Especially now that they're all on lockdown, because of Covid, they're not getting their usual supply of spice so easily. It's about getting people to understand the process that's coming and what they need to do to access the service that they're trying to access. For me it's just about breaking things down into small manageable chunks and reducing their anxiety. Because, you become anxious, then you start having negative thoughts, then it goes round and round and round and by the time someone's had a massive anxiety attack, they're scared to deal with whatever it is that started the whole thing. Their self-esteem's gone; they're beating themselves up because they've failed to do whatever it is that they've started to do but can't remember now because they're in such a panic.

It's just about helping them to break that cycle at an earlier stage. People go into this sort of cycle of depression or anxiety, and it's just about helping them to recognise that early. In the mental health team, we used to call it helping someone create a tool belt. It's different coping mechanisms that work for them in different situations. And having them, so they can pull one out and if that one doesn't work; they keep going till they get to the tool that works. It's just about encouraging them to be open to that idea. You don't try one thing and if it fails that's it, nothing's going to work, it's about perseverance.

It's things like mindfulness, just imagining yourself somewhere nice, breathing, recognise your breath, because we all breathe otherwise, we're dead. But it's just actually concentrating on your breath, then you're concentrating on yourself,

doing a mental scan of your body and just recognising that you're very tense. Then do the touch 2 things, smell 2 things and all that sort of thing or it's counting. I used to do a thing where people used to have a positive affirmation written down on a piece of card and then I'd laminate it for them so they could carry it around with them. And they could look at it from time-to-time and think *"oh look, somebody does give a damn about me, look they wrote it here".* It doesn't have to be something physical, it can just be stop, concentrate on yourself.

I tell a story of when I worked in the mental health team, I had two clients that used to have major panic attacks. And going out in public, going out to a supermarket for shopping was terrifying for them. I said to them one day, individually, at different times, if you're in a supermarket and you feel yourself getting really anxious, go and stand either in the pet food aisle or the sanitary wear aisle, because people know what food they're going to buy their pet, they don't tend to look for deals, and in the sanitary wear aisle women know what they want and men know what they've been told to get. So, you don't tend to have people hovering around browsing. I met both clients' because they both came to a session, not for me but I just happened to be there, and they saw me and they said, we met each other in Morrisons and we figured out that you're both our support worker because we were both standing there taking deep breaths in the sanitary wear aisle. So, it works. It also creates friendships in a weird way.

***Question 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?***

Behaviour Activation and Graded Exposure I find can be useful. But also lived experience. With my life experiences, I've had PTSD, I've come through the other end. I still have it; it doesn't go away. I've learned to cope with that. In this role I can't divulge that, unless there's a really good reason to do so, but it's about saying to them other people experience trauma, I may have had some, I've had a life, how about we try this? Oh, that doesn't work, have you tried it, it's worked for others. Just encouraging people not to give up on themselves. I think just being a caring and empathic person is as good as any therapeutic approach.

***Do you know of any other techniques and models you haven't used but think could be valuable?***

Because we've all recently been trained in AMBIT it's just about understanding the impact of your actions. Understanding that someone might be having a bad day and the impact that they'll have on everyone else around them. And it's about uses of language and so forth. I haven't really used that too much with clients because it's still quite new to me and we finished just before lockdown so that's hindered me using it, but I've seen all sorts of different approaches. You've got Band of Brothers that do this buddy mentoring scheme. I think peer support is invaluable.

*"It's about getting people to understand the process that's coming and what they need to do to access the service that they're trying to access. For me it's just about breaking things down into small manageable chunks and reducing their anxiety."*

I've never used an illegal substance in my life, and I tell my clients that. I say what I know I've learnt from my clients and from books. I'm very clear about that because I think that's fair to them. And if you try and blag it, they'll see straight through you. If you've walked in similar footsteps as theirs, then you're going to understand better than any psychologist that's sat in a classroom for a couple of years.

Deep immersive therapy is quite often used around complex trauma, in the USA it's being used with American military veterans. They get you to tell your story and provide any photographs of where you were at the time, or they just use footage from TV, there's plenty of war films from conflict zones. And they put that together with your story, and you're there in virtual reality; headset, headphones, everything. And the room temperature is put to the temperature it would be at that time of year, the noises and the sounds, the smells, all that are there. And the idea is to get you to live it and realise it's not scary. It's not real. It was once, but it's not now. I think, there's so many different things that can help.

Emotional Freedom Technique. I was asked to be a guinea pig as a veteran with PTSD because I completely disregarded it. Thought it was a waste of time. And I went, and I did get some benefits. Because if nothing else, concentrating on tapping allowed your tongue to loosen up and I spoke more. So, it allowed me to be distracted enough to speak.

Talking therapies is always good. Someone isn't using drugs to the levels of some of our clients unless initially it would have been to numb something and now it's just habitual, or they don't want to kill themselves because they're not at that point, but if they do die then, hey, bonus. I've heard that said so many times. So being able to talk to someone and just get them to chat about what's gone on in their lives and what's going on now and how it's affecting them, I think is really powerful. And listening to them. I don't think you always have to reflectively listen,

but that 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.

***Question 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?***

Dr Simon Warne, he's no longer with Sussex Partnership sadly, but he's the one that wrote the dual diagnosis pathway for East Sussex. He wrote this formal policy and he managed to get STAR CGL really interested in having a dual diagnosis pathway. You're treating their addiction and their mental health at the same time. STAR have got 2 members of staff that run the dual diagnosis for East Sussex, so not really enough. The mental health team tend to take each case on merit. There's a lot of emphasis on medication and psychological intervention; psychologists like people to be abstinent before they treat them, and most antipsychotic medications don't work effectively if you're using. There's this barrier that's put in the way, they know it's important to deal with both at the same time, but because of the guidance they have, they struggle to take that on board and manage that well, because the NHS moves slowly as a rule. One of my old-line managers said it took a hundred years for mental health services to truly understand what an OT's part is in mental health treatment. It is a very medication-based route to go down.

It is something that Fulfilling Lives have been involved with for quite some time. For veterans, the charity I am involved with, pays for psychological interventions for clients with a private psychologist, that do psychological interventions with people that are actively using or drinking. She [psychologist] has said *"there's no point getting somebody to open that box up and not have anything to hide behind when they're struggling*". She said "*I like to work alongside their substance misuse worker. There are areas where it's happening and when it does happen it has very good results as a rule".*

***Are you saying that, while the structural space is being figured out that private psychologists are filling the gap?***

I know one that's still currently working in Hastings ATS that will work with people while they're substance or alcohol affected. But he's one out of I think 20

psychologists. None of the others will at present. But I know that, Health in Mind are now accepting people for counselling, and their counsellors all have a psychology or, mental health nursing background, and they're now opening up so that they will do dual diagnosis treatment. There is an understanding they're starting to come to at the top in mental health services that you can do both. You can have someone actively being treated for their addiction and treat their mental health at the same time. And the outcome might be slower, but the results will be better.

***Do you have any examples of how these two services are working?***

With a client of mine – he's still actively using – but I got his psychiatrist to have a consultation with him every six months and when there was a bit of a crisis a couple of months ago, I managed to get him seen. I called on the Friday late afternoon and he was seen Monday. And that's because I have a relationship with the doctor, where I worked closely with him before, and that's my issue here the fact that it's who you know rather than what you know. So I managed to phone him up and said look he's still using, he said *"how heavy?"* and I told him *"well that's why I'm phoning you because it's gone through the roof"*, he got involved and the substance use has reduced quite a bit and because the psychiatrist has then liaised with the psychiatrist at CGL, they're now, working together. So, his medication has been adjusted slightly, and CGL are in more frequent contact with him. And he knows all he has to do is phone up and get an appointment for his mental health, so it can work.

I think there's a willingness to get there but it's just going to take time and it's just got to show some good results so that the mental health teams think, we can't say no, because if we say no we get bad results, if we say yes we get good results. It's literally that, taking off the stabilisers slowly but surely.

Why I got into this type of work is because a lot of my experiences with services was awful. I was treated terribly by mental health services. The only person outside of my family group that helped me was my GP and he just said to me "look, you're a stubborn bugger and you like to argue with people and won't back down, he said, why don't you go and do this for other people"? I said alright then. I ended up going to university, in the middle of me having this mental breakdown, I decided to sign up for university, do a degree. And then while I was at Uni, I started helping other students, and started volunteering because I thought, well I'm changing my career I've got to build my knowledge. My therapy ended up being a very expensive one because it was a three-year degree. It gave me three years in which I could experiment in different volunteering roles, to build my knowledge, but also to find out where I fitted in. I signed up to a mentoring scheme and my mentor said: make contacts, get to know people, and just don't ever back down.

Pick your fights but don't stop when someone says no, and I've just kept that in my mind.

Firstly, I was driven by anger at my own treatment, now I use that anger in a positive way trying to help others. As a frontline worker, when you're employed by Fulfilling Lives, you're meant to come here with the full package. No-one's got that, you just learn as you go and when you don't know, you ask. To become a frontline worker with Fulfilling Lives, they expect a lot of knowledge under your hat, and you can only build that up by experiencing it. It just makes for a very interesting role in that way because we're a bit of everything. You've just got to understand your own boundaries, haven't you? If something's outside of your knowledge base when your supporting a client, just say hey, I'm going to have to phone a friend. I'll get back to you on that one.

### *Question 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?*

Psychological interventions are about opening up Pandora's Box basically. That's a risk. I had a client that was held for three and a half years and prostituted out regularly. And when she went for psychological intervention, she just fell to pieces and couldn't cope and nearly killed herself a couple of times. It was all wound back and stopped, and then it was built up in baby steps. I think that's where a psychologist has got to use their skill, their experience. And as a frontline worker, my experience, my knowledge, is if a psychologist said yes, they're alright, they're fine for therapy. And I'm thinking whoa hold on they're not ready. It's my job to advocate for them on their behalf. I do always have fears about people accessing psychological interventions because it can be the wrong time. And people want to get better quickly don't they, quite often. If they've made that decision that they want to become abstinent and deal with their issues, they want it done today. And it's about managing their expectations, but also having discussions with the other professionals involved about *"is this truly the right time"*, and what extra wrap round care can we put in place? I'm always hesitant if a client of mine goes for psychological interventions and there's no additional support available. We have the luxury at Fulfilling Lives of having very small client caseloads and being able to spend time with clients. If I had a client going for psychological interventions, I'd meet them before, and I'd meet them afterwards. If it meant spending the whole day with them, I would. I've got that luxury. Not many services do.

I think it's really important to have that network around them, whether it be family, friends, just encourage clients to speak to their family and friends and say "I'm about to go for a psychology appointment, can you be there to help me?" I think that's important. I think it can be really helpful to have some intervention, but I think if you fully open the box and you haven't got everything around them, it's difficult. The way that psychology works the expectation is you go to them. For some of our clients going into a formal appointment in an office building is terrifying. And it's about trying to get that over to the psychologist. That if the person gets that appointment, they might have *"used"* more to be able to pluck up the courage to walk through the door. So, you can have that negative side of they've "used" more to turn up for the appointment, and then the psychologist says, "*I'm not getting anywhere."* There are challenges, and I used to get involved in this all the time. I've literally picked someone up from home, got on the bus with them, travelled to the mental health team, walked in, sat in the waiting room with them just chatting about nonsense – nothing to do with what they're there for and just sitting there trying to distract them slightly, and saying to them, don't be afraid to say I need to stop. And then sometimes I'd end up going into the meeting, other times I've just sat outside and waited for them. It's just them knowing that there's someone there, if it does get too much that they've got someone on their side. I think that's the important thing.

*"Talking therapies is always good. Someone isn't using drugs to the levels of some of our clients unless initially it would have been to numb something and now it's just habitual…."*

I remember going to see a psychologist, CBT therapist, on my own, and she turned around and said well, you've got to tell me more. I was a frontline medic; I wasn't going to tell her stuff. I went home after that appointment and my wife said just tell her this, so I told her something, the poor woman burst into tears and I was re-traumatised. I thought my god, my story must be horrific if just telling her one little snippet of information has got her in tears. And then that made me think I was worse than I was. It's about whoever's delivering that psychological intervention having an understanding of substance use, or that person's background. I think that's very important.

### *Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?*

In Brighton & Hove you've got the GP surgery for the homeless, Arch Health Care, they have a really good track record of helping people because they've got clinical staff in the hospital, which we don't have anything like that here in East Sussex. In the hospitals, I've had a client that was treated appallingly in hospital because he's

a poly substance user, he'll put anything in his body. They just struggled to cope with him because of it. I think for me it's about finding what works out there. If we can find out there's a project somewhere in the country, it's about finding what works out there. There are some amazing projects in Scotland, they are 10, 15 years ahead of England, even with their complex needs they are so far ahead. It's just fantastic. If we can find examples like that and try and get them here that would be very positive.

Hastings has had a history of trialling new things. Hastings was the first mental health team to have peer support workers. And they've had them for 15 years or so.  Not a lot, but they've had them, and they took the model from Scotland. 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. For me it's about finding models out there. Which is why I'm involved in the Health Inequalities theme and the Co-existing Conditions theme within the Fulfilling Lives project because I think they're very closely linked. Health services aren't going to change unless we can prove something works.

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## Jan Larkin

Consultant Clinical Psychologist
Head of Psychology, Turning Point

*Jan started her career as a registered mental nurse and went on to train as a clinical psychologist in Scotland. Since qualifying, she has worked in hospital and substance use service settings and became Chair of the Faculty of Addictions at the British Psychological Society 2012-18. Jan is now Head of Psychology at Turning Point.*

*Recent publications include contributions to Psychiatric Quarterly, the British Psychological Society publications, the Journal of Mental Health, and many more on topics such as the effectiveness of digital interventions, evidence-based practice, managing substance misuse in primary care and wider substance use and mental health support pathways.*

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***"What happens when somebody doesn't attend their appointment? Do they just get a letter to say, "if you don't contact us within 10 days, you're out?" Or, can we do something a little bit more sophisticated than that? And say, "let's have a look at what's getting in the way. Let's make it really easy for you to come back in." We're not here to discharge people."***

***Question 1: In your view how would you describe complex trauma?***

It's interesting because the first thing that pops in my mind is adverse childhood experiences and then I immediately think but it's much more than that. We've been thinking in Turning Point about asking people routinely about trauma. We looked at the adverse childhood experiences questionnaire and decided it was, pretty brutally put together. I wouldn't really want to be asked the questions in a waiting room. And then we look beyond that thinking, it goes beyond the things that are in the adverse childhood experiences questionnaire. I guess 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.

It's probably not the best definition in the world. But the way I think about complex trauma is it's quite different from a one-off traumatic event. Which could affect you in terms of you might have post-traumatic symptoms or flashbacks, but it wouldn't fundamentally necessarily affect your personality or the way you look at the world. Whereas complex trauma, I think does. And so, it goes beyond a list of traumatic events on a questionnaire. I also think about it in terms of it socially. Think of it in terms of communities. It's not just about living in a family where traumatic things go on, but it's about people who are having to deal with trauma at lots of different levels, both individually, in the family, socially, in the community, poverty driven, all of those kinds of things.

***What does it look like and how have you seen complex trauma present itself?***

I suppose fundamentally in human relationships, really. So, perhaps avoidance of human relationships or getting too close to people. Not knowing how much to disclose about yourself to other people and always sort of thinking 'am I disclosing too much? Am I disclosing too little?' Not having an understanding, necessarily, of how much to reveal about personal information, that can be part of growing up in trauma. I think also doing things that really kind of piss people off. We were talking just the other day about somebody who gets banned from all of the pharmacies because of the way that he relates to the pharmacy staff. I think part of it is about not knowing how to get what you want in a skilful way and going in and needing something and not knowing how to go about getting it. I know that people who have diagnoses of personality disorders, are often labelled as 'manipulative'. But I always go with the thought, it's that people aren't manipulative enough, or they're not skilled enough at manipulating other people. The people that are really skilled at manipulating other people are politicians and salespeople. I think it's about a fundamental not knowing how to get what you want.

***What difficulties does complex trauma present in trying to provide support?***

I think there's difficulty at lots of levels. I think there's the system difficulties. So certainly, the idea, for example, in drug treatment services that you provide a service Monday to Friday. It's all very rigid. People have got to come into an appointment and there's a real lack of understanding of the fact that people don't always operate like that. One of my big bugbears is the "proving motivation" thing. So, people want an alcohol detox. They have to "prove motivation" by coming to

groups and that kind of stuff. I think that puts barriers in the way of people who need things. There's a system level, which I think sometimes has got a slightly, distasteful idea that, we're doing people a favour by giving them treatment. They have to sort of shape up and show willing and be motivated. I think it's just terribly punitive. Even when we try not to be like that in services, I think sometimes they drift towards the punitive. So, there's a system level.

I think there's also an individual level. I think people, 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 or whatever. 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.

I think there is a real lack of understanding. I think that's where some of the routine inquiry, trauma-informed publications have been really helpful. For example, some of the online video resources showing somebody maybe acting in a certain way, not necessarily because they want to piss people off, but because they don't know how to act any differently. I think a lack of information, lack of understanding, medical diagnostic things, I think are very unhelpful a lot of the time for people that come with a string of diagnoses. And that immediately puts the staff on the back foot in terms of this person's got eight diagnoses, they're going to be really hard to cope with. So, the medical system, our drug treatment system, staff, our thinking about how people should behave in order to get treatment, or to deserve treatment. I think it's not explicit, but it's implicit in a lot of the things that services do.

### *Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?*

This is probably a really obvious thing to say, but for me, it's got to be about continuity. It's about making some kind of a relationship with somebody. And being consistently there for that person. Not putting up with anything but giving feedback about how to work through the system. And just really basic things. If you say you're going to call at a certain time, call at that time. Being reliable, being calm, being empathic. It's interesting, we've been talking about this a lot at Turning Point in terms of looking at the new alcohol guidelines with Public Health England. We've been talking about what are the elements of a good key worker. I think it's

a really basic human attitudinal thing. It's not about qualifications. It's not about particular fancy types of therapy. We know from the research it comes down to therapeutic relationships.

*"I think it's a really basic human attitudinal thing. It's not about qualifications. It's not about particular fancy types of therapy. We know from the research it comes down to therapeutic relationships."*

People who have got a human caring attitude towards other people. I think it's the most important thing. And it doesn't matter whether that's a psychologist, psychiatrist, a peer mentor, I think it's that person knowing that they can come back to that person, even if it's only a tiny bit of trust, they come back to that person in the event of difficulty. And I think so often we don't do that in services. People change caseworkers every five minutes. They have to go to a prescriber for their script and then they go to the key worker for their care plan and then they go to a nurse for a detox. I think people are really bounced around systems. The way we think about it in services is, well, obviously you'd go to a nurse for detox because they're a nurse and obviously you would go to a prescriber because they prescribe. But I think the experience for people being bounced around loads of different services/workers can be re-traumatizing. So, to come back to the original question. I think it is real basic human attributes. That's what I would want if I were using services.

We use a language about a collaborative approach, but often our approaches are less than collaborative. As somebody in a service, you might have some say in what happens to you. Talking about a genuineness and about how we talk, we use these terms like 'collaborative' and 'working collaboratively with somebody' and sometimes we don't offer a menu of options. And sometimes there is a one-size-fits-all system. And for me, it's also about that person having some choice in what happens to them. It's not always possible to have lots and lots of different choices. But just to have some choice I think is really important. And also, that we are listening to them as an individual rather than telling somebody with alcohol dependence this is what happens to you, or somebody that's using cocaine this is what happens to you. It's about taking that person as a person, which I know it sounds really kind of *hokey* when you say it like that. But, I mean, they are things that are important in any relationship.

***Question 3: Can you tell me about any examples you have of where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Again, within the services that we have at Turning Point, we have psychologists in most of our services. We often speak to key workers about people who are having difficulty engaging in treatment or us - as a service - are having difficulty engaging with somebody. And those reasons are often to do with trauma. There's often this chicken and egg thing about, do you work with trauma first or the substance. Which doesn't really mean anything, does it? Because it's all one person.

*"There's often this chicken and egg thing about, do you work with trauma first or the substance. Which doesn't really mean anything, does it? Because it's all one person."*

Concrete things that we've done - we've thought about where we see the client. That's quite important in terms of, do we want somebody to come into a waiting room full of other people that are waiting, or can we actually go out and meet them where they are? It's not psychological support or psychosocial support, but that flexibility to be able to see somebody at a community centre or the GP surgery, and not expect them to run the gamut is important. Some drug treatment services are quite scary places, I think, for people. And if we're expecting them to come and sit in a waiting room for any period of time, they probably won't. When people are in and out of treatment and on and off scripts. Quite often our psychologists would make an appointment with them and (at the moment i.e. C-19) have a telephone call about what's going on.

To try and come to a shared formulation with the person about what the difficulties are, what their expectations of treatment are, what their fears about treatment are. And help them to navigate the treatment system. Sometimes the psychologists and key workers have done some work using mainly sort of DBT crisis survival type skills with people. So, what gets in the way of you making it into treatment? If it's anxiety, if it's fear, if it's being with a lot of people from the other gender. Looking at how you can use some of these really practical coping skills to be able to get through that in order to get what you want. On a wider level, we've looked at, and it is very jargon heavy, but Psychologically Informed Environments. Looking at working with people, particularly in hostels, at how they can manage safety, which can be really difficult in that kind of environment.

Helping people to feel safe in order to be able to access treatment or make changes. Those things could be practical things. It could be about helping people get different types of accommodation. Or it could be about psychological skills in terms of safety. Looking at triggers, looking at who to spend time with, who not to spend time with, all those kinds of things. The kind of the standard substance misuse things, really.

Generally, we would either work with the client, maybe just in a couple of sessions, looking at some formulation. Helping to come to a shared understanding of what's going on. And that may be enough. Or we could work with the key worker to do some sort of case consultation, looking at what's going on in the relationship. Sometimes we use things like cognitive analytic therapy in terms of looking at where the key worker stands in relation to the client and how they are perceiving the client, and how that's affecting the worker. Because often I think that's where we drift into being punitive when we feel threatened by clients. And then actually we can become a bit accusatory and punitive. So, it's helping staff groups to understand: X-client has been around so many times and every time they're mentioned it's 'they always do X, Y and Z,' so, sort of opening up those discussions, asking 'Well, what's that about and why are we talking about that person like this? How is it affecting us personally? What can we do to let go of some of that punitive stuff and diagnostic stuff, and don't understand what's really going on?' So, at that kind of staff level, it can also be helpful.

But also, I think the other psychological bit is that we work in terms of looking at the processes within treatment. Something we've been working on recently is a re-engagement pathway. What happens when somebody doesn't attend their appointment? Do they just get a letter to say, "if you don't contact us within 10 days, you're out?" Or, can we do something a little bit more sophisticated than that? And say, "let's have a look at what's getting in the way. Let's make it really easy for you to come back in." We're not here to discharge people. All those kinds things are not technically psychological therapies. But I think it's about looking at things in a psychological framework. Things like detox, what we're doing is looking at ambulatory detox. Often, we're expecting people to come into services to get a detox. And just thinking how grim that must be for people who are alcohol dependent and feeling really bad to have to get two buses across town and then go and get your Librium from a service and then get two buses home and then do it again the next day.

So, in the understanding that that's probably really difficult, we're looking at, can we work with a family in the home to do the detox a bit better? Can we use remote stuff to do the detox? Can we check in with a family member on the second day of the detox, rather than ask them to trek across town to come into a service? I think all those things are about meeting the person where they're at and actually making it a little bit less difficult for people.

*"I think if we can contribute to processes and systems being easier and less demanding of people when they're already, in a difficult place. I think that's a really worthy use of psychology."*

And I see that as being something really important as a team of psychologists. I think if we can contribute to processes and systems being easier and less demanding of people when they're already, in a difficult place. I think that's a really worthy use of psychology. It's not just about working with individual clients. I think it's about looking at people's situations with a bit more understanding and with a little bit less of a medical model and a bit more trauma informed.

***Do you have a phased approach? Where a key worker will be engaging in the kind of psycho education, psychosocial side of things, and then is there a threshold or a point where a client might be referred to one of your psychologists in-house?***

We've got very little capacity in terms of psychologists in-house doing psychological therapy with clients. We've only got one psychologist per service. For example, a service like Wiltshire will have three hubs. And, maybe 800 opiate clients. With these numbers of clients, we can't as a service offer a lot of ongoing individual psychological therapy just because we don't have the capacity to be able to do that. Yes, we have a clearly defined psychosocial approaches, we have group approaches, and individual approaches. The role of the psychologist is to train the staff and supervise the staff in the use of those psychosocial approaches. And most of it is psychosocial and not psychological. But the psychologist generally does the formulation with somebody and often to try and help get somebody into a mental health service, as difficult as that is. The psychologist will work with local psychologists in Community Mental Health Teams (CMHT) or Improving Access to Psychological Therapies (IAPT) or wherever to try and help get that person the mental health support they need. The mental health approach is needed outside the Substance Misuse Service (SMS) service, which, sometimes works great, sometimes doesn't. We see this role for psychologists being an advocate for the client. We see that client, have a conversation with them, do some kind of formulation, and then write to the local service we would think the client might benefit from. And advocate for them getting that service, even if they're using substances. We do more of that really than ongoing psychological work ourselves. Generally, most psychologists would only have a caseload of about maybe six to 10 people, if that. Most of it is more assessment, consultation, supervision, training, because that's really all that we can offer.

We've been having a discussion with one of the psychologists who wants to do EMDR training for trauma. My thinking about it is if somebody is at the level that they can actually cope with the EMDR, which is quite triggering, they probably

wouldn't be in an SMS service. I don't agree with keeping clients in a SMS service in order to do mental health work. Because if they've already dealt with their substances enough to be able to do that kind of work, why would they not be able to access that in a mental health service? If we're keeping people in an SMS service to do that work, we're not doing the work of destigmatizing substance misuse. Because we're suggesting they must have a parallel service because they are using substances.

We don't want to recreate that in SMS services for people. It's almost like a two-tier system. If somebody is able to do that work, it shouldn't bar them from getting that treatment the same as anybody that doesn't use substances. We're always having these discussions about how much psychological work do we do? Realistically, we have very little capacity to be able to do a lot of it, to be honest.

### *Question 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?*

I think we started off 10 years ago when I came to Turning Point, we started off very much doing mainly Motivational Interviewing (MI) and Cognitive Behavioural Therapy (CBT). We've moved much more into a bit of third wave mindfulness, acceptance and commitment therapy. What we tend to use for our groups, beyond the initial groups, the lower level groups, is acceptance and commitment therapy, because we looked at it and thought, it's not evidence-based NICE Guidance for substance misuse but it just seemed to fit so well in terms of talking about values. It's very well evidenced for lots of mental health issues. And, in the fact that we know lots of our clients have mental health issues, if we're going to be working with substances, why not work with mental health? So, what we tend to do is use acceptance and commitment therapy. And then we also use DBT skills groups with people because we know that, when people reduce substances, they're going to have difficulty generally coping with emotions and moods. So, what we've done is just assume that everybody would benefit from those things. So those aren't things that you would get if you've got a specific diagnosis, we'd be offering them as a rule as people's substance use comes down.

And that's been quite popular. Client feedback has been, 'it's been nice not only to work on the substance misuse, but to be able to look at mood and dealing with anxiety and all that kind of stuff as well.' Because it's obvious if we just deal with substances some people are going to lapse or relapse quite quickly. So, we have those kinds of general approaches. And then the routine enquiry is what we're trying to bring in, asking people routinely about trauma. We haven't actually

managed to do that yet because of Covid. We're just about to start, I think, to get back to face-to-face training in a few months hopefully. We just thought that's the kind of stuff you just can't do online. It just felt to be such a difficult thing sometimes to ask somebody about trauma. We just thought we don't want to do a webinar or something. We want to actually see people practicing how to do it and deal with it. So, we haven't yet got through into the routine enquiry phase, unfortunately.

***Question 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 substance misuse treatment?***

I actually believe that mental health and substance use services should be commissioned together. I don't think they should necessarily be separate. Yes, joint work is really important and all the policies and procedures. And, we spend ages trying to develop pathways with local mental health providers and having link working meetings and joint meetings. I think the problem is the systems aren't set up to be able to cope with a lot of that joint working. 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, you have to have some kind of a diagnostic process. The way that substance misuse and mental health function is so different from each other, that makes it very hard to work together. I think also we have a great amount of difficulty with our clients accessing IAPT because they're using substances and we spend ages going on about the DrugScope guidelines. And why would somebody being on methadone mean that they couldn't access treatment for anxiety or whatever? I feel quite pessimistic about it having worked in this area for a long, long time, in the sense that our frameworks are too different and because we don't think about people diagnostically. And in mental health services, you have to. It's just such a fundamental block.

*"I actually believe that mental health and substance use services should be commissioned together. I don't think they should necessarily be separate."*

The best we've got to really is having, which is good, joint assessment clinics. In Oxfordshire we've got a psychologist and the local Consultancy Psychiatrist comes in and does a clinic every month, which is brilliant. Because then our service users don't have to go off to the CMHT to be assessed. And that's kind of about as good as it gets, I think, in the current system.

But I think in an ideal world, if mental health and substance misuse services were commissioned together, you wouldn't have those false disparities. I just think that most people with any degree of substance misuse problem has got some kind of difficulty in managing mood. I do feel a bit pessimistic. It's really important because service users tell us time and time again that actually the fear of stopping using or reducing use is what you're going to be left with in terms of your mental state.

*"But there is a wrong door and I think until commissioning changes that's not going to change."*

It's absolutely fundamental. It's obvious to say, but we treat substance misuse and mental health as two completely different things, which to me just seems completely crazy. I would love to be working in a system that wasn't defined by mental health versus substance misuse. And I suppose in Turning Point we're lucky in the sense that we have substance misuse services and mental health services. But even there, we don't always talk to each other, even within Turning Point, which just seems completely ridiculous. But we are trying to do more now in terms of working with our mental health services in Turning Point, in terms of helping them to understand substance misuse and doing cross training and supervision.

But yes, it is fundamental. I think people's experiences are often really bad or being knocked back. And, going back to complex trauma. I don't qualify for that treatment because I haven't got X, Y or Z diagnosis. It's just shocking. I guess that's why in substance misuse services we see everybody because anybody can self-refer, whereas in mental health services you have to reach a certain threshold in order to get treatment. They're just so fundamentally different, aren't they? I remember going to the Public Health England 'no wrong door' event a couple of years ago. And it all sounds great on paper. But there is a wrong door and I think until commissioning changes that's not going to change. You get some really keen people that want to work with each other in certain areas and it's great. And that lasts as long as those people are in post and they go and then somebody else thinks well I don't want to do that anymore. It's not good enough for service users at all. It is something fundamental, isn't it? It needs a fundamental seismic shift in the way that we look at it.

***Is that a seismic shift that needs to come from central government? Health is ring fenced and substance misuse is subject to budget cuts frequently.***

Yes, absolutely. They're commissioned, differently aren't they? From different places, from different bits of money. It's incredibly hard the way that the systems are set up to do any kind of real joint working, I think.

***The clinic you spoke of earlier? We work over in East Sussex - in Hastings and Eastbourne - and we're involved in trying to develop something similar. It was a piece of work we developed between the local trust here and the substance misuse provider. I wonder, in light of mental health and substance misuse not being commissioned together, and that not changing in the immediate future, what would you like to see as the next progression in the joint assessment clinic that you have at the moment? What would be the next good thing to happen? The next kind of evolution of it?***

It probably sounds really basic but, even us in substance misuse being better and more proactive in calling a meeting with mental health workers, calling a CPA. 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. I think if substance misuse services had KPI's to illustrate to our commissioners' evidence that we have had conversations with mental health services about people that we're jointly working with. Even that is pretty basic, I think that would be a start if mental health services were brought to task to evidence how they're joint working people at the substance misuse service. How often in the last year have you had a conversation with the client, and with substance misuse service colleagues about what's happening with that client?

I know it sounds basic, but it doesn't always happen. I think KPI's would be really helpful because then it would make us think actually, we've got to do this, rather than it being an aspiration. And mental health would have to sign up to it. I think it's just sometimes even getting a meeting together with mental health staff in an area and substance misuse staff can take six months. I think KPI's in terms of communication has got to be the first step.

***We've spoken to a couple of other clinical psychologists as part of this work, and both were broadly on the same page. One of them had the view that it's mental health who should be stepping up and taking the lead. But they just can't. They really struggle. To logistically do it in terms of their governance and their policies. So, it's interesting. There is a will there, but there's something structurally that is holding it back.***

But I think we're guilty of that, too, though. We often have these conversations that in substance misuse services we can ask for a CPA. And I think sometimes we're too hesitant, or we think mental health has got to take a lead, which they technically have. But as you say, sometimes the capacity isn't there, the resources aren't there. And I think we need to be more proactive in substance misuse in

saying, 'let's just get around the table,' or, now in the era of remote working, it should be a bit easier than everybody going into a meeting room somewhere. I think the only way it's going to happen is if we are held to account by commissioners. Because if substance misuse services are going to lose their contracts because they're not doing it, then they're going to have to start doing it. I think it's got to be at that level, because with the best will in the world it keeps sliding off the agenda. And that's the problem, I think.

***Question 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?***

Their support might be a little premature in the sense that somebody may not be able to be at the point where they can deal with it and manage it. And if somebody is still using substances, which they would be if they were preparing for substance misuse treatment, it could be too emotionally difficult for somebody. And it may actually go the other way and end up with them not engaging in treatment because they may need to 'up' the substances in order to deal with the distress.

I think timing is kind of crucial. I think it also depends what kind of psychological support. If its psychological therapy such as EMDR or something, then I think that would be quite risky. But I think if it's support, in an understanding trauma kind of way, I can't see much of a risk with that in terms of psychosocial. As we said earlier, building a trusting relationship with somebody, I can't see a risk attached to that.

Well, I guess people talk about overdependence. I hate it when people talk about overdependence on somebody or, being overly dependent on a person or treatment system or whatever. I don't really agree with that. I don't think that's a risk. I think actually, if you're overly dependent you're just engaging in some kind of a reasonable relationship with services

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I think first, it's really interesting to be asked these questions, because it makes me reflect. When you're in the day going from meeting to meeting; it's interesting to be asked the questions and to reflect on it. Part of it also makes me feel a little bit helpless in terms of, it's such a difficult topic. It makes me feel sometimes

critical of the services that we offer in terms of not being as trauma informed as they could be.

I think for me, the province of trauma is not with psychologists. I think that's the main thing for me is that it's everybody's business, isn't it? And for me, as psychologists, our task is to help people to understand how trauma affects people and, that's people on the front 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. I think that's probably more powerful within a substance misuse service than being able to work through trauma with 20 clients across all the services that we've got. I think our job is to do much more of that, reflecting and discussing with staff and with clients than doing psychological therapy, because I think realistically that's not something that we can offer. I think if we do that and we get to the point of actually doing routine inquiry, that's some way towards being as trauma informed as we can be.

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## Karen O'Rourke

BACP Accredited Counsellor and Clinical Supervisor, UKRC Registered Independent Counsellor

*Karen has worked within supported accommodation and homeless services for nearly 15years. Offering therapeutic 121 sessions for clients, staff consultations, reflective practice sessions and trauma informed training.*

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## *"Helping somebody understand themselves and their triggers to behaviours is a precursor to entering treatment."*

***Question 1: In your view how would you describe complex trauma?***

I would start with the clinical term of complex trauma meaning multiple interpersonal traumatic events. When a child has experienced a continuing state of either hyper or hypo arousal - constantly being in survival mode. The psychological and physiological effects compound over time and affects cognitive and physiological processes in the body. This can present challenges managing day to day living.

***What does it look like and how have you seen complex trauma present itself?***

The window of tolerance is a useful model for different presentations within complex trauma. The window of tolerance is a term used when someone has an ability to regulate themselves, tolerate disappointment and can ask for support.

Hyper arousal is more commonly known as fight or flight responses. It may be someone reacts in a very heightened way to something that seems inconsequential to others. For example, someone moving out of their window of tolerance into flight, means they may not attend an appointment.

From the more hypo arousal state, we are going to see a lot more disconnection in someone. Possibly resulting in an inability to be able to form a working relationship with their keyworker.

If someone has substance misuse issues as well, that creates an unpredictability in someone's behaviours. Often it is the hyper and hypo responses that are self-medicated.

***What difficulties does complex trauma present when you're trying to provide support to someone?***

Support starts with a referral. The client might have said "yes", but that may not be a meaningful "yes". Sometimes defiance follows compliance particularly with avoidant attachment styles. So, engagement can be difficult from the start.

If a client has a history of violence, is very aggressive, is very defensive and isn't able to engage in an adult-to-adult way, this can activate anxiety in workers. Managing our own anxieties while offering a practical and therapeutic space for a client asks a lot from a worker in terms of their resilience and energy.

The complexity of working with different presentations and roles can be overwhelming at times. For example, a worker could be involved in helping someone with their mental health, poly substance use, housing, arrears, benefits, their behaviours and interpersonal relationships, attending key appointments, managing risk etc. When someone is ambivalent towards support frustrations can arise when there are pieces of work that can't be completed.

Providing an approach that is assertive and comprises enforcement and support while presented with so many threads to the work asks for commitment and compassion. When a client does not attend an appointment or is aggressive after a worker has invested a lot of time and effort into a piece of work it can be hard to manage this for both client and worker.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

I think helping somebody understand themselves and their triggers to behaviours is a precursor to entering treatment.

No-one picks behaviours that didn't make sense to them when they were young. We chose a behaviour because the intention is to help ourselves. Where someone has chosen substance misuse, we can determine that this is an unhealthy way of getting their needs met. For some they've started their substances in the early teens. Something made sense, or they were given a substance by a relative or friend and it's continued because 'it worked'... 'a substance helped them manage something'.

It can help to normalise about what worked for a client when they were younger but doesn't seem to work so well for them now. Also introducing the idea that the client is not this 'bad' person they just did what they could at the time to cope is less shaming and compassionate to the self.

Psychoeducation can be useful for some to understanding anxiety, its physiological processes and some tools to manage this a bit better. If it's their first time in treatment what is their fantasy about how it will go? Will they be liked, make a fool of themselves, are they scared of telling their story? Are their preconceptions and thought distortions increasing their anxiety?

To be thoughtful about the age and stage of someone in preparing them for treatment. Sometimes a more cognitive approach is more appropriate. Sometimes a more playful approach is more appropriate - speaking to the child part of them that may run the show.

Exploring ambivalence is important - we don't need the client to be committed 100%. It only needs to be 5% commitment, but 5% is 5%. However, let's not pretend it's 60%. There will be a part of them that wants to do it. But are other parts to the personality at play. i.e. the saboteur, the protector, the fear part. And we need to talk to all those parts of someone.

There are specific kind of mindfulness pieces of work that I would use for people to talk to those different parts of them. The part that's the resilient, the get-go part and the part that is really scared and really doesn't want to do something. The part that is very sad and the part that's very angry. Trying to bring all of those into awareness so that they have more control over those parts rather than feeling as though "I've just got to be perfect and I've just got to get it right." There might be some scaling, some visualization tools that can be useful to help hold people steady through this process.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Firstly, for my example of client (A), joint working was key. This client was very aggressive, very demanding, wanting their needs met immediately and very difficult to engage with for a while. Some of their acting out behaviours were seen as lack of commitment to treatment rather than anxiety.

For example, when they were going to an out of area rehab, he was half an hour late to pick up his train ticket, and because of that the service refused to give the ticket to him. So, he missed his appointment and he was discharged.

We spoke with the client about what level of anxiety they felt before and then how hard done by the client felt. Then establishing that the client still wanted to go to rehab we agreed to slow the process down a bit and make sure everybody had a little bit of responsibility. At the same time thinking about how the workers felt protected and safe working with this client.

So, I continued to meet once a month with the client throughout rehab. They relapsed. Then returned within a month.

Something changed the second time around. That was quite significant for them. The first time they wanted it to be perfect, in their words they wanted to 'smash it', they wanted to be the best, they wanted to be the perfect rehab client. And it changed, the second time we could really slow it down for them, that he could be a good enough client. That when things went wrong the focus was on repairing what had gone wrong and that was the focus of a continued piece of work.

Joint working was very important for this client's ability to work through the process of rupture and repair. It reduces the potential of workers entering a parallel process with client's and brings more awareness if one is invited to play a rescuer, victim or persecutory role.

***By persecutory role do you mean taking punitive measures that are maybe unnecessary as a coping mechanism for the worker say, they don't know what to do so the reaction may be to discharge.***

Some clients can be exhausting to work with, sometimes because they are so threatening. I think it's very real. I don't come from a critical place in this, because I've certainly worked with very aggressive clients that haven't turned up for an appointment and I've felt relief.

Those conversations are useful to have as a joint working team about how challenging it can be working with someone. If you become a close team, you're looking after each other in the team. Also, within the AMBIT model making sure that 'key' person having most of the contact with the client is supported. That may be the keyworker in supported accommodation or an external agency. Then if there's any kind of acting out behaviour, you can challenge each other in a supportive way, ask "what's happening? We thought that this might happen." The saboteur is so powerful that sometimes, workers end up holding it for the client. I think there's counter-transferential feelings that we can hold, especially where something anxiety-provoking is about to happen i.e. treatment.

***When you talk about a joint working team around the client who in this instance, with this particular case, are you working quite closely with the rehab exclusively or, are there other services involved in that joint working team?***

The pre-treatment joint work team was me, the accommodation provider keyworker, his substance misuse care-coordination worker, and probation.

***And who creates this joint working team and who leads on it? How do you become involved in this? Who pulls that together?***

My referrals were from supported accommodation, occasionally from substance misuse agencies if I had space and if so that client was in supported accommodation at the time. Once it was clear who the team was around the client – I would start my work which was therapeutic. Apart from duty of care incidents I would leave it to the care coordinator to fill that role.

***Question 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?***

Firstly, normalizing that the intentions of substance misuse are rooted in wanting to meet a need. It's just not a healthy way to meeting a need. The majority of people I work with have personality disorders. And I'd say probably a quarter of them were disturbed by the phrase 'personality disorder', thinking that they were wrong, that nothing they did would work, or they couldn't do anything because their essence of their personality was 'disordered'. So, in terms of doing a big pre-piece of work around building their agency and sense of choice in the path they take now felt useful.

Motivational Interviews, pros and cons & decisional balance. Really having a good think together about what the substance gives them. Then we can rationalise how terrifying it can feel to have that taken away.

Clients have often had adults in power during their early life that have been dangerous. So, they have built fire escapes for themselves to manage their overwhelming feelings. But now where's their fire escape? They're already anxious. They know they can't be in flight mode in order for rehab to work. So, thinking about what other 'fire escapes' they do have. Using simple language to get people started in thinking about emotions i.e. happy, sad, anger, fear. Language is its own fire escape.

*"They might say, "yes, I really want this. I really want this". But, with the body a whole different experience is happening. In their body, they're terrified. So, we really need to get those two things linked."*

Psycho education is helpful, and I think it's difficult to put it into a formal piece of work. I think it's a very curious place when we're using different techniques and models. We don't want to make it too formal, with lots of worksheets and homework. Anything we use is with the aim of helping connect the body and the mind of the client that we're working with.

They might say, "yes, I really want this. I really want this". But, with the body a whole different experience is happening. In their body, they're terrified – anxious. So, we really need to get those two things linked. And again, we need to pay attention to the saboteur: asking 'How is this going to be different to the last time?' If people get evicted because of angry behaviour, well, it makes sense because there's flight and then there's fight. So, in these circumstances we need to ask clients, 'So how do we manage your anxiety. Because you already know that this is probably going to happen?' So, having very authentic conversations with clients can be helpful.

It can be difficult when the answers from clients (about managing their behaviours) are about stopping other people's behaviours. It helps to observe patterns and stay curious about their part of the process.

Also, as workers, we need to ask ourselves how are we going to keep ourselves buoyant and curious? And if we're not, if it just feels like Groundhog Day every time, we speak with somebody, what do we need to do in order to re-engage our motivation? I think there are lots of creative things that can be used that can help both workers and clients stay engaged. In this, pre-treatment stage, I certainly used to go coffee shops quite a lot and used salt and pepper pots that were on the table to present different ideas. i.e. window of tolerance. Where they felt

someone was pushing them into a hyper arousal. I'd move them about the table like a car rally. Then asking them to move them (the pepper pot) and how can they navigate around the other (the salt pot) Using objects, and metaphors and thinking creatively, helps soften some of the messages that we're giving.

As workers we can also reflect on attachment styles to help engage with clients. So, somebody that was more avoidant, we would maybe take a bit of a step back. Maybe not be so familiar i.e. *How are you doing? You know, I was so pleased when you rang me to meet up.* We wouldn't do that. We would hold ourselves back a bit from that softer way of communicating.

Somebody that's ambivalent we'd be noticing that every time we have a meeting with them, we end up with this list of things and they keep us busy all week. We're picking up more than we should do. We would want to share whatever task we can with the client. We also need to be very mindful of endings. If we have a crisis at 4pm every Friday – what is the client communicating, then? Likely it is 'don't forget me' so let's book in a meeting or call for Monday or Tuesday. It can really help reduce the anxiety connected to absence.

As workers we can use the drama triangle and parent, adult, child models from transactional analysis. If I feel I've been in critical parent all day I definitely need to move out of that at some point soon! I think it's good as a check about what roles we have been playing. The same with the drama triangle, am I being invited into rescuer or another role? Again, with awareness brings an ability to change the role we are playing and therefore the piece of work we are doing.

Techniques supporting interventions seem to be more successful when used as a toolbox rather than a formula. Depending on where the journey goes with the individuality of the client. We don't know what path we're going to walk down with a client when they're telling us a story. We don't know how we're going to react. So, it's very difficult, I think, to be formulaic at this stage.

### *Question 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?*

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 joint working is very limited. Though the times where I did see it, sometimes there was a CPN who had a strong relationship with the client, sometimes not. The main root of mental health support came from the substance misuse team.

In terms of joint working, I think whoever is involved in that person's care at that point need to be communicating and to be talking about what role everyone has; that's the most important thing. Whether it's mental health or whether it's probation or whatever agency. When joint working, we're sharing our concerns, we're highlighting where splitting is going on in the group and asking how we challenge each other. We are also agreeing on a consistent message within our different pieces of work.

***So, it isn't a prerequisite. It's not something you think has to be in place, mental health representation, as part of a joint team working round the client.***

I think it's important to get somebody's medication right before they go in to rehab and help somebody stabilise with medication. I think it's important where somebody is on medication that involvement is joined up. I think whoever that client has got relationships with at that point, that's the important cohesion. If somebody is at the point where they're saying 'yes, I do want to go to rehab', the people that they've got around them at that point in time, are going to be the most important relationships.

Getting somebody connected into mental health services with substance misuse is difficult. So, it's more likely to be disappointing for clients than it is successful. Which can create problems at that point. I think mental health involvement is useful for a clinical perspective on their current medication, should it be continued and if their medication was reduced quickly would this be harmful.

I think when you've got trauma and you've got substance misuse; you need authentic care. The medication may help somebody reduce their anxieties. In terms of another worker, my question would always be what are mental health services going to add to this relationship, this joint working relationship? If it's for a specific piece of work, then good. If there is a client going into a psychotic episode regularly, then yes mental health input is invaluable. But if we're talking about really heightened behaviour or somebody is disconnected and it's because of trauma, it's more difficult to make a call as to whether mental health input would be useful or not. Connection with the client and their GP, the Homeless Nurse Team and care coordinator (with any scripts that are being provided) is, as always, very important.

*"I think when you've got trauma and you've got substance misuse; you need authentic care."*

Many people with personality disorders that I've worked with are functioning in life now, with or without rehab. Sometimes supporting the client with just myself and another worker has meant the client has managed to reduce and stop

misusing substances. And other times the client has needed rehab and failures and multiple admissions. For some, cognitive capacity is so low that it's difficult to see how they can stop without external barriers to them using substances. And I'm not sure in any of those examples that spring to my mind, what extra support mental health would have given us. I would like to see all the services being used, for their expertise. I certainly believe that the dual diagnosis clients are at times let down by mental health services.

***Question 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?***

l think with authentic care risks are minimized. If there's a worker that really wants a relationship with a client who is avoidant, that could be very distressing for the client. With somebody that's ambivalent if the worker is cancelling appointments or being late for appointments that could be really distressing for a client too. I think those ruptures can affect a client's movement into rehab. There's got to be some predictability. So that's how I would manage it on a case by case basis and think about the boundaries, and about what can I offer. Because if you've got a high caseload, don't offer, once a week; offer once a fortnight if that's what you can do.

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I think in supporting staff we all need to be aware of the burnout inventories: overwhelming exhaustion, detachment, depersonalization, cynicism and lack of accomplishment. Having emotional support within the wider team and checks within ourselves to prevent burnout.

I think having healthy challenges within the organization culturally is important. All organisations have their own cultures and having healthy challenge allowed in that culture seems to work really well.

People's own self-care and their own management is a really big part of this work. How are people aware when they're feeling pulled out shape and aware of when they're not feeling okay? And how do they notice it at the beginning so that it doesn't transfer into burnout?

I think if staff know that somebody has got their back from someone in their team or joint working teams, they are less likely to experience feeling isolated working with clients. The important result of this is that we can therefore offer more containment for the client.

For further information about Karen's work, please visit:
https://orourkebrightoncounselling.co.uk/

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## Martin Curtis

Multiple Complex Needs Worker, Fulfilling Lives South East Partnership Project

*Martin is the dual-diagnosis specialist worker for Fulfilling Lives in Brighton. His work includes supporting a small caseload of clients who have multiple and complex needs including a dual diagnosis, a history of homelessness and involvement with criminal justice agencies. Martin has also had systems change training from Lankelly Chase in 2016 and is interested to see how his experiences of working in frontline substance misuse and homelessness services since 2012 can be used to inform the development of services to meet the needs of those most likely to fall through gaps in service provision. Martin is also interested in trauma informed care, psychological support for clients with a dual diagnosis and equality of opportunity for clients who face severe and multiple disadvantage.*

***"Giving clients a positive experience connecting with other people and that they can actually trust other people. It's one of the most basic human needs, and it's one that people who've experienced complex trauma may not have had positive experiences of in the past."***

***Question 1: In your view how would you describe complex trauma? What does it look like and how have you seen complex trauma present itself?***

Complex trauma is where somebody has multiple experiences of traumatic events. In my experience this usually includes events from childhood, so childhood neglect, childhood abuse, and then multiple traumas throughout life; absent caregivers, caregivers who were neglectful, caregivers who are narcissistic, and then repeated experiences and problems at school which go on into later life.

These problems can include developing relationships with other people, I have found that attachment styles have a lot to do with it. Many people have ambivalent attachment styles, or they've become avoidant of other people, don't

trust other people and find it challenging having been let down previously by people who are supposed to be primary caregivers. In later life they then get into relationships that aren't very helpful, that create further traumas. Problems with complex trauma manifests itself particularly in the client groups that I have experience in working with, people with multiple and complex needs.

It also manifests itself in that clients who have experienced complex trauma develop persistent, fixed attitudes to life that cannot be changed with medication alone. Sometimes medication can help alleviate anxiety and depression etc, if that's a feature for them, but they have a persistent and fixed attitude to life and other people. It compounds every other area of their life, it is pervasive, it straddles across every single domain of their life. From the way they look after their physical health, the way that they are unable to do anything to look after their mental health and their mental wellbeing and, substance misuse can be a feature, as can self-harming behaviours. I would be looking at persistent, pervasive and problematic behaviours as one indicator that someone has experienced complex trauma.

***And these behaviours that present themselves, is that quite consistent across the high needs complex clients that you support?***

It's difficult to say exactly because one person's presentation will be very much different to another person's presentation. For example, I've got somebody that I work with who is really avoidant of people, really mistrustful, doesn't trust anybody but at the moment he trusts me. How long that will last for I don't know, but he doesn't trust anybody else particularly, it seems. Other people want to see me all the time but don't particularly want to do anything that's focused towards getting treatment, getting better, improving things, they just want to see me/spend time with me. I think it would be naive to say that isn't going to help them, but I've not got enough availability to see people as often as they would like to be seen, and I've only got a case load of seven clients. Imagine if you're working for an organisation where your case load is between 50 – 70, and you've got say 10-15 clients who monopolise most of your time, that take up two thirds of your time. These would be the clients with experiences of complex trauma that take up all your time because of either high-risk behaviours (including avoiding appointments and requiring regular follow up) or they just want to see you all the time or ring you every five minutes to tell you what's going

*"I think it takes good clinical supervision, and it takes good organisational supervision as well, and it's good to talk with peers. Using multi-agency, multi-disciplinary support is key. It is really important that no one worker carries the full load. So, a little bit in line with the AMBIT model."*

on, but without any particular commitment to do anything like go to rehab or engage in substance use prescribing. But they'll value speaking with the service.

***Would you say that that's one of the most challenging, most difficult aspects of supporting someone with complex trauma? Are you saying it's kind of an ambivalence to accessing formal support of some kind?***

I think it is challenging for professionals to maintain a high degree of aspiration for their clients in the face of them frequently missing appointments or turning up heavily intoxicated. Or you explain to them what they need to do to get to a certain point so that they can go to rehab but find they are unable to take any of the steps and will not really follow any of the advice. It takes a high degree of patience; it takes a high degree of skill and the need to use a lot of empathy with this client group. To be genuinely empathetic and understanding is a challenging art to learn. I think it takes good clinical supervision, and it takes good organisational supervision as well, and it's good to talk with peers. Using multi-agency, multi-disciplinary support is key. It is really important that no one worker carries the full load. So, a little bit in line with the AMBIT model.

If you are the worker doing the main client facing work, then you need to know who you can debrief with, to get ideas from, because it is difficult to maintain consistent support for people when ambivalence is their main presenting issue. Also, a lot of clients present with a disorganised attachment, so they can be quite angry, quite aggressive, but they are probably low risk of hurting us once we've got a relationship with them. There is always that unpredictable nature of complex trauma. People can become very angry very quickly. Their ability to tolerate emotional distress is not very high. Just saying the wrong thing accidentally without intending to cause any distress can sometimes cause somebody to start shouting, swearing, etc. Even wearing something that reminds them of someone in their past can all trigger a client recalling a previous and unresolved traumatic event.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

I think many people who've been let down can find it beneficial to have someone work with them in a really relational kind of way. Build up a relationship with them, really listen to them, get to know them, spend a lot of time with them, and encourage them to set goals. And when they deviate from those goals, remind them to get back on track. I think it can really help to prepare someone to access

formal substance misuse treatment. I've got a couple of examples of people that I've worked with and provided some psychological support, and one of them was with Nicki [Nicki Taylor, psychotherapist], when she was still with Fulfilling Lives. I'll talk about the client who was working with Nicki first.

***That would be good because I was going to ask what this might look like and what steps might be put in place in preparing someone from a psychological perspective, so if you could comment a bit on that, that would be really helpful.***

In terms of preparing somebody for rehab, I think it's really vital to know and understand what rehabs are like and to think about the issues that somebody might encounter. People can think that going to rehab will be a panacea, not properly considering what rehab looks like, that it involves living with other people which is inevitably going to bring up problems and difficulties. For some people it's confidence building, like handholding, taking people to appointments, things like that, being there for somebody. I think most of the care coordinators I've met who provide substance misuse treatments are really good, really experienced people, well trained, and I think where the system lacks is sometimes the consultant reviews at the substance misuse treatment are not often very mental health focused, and tend to be more focused around substance misuse. They don't take enough account, I feel, of people's history of trauma. They do take account of people's physical health, much more so with alcohol clients, because of the effects on liver health and prescribing medications to support people to withdraw from alcohol is something they do. So, they have to consider physical health at that point. Blood test results and liver function tests inform the kind of detox somebody requires in order to be safe physically (e.g. inpatient or ambulatory).

Complex needs workers help to prepare somebody for the reality of attending appointments, what that's going to be like, that it's not necessarily going to be a really personalised service, they will have to wait their turn, and will likely have to return for further appointments. The appointment's themselves are good, it is the environment at the substance misuse service that clients with complex trauma can find very traumatic.

It is difficult, going into an environment where there are other people, some whom you may have history with, it is unpredictable and can feel unsafe. Titration (on Opioid substitute prescribing) can be a concerning and worrying time for people, only to get their methadone increased by 10mg at a time, it's a very slow reward system. The reality is that can be very difficult for people, so any psychological support is likely to help clients to manage these experiences of using the service. I work with another client who's got a really playful personality,

quite oppositional at times, quite defiant. If you say one thing to him he'll do the opposite, but he really wanted to go to rehab, so it was a matter of meeting him every Wednesday morning and taking him to the St Thomas Fund drop-in group and getting him to go there. I turned up to see him once and he was just rolling drunk, laughing, and joking, and saying *"come and sit down with me".* I had to remind him *"no I can't work with you when you're this intoxicated, I'm really sorry. You know, you said you wanted to go to rehab, how is this helping you get to rehab? If you want to get to rehab you have to get back on track, I don't think this is the right track for you to be on if you want to go to rehab. So next Wednesday get there by yourself and I'll meet you there."* And I've turned up the following Wednesday and, he turned up. It was working with the fact that he really wants to see me and spend time with me. I had to use that opportunity to provide him support to achieve the goals he had identified, and he did manage to get to rehab.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Prior to working for Fulfilling Lives, I worked with somebody who presented as very paranoid. He may have had paranoid schizophrenia or paranoid personality disorder. This client was so paranoid that he thought people were casting spells against him and doing magical things to make him feel bad. He frequently obsessed that people were talking about him or looking at him. I was able to teach him a few simple techniques on checking his thinking, to reality test his thoughts, ground himself by feeling his feet on the ground, taking some deep breaths etc. I managed to help him to stay calm enough to go to rehab, stay in rehab and complete it successfully. I also was able to support him to get him linked in with mental health services.

***You've got a lot of examples where you've provided psychological support in preparation for treatment, had that not been in place - so you weren't in a position to provide that - would they never have accessed rehab, or would it have been much further down the road?***

The one I was just talking about would have accessed rehab anyway, but I am not sure he would have stayed the course, I think he would have left. He did relapse when he was in rehab, I went and found him and encouraged him to go back. Without me doing that he would have not gone back of his own volition. It is likely that clients who are experiencing severe and multiple disadvantage and with complex trauma would not be able to access rehab independently, and if they do would not complete successfully.

Some clients wouldn't have managed to get to rehab at all and in other cases once they had got to rehab they would have come into conflict with other people, and they would've then left, they wouldn't have been able to stay. And where people relapse and the rehab has a lapse or relapse policy, they wouldn't have gone back because of feelings of shame which would probably trigger earlier traumas. Therefore for a client going to rehab, it is a big consideration, because 1) they've got to give up their housing to get there, 2) they've got to give up their substances to get there, and 3) they've got to live with other people (all who are experiencing similar things and who might trigger each other, earlier traumas and things). So that conflict is going to come out, in rehab groups and things. I don't know how they are working in Covid-19 to still take groups when in the rehab, but I imagine they must be having to work in different ways.

***So, it sounds like quite a lot of pressure on the individual going to rehab. I guess that's where the value of being as psychologically prepared as possible really comes into its own? Because you're describing really quite complex quite dynamic relationships that are historical, that have maybe played out on the street, and are now going to be in the confines of a house.***

Clients are going to be living in a house with about seven other people, all from Brighton and they've all got history from Brighton, they've all used drugs together, dealt drugs with each other or heard about each other from other people, rumours and street talk/stories and things like that. It can be very complex for the rehab staff to unpick those relationships as they evolve. Some clients might go into rehab and think "I don't fancy being in rehab with that person" and then get on really well and might really enhance each other's recovery, but at the same time there are going to be examples of where people think "this person's alright, I know them from the street" and then they are going to have a negative impact on each other's recovery. I think the value of somebody who can help unpick these relationships is important. I did quite a bit of work with clients in rehab, who rehabs referred to me, clients who were having difficulties, to encourage them to stay the course. Just provide a little bit of emotional support, a bit of reassurance. There were different stages of the rehab journey and clients can become anxious around Move On. So yeah, I think any extra support that can be given can be helpful.

*"I would like to see mental health services that deliver substance misuse interventions, and substance misuse services that deliver mental health interventions."*

***Question 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?***

The first thing I use is myself really. I try and demonstrate, or role-model somebody that they might aspire to be or qualities they might want to have. So, I try to be consistent, friendly, approachable, understanding. I use my listening skills, reflect things back to people to demonstrate I heard what they are saying, help to reality test their ideas, reflect back to them so they can hear what their voiced ideas sound like, help them to realise that what they are saying isn't such a good idea, or maybe not realistic or untrue.

I often use something called acceptance and commitment therapy when people become obsessively focused on one aspect of something. I use an exercise I picked up off a YouTube video that many clients have reported is helpful. Trauma stabilisation works, so mindfulness, asking people to put their feet on the floor, breathing exercises, things like that. The drama triangle is good. I quite like transactional analysis and I constantly look up and research new ways and new things to do, come up with worksheets that clients can use or exercises involving whatever is at hand such as mind maps.

***Is there any particular technique you employ that stands out? One's that you always get a good response from, or is it client-by-client?***

I have found with the drama triangle that you have to be selective about when you use it, same with the trauma stabilisation. I always pick and choose when I use that with the exception on the commitment therapy, but the main tools I have in my toolbox are active listening, mirroring, reflecting, being friendly, smiling, having fun with people, being accepting of them as a human being, being empathetic. They're things that really work. Spending time with people. Valuing them enough to spend time with them.

***Is it fair to say those things work well, consistently across the board because they are of universal, and as humans people need that positive interaction from people, and that your clients may not have had that in the past.***

I agree that it's a universal thing, about connecting with other people, it's about giving clients a positive experience connecting with other people and that they can actually trust other people. It's one of the most basic human needs, and it's one that people who've experienced complex trauma may not have had positive experiences of in the past. Developing new relationships with people is something

they hold a degree of mistrust towards. So, giving them a positive experience of a new relationship is something that can really help.

***Question 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?***

I think there's definitely scope for that to happen more. I am aware of cases where services working together would be better. I have examples where it's worked reasonably well, but one of the problems is that with the best will in the world mental health services are not going to be able to work with clients on their mental health if that client is always intoxicated. It simply is not possible. If a client is refusing mediation, and if medication is the only treatment that can help, that adjusts their mood, or helps them to sleep, or reduce their paranoid thoughts, then there may be dangers from prescribing if the client is using other substances to a high degree, or chaotically using other substances and at risk of overdose.

I would like to see mental health services that deliver substance misuse interventions, and substance misuse services that deliver mental health interventions. I think the biggest problem I see for our clients is that if they present at mental health services first, have access to a team with social workers sat within the team, and so that increases their ability to secure funding for things that people who access substance misuse services perhaps would not get. There's also the whole separate mental health housing pathway in Brighton, that people who are only open to the substance misuse service cannot access. So, getting somebody linked in with mental health services if possible is always one of my keys aims if I can and it will benefit the client (and they are willing to have that support).

***So, it opens a few more doors for your clients?***

Yes, absolutely.

***If I'm hearing you right, in terms of preparing for substance misuse treatment, are you saying that it isn't always necessary or appropriate for a statutory mental health service to provide that psychological support, and that it can be done by non-specialist frontline workers?***

It's difficult to generalise and each case will have to be decided by assessment and treatment planning. It's going to be down to the assessment and what presents at the assessment really. Discussing cases in multiagency forums to decide what

the best pathway is for somebody is often helpful. I know that if somebody is having their mental health issues addressed, then possibly, that could increase or improve their chances of dealing with their substance use issues. The same is also true in reverse, so if somebody is accessing substance misuse services, then they'll stand a better chance, I feel, of improving their mental health through some form of treatment or accessing peer support/mutual aid.

***When you have a client come on to your case load, do you always try and make a referral and get access to statutory mental health services, or is it dependent on what the client's situation is?***

It depends on the client's situation and if possible I'd get the GP to do it. I think quite often it depends on where the person lives, whether it's east or west Brighton or if they are homeless. If somebody is homeless or in emergency accommodation, then I can refer them to the mental health homeless team which is quite an easy way to refer, because anyone can refer into them and they give equal weight to a referral from a GP or me. For ATS [Assessment Treatment Service] it's a bit more complex, and what I've done before, is wait until somebody is abstinent in rehab, and got them to self-refer to the Wellbeing Service, and then the Wellbeing Service has done a risk assessment with them over the phone and decided that the level of risk is too high. As a result, the Wellbeing Service refers them to the ATS. I'm not sure if that route still works. I mean there are many ways into mental health services, a mental health rapid response service crisis team, crisis team and the mental health liaison team at the hospital is another way to get somebody access to the ATS.

***Can I just refer back to something you said previously which was, ideally you'd like to see mental health services that provide a substance misuse intervention, and vice versa, could you speak about that a little bit and how you would see that happening. Are you talking about a multidisciplinary team?***

I am referring to a multidisciplinary team because I went on some training when Pavilions first started in 2015/2016 (previous drug and alcohol provider 2015 – 2020). Pavilions had dual-diagnosis nurses who would attend the team meeting at ATS, and so they setup a training afternoon where we trained with some ATS workers and mental health liaison teams, MHRRS [Mental Health Rapid Response] and the Crisis team. And so, there were people from different pathways within the mental health treatment system and substance misuse workers. The consensus seemed to be that the mental health teams had clients open to them, or patients open to them, who had substance misuse issues, but weren't really sure how substance misuse services worked. All the substance misuse service workers had

clients who had some degree of mental health issues and they weren't really sure about how best to advise them.

Upskilling mental health service workers in substance misuse intervention and vice versa, would be a way forward and it would be good to have people sat in the same team. However, my experience of dual-diagnosis work with Pavilions was that most of the time the mental health liaison workers, unless somebody has what's classed as a severe and enduring mental health issue, i.e. one that responds only to medication such as schizophrenia, paranoid schizophrenia, depression, were equally unable to gain access to mental health services for presentations that include complex trauma.

***So, a diagnosable mental health issue?***

Yes, and complex trauma doesn't often fit that. It is, in essence, personality disorder, and some people don't like the term personality disorder. I've got clients who have been diagnosed with personality disorder and really like the fact that they have the diagnosis, that they know how to frame what's wrong with them. They have always had the feeling that something is terribly wrong with them, but nobody's been able to explain to them what it is. When they've been diagnosed by a psychiatrist with personality disorder it's like *"ah well that makes sense. So that is why I don't trust other people, so that's why this, so that's why that…."*

They can easily to relate to it and understand it and then they understand that medication doesn't cure their personality disorder although it might help to alleviate anxiety or depression that goes alongside it. Having that diagnosis can be very helpful, but I think where someone has more than one diagnosis it's never going to be easy to work with that presentation anyway.

***What about the Navigator Team in Brighton? Is that the kind of thing you're thinking about? As they have workers from mental health, substance misuse, and DV services [Domestic violence].***

It wasn't no, but it is a very good model I feel. For a multidisciplinary team to work you need people that are onboard with each other's disciplines, and appreciative of each other's disciplines. It would be great if the Navigator Team also had an occupational therapist. I think that is going to happen, but I think what I was more thinking of was that there are statutory mental health services working in one field who are unable to do substance misuse work, and then you've got substance misuse services who are unable to do mental health work. So, to save somebody from having to engage with two services when engaging isn't easy for them would be to have a genuine dual-diagnosis service.

***Question 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?***

It depends on the nature of the psychological support pre-treatment. If a client is seeing a psychotherapist or a counsellor for one hour per week, and that's not done on outreach basis, and the appointment's say on a Wednesday afternoon from 15.00 – 16.00, there may be risks 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 and process difficult feelings that are evoked in counselling and therapy sessions definitely create risks of how that might present behaviourally, in increased risk-taking behaviours, increased substance misuse, increased feelings of paranoia, incidents of self-harming. I do think those risks are there and need to be taken into consideration.

*"Upskilling mental health service workers in substance misuse intervention and vice versa, would be a way forward and it would be good to have people sat in the same team."*

If a client has a good enough support package around them, therapy could be safe. I think the way that that could be managed, is, a colleague gave me an example recently where somebody was having psychodynamic therapy and it greatly increased their risk-taking behaviours. They benefitted hugely from the first three or four months of treatment, then about month five, they started to self-harm more, and started to carry knives and so they stopped the psychodynamic therapy and the risk-taking behaviours reduced. The client chose not to go back into that form of therapy.

I think if there's multiagency support around the client and the therapist is part of a team of people, then yes that can work, although that will have some implications on confidentiality with the therapist, because therapists will need to work with part of the wider team. A case I work with currently where one of my clients has a therapist, and the therapist doesn't divulge in a specific way what the client discusses with her, but does divulge any concerns, and give us guidance on how best to work with the client.

***So, on the whole, are you someone who would advocate that under the right circumstances and done properly, that psychological support pre-treatment is beneficial?***

Yes, broadly speaking,  but it has to be decided on a case-by-case basis, and it has to be done in such a way that if the client accepts the help, and then decides it isn't for them, that when they end the sessions that it doesn't reinforce a sense of failure or make them feel shamed or stigmatised in any way.

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

Yes, and this is Covid-19 specific. I 've been attending one or two workshops every week in the evenings, they are two-hour long workshops, and they are all around different aspects of psychological support, such as personality disorder. I attended a workshop yesterday on vicarious trauma and transactions, and working relationally in the Covid-19 environment, and what that means for people, and what that brings up and how to look after ourselves and how to look after our clients. So, I believe there should be a higher expectation on training and continued professional development for substance misuse and mental health workers during Covid.

***To understand each other's discipline?***

No, to have training in whatever they're interested in that relates to their work to upskill themselves. Workers tend to go on all of the mandatory training that their organisation suggests, but with Covid-19 a lot of that training isn't able to happen due to social distancing. There are online training sessions that are really good, really interesting, and I think people should be encouraged to take advantage of them. That would have cost implications for their organisation, but the cost now is very low.

There's a website called online events CPD and it's through Evenbrite and they've got loads of workshops. On trauma stabilisation work, dream therapy. A wide range of topics. It's all really interesting and can be tailored and made relevant to our clients. And I think six or seven years ago when I started working in substance misuse, there was quite a high expectation that you have qualifications that support you doing your job. Now that doesn't seem as much to be the case. I did a peer mentoring course, two NVQ's and these used to be funded, I don't know whether that's still the case, but I think that more and more training should be provided.

I've been quite lucky working with Equinox and Fulfilling Lives that I've had access to some really good and unusual training like KUF's [Knowledge and Understanding Framework] personality disorder training, vicarious trauma

training, compassion fatigue training. I have benefitted from lots of really good and relevant training that workers in other services would not have access to.

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**Twitter:** @MEAMcoalition

## Michelle Butterly

MEAM Partnerships Manager - London and South East, Mind

*Michelle is a partnerships manager with MEAM and is part of the Equality Improvement team in Mind. She provides bespoke packages of support to MEAM Approach and Fulfilling Lives areas in London and the South East of England to help them improve outcomes for people with multiple needs. She has a special interest in developing trauma informed systems.*

*Michelle has a long background working in supported accommodation with adults experiencing enduring mental health difficulties. She has also worked as a forensic mental health practitioner in liaison and diversion services and is pursuing training in forensic psychotherapy. Her most recent role was supporting the implementation of psychologically informed environments (PIE) in a young person's homelessness charity.*

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***"It's more than training operational staff, it's about the culture at every level of the system that supports those using and delivering services."***

***QUESTION 1: In your view how would you describe complex trauma?***

There are a range of sources you can use for a definition of complex trauma, whether that's from a psychiatric diagnostic manual, the trauma literature, psychoanalysis and even the School of Life! What I use and draw from may differ depending on who I'm talking to and what I'm talking to them about. I find it helpful to have a range of sources for those reasons. Most importantly though, my understanding of complex trauma is grounded in the personal and professional relationships that I've had with people who have had traumatic experiences in their lives.

The ICD-11 Classification offers a comprehensive outline of Complex PTSD. According to that definition, trauma can develop after one event but more commonly, it emerges following a series of events that were threatening, where the person was unable to get away and felt helpless and overwhelmed. For example, domestic violence or childhood sexual abuse, the types of events that

overwhelms the person's ordinary capacity to cope, except of course, ultimately people very often do cope. What isn't quite captured in this categorisation though is the inter-generational consequences of trauma which we're learning more about through the field of epigenetics. In my experience, inter-generational consequences for children where either one or both parents experienced trauma can make it hard for the parent to be a benign presence to help the child to manage their emotional lives, because they themselves have had their own emotional development knocked off-course.

According to the ICD-11, there are three core difficulties for a person with Complex PTSD and these are severe and persistent. The first one is significant difficulties regulating emotions where the person gets quite stuck in extremes states of mind. At these times, it can also be difficult for the person to understand what emotions they're feeling, to be able to name them and to get a handle on them - in other words, to Mentalize. This is a very painful state to be in because a person can feel out of control, I've worked with people in this state of mind who describe feeling like they're going mad.

The second key difficulty relates to a person's sense of self and their self-esteem and how this is impacted by the traumatic events, they might feel a terrible sense of shame or guilt. The experiences significantly impact how the person see's themselves, the degree to which they feel a sense of value and linked to that is how they imagine others' value them. The third difficulty is in the arena of relationships, how they get along with other people, make, sustain and manage their relationships. I would also add to that the way people make use of or may struggle to make use of helping relationships. You can imagine someone who has been treated poorly by their significant others, people they trusted the most not feeling at all trusting or hopeful when being offered help and support by well-meaning professionals, why would we be any different (they may think)!

### *QUESTION 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?*

Working in an intentionally relational way with people who have experienced complex trauma has inherent therapeutic value, at the very least it means avoiding doing further harm to people who have already had a tough lot. It also feels helpful to define what it means to use the word 'psychology' in the context of a non-clinical setting. How I make sense of it is thinking about how we understand and make links between behaviour and mental processes,

recognising that behaviour can be meaningful and is worth taking the time to understand.

When I worked in a young person's homelessness charity a young person returned to her hostel and intentionally smashed a window in her room. There was a lot of talk about how to 'manage' and deal with this behaviour, what we later learned was that the young woman thought she'd been ignored by her mum in the street (maybe she was, we'll never know). Her coping skills were more physical than psychological, she struggled to name her emotions and instead acted through her body, her upset. If we were working in a psychologically informed way, as we are trying to do, we would want to consider, with the young person, how she was feeling and to help her put emotions into words instead of fists through windows! That's not to say that you don't manage boundaries, but that you do this in a way that helps people to understand boundaries and consequences, and crucially that emotions can be named and heard. If a person can name these feelings, they may be less inclined to act on them, that again relates to mentalizing.

So *psychological support*, among other things, is about understanding how our overt behaviour can be meaningful and worth reflecting on and that can be supportive for a person. There are different psychological models that can be used such as, Cognitive Behavioural Therapy (CBT), Mentalization Based Treatment (MBT), psychodynamic, attachment theory. There's not necessarily a one-size-fits-all model for all human behaviour but I think it's important to have the idea of *psychological support* being rooted in a psychological model of human behaviour.

Psychological models can also help us to understand how systems and organisations behave and how sometimes they end up mirroring the very problems that people are trying to get away from. For example, settings can be stressed, fatigued and a burnt-out, depressed, hostile and even anti-social. In order to be helpful to others, you need to be doing that within a system that's helpful to you.

*"Systems can end up mirroring the very problems that people are trying to get away from."*

***I read in your bio that you've worked a lot in setting up psychologically informed environments. Was that an approach or was that a programme that you'd implemented?***

I worked with FEANTSA on the PIE4Shelters European project. As a homelessness charity we started working on it to become gender and trauma informed and improving the experience of women who had

experienced gender-based violence. We also had a specialist mental health service within the Camden hostel pathway supporting young people aged between 16-25. We were using an overarching model of Psychologically Informed Environments, but chose to be more focused by using a model of Mentalizing through the implementation of the AMBIT model developed by the team at the Anna Freud Centre. AMBIT is a mentalization-based treatment approach based on attachment theory and neuroscience. In working to understand behaviour it can also be useful to be curious about possible connections between early experiences and later adult behaviour. Essentially, this is thinking about human development: what do we all need in order to have an ordinary developmental trajectory? And where might problems arise when our early needs aren't met? I think that needs to be included in any definition of psychological support.

Understanding the link between developmental trauma and later substance misuse is helpful when supporting people who want to change. The strength of addiction can be hard to understand when you see people doing so much damage to themselves, but if you can understand some of the processes involved, what function the addiction may serve and what kinds of feelings and the risks that might emerge when they stop using, if you don't look beyond behaviour, you may find gaps in your practice.

So, ideally you would have all of those things in place: You'd have a clear definition of the term 'psychology' and how it relates to your task, that would be rooted in a theoretical model and those things would be supported by an understanding of the origins of complex behaviour and change. So to finally arrive at an answer to the question, I wondered about the importance of supporting people to sustain relationships, if they can sustain relationships with support workers in the pre-treatment phase, that may extend to them sustaining relationships with support during their treatment. If a person sustains relationships, then perhaps they can sustain their accommodation and we know the importance of stable accommodation for sustaining a substance use treatment and later recovery. It's also about inclusion, if people feel valued and included in the pre-treatment phase, that may help to sustain the treatment itself.

I also thought that if you begin to work with someone in a psychologically informed way, it may support their own understanding of what to expect from their treatment and the psychological work involved when they get there and beyond. I also wondered if it might impact the sustainment of their treatment and therefore, enhance their treatment overall.

In Mentalisation Based Therapy (MBT), treatment starts with a pre-treatment phase. MBT is predominantly for people with personality disorder but with such

overlap between complex PTSD and borderline personality disorder, there may be some benefits from the approach that could help people with complex trauma. The term personality disorder makes a lot of people very unhappy, who wants to be thought of as disordered? But there may be learning to be had from the approach if we can put labels aside.

***QUESTION 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

Early in my work in mental health, I worked in supported accommodation with people with enduring mental illness, as it was then described. One of the women we worked with had a history of complex trauma, but also had a diagnosis of borderline personality disorder which enabled her to access a particularly good psychotherapy service which had daily activities, large and small group psychotherapy as well as individual psychologically informed support via her case manager. The psychotherapy group treatment used a Dialectical Behaviour Therapy (DBT) model. We were quite a psychologically minded team, we had good trusting relationships with one another, some of us were studying psychotherapy and counselling. We attended a ten-week training course from the Tavistock and Portman NHS Foundation Trust which presented us with a psychoanalytic framework for thinking about human development and how to support people with complex trauma and what might go wrong in teams when they aren't adequately supported to do this work. Following on from that, we had clinical supervision which helped us to remain together as a team through lots of difficult times, say when we had a client who attempted suicide or self-harmed badly.

A supervisor of mine said quite aptly, in order to contain other people you first need to be contained yourself, I see that as the responsibility of the system and the organisations that support the workforce to work with people using services. I think that through my team's interest in people, our training and personal learning, and with the help of one another and our supervisor we were able to be a containing presence to this woman while she was in her treatment. Another service may have responded quite differently to her repeated self-harming, perhaps with more blame and less compassion? She wasn't in treatment for substance misuse, but she was in another demanding form of treatment which required a level of support outside of her day psychotherapy.

***Could you tell me what DBT is?***

This isn't really my area of specialism, but I believe Dialectical Behaviour Therapy is a form of group treatment with a cognitive approach that's been found to be helpful for reducing self-harming behaviour. I think they incorporate different techniques such as breathing exercises. In the psychotherapy programme my client attended it was group psychotherapy as well as one to one. There are overlaps between DBT and MBT from what I remember.

St Mungo's has an in-house psychotherapy service called Lifeworks, that was set up as part of their psychologically informed environments work. They had good outcomes for tenancy sustainment, employment, meaningful activity, reduced evictions and reduced use of an emergency services. That might also be worth knowing about. There's also a psychologically informed environments Good Practice Guide that was written a long time ago now in 2012 but, again, that might be helpful as part of this work.

***QUESTION 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?***

The most rigorous approach that I have advocated for was the AMBIT model. This model uses mentalization based approaches, it has a sound evidence base for understanding human development, what happens when that's knocked off course and how we can understand the types of behaviours that we may see and describe as complex when we have no other way of making sense of them. It also uses attachment theory, which is incredibly helpful for recognizing 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.

The approach centres on the team working with the individual. I said earlier that some of the problems that we can experience with people could also be seen in systems and services; you can get very dysfunctional teams and very toxic environments. By advocating for support for the network that surrounds a client you can have an impact on the client.

As a forensic psychotherapy trainee, my personal leaning is psychodynamic. This is an approach where we think very carefully about unconscious dynamics and the types of behaviours and attitudes that can be lived in a known but in an unspoken way. For me, the unconscious is always there, whether we like it or not! Unconscious processes may not always be the most relevant or pressing issue to deal with, but it will always emerge, whether you pay attention to it or not. It's a

shame it's not a more popular framework because it's helped my practice in every setting that I've worked in. I find it helpful to consider what might be going on under the surface.

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 team's 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.

In my own training, we look at both aspects of the work, we think very carefully about our client facing work, we think about personal histories and the here and now, we also look at organisations and try to understand how problems can take root in larger systems. An example of this might be the system around the person getting a bit fragmented and not working in a joined-up way. If an organisation wants to develop trauma informed approaches the work needs to happen widely, in the organisation itself and not just small pockets of work.

***QUESTION 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?***

I fundamentally believe that joined up working should be an absolute minimum, the MEAM Approach is essentially just that! Partnership working and sustainable change for people experiencing multiple disadvantage. At the very least, you share skills, knowledge and expertise and can respond to people in a more rounded way. That needs to be embedded from a commissioning level and then filtering through operational work with each informing the other. Operational teams shouldn't be reliant on building good relationships with other agencies, collaboration needs to be built into service design.

A common problem operationally is that services often oppose one another because they've been commissioned in silos with different aims and objectives, different models and ways of working, different ways of reporting and commissioning expectations, and different ways of understanding people - the

potential for conflict is there from conception. It is fundamental to have joined up practices and come together on shared values and principles and approaches.

### *How does MEAM, Homeless Link and Clinks work together and join up?*

*"Even though the reason why people use substances is vastly complex, fundamentally, joined up working should be an absolute minimum. At the very least, you can then share skills and knowledge. And I think it should also start from a commissioning level."*

MEAM is a coalition of national charities; Mind as the biggest national mental health charity, Homeless Link as the umbrella body for the homelessness sector, Clinks as the umbrella body for voluntary sector of criminal justice organisations and Collective Voice representing the substance misuse sector. MEAM was formed in 2008 because of a recognition that these respective agencies, on their own, were not effective in supporting people experiencing multiple problems and there was an understanding that they would be more effective if they worked together, pooling their collective knowledge and skills and resources. Core principles for MEAM are collaboration, applying a systems lens to social problems and being trauma informed.

I work in Mind and sit within the equalities team. I also work as part of the national Local Networks team in MEAM. We are an embedded team, so I work with colleagues in each of the coalition organisations. The benefit for me and my areas is that I have colleagues with different specialisms and access to knowledge from their sector that I can then share with local areas. We work across a network of around 35 different local MEAM Approach areas as well as Fulfilling Lives Projects, so there's a vast network to connect and learn from. Another benefit of this style of work is that it keeps multiple disadvantage on the agenda for the coalition organisations.

When I worked in forensic mental health, I wasn't a women's specialist worker but I had colleagues who were and when I was in supervision with them, I always benefited because they just saw things through a very different lens - and it was specialist. If you can have as many specialists around you as possible, that adds value. Even though I have a criminal justice background, it's not quite the same as my colleagues from Clinks. It just adds so much if you can if you can have that specific and specialist knowledge around you all the time, or at least have access to it.

***QUESTION 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?***

The Hippocratic oath, 'do no harm' comes to mind here. People, poor practices and processes in organisations can do harm, that's systemic trauma. 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. I think there's a real risk of that with trauma, people using the term to refer to everything. Instead of it being practice enhancing and supporting the development of relationships, it can become reductive.

Overuse of the term trauma and failing to recognise it as part of mental health is also a risk factor. A trauma training and developing a trauma informed practice should sit alongside a mental health training as a compliment to it. If we work with people with significant mental illnesses such as psychosis, people would also benefit from understanding that.

*"...people in positions of authority, they absolutely need to be informed, bought in, you know, they need to be part of the process."*

It's also not just about staff training. It's about the culture within a system supporting all the work that happens in that system. A good example of this is from a meeting I attended following a serious incident and the non-fatal shooting of a young person. A director said 'well, but he wasn't killed, he's still alive', it felt incredibly dismissive, as though we should not feel shocked by the incident, or that it wasn't traumatic because it didn't result in a fatality. That wasn't a very trauma informed response! Yet trauma was being talked about a lot as an approach to develop, the difficulty in this situation was that it was not sufficiently supported at the most senior level, which was undermining to the approach. People in positions of authority absolutely need to be informed, bought-in and part of the process. This isn't about getting operational teams to do the work and then all other processes remaining the same, it's essentially a change process.

Another example of that is from a local area developing approaches to trauma but having difficulties with the way services are commissioned that don't support the flexibility needed to apply some of the ideas - such as not evicting people. So, there's something about the coherence of the models that you're wanting to apply, needing to fit across the whole system.

I reflected on how the incoherence of a model could also be a risk to someone's support pre-treatment and more generally in services too. I started to think about how you might manage some of these risks and I wondered about the importance of transparency and expertise. It feels important to recognise the gaps in our own knowledge, in my last organisation we weren't experts in gender so we brought in other people who could help us to improve.

***QUESTION 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I would always emphasize the importance of the system in any work that takes place. The culture in the team, organisation and system needs to be considered, rigorous and reflective, and that people can feel this throughout all your work. Modelling your values is a good way of sense checking how you're doing with any of this, how do you feel at work, how are relationships with colleagues, how do people feel using the service?

I would also add that more recently, my own learning has been enhanced by working in Mind as we do the necessary work to reflect on our internal processes and work to become a proudly anti-racist organisation. I have been reading about race, and racism, BAME and BIPOC mental health (Black, Indigenous, and People of Colour Mental Health) and painfully realising the gaps in my knowledge that need re-addressing. I feel that I better understand the intersectional nature of disadvantage, the social determinants impacting individual trauma and how approaches to psychological support need to reflect people as they really are, not just our blinkered view that everyone is the same.

For further information about the work of MEAM's work, please visit: http://meam.org.uk/

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## Niamh Cullen

Public Health Manager (Drugs & Alcohol), Public Health Calderdale MBC

*I started my career working in children's homes in 1984 and did this until qualifying as a Social worker in 1992. Since then I have specialised in substance misuse and criminal justice working in the NHS, local authority, probation service and the voluntary sector in varied settings ranging from the streets of London to prisons.*

*In my current job as a Manager in Calderdale Public Health Team I am responsible for the commissioning of treatment and recovery services for people of all ages with drug and/or alcohol problems and the prevention of problematic drug and alcohol use.*

***"If you are trying to undo 30 years' worth of trauma, then expect to work with someone for a couple of years and build that relationship over time sometimes 10 or 15 hours a week. You might be there to let the plumber in, you may be supporting them to an appointment. It's that 'stickability' I think that makes a difference."***

***Question 1: In your view how would you describe complex trauma?***

I've worked for 35 years in health and social care, I started working in children's homes then a number of other settings, hostels, prisons and outreach work, social work and probation, then focussing on drugs and alcohol for the last 20 years.

I began to realise that I was growing up in my career path with the same most vulnerable kids from the children's home that I first worked in, coming across them in the hostels, on the streets and in prisons.

I worked in a community drug team in a large mental health trust 20 years ago, I was young and curious and just couldn't "get it" why were some people diagnosed with mental illness and others who were to me so obviously unwell not?

It was the early nineties a time of plentiful resource. My Director got me access to a series of lunchtime lessons with the team of Psychiatrists where I learned of the *pyramid of psychosis* and other such theories. They sent me to work on a local locked mental health ward for a fortnight. All I saw were the same people again having developed more maladaptive behaviours or coping mechanisms. It was, in the main, I witnessed people who had been damaged by their life experiences, many of whom had started with troubled childhoods. I became no clearer.

For me, it's only been in the last 10 years, working with the world of recovery and children's services, that I have been introduced to the language and developing understanding we have of trauma, which for me was the damage that I clearly saw in people that I have worked with in those various settings over the years. It has been an organic learning process for me. I understand that Type 1 trauma is a single event that could be horrific, whether it be child sexual abuse, whether it be bereavement. And that Type 2 trauma is much more chronic and related to your caregivers often. And that's what we deal with most of the time is Type 1 and 2, then it is complex trauma. The people we work with are regularly retraumatised. For me it's good to have the language and a theoretical base to help us understand the impact it has on thinking, emotions and then behaviour that we witness in our work.

***And what you've just described, by sharing your journey, you've seen that damage in many different settings?***

Yes, when working for 20 years in London, in a variety of settings I did on occasion see individuals in different settings over their life course, children's home, Y.O.I. and then when doing outreach work. I have recently undertaken a thematic review into the deaths of five men living a street-based lifestyle. Four of them had over their life suffered traumatic brain injuries. The street-based lifestyle can be violent, people get hit on the head a lot, often not involving any criminal cases. Again, I don't think we acknowledge the impact those injuries might have had over time. I don't think this is unusual in the hardest to reach, street-based populations we work with who may well suffer a traumatic brain injury and complex trauma.

***Question 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

I understand that there are psychological interventions that are evidence-based for trauma and PTSD, whether that be somatic work or whether that be Cognitive Behavioural Therapy (CBT) or Eye Movement Desensitization and Reprocessing

(EMDR). All of those things are there, but in my mind, there is good work to be done before getting to a point of effectively accessing such services, there are issues about thresholds within those services alongside the fact that such interventions remain scarce resources.

In order to access such clinical interventions our job is how to stabilize an individual's chaotic situation, initially with substance misuse. And really that's where all the work around creating psychologically informed environments, workers supported through reflective practice, around sustaining long term pieces of work that navigate and support people through the systems, always starting with the individual's needs and their realistic starting point.

I'm interested in non-clinical interventions, particularly focusing on the five ways to well-being. We use those as the cornerstone of our work with recovery. I have seen the impact of people finding jobs, friends and homes, we have a thriving recovery community here in Calderdale and solid members of that community have come from the streets. I'm interested in how we embed psychologically informed and trauma-informed care into our early engagement with people, and how to prevent them from having to re-tell their stories.

***Our question is quite honed in on how would you get somebody into that formal treatment space. But I like how you pulled up and thought actually there's a whole environment before you even have the conversation about that.***

I'm not sure that everyone necessarily needs clinical therapeutic intervention. In the right environment stability may be achieved by developing the right psychologically informed environments. In the Westminster PIE work, there is a good checklist, I particularly like the first one: *only recruit staff that want to be there and are compassionate.* Moving away from rules-based approaches, to how we involve people in their care and how we stick with them. And the other consideration is how we invest time. If you are trying to undo 30 years' worth of trauma, then expect to work with someone for a couple of years and build that relationship over time sometimes 10 or 15 hours a week. You might be there to let the plumber in, you may be supporting them to an appointment. It's that 'stickability' I think that makes a difference.

***Question 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

We've had a street outreach team for three years now. We're a small northern town and like lots of towns in the last two or three years we've been experiencing

those city problems, where tents appear on the streets. I don't do much direct service user engagement but being a small local authority where I live and work, I have got to know people.

We had a tent appear outside Sainsbury's probably about three years ago, during the winter. At that time, we had no street outreach team and the response to the tent being there was led by the community safety and enforcement team. From the litter, I recognised signs of drug use and delivered a 'sinbin' to the tent, he was an injecting drug user not in treatment and very resistant to accessing treatment. Drugs workers did visit the tent to attempt to engage him, but this was pretty inconsistent. This went on for months, he then moved the tent next to the heating vent just before Christmas and a friend joined him. I have had the opportunity to interview him recently, he describes that Christmas, waking up to shoppers having given him hundreds of pounds and lots of food over that period, perhaps Christmas shoppers feeling guilty. They didn't need to offend so were never arrested, had enough money for drugs so didn't want help and chased workers away. Within nine months, his friend died in the tent, however, he remained resistant to change becoming notorious.

When I interviewed him as part of a review into a spate of deaths on the streets that winter, he was housed in a bedsit and had been there 3 months, was not in drug treatment but was considering it. I asked him what had made the difference. He told me it had been the consistent effort over time of an outreach key worker, he described her as "gritty", always honest with him and said to me that she had "stuck" with him. They were, for him, the most important key message for me: that you don't give up on anybody. He's still in that bedsit, no evictions, it might take another year for him to engage in drug treatment. It's important that we are realistic, celebrate incremental gains and recognising those small achievements. He is so very different when you look at him now; he's not as angry, he's not as scary. He's engaged. He's practiced engaging with other people, he has things to offer and I think he's beginning to believe that.

It's that stuff, the patience, the waiting and being consistent. It's advocacy and navigation and not just signposting. We've learned locally that we need to work actively with people, we need to take people to appointments; we need to translate for them. It's not a case of saying 'so-and-so was referred.' They weren't referred; they were told here's an organization and given the number and they probably haven't got credit on their phone!

***And just thinking about what you said about 'stickability', that phrase for walking with people, do you have a view on the critical time intervention; the nine-month programme that some organizations are trying out with some***

***clients. I saw a report, only last week one of the Fulfilling Lives projects had tried this out and had varied success. I just wondered if you had a view on that.***

It's difficult, isn't it, because the ideal response is an individual response. It'd be really difficult to say nine months, someone may have a four-month prison sentence in the middle of that. The other thing is the consistency of the worker. Nine months is no good if you have three different workers. For me, it's about that relationship which is absolutely key. I would say why not 12 months, why 9? I'm not quite sure what the magic bullet or the evidence is on that. But it would be a start. We're obsessed with recovery in our world and we don't make a strong enough connection between what we call harm reduction and recovery. I see things like outreach and needle exchange delivered in an optimistic way as pre-recovery.

*"And that's all about the psychologically informed environment way of working. We look at assets. We don't just talk about deficits. That's really important. And the skills that people have to bring. Transferable skills. Logistics wise when it comes to shoplifting and managing addiction, there's lot of skills there that could be utilised in other ways."*

***There's nothing worse than hearing a list of all the 'problems' about somebody. You think, why bother then? Let's think about what their strengths are, what they could offer themselves?***

And that's all about the psychologically informed environment way of working. We look at assets. We don't just talk about deficits. That's really important. And the skills that people have to bring. Transferable skills. Logistics wise when it comes to shoplifting and managing addiction, there's lot of skills there that could be utilised in other ways.

***Question 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?***

***And you mentioned PIE. Is there anything specifically around that or other models that you've adopted?***

For those living a street-based lifestyle often with multiple and complex needs, we want to be able to offer a safe space where assessments are done. We want to consider from scratch how we can embrace the learning on trauma informed care and reflective practice and consider the potential for co-production in the development of such a project. We want to do things differently. We want to

consider what that project would look like, what kind of staff we want to recruit, and what support we offer. We're trying to shift from an emphasis, (particularly the drug treatment service), where our staff are absolutely brilliant at 'bean counting', brilliant at filling in TOPs forms and all kinds of performance-related monitoring, when in fact we've lost the emphasis on reflective practice.

We want to invigorate the workforce, provide training so that they are understanding trauma informed care, de-escalation techniques, and the relationship between thoughts, emotions and behaviour and the trauma. We want to reframe the perception of this group to recognise their vulnerabilities rather than demonizing them.

***And when you say, 'reflective practice', what does good reflective practice look like for you?***

We have had the opportunity through our Covid response for this group to set up a shelter. The unusual circumstances meant that we had workers seconded in from across the council to work with this group for the first time, we had people from learning and leisure and their openness was really interesting. They weren't tired, they weren't negative or fixated on rules.

This resonated with the review into our street deaths, which highlighted a lack of professional curiosity and a post-austerity burnt out workforce. Similarly, the Community Safety Wardens when interviewed during the review demonstrated high levels of curiosity and empathy, attended funerals, had direct contact with families, and knew more about these men's' life stories than the workers and professionals involved in the cases.

The Covid Shelter team have implemented thorough handovers, talking about what their shift was like, how it impacted on them, what they could have done differently, what might have been going on for their clients at the time.

There are many examples of reflective and client centred practise during Covid, whilst I was in the shelter recently, I observed a 22-year-old worker seconded from a local swimming pool. First off, she asked if we could arrange for her to stay until the end of September because she loved the work so much, and then said, " *X, ( a crack using resident ) is not very well this morning, I think she's suffering from crack withdrawals, the GP has given us some medication, but she's worried about walking to the pharmacy because she sees dealers, is it OK if I go with her?"*

That's the interventions we want to be habitual. Sadly, we may not have witnessed the same response from an experienced worker who's worked in the same post for years and is on the third generation of one given family.

***Question 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?***

I think this is key and locally our primary challenge. The reality here is a middle-class alcoholic approaching their GP, doesn't meet the same challenges. They could probably be seen in a local mental health team with a drink diary and they probably wouldn't worry too much about it.

*"Thinking about this work and where we are now, I think we're a journey away from formal treatment interventions for most. When I say most, I'm looking at the more chaotic, complex needs."*

For those with more chaotic lifestyles and multiple complex needs this is much more challenging. Whilst this is a national problem it is acute for us locally. We have tried working with our local mental health trust for the last year to secure some dedicated dual diagnosis resource, they do not currently deliver anything as it isn't specified in their contract with the Clinical Commissioning Group (CCG). We have nothing yet and it is apparent that it's perceived as a substance misuse services problem. We are currently working on a service remodelling in our drug and alcohol system and are hoping to be able to second a CPN to come into our system who would carry a caseload, operate a duty system for our most vulnerable and most importantly help us to navigate the mental health system better for our user group. This is slow work, but we now have the support of local senior leaders.

When we're talking about access to mental health services, we're way beyond saying 'because we'd like you to offer EMDR", we're talking about people that are florid and unwell, that need mental health assessments. Our primary concern is for the really poorly people. We hope the assessment house model will give us the appropriate facility to stabilise people in their substance misuse (and that doesn't mean dry or drug free) and facilitate those needed mental health assessments.

We are fortunate to have a local recovery community that run a detox house. It's an ordinary four bed terraced house staffed by people in mature recovery. It enables us to offer a flexible detox facility for local people rather than sending them out of area, where they can rebuild local support systems whilst in the

house. We are unable to offer this to those who have high physical or mental health care needs as we have no onsite clinical staff. It's a group living model, they attend our recovery day programme during the day, and in the evenings attend local mutual aid meetings. It has got a 12 Steps focus, which is what we know works for most people locally and actually research shows this is worldwide.

The house is able to offer stabilisation for example, stabilising on methadone and undertaking an alcohol detox. Interestingly it's not unusual for someone to detox from alcohol and then request to further detox from methadone. The flexibility for someone to stay as long as they need to, often 2 -6 weeks is essential. Such flexibility is cost prohibitive when relying upon specialist in patient detox facilities.

Another local challenge is our adult health and social care service response to complex needs and vulnerabilities and safeguarding processes in relation to this group. This is our priority for our work with MEAM. We are working to carve a clear pathway for triggering a multi-agency response to complex cases. We have leadership support and the Assistant Director of Adult Health and Social Care has chaired the initial multi agency meeting for us. We're working to get the mental health trusts on board to develop our response to Dual Diagnosis.

***And are you hoping that CPN role would be something that's quite close to that accommodation so that they could link with it?***

Locally we don't think supervised consumption is enough for this client group. It's hard to keep pharmacy counter staff trained, as there is a high turnover and they won't pick up on dark yellow eyeballs or other signs of poor health clients may present with.

Last Christmas, as I walked through Halifax, a service user I know, rushed out of the chemist and into me. He was a little flustered and told me he had just been caught not swallowing his medication. As I sympathised, he told me, 'don't worry love, I've been doing it for three years, it's the first time they've noticed.'

As a system we felt that when it comes to the most complex cases, we should be seeing them every day. From next April we are going to put a methadone dispensing machine in our thriving recovery centre, The Basement Recovery project. It's a beautiful service developed by the recovery community over 10 years. It looks very *not* like a drug service. There are pool tables and there's breakfast. It's a calm relaxing space.

We are going to use a mortality risk indicator developed by Humankind, our local treatment provider to target those we are most concerned about and get them

coming in every day for their methadone. We hope that being exposed to people in recovery, some of whom they know combined with the smell of bacon butties will entice them one day stay and have one.

This is where we hope to have access to a primary health care nurse and a CPN on a daily basis building relationships and assessing individuals need over time.

The drug and alcohol treatment market is dominated by a few very large providers, it's been really imperative to grow and support our homegrown grassroots-based recovery community, this new development means that the small provider is going to be the landlord for the larger provider. A sort of system co-production. We remain a way off being able to offer a range of clinical psycho-social interventions, we are getting the structures in place so we can keep people as safe as possible for as long as possible, in the hope that the good kind work that people do in the meantime helps facilitate their longer term recovery.

***I think what I'm hearing is that your perspective is investing in those early ingredients of providing spaces where people feel welcome and supported. They can see hope. You've got a motivated workforce that will provide that platform for that recovery journey and you can't have that access to formal treatment being focused on without those ingredients being right.***

I think without those ingredients the most we do is provide substitute prescribing in a very narrow transactional way. We learned a lot during the pandemic, we have been able to provide methadone to people in the shelter within 24 hours. We had the challenge of having to keep people in who were alcohol dependent when there was no income from begging or shoplifting and we really wanted to keep them out of hospital. And that's why we've looked at things like a managed alcohol programme. We devised a simple managed alcohol programme, buying vodka at the local shop and with support from our clinicians developed safe ways to stabilise or even reduce alcohol using vodka did work. It did work, no one fitted, no one died, and two men actually fully detoxed this way. We had to respond quickly and flexibly.

***Question 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?***

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 in risky behaviour in those that disengaged.

Sadly, our challenge has been accessing sharp end mental health services for our chaotic cohort. In the last year, we have managed to get a couple of people sectioned when they were still using. We eventually managed to get them assessed at their most stable points, through the dedication and perseverance of street outreach workers. The risks are always communication and rapid discharge without discussing that with support workers. We've had people discharged from A&E and being sent in an ambulance to a housing options service at five to five on the Friday. They've gone into A&E with a mental health crisis and, then what we get more commonly is that because of their intoxication, they're referred to the mental health liaison team in the hospital. They say it's a primary drug and alcohol issue and then sign post them back to drug and alcohol treatment services. There are also problems with IT system communications between services often meaning GPs and drug services are not aware of such A&E attendances.

***And were their concerns prior to that pilot starting about risks and people engaging in CBT that you had to manage or overcome?***

I wonder if some of that is about the level of organisational appetite for risk. It's important to check ourselves on risks for the individual versus the risk of the organisation. I think we need to be realistic about the levels of risk these people face every day, big risks that are often life and death, fitting, exposure, assault, sepsis. If somebody went for CBT and it didn't work, is a risk that it would prevent them from engaging in any further treatment, most of the people we work with have had so many disappointments from services, I'd have thought it was worth the risk. You can't do much worse than the situation these people are in and have experienced. It's important to try and keep trying because you can't do much more damage than has already been done.

***Question 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

*"You can't do much worse than the situation these people are in and have experienced. Better to try and keep trying because you can't do much more damage than has already been done."*

Several years ago when we were reviewing medications in relation to recovery there was a shift in favour towards buprenorphine it was felt that it had less impact on cognition and would enable people to better participate in group work and talking therapies than methadone, for example, pilots are allowed to fly when taking it!

I went to a probation women's group and was talking to a couple of really articulate women about how they felt about switching prescriptions. It was really interesting they identified methadone as a trauma drug, they told me that they found that methadone helped numb their trauma, both women had suffered childhood sexual abuse, institutional sexual abuse and then rape as adults. They described feeling scared of letting go of the methadone because they felt it helped bury their feelings.

Early in my career, I worked in a big clinical substance misuse service, we had full time psychologists, usually with one or two students. Of all the clinical disciplines their input at our monthly supervision around cases was always the most useful and the most practical. Give me a psychologist over a psychiatrist any day of the week. I think we need this resource in our system. It's an expensive resource that used sparingly to support workers and to support the kind of reflective practice that we want to see, would be brilliant.

***So, psychologists being in the role of supporting the wider staff rather than picking up clients?***

Yes. We've probably got about 800 people at any given time in our treatment system. You're never going to get more than one psychologist. And, how you ration that would be to brutal, so it would probably be a better use of resource supporting and developing staff.

For further information about the work of Public Health Halifax please visit: https://www.calderdale.gov.uk/v2 . And if you would like to find out more about the Basement Project please visit:
https://thebasementproject.org.uk/calderdale/calderdale-recovery-steps/
Or
http://www.calderdaleinrecovery.com

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@OliverStanding

https://www.collectivevoice.org.uk/

## Oliver Standing

Director, Collective Voice
Chair, Expert Citizens

*Oliver is Director of Collective Voice, the national alliance of drug and alcohol treatment and recovery charities. He is responsible for its day to day leadership and delivery of its main activity – policy and advocacy work to help bring about an effective, evidence-based and person-centred support system for anyone in England with a drug or alcohol problem. Collective Voice also shares good practice and brings together networks across the sector.*

*Before this Oliver worked for Adfam (the national charity working to improve support for families affected by drug or alcohol use) for eight years, latterly as Director of Policy and Communications; the Family and Parenting Institute; and Skills for Justice.*

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***"The system, which we're all part of, perpetuates this idea that you have all these separate doors that you have to go and knock on."***

***QUESTION 1: In your view, how would you describe Complex Trauma?***

Obviously, I've got a bias towards drug and alcohol use, misuse, addiction, recovery, however you want to frame it. I'm aware your frame is wider in terms of multiple and complex needs but for me, the issue of multiple and complex need has always been central and inherent to any meaningful discussion about addiction. Because if you look to see who uses drugs and who ends up with a drug problem, there are two different groups of people. The more middle-class you are, the more likely you are to use drugs, but the less likely you are to develop a problem with them. And I think that speaks to this question because it makes clear that the kind of protective factors that we have that stop us developing problematic relationships with drugs are not internal. There's this account of drug use that people have made bad decisions or they're kind of weak. That account places responsibility for developing a drug problem totally internally; it's just that person, they've made some bad decisions.

*'the issue of multiple and complex need has always been central and inherent to any meaningful discussion about addiction'*

What I believe the truth is, is that a lot of the reasons which shape how we use drugs, interact with drugs, have positive or negative experiences of drugs - and of course, the majority of people who use drugs have a good time and they don't develop problematic relationships with them - And the reason for that is the people who end up with the drug problems usually have some experience of trauma. And that might be a kind of trauma in a more acute sense of a real psychological harm associated with sexual abuse or physical abuse or neglect as a child or violence. But also, it's often, I think, about the trauma of really entrenched poverty and the trauma of really profound social exclusion. When we talk about trauma, people don't immediately think 'ah poverty, social exclusion' because we're more used to thinking about these intense, shorter term, deeply traumatizing events like we touched on. But it's really important to point to that as the bedrock. People who feel marginalized, who feel that society's chucked them on the scrap heap and usually have experienced a series of interlocking, overlapping sets of experiences, which includes the long-term anxiety of living in poverty, all that that brings; poor quality housing, unfortunately, worse outcomes in school. The deck is stacked. Again, it's if you're poor, basically. And we've seen that in Covid. We've seen the way that inequality has this epidemiological quality that's shot through our society. You see all these little trends where any negative thing that happens to us lands and poor people come off worse because they don't have that personal or social capital. And that's a very negative account, of course, because there's lots of people actually recovering and doing amazing things.

But to go back to your question, I think it's, usually for a lot of people a whole series of overlapping issues which often go back to childhood. And it's clearly different for different people. And, there are some people who don't have any of that and they still develop a problematic relationship with drugs or alcohol. And they probably say, 'how has this happened? I don't understand'. And the answer is we probably don't know. I'm not sure the research can tell us. Some people say it's just something in your brain, 'addictive personality'. Who knows? I don't think we have all the answers.

***QUESTION 2: Can you explain how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment?***

I think it could be hugely effective and useful and has proved to be for many people. The problem at the moment is we've seen quite significant disinvestment in drug and alcohol treatment services. And one consequence of that, amongst others, is that the provision of that intense psychological support, which is needed

sometimes for people, sometimes over quite a span of time. Some people are simply not getting that. And that means that either they don't then access treatment or if they do then access treatment, they're not at a stage in their own recovery journey where they could do it in a meaningful way.

If we take it as a series of logical propositions: If people develop drug and alcohol problems in many cases because they've experienced a lot of trauma and treatment offers a way to move forward in their life, to get past these drug and alcohol problems. If you then go into treatment without having had that psychological support at the right time, the treatment will be dealing with your opiate use, your alcohol use, your heroin use. There will be some psycho-social work delivered alongside the clinical bit of treatment. But again, that's been impacted by disinvestment. And if you've experienced really complex trauma, feel a lot of psychological damage, some motivational interviewing, some group support, mutual aid and work on relapse prevention, all of which are great, it's not criticism (they're all essential building blocks and highly evidence based) that is not going to be enough for you if you've had five years in a very abusive relationship or you're a woman experiencing multiple needs who's had their kid taken away or someone who's experienced multiple episodes of very complex loss and bereavement or someone who experienced sexual abuse as a child. These are just some examples. But clearly the regular core bit of treatment is not enough for you. And there might be a risk that actually without that preparatory work, if you go in to get treatment and someone says, 'oh, hey, how are you doing? We're going to do a bit of support'. You're opening up this huge 'can of worms', for want of a better phrase. And actually, that frontline drug and alcohol worker who might be amazing at their job, they're not a psychologist. They're not a psychiatrist. They might be fantastic at delivering CBT and motivational interviewing and running therapeutic groups or working in a rehab and be doing an amazing job. But they're not skilled or ready to then deal with someone's very complex trauma. If that is then unearthed in treatment or in rehab, there's a risk if there's then not within the system, that element to support their more in-depth psychological needs. A decade of disinvestment has stripped out some really crucial elements from our system.

***QUESTION 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

This is one of the questions I can probably answer only very briefly. Some of the charities that I work with do have psychologists working for them. So, there is a track record of psychologists working within the addiction and recovery field.

Turning Point, for instance, one of our members has a Head Psychologist. They've got that expertise not just within the rank and file, but actually in that top team. So that's informing the kind of clinical governance they work within. I can only speak from that kind of system perspective. Yes, it absolutely is happening, but not enough to help all clients who have generally had pretty tough lives as we know. If you ask the charities that I work with, 'if money was no object, would you like more psychologists?' They'd all say, 'Yes, of course we would.'

***Through your network and your charities, is there any evidence that you have access to, say Turning Point, for example?***

We can talk about this in the abstract. You know, 'should there be more psychological support?'. Ask a hundred people, they'll all say 'yes'. The problem is not 'have we got this fine-grained piece of evidence over here?' The problem is that there's not enough money. The funding and commissioning structures have led to a denuding of the system in terms of some of this stuff. You can't divorce it. And I know Fulfilling Lives isn't going to be politically campaigning, but just to contextualize, because a lot of the barriers, they won't be overcome because people aren't willing to do it or don't value psychology. It's because 'actually we can't afford to do it'. And the commissioning is through that local level. It's not even something currently that someone in the centre can mandate to happen because there's this model of localism. The decisions are being made by the directors of public health and local government. They're dealing with horrendous local cuts to local government. There's a key role for elected members. Your local councillors who've got a brief covering adult social care, public health, etc, etc. They're politicians, so on the one hand, great democratizing everything at a local level. But the other hand, if you're a local politician and you've lost basically half your money over the past decade to spend and you're getting petitions to keep the local library open, fill the potholes, you're legally required to protect vulnerable children, deliver adult social care to the elderly, you're dealing with Covid. There are loads of things mandated by law. The highly stigmatized group of people you're serving through Fulfilling Lives, it's sad to say, they're bottom of the list in terms of political priority. And very few members of the public are going to be petitioning for those local politicians to spend more on drug treatment. It's important to recognise that context.

*'The problem is that there's not enough money. The funding and commissioning structures have led to a denuding of the system in terms of some of this stuff. You can't divorce it.'*

***QUESTION 4: Can you tell me about techniques or models that you've used that worked well in supporting someone with complex trauma to prepare them to access formal treatment?***

The traumas people experience is often connected to family. Bereavement, loss, parental substance misuse. A pretty high proportion of people who develop serious drug or alcohol problems had a parent who had a serious drug or alcohol problem. Or a sibling as well, that's often really overlooked. I used to work for ADFAM, the national charity for families affected by drug and alcohol use. And we'd come across this all the time. There's a bit of focus on the person with the drug or alcohol problem. There's sometimes a bit of focus on the parent, although it's often to blame them, the sibling is often overlooked. And there was a lot of instances of a younger child who had an older, maybe a brother five to ten years older, serious problems, all the parental attention is going on that kid, understandably. And you had the other kids suffering a different kind of trauma because they grew up feeling overlooked and like they weren't getting attention.

***QUESTION 5: To what extent do you see statutory mental health services and substance misuse services, how important is it, do you think, that they work together in order to aid someone to access formal treatment?***

Taking those questions separately, how important is it? Exceedingly, 100 out of 100. The problem with silo's is these issues, they exist as ways to organize public services. They don't exist in compartments in people as we know. And the amount of people, including lots of family members, who have been tearing their hair out because the system, which we're all part of, perpetuates this idea that you have all these separate doors that you have to go and knock on. Maybe you get in, maybe you don't. Maybe it's a rainy day, maybe you feel shit that day and don't ever go back. To try and get this central suffering in your life, which is just one thing. I mean, it's multifactorial, it's complex. But to you, if you've got a serious mental health problem, which you're medicating with a ton of alcohol, they don't feel like two separate things. Well, as far as I know, from speaking to a lot of people. It just feels like one thing, like you're really unhappy and, life's pretty crap and you need some help. And as a system, we've said to people, 'go to that door on that side of town with people in different uniform who use different language, who are funded differently, commissioned differently, different vibe, different opening hours, different logo on their T-shirt for one bit of that problem. And then go to the other door right on the other side of town, different bus to get there for that other bit of your problem. And by the way, those two people that you see will make you repeat your traumatizing story to them'. They won't talk that well to each other. They should do and obviously some do, but often it doesn't work.

They won't really work in a particularly coordinated way. And often you won't get through the door anyway because you're going to go to that door and they'll say, 'You've got to go to the other door.' And then you go to that door and they say, 'You've got to go to the other door.' That is that. Putting it bluntly, that is the experience of a hell of a lot of people.

So, this issue of dual diagnosis or call it what you will, has been with us for decades. I've read stuff 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. And the frustrating thing is we've known this issue, as I say, for decades, there's really good national guidance on it. There's good guidance from NICE. There's guidance from PHE. There's a policy recognition of this issue. There is the mantra of 'no wrong door'. Fantastic. If it worked in practice, it would be brilliant wouldn't it? You'd just go to any door; you'd get help and referred to the others in an effective joined up way. I took a group of family members, primarily mothers of sons in their 30s with very serious drug problems to the Home Office to meet some civil servants. And, took them into the heart of Westminster and everyone asked questions. It was a really nice event. But one of the questions I posed was around dual diagnosis, which, by the way, the family members they've never heard that phrase. They don't know that's what we call it. And the question was 'There's this mantra of "no wrong door": does that resonate with your experiences?' And they just laughed in my face.

I mean, literally, that was just so far from their experience. It's quite a tricky one. But if we're saying there's recognition, if we're saying there's guidance, the problem seems to be either systemic, i.e. the two systems are just so different, they're not interlocking. And there's definitely some truth in that because one is commissioned through local government and it's got a public health wrapper around it at the moment, it has for ages, that's drug and alcohol treatment. And then mental health is commissioned through the NHS. So there seems to be something about those systems just not quite meshing. That's then against a backdrop of lots of money coming out of the system, particularly over here in public health and local government, but, arguably also out of the NHS. So, that always just makes things worse because people retreat into their silos and batten down the hatches.

And this seems to be something about culture as well. And culture is different from the systemic issues, although it's kind of related. The systems breed cultures and vice versa. But this seems to be something where admittedly I'm biased because I'm from the drug and alcohol side of the fence. Drug and alcohol workers are used to dealing with people with mental health problems, it's kind of part and parcel if you've got someone with a serious drug problem. Very few people walk

up to treatment service and say, 'my life's great apart from I'm addicted to heroin or alcohol', it's more a case of 'and I'm anxious and I'm depressed' and there's this and that. And that is fine up to a certain level. The kind of low-level mental health problems, actually the substance use workforce is probably skilled in dealing with, but it's once you then start to get issues that are more serious. If it's really serious, obviously, you're likely to get some support from the mental health side. But it's almost like there's this band in the middle where the mental health problems are pretty bad, but they're not quite bad enough to cut through on the mental health side. You've got substance misuse workers on the frontline, they're not senior jobs, they're not paid loads but are dealing with and holding quite a lot of risk.

***Do you know of good examples of any locales where substance misuse and mental health services, actually joint work well?***

Yes, I probably painted a bit of a bleak picture there.

***I don't think you have. Just to touch on the point you were saying that there is a strategic will and there's a political will for these two systems to talk, but it's when you get lower down to the ground, it comes into focus how challenging it is to get these two systems to lock?***

I think the strategic and political will has waxed and waned a bit. I think partly that's because it is really difficult. And there's a sense of we've tried, we tried this, we tried that. Maybe it didn't quite work. And maybe the political will, then kind of waves a bit or there's just different competing priorities. But from the drug treatment side, it's a really exciting time because of the Black Review taking place at the moment, which is looking at this whole piece. There are potentially some very radical changes or, potentially radical, let's say changes on the horizon in terms of funding and commissioning. That's clearly all in scope. And one of the things that the questions of the review makes clear is there's a sense from the centre that they don't have enough control over local areas. All that local variation that I said, all that lack of political priority If you're in central government with an addictions brief in the Department of Health and PHE, you're probably looking at that going, 'uh OK, the localism experiment hasn't quite worked'. Some areas are great, don't get me wrong. Really fantastic partnerships, amazing commissioners, fantastic DPH's. But there's undoubtedly quite a lot of regional variation. So, there's a lot of change on the horizon. And potentially some of that power could be pulled into the centre. If that happens, then resources like what you guys are writing I think would be really useful for saying, look, we know that dual diagnosis is one of the biggest two or three issues in our field that we haven't cracked. It's knottier than, say, the interface between substance use and housing and homelessness, which is not to say that's perfect, it isn't. It's knottier than the

interface with criminal justice and people coming out of prison. Again, there's massive problems there. Wherever there's an interface and a transition there's a problem. But just in terms of numbers, for every hundred people with drug and alcohol problem, maybe ten of them had some experience with the criminal justice system. But, 90 probably had some kind of mental health issue at some point. I just made up those numbers, but just as indicative ones. So, is there a political will? I think so. But sometimes with politics, there's a sense that every problem has a solution if you could just chuck some money at it and actually this isn't just about money. Money is really important clearly, but it is about that collaboration. It is about that political leadership driving the kind of imperative for people to work together and get out of their comfort zones. So, it is there and hopefully the Black Review might bring some stuff around it.

***And in your experience of what you see nationally, are there examples in some localities where substance abuse, mental health is working well together. And if there is, what is the Formula X? Why is that. Is it down to just a drive at a local level and it comes down to relationships and that's what makes things flourish?***

I think there's two answers. Within the current constraints of the system, they'll always be good workers, there will always be good managers. They'll always build relationships. They'll always understand how the other person sees the world and have some knowledge of complimentary systems around them. And there will be joint working, just to counterbalance the sort of bleakness of the picture, that is happening, clearly. So, that's kind of one answer, that's working within the current system.

*'And if you use that alliance model, potentially you could get something much more nuanced and more accurate and more collaborative and then have space within the system to try stuff.'*

And then there's the systems change type answer: Yes, there are ways to commission things differently which are likely to bring about better working. So, what's a good example? There's a few areas of the country where commissioners are actively moving away from a transactional hierarchical procurement-led process where, you've got the commissioner with the power who says 'I have this sort of mini god-like perspective, I think we need System X, there's two and a half million quid in the kitty who's going to bid for it?' And that's very marketized, rightly or wrongly, it's got some advantages and disadvantages. And then people say, 'yes, of course, I could meet your outcomes and, you know, we'll specify all this big set of outcomes right at the beginning because we know exactly how the system is going to work.' And then, of course, when you actually do it, we know that systems are complex and human beings are definitely complex. And the current palette of outcomes

that public health commissioners have got to work with, means that maybe providers aren't incentivized to deliver or focus on some of the wider outcomes which are actually central to recovery. Recovery doesn't just mean, stable and stopping using a drug. It means 'I've got my relationships back', 'I've reconnected with family', 'I'm volunteering', 'I've got a pet'. All this, quite 'normal' day-to-day life stuff that's actually incredibly important. But as a system, we don't focus on that. We don't capture that. We focus on this narrow scope. There are some areas where commissioners have deliberately pivoted away from that towards something more collaborative, more devoted to learning, more iterative. And they've done that through alliance commissioning models. In some areas, you might have a commissioner say, I just want to manage one relationship with a provider. A big national provider would come in as a prime provider and they might be big enough to just do everything. But they might also say, oh, well we'll sub-commission this local service users or group or family support group. But there is a way to do it where you say you get all the relevant people around the table at the beginning, you kind of build those relationships, build trust, try and lock in that really collaborative work between providers, but also between the voice of lived experience and the commissioner. The commissioner is this kind of steward of place or steward of system. So mass people together, build the trust. So much of it is place specific. So much. Are you in a super poor bit of the country or a wealthy bit? Is the population totally white or is it very mixed in terms of ethnicity? Is it in a deindustrialized part of the country where the coal mines or steelworks were? Are there local populations of women in sex work? There are a million variables, isn't there, clearly. It's very important to take that on board. And if you use that alliance model, potentially you could get something much more nuanced and more accurate and more collaborative and then have space within the system to try stuff. OK, well, we thought it was going to be X, Y, Z as the biggest issues, it is actually X, Y and Q, but that's OK, because we've got that trust to say we're going to flex this a bit.

And it's places like that I think where that natural partnership is flourishing a bit more. And there's one example in Plymouth where they brought together all the different teams and strategies and everything, put everyone in one building. It took a while because it's a big piece of work. Did a big overarching strategy, gave everyone the same badge. So, you're not an NHS commissioner or a public health commissioner, you're a such and such. And basically integrated the commissioning teams and crucially, the commissioning budgets and then immediately, of course, you're going to get a more holistic approach from that because you've got people on the same team and so much of it comes down to organisational boundaries, organisational cultures. And you get really good people who are compelled by the system to sometimes occasionally do things

which aren't helpful. It's not because they don't care, it's just because they're kind of locked into the specifics of system requirement.

***That's really interesting. So, they are examples of where localism has done what it was meant to do?***

Yes, exactly. And that is a really good counter to the argument to just 'OK, pull it all to the centre, we'll sort everything out and mandate it.' You'd lose that kind of 'let a thousand flowers bloom' quality. So yes, some of those flowers have bloomed and some have shrivelled and died. Is that a price worth paying for or is there a sweet spot? My argument is that it's not all centralism or localism. There is a sweet spot where you could have a bit of both.

***QUESTION 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?***

I guess the two obvious risks would be the psychological support unearths some really big stuff, and that person then went into treatment with those issues, not fully well. to a point where they can engage with treatment successfully. I suppose that would be a risk. But the way around it would just be to try and make sure that that person was at a level where they were ready to go onto the next phase of the system. And inevitably, the way to do that is partnership working between those different bits of the system. It's all about personalized care. That's one of the mantras from us. It's all about working with that person at that point in time, drawing on the different interventions and absolutely listening to them as an expert in their own life. So that would be one risk. And then the other risk would be that the psychological support, couldn't be successful because that person was still so immersed in their addiction and some of the challenges around that. On paper it looks great because we can draw a pathway and say, 'well, trauma causes addiction.' To deal with addiction, you have to first deal with the trauma, then you go into treatment and then someone comes out happy and healthy at the end. But actually, to engage with psychological support, if you're really in the thick of things with drug and alcohol use, you just might not be there, you might not be ready. And then, people have a bad experience because someone turns up intoxicated and then they end up getting kicked out because they've not turned up to a couple of appointments and stuff like that. So again, it goes back to the chicken and egg. Do they need a bit of work and support on just reducing use and some harm reduction around keeping safe and reducing that a little bit to enable them to access psychological support to then make some big steps to then go into treatment or not.

***QUESTION 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

Just to say it's really important. I'd like to think we could get to a point where the system has it as an element. We're definitely not there at the moment because of disinvestment. But as I say, there's some positives on the horizon with the Black Review. If we get more money, to put it crudely, and it's not just money, it's political leadership. It's political attention. If we were to be one of the cross-cutting priorities for the government, around addiction, then that would be a good start. I suppose I'm just saying there's a window of opportunity to actually be getting these messages out.

***In terms of localism and centralism, do you think there is a definite need to review localism and that it isn't working effectively?***

Yes. To go back to the sweet spot argument, what I'll be saying is we'd welcome political attention and leadership on addiction. They're framing it as addiction, so I'm just using that because it's likely to be cross cutting. So probably alcohol, drugs. They're talking about gambling and addictions to medicine. It's likely to be that kind of crosscutting thing. We'd welcome that. There are whispers of a new unit being set up in government that would be like a delivery unit. Historically, or in my experience anyway, the civil service is amazing at making policy, but it's less good at delivering it. The drug strategy from 2017 is a great example. It's actually pretty good. You'll be able to find detractors because they'll always be people wanting to do that. But it's kind of balancing harm reduction and recovery and localism, it's actually quite good. The problem is that some of it hasn't happened basically. It hasn't really all been implemented, and some of the stuff in it is unmeasurable. Bits and bobs have. But I think the response to that is this idea of having a unit in the Cabinet Office or very close to No.10, Prime Ministerial involvement and potentially having a small amount of these very knotty kind of crosscutting issues. The reason that they need to be there and not in a government department is because they're relevant to so many departments. At the moment, you've got drug policy owned by the Home Office. You've got bits of alcohol policy mainly owned by the Department of Health. You've got a lot of the work on drug policy actually done at the Department of Health. But because drugs are illegal, you've got the policy ownership in the Home Office. But you've also got a lot of relevance to the DWP because it's about employment and getting people back into work. You've got a relevance to DFE because there's an agenda around parental substance use and families. You've got a relevance to the MoJ, clearly, because of criminal justice, probation. So, it's really crosscutting and there hasn't

been a mechanism in central government for the past decade to really bring people together. So that is why we're saying, yes, there should be something in the centre. It has to be departmental; it has to bring people together. And there has to be a high level of political buy in, basically, a drive-in energy from No. 10/ Cabinet Office. Now, that doesn't mean you're totally scrapping localism. We're not saying that commissioning should go back to kind of NHS sort of central. But that central presence, if you like, would have some kind of levers to use the civil servant phrase over kind of local areas and be able to intervene if they were not up to scratch. So that to me feels like the sweet spot.

Then I think the outcomes point is really important. At the moment, the main outcome is around successful completions. People have been through and yep, right, this person's good to go. Which, OK, fine, that obviously makes some sense. But is there a risk that you're then incentivizing people, services to say we need to get that person out of treatment because we need to say we've supported 80% of the people or whatever. What about family? What about jobs? What about all that wider stuff? Is there a way we could bring that in? Is there a way we could just look at personal well-being? Maybe a person is still on methadone and they're saying, 'my life is great, so much better than it used to be. I feel stable, I feel secure. I've reconnected with family and friends, I'm volunteering.' Who are we to say that's not a fantastic outcome for one particular person? I think there's something around outcomes and money. There has to be more money and it has to be protected because at the moment, the substance misuse money is in the public health grant. The public health grants got a ring fence around it. But that ring fence: A. It's is around the whole of public health so it can be spent on other stuff. But, B. That is scheduled to come off March 2022. And there's lots of advocates in HMCLG and local government, saying why is there a ring fence at all? There should be no restrictions on the money that is in the settlement from central government to local government. If you believe in, and this is intellectually coherent, if you believe in localism, you just give them the cash and say 'you're in charge. You get on with it. As long as you meet the requirements of the legislation for what local authorities have to do, just crack on'.

For further information about the work of Collective Voice, please visit: https://www.collectivevoice.org.uk/ and follow Oliver on twitter at @OliverStanding.

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## Piercarla Katsaros

**Former:** Lead Dual Diagnosis Practitioner for Fulfilling Lives Islington and Camden, Senior Mental Health Practitioner at Camden & Islington ('C&I') NHS Foundation Trust
**Currently:** Clinical specialist at C&I NHS Foundation Trust

*I grew up in Rome in an Italian-Ethiopian-Greek family. As such I have had the good fortune to have a diverse cultural background which still influences me to this day, I have worked mostly in community settings, both through the NHS and non-statutory sector, primarily as a clinician in dual diagnosis, working with service users and their families. I am currently re training as a systemic psychotherapist.*
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## *"It's all about relationships. And trust is very important"*

***QUESTION 1: In your view, how would you describe complex trauma?***

First of all, complex trauma is what is complex for the patient. So, I don't think it needs just the view of the clinician or the therapist; you really need to also see the view of the patient or the service users. During my career, I've noticed that trauma affects people in different ways, that people either become more resilient or less resilient. I've worked with women who had, in my opinion, enormous complex trauma following abuse, child abuse and domestic violence but that they were actually much more resilient than most people. That they had different traumas, that they were maybe related to more than the simple loss of perhaps their grandparents. So that for us as a therapist, we would say, that the complexity is also dependent on the resilience of the person.

In addiction you can't just determine what is one complex trauma that many different people face. And mainly in places like in London and Brighton, where you have different communities, trauma can also be attached to culture, to where you come from. For example, just looking at PTSD and people coming from areas where there is a lot of war or people that have crossed different countries to arrive here. Or, there are traumas related to cultural attachments like forced marriages or imposed cultural views on sexuality and masculinity. And so, trauma can have different faces.

So, I think it's very difficult to describe what complex trauma is, in a sense. For me, it can be different and take different forms. But it is important to actually acknowledge that there is trauma and then it's important to unpack what the complexity of that trauma is for that person. And I think that is much more important than actually arriving at a definition: this is complex trauma.

***What does it look like and how have you seen complex trauma present itself?***

There is that problem with engagement. Also, because when we have some complex trauma, we also develop what you would call a different mental health disorder. So, you will have people that have a personality disorder, people that have a borderline personality disorder, people that will have PTSD. I hate the word 'disorder', but these are diagnoses that then need a particular way of working with clients. For example, MBT [Mentalization-based therapy] is very good and mentalization is proven to be very effective with a patient with complex trauma. It can be used in groups or one-to-one and can actually guide the patient to a point of engaging a bit better with services. Although there is often a problem with engagement, the underlying problem is often trust, and the client feeling able to trust. It's not just because there is not trust in services. For someone, with a personality disorder they often have challenges in trusting those around them. However, in my experience, I've always been really impressed with how people with complex trauma manage to cope: they have such amazing coping mechanisms that they have developed during their own experience of traumatic events and that resilience can help them jump through lots of support steps.

So, engagement is difficult, but it's key. And I think using good tools - and I'm not saying psychological tools because I don't think the psychology, if someone is using substances, is always doable, because you could get to a point where you could actually put a person very much in danger. But a good psycho-education and psycho-social approach and using good tools is really important. Using good MBT and having more people trained in MBT would be a good step forward. The Anna Freud Centre is offering very good training in MBT and I think those trainings should be available for people who work with people with complex needs. And there are lots of systemic tools, that can be used. Also using very basic motivational interviewing techniques can help a person to arrive to that moment of mentalizing that change is needed for them to be engaged with services.

***QUESTION 2: Explain to me how psychological support for someone experiencing complex trauma might help in preparing to access formal substance misuse treatment.***

Again, I would never say that formal psychology, so psychological intervention, is something that is actually suitable to someone that is still using substances So it needs to be some sort of psycho-educational, psycho-social support that can actually help the patient to move on.

Things have changed very much in the past 15 years because commissioning and drug services are becoming so competitive and contracts are asking for more, for less. But in the past, we used to be all trained in MBT and we used to do it every year, every psychological initiative that was coming out. We were being trained thoroughly, we had one hour to sit down with patients and it's not happening like this anymore. Drug workers are very underpaid. So, you have people in services that have not been in the work for long, you do have people sometimes that are not prepared to do certain bigger pieces of work because drug work is not seen as support work. This line of work is actually something where there should be a lot of psychological intervention, a lot of psychological support, based on the psycho-educational techniques and tools. There are a lot of things that can be done in drug services to engage people.

In the past, we used to have big outreach services that used to go out and do a lot of outreach in day centres and all these types of commissioned activities that used to happen before, are just becoming smaller and smaller and smaller. Funding is much less, so also having appropriate support is becoming less available for our clients. Let's be honest, if staff are not trained appropriately, and staff do not have the appropriate time to spend with clients because they have a caseload of 60 people on their books then they can't do proper follow ups or proper one-to-ones - how then can we retain people in treatment? And this should not just be about helping people arrive in treatment, it's also about retaining them in treatment. Having people arrive into treatment and to have the relevant prescription - I don't think it's complex, it's not difficult. The most challenging part can be actually helping keep them there in treatment services, helping people to pick up that prescription every week, to come to the one-to-one with you, to sit down and have a cup of tea and to actually have a conversation.

***That's really interesting. And I think you've brought out a very unique perspective on some of the structural challenges around. So, it's not really just accessing, it's also retaining and maintaining that support.***

It's maintaining support and retaining staff.

I come from a harm minimisation perspective. So for me, the most important thing is to keep the person not just alive but healthy and minimizing the harm that they do to themselves – it's not just about 'stopping drugs' as for some people this

is not feasible because the trauma is too much. But it is actually more feasible to help them stabilize and to have a life that could be normalized. Now, normalizing to a new reality will be different for every person. But, for example, it may be important to work on harm minimization in the context that it will help someone retain the housing they want and then from there they may build up confidence to engage in some training, and from there to do many other things, which they can still do while they're on methadone. But the important thing is to have trust, the relationship, where a person can say, 'OK, I think I can do this, or I think I can move on to this'.

***Psycho education and psycho-social tools: what would it look like? And what are the steps to prepare someone?***

You can use the mentalization tools, you can use motivation interviewing, you can use a very basic CBT exercises, you can use genograms. For example, I'm working with someone at the moment that has a long history of domestic violence and we started working on the genograms and through that she could start to see how she grew up in violence – her mother had a history as a victim of domestic violence and her grandmother was a victim of domestic violence. And so, we went back on three generations of violence, so the mentality of accepting that violence, and the mentality also of coping in that violence. You can then start to explore questions like 'How does your mum cope?' 'How did you cope?' 'Do you numb feelings?' 'Do you think that this is normality?' Sitting down inside and actually I have my patient say, 'Oh, I never thought about that.' And the client started to see how she mimicked the same behaviour that her mum was using. Although it's happened all her life, on a very small piece of paper with a genogram, it helped bring more clarity to her situation.

Mentalization is one of the oldest tools that human beings have been using. Preparing the person to actually see that the behaviour is there because, behaviour is being mimicked, because the behaviour is part of coping. And how actually that behaviour brought the person to do certain things. I worked with a person, she was around 56, been drinking for all her life. She was living with a person that she called 'mum'. But then at the end, I realized that the other person wasn't her mother. She wanted someone to be her mother. So, she called this person 'mum'. She had a diagnosis of ESPD (emotional severe personality disorder), she actually tried to take her life every couple of weeks and she was very well known to services, although she wasn't open to, she refused to go to, alcohol support services and she wasn't open to personality disorder services because she was drinking too much. She was drinking up to 20 pints per day of strong lager. She wasn't going out of the house as she was agoraphobic. When we started working together for the first two appointments I went into her house and

then I said, 'if you want to see me again, you need to come out.' And for the next time we agreed to meet inside the park as it was halfway between the service and her house. And then for the next appointment I asked to meet inside my office.

We started doing a bit more structured work. So, I guided her there and then I started having the alcohol service to come and meet me with her. And the alcohol worker used to come and meet both of us. At that point there was trust for two people and then she slowly started coming to the appointment with this 'mum'. We started talking about different things and then after three or four months of weekly appointments with me and a weekly appointment with the alcohol worker, we started talking about, how she felt she couldn't go into groups. And then slowly we worked on the groups and why she couldn't go into groups and, she disclosed she had been gang raped. So, we didn't work on that because we couldn't unpack that because that would have brought it to a state that we couldn't have supported her. But we started working on, 'OK, but what about if the alcohol worker comes with you the first time to the group?' And then she started going to the groups and she started really enjoying the groups because she became very chatty. And slowly, after six months, she went into a women's-only rehab detox, and she stayed. She decided to move outside London and she's still alcohol free. She's stable. This was a lot of work that myself and the alcohol worker put into this case. And although it was much appreciated by the services and everything, it was a lot of time. But then when you have those caseloads working with people who have complex needs, usually half of them can't go into drug and alcohol services. And, in this case, the drug/alcohol worker on her own would not have been able to do it. So, I think the pre-treatment preparation is important, but also the training is important for service workers and for them to be confident to implement their training.

***I just wanted to check what you see as substance misuse treatment. Is it just detox and rehab or would you say it's broader than that?***

*"Mentalization is one of the oldest tools that human beings have been using. Preparing the person to actually see that the behaviour is there because, behaviour is being mimicked, because the behaviour is part of coping."*

Substance misuse treatment is everything that will make a patient stable. OK, if someone wants to go to detox, then rehab and they see that as the important thing for themselves. Someone wants to be detoxed in the community and can cope in the community, that's good. If someone wants to stay, as I said before, on prescribed medication all their life, because that is how they can cope, why not? We need to see person to person what treatment is. Treatment has to be about how it will minimize the harm that that person is doing to themselves and to others around them. That, for

me, is treatment. If we have someone that is actually managing to access services, to stabilize and to start achieving small goals. That is already a very big part of treatment.

***QUESTION 3: Can you tell me about any examples you have where psychological support has helped enable access to formal substance misuse treatment for someone you have been supporting?***

I have lots of lots of examples but again, it's not the psychological support in the sense of psychology, I want to be really clear on that, because, it's a big difference at this stage of pre-treatment work. Lately I've been working with someone and with the hospital to prepare them to not attend A&E so frequently and encourage them to engage with the drug services. And she's not been attending A&E, she's engaging now with drug services. It's been collaborative work; it's been very much working also with the hospital workers. In that case, I've worked more on a systemic approach, working with giving responsibility also to the client and actually making a point of how the behaviour of the client was making people around her feel. And acknowledging that the behaviour was making an impact on other people around her and how those people were feeling, and that was really, really powerful for her to help her have time to reflect and understand. We would talk through questions like 'how do you think Mary, the key worker, feels when you take an overdose and then you go to hospital and you don't want to present to the services out there?'. The client said, 'oh, she doesn't care because she's just here for her salary'. And then Mary got quite emotional, she said 'no, I do feel, you know, that I'm not just failing my work but I'm also failing you'. And actually, just that expression of emotion made a change because the client could see that someone was emotional about her and from there a kind of bond started.

It's all about relationships. And trust is very important. Trust is not doing everything the client wants but it's actually also reinforcing when there are mistakes and putting in boundaries. Because someone with a personality disorder loves boundaries because they have often never had them. They respond very well to boundaries because it's that need of being stopped. And it can relate back to child development and how boundaries can help children process all the new things in the world in a smaller, step by step way. It's very similar to someone with a personality disorder because a child is trying to cope and everything is too big for them, it’s too much, it's oppressing. So, that’s where clear boundaries can be really useful.

***QUESTION 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?***

I work very systemically because I think a person is not just a person, it's the system around the person that's also important. And when we talk 'systemically' people think 'oh family therapy'. No, systemic therapy is the system. It could be the hostel; it could be everybody that is involved with that person. And I've been using it a lot in hospitals with patients and it works really well.

***Could you explain the difference? I mean, because I don't know either of these therapies, the systemic and the family therapy.***

Systemic therapy is also called systemic family therapy because it's used very much with families. But there is a lot of research and opinion that it can be used more widely. The system, can be the hostels, can be important 'others' in someone's life, it can be couples. So, it can be used with anything. I also frequently use circular questions and I also like to use the 'magic question', we call it. For example: 'If today was a sunny day, where would you like to be?' And we explore that in conversation. These are very much reflective questions. Another example could be if someone is using substances for a long time, I would ask 'OK, if tomorrow you would wake up, and you were completely clean, what would you do?' And it's quite interesting to actually see them answer, to have time to think what a day would look like if they were clean. It can actually be quite daunting for people, because they may never have thought about it in depth. Because you would think if I had the magic wand, I would be clean. That is something that someone would tell you. But if you were already clean, if you wake up clean, then what would you do? How would you spend your day?

I use quite a lot of motivational interviewing attached to some MBT, so some mentalization. But I like to do mentalization also attached to genograms and attached to ecograms. Ecograms are really good because they allow you to work with all the system around a person, and all the important things they have in their life.

But actually, you can try lots of different things. You can work puppets and things. Systemic psychotherapy is very much attached to the use of all different things, because you need to use anything that people express or connect with, because a lot of people don't like to express themselves. For example, in an exercise that I do with clients, we divide a page into six sections, and I start saying draw anything that looks powerful to you. And then on the second square, you're asked to put something down that is happy, and on the third draw something that is very sad.

And then when they finish everything, you actually have the person comment on the drawing, and you look at the drawing together. And some people by the third drawing say, 'oh my God, I'm talking about me, and I never thought that I was going to talk about me.' Or some people realize it just at the end. But again, it's not something that will open those really intimate boxes that long-term psychology can and that could be dangerous with someone that is actually not clean.

***QUESTION 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?***

I believe in a mix of services. When you have a consortium of statutory and non-statutory services working together, to me those are the best services because you have the different expertise.

The working together of mental health services and substance misuse services is discussed often as being challenging but this is not just because they don't want to work together. I think it is a much bigger thing here about how they're getting the money and how they're getting commissioned. So, it's a bigger thing than the working relationships. I don't think that many drug services are trained enough to work with the mental health of patients. And the other side, I don't think that mental health services are trained enough to work with addiction services. Commissioning should be 50/50 commissioning for a big service that can take mental health and addiction. Because I think like this, with separate commissioning of mental health and addiction services, we're going to continue with the 'who is supposed to take responsibility?' question. And the person stays stuck inside in the middle.

***Would you have examples of where these two services are working together, any good practice examples?***

In Haringey, in London, there is a big dual diagnosis team and they're all working well together because the dual diagnosis team is in the hospital. There are three or four providers altogether so it's a consortium and they have a very good relationship with mental health because addiction consultants come from the mental health, logically, from the mental health cohort. So, there is good communication, it's a place where the drug services are invited to the CPA's ('Care Programme Approach'- a yearly review meeting with a mental health care-coordinator).

For the addiction side and for the dual diagnosis, the mental health trust in Haringey is good. The Maudsley Hospital (South London) have a good provision also in the wards because now they have a big dual diagnosis team. And Oxleas NHS Foundation Trust, have a good dual diagnosis provision. In Camden and Islington, I'm the only one focussing on dual diagnosis, and I specifically work in this pilot project and specifically to work with the psychiatric liaison. They're keen for the work to continue, so I'm going to become part of the psychiatric liaison post. So, there is going to be a post here still just for dual diagnosis.

*"And the working together of mental health services and substance misuse services is discussed often as being challenging but this is not just because they don't want to work together. I think it is a much bigger thing here about how they're getting the money and how they're getting commissioned."*

***QUESTION 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?***

Psychological support to me is psychology.

And yes, there are risks for someone that is actively using drugs to do long term psychology. I have seen people doing private psychology for years and the drug use escalating enormously because they couldn't cope with what was happening and they needed more numbing. I saw people also taking their life because, certain things that were opened up and they couldn't cope with it. There are a certain group of people, that we need to agree they will never arrive to that place where they can safely engage with psychological support. And we need to be happy with that, because some will never access it because they don't want to access it and we need to actually help our clients arrive to a state of contentment that minimizes their use and helps them towards their recovery. But we need to also have them to own what they want from recovery.

Harm reduction is very important, it's an amazing tool that we use also to engage people. Just think about that first needle exchanges in the country, how important was that? That engagement in that little room whilst you would give them needles. And how much in a way, certainly at the time the big boom of HIV, infections came down because of that. And then, you know the Hepatitis C campaign. I'm part of that working group, the pan-London group. So those things are very important to have people that are healthy. And to have people that can slowly make choices.

I don't think anybody should be pushed to do things that they don't want to do and that, I think is very, very important to have in mind. If someone arrives to have

a healthy relationship, a somewhat healthy relationship with their own selves and a healthier relationship with their drug use, and they want to stop there because at that moment they can't go further; I think we need to respect that.

There are lots of people out there who are homeless and that haven't been in. And it's very important for us to motivate them, to engage them to have them to be housed, if we can, to help them. But there is always going to be a limit to how much. We're not there to save everybody and we're not there to change a person into something that we think they're supposed to be. We're there to have someone that is actually content and has a healthy life. Or, however, healthy it can be. I know of a client that was homeless for a couple of years, many, many years ago. And now he's a barrister. Fantastic. There are those stories. But that is one or two. I talk to clients who were homeless for years and now they recognize me in the street. They can stop and have a chit chat and they're not completely stoned and they're not completely off their head and they're actually carrying bags of food because they're going to cook at home. That is a big achievement and we need to recognise it.

***QUESTION 7: Is there anything else you would like to say around multiple complex needs and psychological support?***

I think that there is a lot of need for training for staff. I think that there is a big need for commissioners to understand the patients and not only KPIs and numbers. It's important to understand that when we actually talk about multiple complex needs, that's already telling us that they're multiple, they're different, and every person is different. And we need to look at that not just as 'oh we're going to do this very smart care plan'. It's not just about the smart care plan, it's about the relationship. It's about how much you're actually engaging with that person. It's about the trust that you can have with that person. It's also about how to challenge the person in a way that works well for them. It's about putting the appropriate boundaries in. So, the workers need to have all those skills that only thorough training for staff and to support them to be supervised appropriately, that will be the challenge.

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 a session. A worker that has a caseload of 60 - 70 patients, you can't do that level of work: it's impossible, you're not able to do quality work.

In the past, when support staff were doing more one to one work, because we used to have a bit more time, you used to call this type of 'pre-treatment' support 'psychological intervention' or 'psycho education intervention'. This described how workers would be using some psychological tools, the tools to actually open up a conversation. So there are lots of tools that we can use and that we used to use but actually at the moment, they're not really using them anymore because there's not that time for preparation and often, there is not even the time to do it in practice with clients.

For further information about the work of Fulfilling Lives in Camden & Islington, please visit: https://www.shp.org.uk/fulfillinglives and for further information about the work of Camden & Islington NHS Trust, please visit: https://www.candi.nhs.uk/

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