THE TRAUMA STABILISATION PILOT

A Review of Trauma Intervention for People with Multiple and Complex Needs

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EXECUTIVE SUMMARY

Substance misuse and mental ill-health are common issues for people with multiple and complex needs, and are often linked to experience of trauma.

The Trauma Stabilisation Pilot provided an accessible trauma intervention for 10 women over 10 months. Contrary to the often arbitrary requirements that prevent clients from accessing the services they need; participants did not need to be 'stable enough' and their difficulties were not regarded as 'too complex'.

Trauma stabilisation provides practical strategies to manage the present symptoms of trauma, whilst avoiding exploring past trauma. Participants were curious about their trauma symptoms and motivated to gain insight into their behaviour as a response to trauma, rather than attributes of their character which compound feelings of guilt and shame. Women wanted to engage with trauma work through the Pilot, despite the complex difficulties they continued to face.

Through an assertive outreach approach, trauma stabilisation encouraged engagement and helped clients access further treatment and support: mental health services, residential rehab, in-patient detox, physical health treatment, housing, substance misuse services and legal proceedings.

Participants felt they were more likely to go to rehab and more likely to do well when they got there.

KEY STATS

5 clients are on a waiting list for rehab

1 client is in rehab and 1 has completed a detox

5 clients started substitute prescribing

Trauma stabilisation was also delivered through a group, with **2** of **4** attendees going on to rehab

FULFILLING LIVES SOUTH EAST

The Fulfilling Lives South East partnership (FLSE) works across Brighton & Hove and East Sussex and is one of 12 projects across England funded by the National Lottery Community Fund to support working age adults with multiple and complex needs (MCN). Starting in 2014 and ending in June 2022, its purpose is to collaborate with partners to bring about lasting changes to the way services support people with multiple and complex needs.

MULTIPLE AND COMPLEX NEEDS

Multiple and complex needs (MCN, also referred to as multiple disadvantage) are persistent, problematic and interrelated health and social care needs which impact an individual's life and their ability to function in society. They are likely to include repeat street homelessness, mental, psychological and physical health problems, drug and/or alcohol dependency, and offending behaviour. People with MCN are more likely to experience violence and abuse, including domestic violence, live in poverty and have experienced trauma in childhood and throughout their lives.

THE TRAUMA STABILISATION PILOT

CONTEXT

Trauma related mental health problems are a growing concern, with strong links to formative childhood experiences and deprivation (Wheeler, 2018). In 2021, the Fulfilling Lives South East (FLSE) Partnership produced The Perspectives Project (Rieley et al., 2021) which pulled together experiences of complex trauma and substance misuse treatment support in Brighton & Hove and East Sussex. The Perspectives Project found substance misuse (94% of clients) and mental ill-health (96% of clients) were the most common issues for clients, with 90% experiencing both as co-existing conditions alongside complex trauma linked to childhood experiences.

"I really want things to change but I can't maintain or stick to things. I think this is because of the things that have happened to me over the years." **Violet (Pilot participant)**

While thinking about trauma, treatment can often focus on a client's past trauma experience (also referred to as exposure-based treatment, exploring what happened), whereas trauma stabilisation focuses on the present trauma experience showing itself as 'trauma symptoms'. Studies and randomised control trials have found trauma stabilisation to be highly effective in relieving trauma symptoms (Steinert et al., 2017; Mattheß et al., 2019) which can include: nightmares, poor sleep, being easily distracted, poor memory, feeling distant from others, perceiving the world as hostile, struggling with intimacy, poor control of emotions, impulsive behaviours and remorse and self-loathing (Miller, 1994).

The local experience of FLSE has been that people with trauma symptoms are often excluded from the support they need because their presenting behaviours are at odds with expectations of the service (Rieley et al., 2021). There are a multitude of factors, in addition to presenting behaviours, which may also restrict access to trauma therapies: practitioner confidence and understanding, service availability and design, gatekeeping limited resources and, unclear or arbitrary criteria (e.g., not being 'stable enough').

THE ROLE

The Trauma Stabilisation Pilot role sits within a dedicated Practice Development Team that invests in practitioners who think creatively and reflectively about pragmatic changes to practice from within placement organisations across Sussex. The team collaborates with their placement organisations to trial new ways of working and embed changes that are shown to have a positive impact for clients with MCN.

The Trauma Stabilisation Practitioner's purpose was to deliver Phase 1 trauma stabilisation through an assertive outreach model to women with trauma experience. The role was trialled for 12 months (July 2021-June 2022) and based within BHT Sussex. Its aims were to:

1. **Explore and evidence that clients can attend regular sessions and manage their trauma symptoms**
2. **Use trauma-informed multi-agency coordination to create conditions that are supportive of clients working towards their recovery goals**
3. **Help clients to meet the referral and waiting list requirements of residential drug and alcohol**

TRAUMA STABILISATION

While Trauma stabilisation as a standalone intervention is relatively new, it's emergence can be tracked from development of post-traumatic stress disorder (PTSD) treatment in the early 1990's. Judith Herman (1992) published the now seminal work Trauma and Recovery, with a three-phase model for treating trauma that has influenced subsequent work: (1) Establishing safety and stabilisation (trauma stabilisation), (2) re-telling/exploring the trauma story (trauma exposure), (3) reconnecting with others (Herman, 2015). Early evidence of the impact of Phase 1 trauma stabilisation can be seen in Cloitre et al.'s study which found, in addition to developing the therapeutic relationship, it improved emotional regulation and the success of subsequent Phase 2 'exposure' work (2002). Trauma stabilisation has remained in the first phase of many treatment models and is widely valued in preparing the way for more in-depth work (Van der Hart, 2006; Gilroy & Caroll, 2009; Shapiro, 2012; Cloitre et al., 2002).

Repairing a lost connection to reality (Everstine & Everstine, 1993), reducing 're-enactments of trauma' (Stewart & Dadson, 2012), skills-building (Van der Hart, 2006), 'resource activation' (Mattheß et al., 2020), somatic approaches and sensory grounding techniques (Gilroy & Caroll, 2009; Gentry, 1998) are all considered effective parts of the process. Although perhaps the most powerful element is, as Miller (1994) describes, understanding and legitimising a person's emotional and physical response to trauma. Seeing behaviour as a legitimate response to trauma rather than evidence of a 'disordered' personality has been a valued insight amongst clients of the Trauma Stabilisation Pilot:

Mari hadn't come across this idea before and at times she was very tearful because she thought she was just a bad person… This was a bit of a 'shift moment' for Mari who was able to see she wasn't a bad person, that she was having an understandable reaction to her trauma experiences, and that these things could change. **Extract from Mari case study (Appendix 3)**

Concern about a lack of evidence for the need of stabilisation before trauma-focused treatment (De Jong et al., 2016) has been addressed explicitly in Mattheß et al.'s work which reported remission rates of over 90% in cases of diagnosed and pre-treatment stage PTSD (2019; 2020). Others have also found trauma stabilisation is effective with suspected but not yet diagnosed PTSD as well as those with a diagnosis (Eichfeld et al., 2018).

THE MODEL

The Trauma Stabilisation Pilot adapts established trauma interventions in two key ways (1) it is delivered within an assertive outreach model and, (2) the sole focus is on the trauma stabilisation phase of Herman's (1992) established treatment model. This comes from a need to make trauma interventions accessible to clients with MCN, identified in the reporting of trauma experiences and symptoms over several years of direct work with FLSE clients (Hard to Reach?, Murphy et al., 2020).

The hypothesis behind the approach of this role is that clients are more likely to engage consistently and meaningfully with an assertive outreach model. Additionally an increased awareness and effective strategies for clients to manage their trauma symptoms will allow them to pursue their hopes and goals and benefit from support services including; residential rehabilitation, stable housing, social support groups, long-term physical health treatment, mental health treatment services and, private therapeutic treatment.

The Trauma Stabilisation Practitioner explored sensory-based grounding techniques as well as promoted learning about trauma with female clients based in Brighton & Hove throughout this Pilot. Warner et al. (2014) make the case for somatic regulation in adolescents where 'pervasive problems with self-regulation' mean they struggle with 'language based treatment models'. The benefits of alternatives to 'sit-and-talk' interventions have been documented numerous times in FLSE case studies and this role built on these experiences and worked with clients to tailor interventions that enabled regulation and reflection.

THE PARTICIPANTS

The Trauma Stabilisation Pilot worked with 10 clients who identified as women for an average of 9.5 months from August 2021 until June 2022. There was an eleventh client who after eight weeks, did not feel able to engage in trauma stabilisation work with pressing physical health issues - they have not been included in the data. Flexibility was granted where practical, but the criteria for participants were:

- Live in or receive services in Brighton & Hove
- Have a substance misuse care coordinator
- Be able to and have a level of interest in going to residential rehab in the next year
- Have a primary keyworker
- Not have their own housing tenancy
- Have an interest in using trauma stabilisation to explore their experiences
- Consent for their story to be anonymously included in FLSE reporting and publications about the Pilot

MEASURING THE IMPACT

To assess and capture the impact of the Pilot, the team used a selection of data sources. They paid particular attention to the levels of client participation with the Practitioner and trauma stabilisation tools because FLSE had seen across their other projects that participation and engagement often leads to positive outcomes in other areas of life for people experiencing MCN.

Data sources included:

Qualitative data:

- **Case studies:** Three extended case studies have been included in the appendix of this report and are referenced throughout. For privacy reasons, pseudonyms have been used and some changes in details of the story. Case studies were developed through 1-hour structured interviews with the Practitioner taking notes, checked back with the Practitioner for accuracy and anonymity. These case studies provide a significant insight into the experiences of the clients and the work of the Practitioner. We encourage you to take the time read them.
- **Client structured feedback:** This helped capture feedback from clients on how they felt about their likelihood of going to rehab and particular support provision they had found helpful through the Pilot.
- **Nomination information and end-of-Pilot follow-up information:** This captured the support network around the clients, client goals, recovery plans and support needs.

Quantitative data:

The Pilot captured Homelessness Outcome Star scores, Progress Tool scale scores, completion of key trauma stabilisation tools, number and type of engagements with professionals via the Nomination information and structured feedback tools.

- Engagement stats (Number of: In-person meetings, phone calls/texts/emails, DNA's and contact with professionals) [Fig 3, 4 & 5]
- Worksheets completed [Fig 2 & 7] within personalised client workbooks to support trauma stabilisation activities
- Adverse experiences during the Pilot [Fig 1], as defined by experiences listed in Figure 1 below and collected throughout the clients' journeys with the Pilot.

THE IMPACT OF THE PILOT

The Pilot has found that women with MCN want to engage with trauma stabilisation and they can do this effectively and safely. Despite the high levels of adversity faced by women during the Pilot, there is evidence they have been able to undertake trauma stabilisation work and that this has moved them closer to achieving their goals.

The impact of the Pilot has been grouped into thematic areas below.

1. STABLE ENOUGH?

EXPLORING THE EVIDENCE FROM THE PILOT THAT CLIENTS CAN ATTEND REGULAR SESSIONS AND MANAGE THEIR TRAUMA SYMPTOMS

The experience of FLSE is backed up by the wider literature which highlights a reluctance to carry out trauma work (Van Minnen et al., 2018). There is emerging evidence that trauma work is both safe and effective for people with co-existing conditions including substance misuse, historic and childhood sexual abuse history, personality disorders, non-acute suicidal ideation and even schizophrenia (De Jongh et al., 2016). Yet this conflicts with the experience of FLSE clients with personality disorders being told they cannot be treated and arbitrary requirements for clients to be abstinent from drug and alcohol use for six months, (FLSE, 2019).

"I can show that I do work with support if they don't judge me and understand me. People are too quick to blame me for everything." **Violet, client's reflections during the Pilot**

During the Pilot, the 10 women who took part underwent significant adverse experiences on top of pre-existing trauma, diagnosis and continuing drug and alcohol use:

ADVERSE CLIENT EXPERIENCES BY NUMBER OF CLIENTS DURING THE PILOT

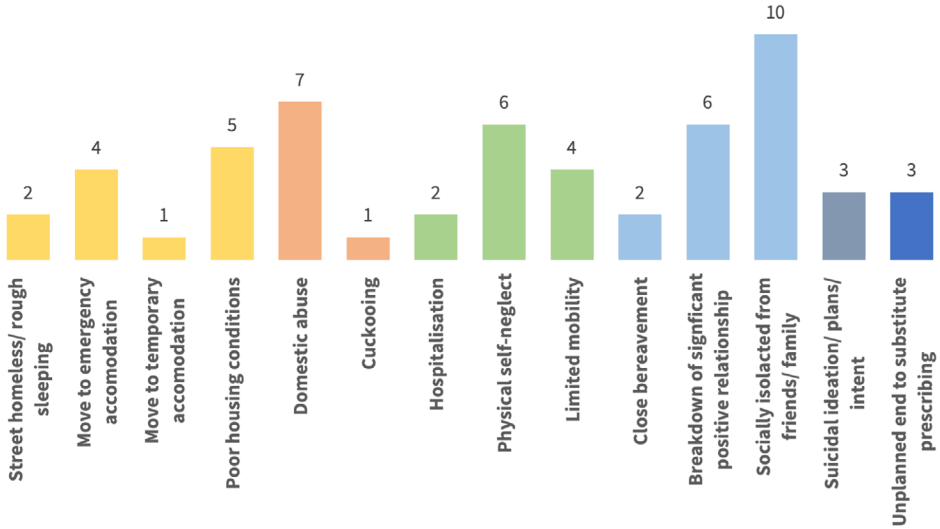


Figure 1

Despite these challenging circumstances and events, the Pilot clients continued engagement and were able to explore complicated subjects related to their trauma experience within the safe relationship with the Pilot Practitioner. This can be seen by the number of trauma stabilisation worksheets and topics clients were engaging with during the Pilot as illustrated below:

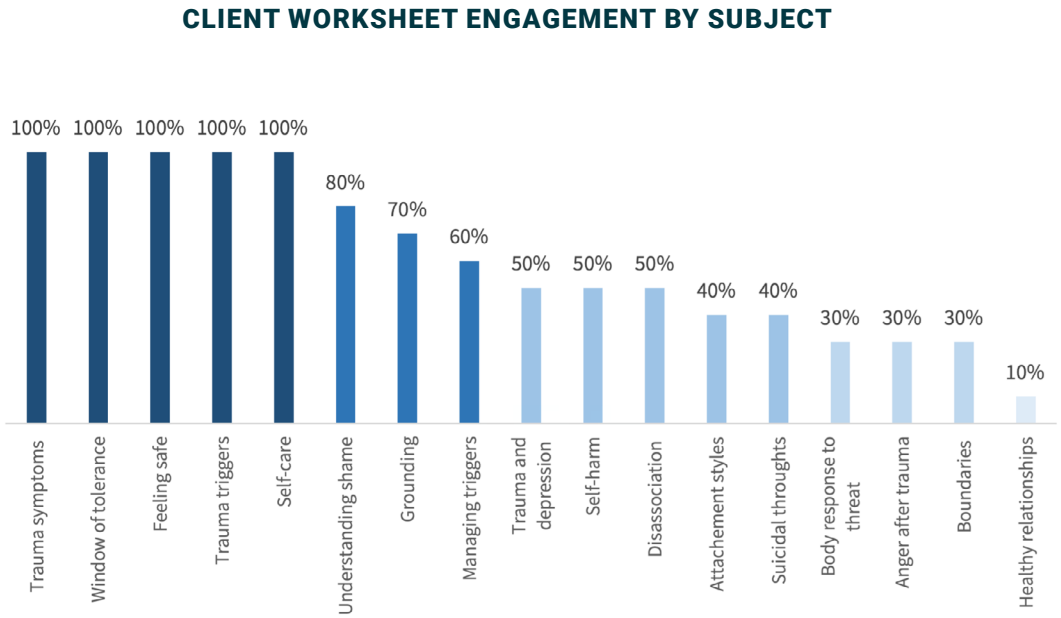


Figure 2

These worksheets were printed resources collated by the Practitioner into personalised folders for each client. Some worksheets used visual prompts to frame discussions about the topic and others had space for the client to write responses. The Practitioner regularly revisited each subject and the worksheet itself throughout the intervention, with evidence that clients themselves used these to help explain their thoughts and feelings to others:

Gemma introduced work around the 'window of tolerance' with a visual worksheet. This seemed to compliment Davina's learning style and was something they returned to a lot. Later Davina would use worksheets like this to explain her experiences to her old foster parents. **Extract from Davina case study (Appendix 1)**

Further evidence of the ability of clients to engage meaningfully despite high levels of complexity is shown in the number of in-person meetings, telephone calls, text messages and email exchanges between the client and the Practitioner. On average there were 46 points of contact between each client and the Practitioner over the duration of the Pilot. As Figure 5 shows, average client contacts went from 3.2 per month in the first months of the Pilot to 5.1 per month for the remainder. Of the 177 completed in-person meetings with clients, only 15 were arranged and then not attended by the client, with many of those later offering reasonable explanations.

Several people didn't think Lucy would be able to engage in therapeutic work because of what they observed… In fact, Lucy has been one of the most consistently engaging people on the Pilot.
Extract from Lucy case study (Appendix 2)

2. OUTREACHING IS KEY

THE POSITIVE IMPACT OF CREATIVE ASSERTIVE OUTREACH AND COMMUNICATION COUPLED WITH TRAUMA STABILISATION.

Case notes from the Pilot show a flexible and proactive approach for supported client engagement. There are multiple examples of the client not being in the location agreed but the Practitioner taking the initiative to call the client and head to their location:

There were times when Davina wasn't where Gemma had arranged to meet, but Gemma was able to get to where she was in town. **Extract from Davina case study (Appendix 1)**

There are other examples of clients initially not attending without explanation, followed by the use of assertive outreach strategies from the Practitioner to re-engage them. Assertive outreach strategies included attending their address, leaving a note or phone credit with staff at their accommodation and liaising with other professionals on frequented locations and going out to try to meet them. This further supports the wider FLSE experience of assertive outreach being an effective approach to getting higher levels of engagement from clients with MCN.

"Gemma could come to where I was as I hate big services and who I might see." **Leone, Pilot client**

While in-person meetings may be considered more valuable, the case study of Davina shows the progress that can be made with a client who often prefers indirect contact through phone calls and text messages (16 in-person meetings to 61 phone calls and text messages over nearly 10 months):

It became clear that Davina couldn't always manage some of the ways services were trying to reach her, but this wasn't about motivation. Davina's attachment style meant she really struggled with face-to-face meetings, feeling overwhelmed and then shame at not being able to get through something as simple as a meeting. Extract from Davina case study (Appendix 1).

Of the 10 clients, only three showed a strong preference for indirect contact with the Practitioner with the overall average being 39% in-person contacts to 61% indirect. Many of the in-direct contacts for clients who preferred to meet in-person were to arrange in-person meetings or prepare for them:

In-between meetings, Lucy would sometimes text or call Gemma and she liked to get emails with some information to look at before their next appointment. Lucy was very analytical and liked to make sure she really understood the topics Gemma would bring before allowing herself to engage with it emotionally.

Extract from Lucy case study (Appendix 2)

"…people didn't understand that I need outreach support to engage and since having Gemma I have been able to build trust and make changes."

Lucy, Pilot client

Over the course of the Pilot, most contacts were with the client rather than other professionals from other services also involved in supporting the client. A significant number of contacts with professionals were information sharing from the Trauma Stabilisation Practitioner. While the number of contacts itself can be a good indication of engagement, it does not give the duration or quality of that contact. However, the average length of in-person contacts is just under an hour and it's likely some telephone calls and email exchanges took a similar amount of time; text messages will have been considerably less.

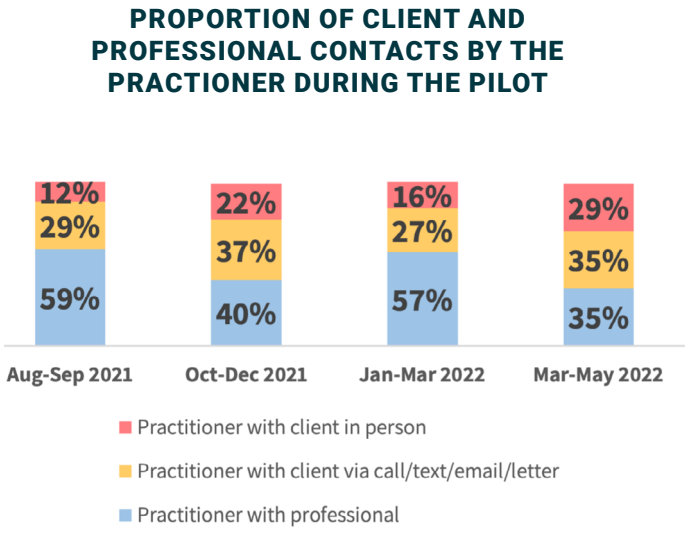


Figure 3

Figure 4

At the start of the Pilot, it was expected to see a higher level of contact between the Practitioner and professionals than with the client. However, as Figure 5 shows, a pattern has emerged which may have been expected to continue and which shows the strength of an outreach-based model of therapeutic intervention. As client contacts increase, the need for professional contacts decreases and, as clients go through periods of disengaging, professional contacts increase for a period followed by increased client contact again:

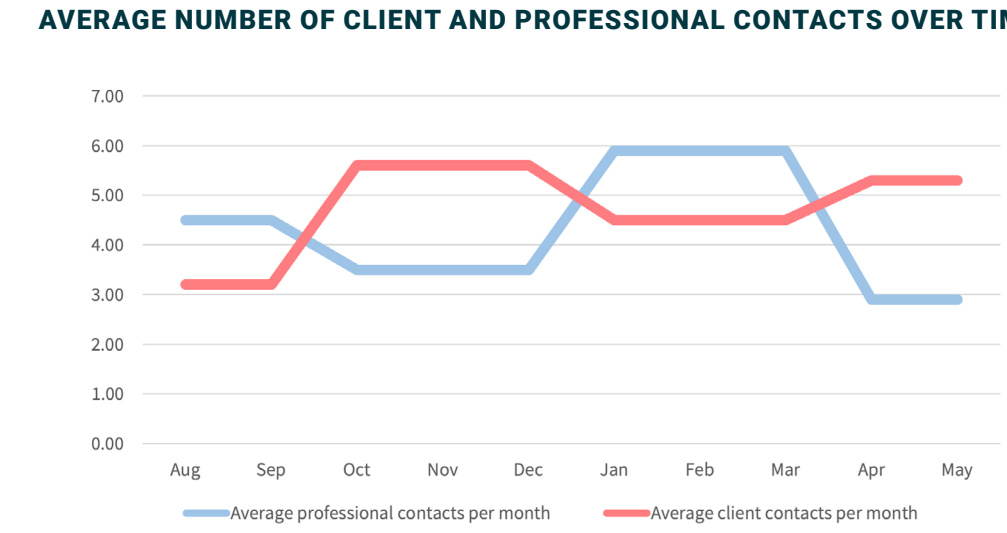


Figure 5

3. OPENING DOORS

USING TRAUMA-INFORMED MULTI-AGENCY COORDINATION TO CREATE CONDITIONS THAT ARE SUPPORTIVE OF CLIENTS WORKING TOWARDS THEIR RECOVERY GOALS

Throughout the Pilot, FLSE learnt that supporting clients better understand their trauma symptoms and sharing tools to help manage them facilitated access to further treatment and further engagement with other support services. By reducing the trauma symptoms which may seem undesirable or unworkable by some services, access to (and increased engagement with) mental health services, residential substance misuse treatment, treatment of physical health conditions, improved housing provision and participation in social support groups was also facilitated.

"They [support services] have stuck around and listened more… It's so nice to have someone care and want to understand me. [I'm] really scared I will be forgotten about [after the Pilot]" **Violet, Pilot client**

"…housing are listening more and [I've] been able to engage better with CGL (drug and alcohol service). [I] felt really heard and understood as most services don't' understand what out life is like." **Leone, Pilot client**

To enable the Practitioner to keep a focus on trauma stabilisation work, each client was required to have a primary keyworker. However, in many cases it became apparent that care coordinators and professionals from statutory services named as primary keyworkers were not routinely providing practical support or outreach to clients where limited mobility was reducing their ability to travel to appointments and groups.

While work was undertaken within this outreach model to achieve more favourable circumstances for clients participating in the Pilot (e.g., housing stability, consistent access to a methadone prescription, alleviating hunger, supporting access to medical care) exploring the content of the therapeutic and psychosocial interventions could experience significant delays. In response to this, the Practitioner supported the primary keyworkers and other support staff explore different perspectives of the clients. The Practitioner often shared her knowledge of trauma and trauma symptoms to decode client behaviours and paired this with useful suggestions for other support staff to support clients manage their trauma symptoms. This was shared through the Practitioner attending multi-agency meetings and case conferences, proactively sharing a trauma-informed perspective that enabled different conversations to take place about client support and engagement.

Gemma presented a trauma-informed perspective of what might be going on for Davina which seemed to lead to more compassion and understanding where they had struggled with the way Davina could sometimes come across… At the start of the Pilot Gemma would regularly get calls from the mental health service saying Davina had been shouting at them on the phone, which happened when she felt threatened. Often this led to concerns they were not able to work with Davina. Since taking this approach, they haven't reported any more incidents like this. **Extract from Davina case study (Appendix 1)**

This has led to Lucy getting better practical support as well; being able to go to medical appointments by herself for the first time by using diaphragm breathing techniques to help stay grounded and visual techniques such as imagining herself as a super hero in that situation… Lucy is now getting more medical support than she's had in a long time and is getting treatment for things that were previously neglected… Lucy now has a better relationship with the drug and alcohol service where before there seemed to be a lot of misunderstanding about her behaviours. **Extract from Lucy case study (Appendix 2)**

The learning from the Pilot suggests that trauma stabilisation supports both clients and the wider support network to better connect and engage with each other. Examples are included below of a variety of settings where this has been the case.

PHYSICAL HEALTH

At the start of the Pilot, six clients reported physical health conditions that were unsupported. The task of addressing physical health needs is often entangled with low feelings of self-worth, shame and being unworthy of care. Beyond this, clients needed support with the practicalities of attending multiple appointments, strategies to manage trauma symptoms related to medical interventions and numerous appointments across the city and in nearby counties. Of the six clients who participated in follow-up feedback at the end of the Pilot, four reported new support with their physical health.

"…I had avoided hospital appointments due to anxiety and shame. Had old domestic violence injuries that have caused arthritis. Gemma helped me go and reduce anxiety to attend. Now can go alone and have the treatment I need. Without this I would be without treatment and drinking to numb pain." **Lucy, Pilot client**

"Will now get self-harm treated and I have grounding tools when I'm there to help me stay calm." **Davina, Pilot client**

MENTAL HEALTH

Six Pilot clients reported a diagnosis of mental health conditions including bi-polar disorder, emotionally unstable personality disorder, anxiety and depression. All 10 clients reported other mental health conditions including ADHD, suicidal feelings/intent, suspected schizophrenia, PTSD, depression, self-harm, drug-induced psychosis and intrusive thoughts. At the start of the Pilot, five clients were taking prescribed medication for mental health conditions, and none were receiving therapeutic services. All six Pilot clients who provided follow-up feedback stated a positive change in mental health support including new support services, new insights into their mental health and a greater sense of being able to manage their mental health:

"[I] never had support before around my childhood trauma. It's helped me see things different and why I make decisions that punish myself." **Aminah, Pilot client**

"I haven't been sectioned or in crisis since working with Gemma. I still struggle with anger but people are starting to understand me more and help me regulate." **Davina, Pilot client**

"…never had therapy before and realise how much I need it. Mental health [services] declined support due to alcohol use but I was anxious and depressed before addiction… [I'm] only just starting to understand how abuse is linked and that it's not my fault." **Lucy, Pilot client**

"…I feel calmer and able to link my behaviour to trauma. For first time in years I am not using. [I'm] seeing my family and feeling better about myself. I still struggle with shame but now I know what it is and what to do." **Leone, Pilot client**

HOUSING

The Pilot Practitioner played a significant role in supporting clients with their housing needs. However, in moments of housing crisis, addressing these issues prevented therapeutic work. Four clients moved to emergency accommodation placements and two of these clients were moved three times during the Pilot. The Practitioner looked to use experiences such as this to build a relationship with the client and suggest strategies to manage trauma symptoms that could be exacerbated under stress.

…[The practitioner gave me] support around cleaning and fixing doors and windows due to [damage caused by my] ex-partner. Gemma helped me ask for what I needed." **Aminah, Pilot client**

"[The supported housing provider] are wanting to help me when upset or angry and not just kick me out." **Davina, Pilot client**

At the start of the Pilot, four clients were in emergency accommodation or homeless, and another client reported being at risk of losing their tenancy. By the end of the Pilot, only one client remained in emergency accommodation. Four clients made positive moves to an improved accommodation situation and the other six successfully maintained their housing situation. Of the six clients who provided feedback, three were planning positive housing moves in the near future and none were concerned they may be forced to make a change (e.g., due to being evicted or made homeless). In addition, the case study of Davina (Appendix 1) shows the Practitioner was able to continue trauma stabilisation support during an extended period of homelessness, with the client now being in stable accommodation and on a waiting list to go to rehab:

Seeing that Davina now had much better relationships with the services around her, she was offered another place in supported accommodation. Gemma went with her to look at it twice. Although housing services said Davina had no other option but to stay there, Gemma wanted Davina to be aware of the choices she had and decide for herself. **Extract from Davina case study (Appendix 1)**

LEGAL PROCEEDINGS

At the start of the Pilot, three clients reported pending criminal investigations and court proceedings. Addressing avoidance of participation in proceedings against the clients required a similar approach to avoidance of medical care. There is also evidence the Practitioner was able to provide trauma-informed support to clients as the victim in legal proceedings.

"Gemma supported me in court and explained why I was triggered when arrested. I avoided prison and now on probation and have more support in place." **Davina, Pilot client**

"…due to Gemma's support and understanding around coercive control [the] Court dropped charges from intent to supply, which would be prison, to possession… which is likely to be [a] community order." **Extract from Mari case study**

4. THE ROAD TO REHAB

SUPPORTING CLIENTS ACCESS AND ENGAGE WITH RESIDENTIAL DRUG AND ALCOHOL REHABILITATION SERVICES

Information in the clients' nomination to the Pilot showed most were worried about their drug use (seven clients), alcohol use (two clients), or both (one client), and were using a range of substances: Heroin, cocaine and crack cocaine, pregabalin, benzodiazepines, tramadol, illicit methadone and GHB (gamma hydroxybutyrate). Five clients disclosed poly-substance misuse and cocaine, or crack cocaine, was the most prevalent substance (six clients). Six of the clients reported going to rehab before with 16 attempts between them. At the start of the Pilot, nine clients said that going to rehab was part of their plans and one was unsure.

The Pilot aimed to support clients access and engage with rehab services and a key component of this was helping clients to meet the referral and waiting list requirements for residential rehab placements. The Pilot demonstrated positive impacts in a number of ways:

- **Building confidence to work with substance use services and rehab**
- **Supporting increased engagement with substitute prescribing**
- **Developing coping strategies to manage trauma symptoms in support of work with substance misuse services and rehab**
- **Supporting access to residential rehab waiting lists.**

In addition, clients' perspective of their ability to go to and do well in rehab has improved:

During the Pilot, five clients started substitute prescribing programs (usually methadone) and three of these five stopped complying with the prescription (aka. going 'off-script') at some point. Two of the clients who started substitute prescribing are now on a waiting list for a rehab place and one of them went 'off-script' for a period.

COMPARED TO WHEN THEY FIRST STARTED ON THE PILOT, HOW PARTICIPANTS NOW FEELS ABOUT THEIR CHANCES OF:

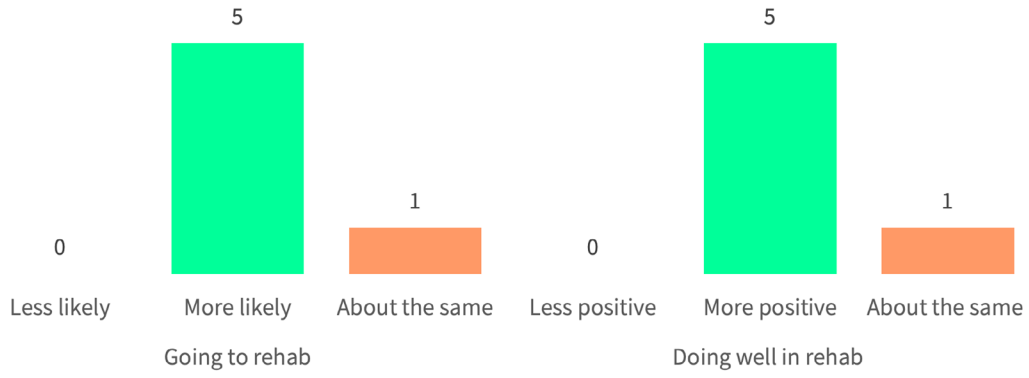
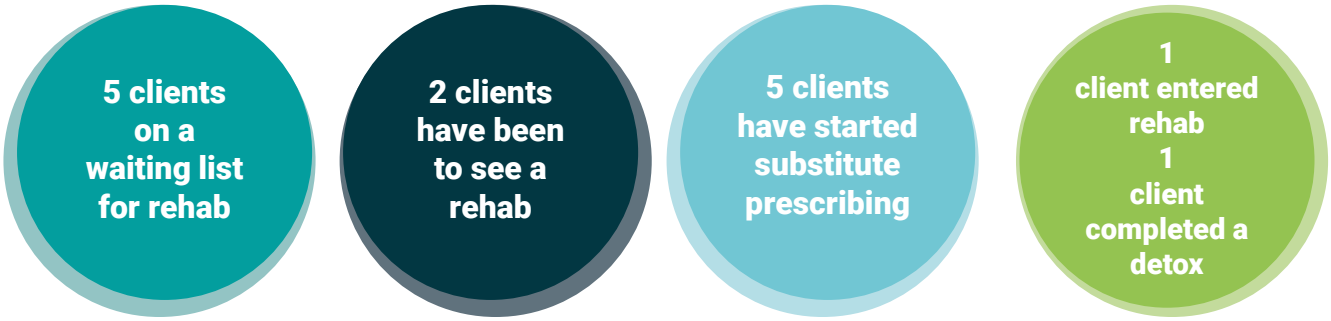


Figure 6

At the start of the Pilot, nine clients said that going to rehab was part of their plans and one was unsure. Where clients had previous experience of rehab, the Practitioner worked to identify which trauma symptoms may have limited their ability to achieve their goals and then supported clients to explore strategies that would work well for them to manage and respond to their trauma symptoms:

"Gemma helped me understand why I struggle around others when I was in rehab and how I can manage anxiety. I still struggle with being myself but I… allow myself fun and not always punishing myself… [I] better understand how my trauma is linked to drinking." **Lucy, Pilot client**

Mari wanted to go to rehab but her chances didn't look great; she'd been to both the local and out-of-area rehabs several times and told by one she was not allowed to return because she got into relationships… They talked about Mari's relationship style being disorganised and anxious and saw how this matched the relationships she got into in rehab. **Extract from Mari case study (Appendix 3)**



Throughout the Pilot, clients have been accepted onto residential rehab waiting lists with the support of the Practitioner. Clients reported that the Practitioner and the work they did together has enabled them to be well prepared for residential rehab and ssupported them more broadly. Clients spoke highly of this support and the data suggests that the more clients were able to engage with trauma stabilisation, the more likely clients were accepted onto rehab waiting lists.

"I feel like I can tolerate groups more and say when I'm feeling triggered and need space… still struggle to ask for help but I've been talking about my trauma, and it's been okay so feel like I can do it again." **Mari, Pilot client**

"…I understand myself more and feel I'm getting better at regulating emotions. Can see a better future for myself and no longer blame myself for all the bad stuff… I have been able to talk about stuff for the first time and feel that I can again if I trust people." **Davina, Pilot client**

THE PILOT'S WIDER SYSTEM LEARNING

RELUCTANCE TO ENGAGE IN TRAUMA WORK

Eichfeld et al. (2018) summarise, 'effective trauma therapy can also significantly reduce post-traumatic symptoms without the need of trauma exposure' (i.e., talking to the client about the events of traumatic experience). De Jongh et al. also point to several studies in an emerging evidence base that show trauma treatment is effective and safe for people with co-existing conditions: Including substance misuse, historic and childhood sexual abuse history, personality disorders, nonacute suicidal ideation and even schizophrenia (2016). Yet this conflicts with local experience of clients with personality disorders being told they cannot be treated and arbitrary requirements for clients to be abstinent from drug and alcohol use for 6 months, (FLSE, 2019). The Pilot has found clients wanted to engage with trauma work, but it was more frequent to encounter staff and services who were unfamiliar with, or not confident in taking trauma-informed approaches.

RELUCTANCE TO ENGAGE WITH MULTIPLE AND COMPLEX NEEDS

Captured in case studies, the local experience of the FLSE project is of many clients experiencing MCN not receiving access to statutory mental health services, with the feedback that clients are 'not stable enough'. During the Pilot, clients and the Practitioner did encounter such feedback, however, the trauma stabilisation work offers a new approach and lens to explore these views of stability and readiness.

The National Institute for Clinical Excellence (NICE) treatment guidance focuses on clinically diagnosed post-traumatic stress disorder but notably states that, 'comorbid drug or alcohol misuse' should not result in exclusion from treatment. The guidance goes on to outline the need for recognising personal circumstances such as the client's housing situation and to support them to manage barriers to engaging with trauma therapy, 'such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception' (NICE, 2018). De Jong et al. (2016) raise significant points about exposure-based (past trauma) treatment being both safe and effective with PTSD, complex PTSD and a whole range of co-existing conditions. This in turn leads to a concern that mental health services are both creating a requirement for stability that isn't evidence based while also not being equipped to offer interventions for clients to meet the 'stable enough' threshold. De Jong et al. drive this point further, highlighting the potential demoralising impact on patients of being told (or even worse, left to infer) that they are not capable of dealing with their trauma with labels such as 'complex' and 'complicated' compounding the impression clients will not be receptive to treatment. What's more, the experience of the Trauma Stabilisation Pilot has found this to not be the case.

Another factor is hinted at in the wider literature concerning trials of PTSD treatments, with Eichfeld et al. mentioning criteria can exclude clients with MCN that are so often associated with trauma (2018). Logging and tracking decisions around service rejection and measuring this against transparent criteria would likely guide commissioners to gaps and barriers in accessing these services and shed light on whether this is due to unsighted service needs or attempts to protect service capacity. In the case of the former, the usefulness is evident. Concerning the latter, it may help build the case for increasing resources to meet demand.

GROUPWORK

The Practitioner and a member of the FLSE Service User Involvement Team trained in the Seeking Safety model for addressing trauma and addiction. This was with the intention to explore a groupwork program that may act as a referral pathway for clients to the Trauma Stabilisation Pilot and consider the demand for trauma stabilisation in a group setting. Seeking Safety is also a present trauma approach that aims to help clients recognise how their lives would be if they felt safe and discover new strategies to manage their trauma symptoms (Najavits, 2022). Seeking Safety is reported to be, 'the most empirically studied model' for the dual diagnosis, with a particular focus on women and girls with a history of sexual and physical abuse (Najavits, 2009).

Selecting some of the 25 topics available in this model (such as asking for help, healthy relationships, creating meaning, healing from anger and grounding) and consulting with a rehab who have adopted this model in group settings, eight sessions were offered to 4-6 clients with MCN. These clients were not clients of the Trauma Stabilisation Pilot and were self-referred to the group through advertisement at, and networking with, local drug & alcohol services. The clients of this group were self-selecting in terms of their ability and willingness to engage in a groupwork programme and as such, they tended to have fewer complex presentations than the clients of the Pilot. Worksheets and materials for the group were sent in the post to the attendees in advance and they were able to call the Practitioner between sessions to ask questions about the content.

Some women used the group to explore how they would explain their trauma symptoms to professionals and services they were working with, some expressed anger at not being given a trauma perspective on their situation before and several reported being able to better regulate their emotions and take part in social activities. Of the four regular attendees, two have since gone on to attend rehab after completing the group.

LOOKING TO THE FUTURE

SERVICE DESIGN

WHAT WORKED

The basic components of the Trauma Stabilisation Pilot demonstrate a model that is effective at engaging clients, supports them to better manage their trauma symptoms and increases their ability to engage with other support services and treatment pathways. The foundation of this approach is the assertive outreach delivery of trauma stabilisation work by a capable and appropriately trained practitioner.

This is also a cost-effective intervention. A monthly cost of the Trauma Stabilisation Pilot with a single practitioner has been calculated at £4,400. This includes practitioner wages, employer contributions, line management time and support, clinical supervision, training & development, a contribution to the administrative functions of the host organisation, client expenses, use of a mobile phone and access to an electronic lone working device. Within this cost the Practitioner has also provided additional value by running a 10-week trauma stabilisation group (for 4-6 clients), delivering trauma-informed training to local services, participation in a report on the use of clinical supervision and work on women's experience of rehab.

A successful element not explored in detail in this report have been the quick availability of funds to allow the Practitioner to support small costs such as hot drinks at a coffee shop, taxi fares to a medical appointment or a low-cost mobile phone. More significant expenses were discussed in line-management supervision to assess the potential therapeutic benefit. The Pilot learnt from the widespread use of expenses budgets in previous FLSE outreach work by ensuring the Practitioner had an expenses card that could be monitored with a budget of £50 per client per month. However, the average spend per client was much less than this at £38.86 per client per month. The Pilot used the Equals Money service to manage this card. Learning from previous work, it was important to limit any chance of the Practitioner needing to use their own money and claim back expenses as well as move away from a petty cash system.

Another valuable (and essential) element of the intervention has been the availability of regular clinical supervision. As the case studies mention, clinical supervision played a valuable part in effective practice as well as allowing the Practitioner to negotiate more complex client dynamics. While clinical supervision is not widely offered in drug and alcohol outreach interventions, it has been essential to the safe delivery of trauma stabilisation which should not be considered without this in place.

The use of worksheets collated into personalised 'work books' has been evidenced to be an effective way of communicating learning and stimulating discussion with clients around their present trauma symptoms. As mentioned, the experience of the Trauma Stabilisation Pilot is that clients engaged with the personal touch that was generated by the Practitioner sourcing and making the worksheets. Considering this, we would recommend avoiding mass produced resources which may run the risk of reduced engagement from clients. For this reason, we have also not made copies of these resources available.

WHAT NEEDS IMPROVEMENT

The framework of the intervention was setup in five weeks due to a desire to maximise the amount of client facing support time. In hindsight, planning could have started earlier and enabled 18 months of client direct work and an additional two months to end and review the work. Many of the clients who are currently on a waiting list could be reasonably expected to go into rehab placements within the next 2-4 months. More time would allow the Practitioner to complete the planned 4-weeks of overlapping support when they first go to rehab. This time is also intended to allow for the handover of learning about the client's communication and engagement styles as well as support them to practice trauma stabilisation skills in their new surroundings. Overall, we have learnt the clients were able to develop trusting and effective relationships with the Practitioner in this time. However, more time was needed to help them address the years of unsupported health and mental health needs, navigate the challenges of existing abusive relationships and ensure basic needs are being adequately supported.

Outreach workers are often familiar with lone-working practices, but what was not foreseen was the combined impact of being the sole Practitioner and the coronavirus pandemic. The latter meant less staff were present in office spaces to provide informal support. As the sole Practitioner, they were not able to benefit from the peer support of a team. While clinical and line-management supervision was adapted to improve support to the Practitioner, this was not able to substitute a familiar office base and team environment. We would strongly recommend that any future service is either delivered by a team of trauma stabilisation Practitioners or that they sit within a similarly tasked team of therapeutic and outreach practitioners.

The nomination process was able to suitably identify appropriate clients for the Pilot, but it has since become clear that many of the client's needs were not fully understood by professionals at this stage. We believe this is a symptom of clients with trauma experience being isolated and withdrawn from services meaning physical ailments, abusive relationship dynamics or poor home conditions may go unnoticed by services. The inclusion of a named primary keyworker in each client's nomination was intended to identify a professional who would be able to support client's practical needs. The experience of the Pilot has been that care coordinators and professionals from statutory services do not provide this support and often looked to the Trauma Stabilisation Practitioner. In Violet's case, the Practitioner was providing daily support for several weeks so she could get her methadone prescription when a serious injury limited her mobility. The drug and alcohol service refused to support this need. In future, we would recommend stronger scrutiny of the capabilities of a named primary keyworker to reduce the risk of practical and task-based support needs detracting from the relationship-based trauma stabilisation work. At the same time, we recognise incidents where supporting practical needs has been linked to a relationship-building opportunity or therapeutic benefit. We would recommend written agreements are established with professionals in the client's support network to identify who will take responsibility for supporting various practical tasks. The Practitioner will then remain free to provide practical support where there is a benefit to the trauma stabilisation work, relationship-building and promoting client engagement.

While assessing potential clients for the Pilot, there was an attempt to accept five clients with high support needs and complexity and five clients with a lower level of support needs. However, as Figure 1 indicates, all of the clients eventually fulfilled the criteria of high support needs and complexity.

While this did serve to support the case that such clients can engage with trauma stabilisation, it placed a high level of demand on the Practitioner. In contract, the trauma stabilisation group (which has since seen two clients attend rehab), appears to have suited clients with a lower level of complexity.

It is likely the clients for groupwork were in some way self-selecting due to their ability to engage in group environments. We have considered that the impact on the trauma stabilisation Practitioner may be reduced with a blend of individual casework support and group facilitation. Given the exposure of the Practitioner to the adverse experiences of the clients, this is likely to be useful to sustain a high quality of practice.

MEASURING IMPACT

Measuring the impact of new services such as the Pilot is essential to communicate the value of the work to both the clients themselves and to the wider systems intended to support them. The learning in this report shows that the work of practitioners in these roles is often complex, nuanced, and sensitive, and any monitoring framework used in the future should seek to reflect this.

Participatory approaches such as Collaborative Outcomes Reporting (Dart & Roberts, 2014) have the potential to provide a more flexible and proportionate approach to evidencing impact, which provides space for emerging outcomes and involves the practitioners themselves in setting outcomes. Case study work would be enhanced by applying a social enquiry method such as Most Significant Change (BetterEvaluation, n.d.), to draw out the key factors which have facilitated positive changes in the lives of clients.

While the Pilot has been able to generate detailed and informative case studies, future work around this could benefit from embedding it as part of the model of practice. Where clients are able to, the process of identifying and telling their story may act as a useful therapeutic tool and serve as an opportunity for client co-production in the evaluation of the service.

SYSTEMS CHANGE

Through the work of this Pilot, the team has reflected that the impact of this role would be enhanced if the wider support system consistently took a trauma-informed approach. If the support system could scale up efforts to work in this way, we believe services will become more accessible, less stigmatising and more effective for people, particularly women, experiencing MCN. We align with the recommendations and findings in the Dame Carol Black Review Part 2, particularly the Review's commentary about the need to acknowledge trauma and equip the workforce to work with it:

> ***'For many people, mental health problems and trauma lie at the heart of their drug and alcohol dependence. Commissioners of substance misuse services and NHS mental health services must either provide a better pathway between the services or integrate their services. Above all, the workforce in both services need to be trained to deliver more and higher-quality psychosocial interventions.'***
> Independent Review of Drugs (Black, 2021)

During the Pilot, we have also learnt about the concerning way the support system is organised across housing, treatment pathways and benefits services. The team has seen significant issues with women accessing rehab and this negatively impacting on their long-term housing security. Where women have their own accommodation, they are likely to lose this by going into in-area rehab due to the placements being funded by housing benefit. The housing benefit is re-directed for rehab placement costs, and this results in women needing to 'give up' their accommodation.

This is not the case if they were to go into hospital for treatment or receiving NHS Community Care funding for an out-of-area rehab placement. In-area placements are often preferred by women. We are concerned by the current processes because the issue of out-of-area placements has a knock-on effect for victims of domestic abuse where they are separated from local support networks or lose their housing as a result of going to rehab. This increases risks of street homelessness, returning to perpetrators of abuse for accommodation support, and high risks of placements for women into unsuitable emergency/temporary accommodation when they complete their residency at a rehab.

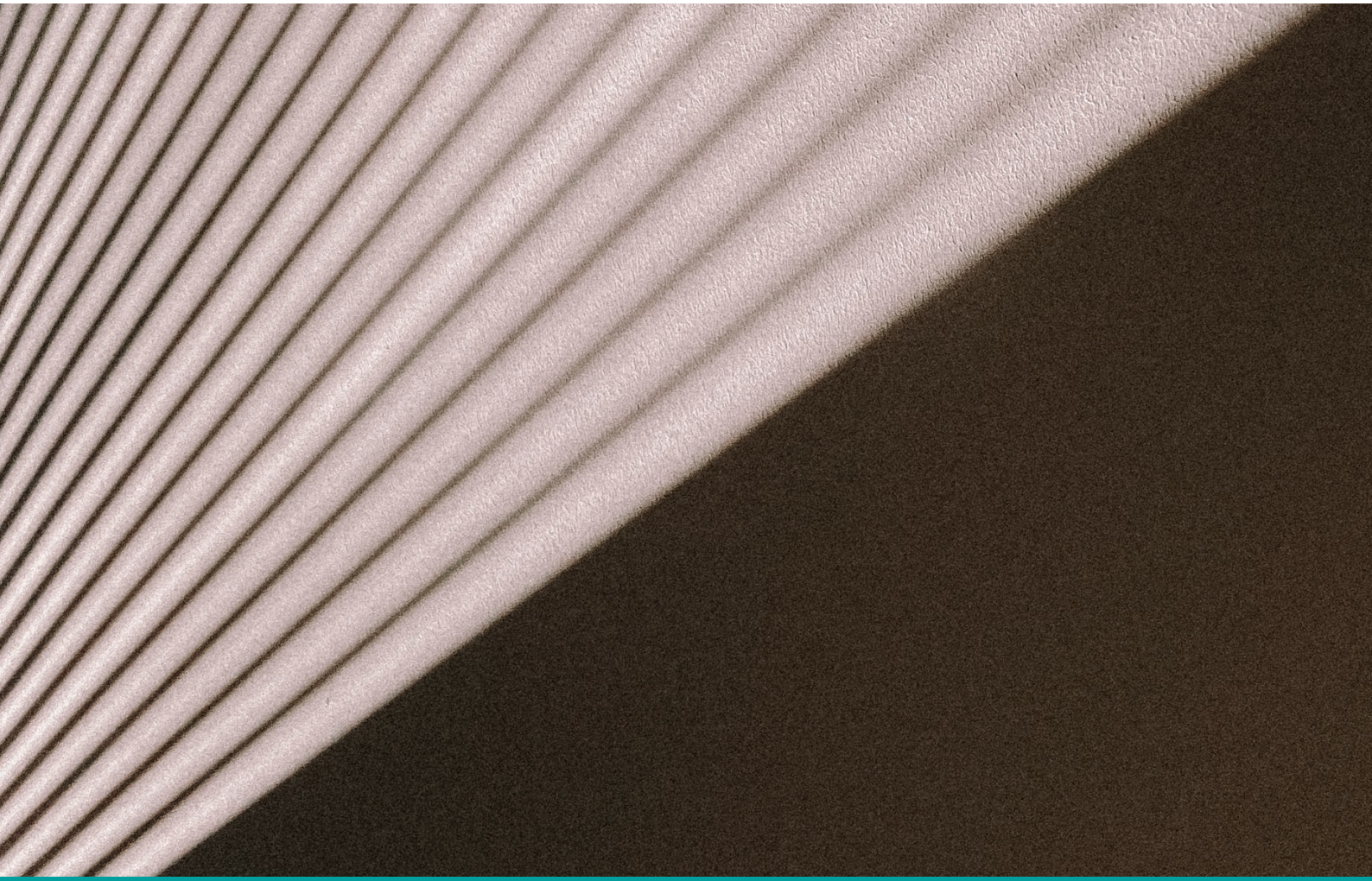
The wider support system could better respond to the needs of women with MCN and seeking in-area rehab placements by:

- **Seeking dedicated funding for in-area residential rehab to support women attend in-area placements**
- **Looking at creative rent payment agreements with landlords/housing agencies**
- **Recognising that rehab is not housing**
- **Consider innovative and community-based rehab services where women can return to their home after four weeks of residential detox (covered by housing benefit overlap)**

BEST HOPES FOR THE FUTURE

"My hope is that trauma stabilisation becomes a valued part of recovery support offered to those impacted by multiple disadvantage and designed beyond the traditional therapy room, as trauma, addiction, physical and mental health all go together. We have seen positive results in this Pilot using an outreach model and building from what clients can tolerate and engage with, rather than taking a deficit-based approach. Trauma impacts so many in society and yet so many of our clients are denied the therapeutic support due to 'not being stable enough' or needs that are felt to be 'too complex'. We need to change the idea that people are not ready to understand how their behaviours are a result of trauma because they are ready; they live with their debilitating symptoms every day and by offering compassion, psychoeducation and relational tools they can break the cycle and start their healing journey." **Gemma Harfleet, Trauma Stabilisation Practitioner**

"I can see a time when it becomes normal to have trauma stabilisation workers in services, when it's a regularly advertised job role and, and when we can look back and wonder how we thought we were going to help without it. If services become curious and confident about trauma, it could be as significant as when we stopped routinely institutionalising people for their mental health." **David Garrett, Practice Development Coordinator**



RECOMMENDATIONS

FOR COMMISSIONERS, BUDGET-HOLDERS AND DECISION-MAKERS:

SERVICE OPTIONS

- **Offer different treatment options** for women who cannot access residential rehab, such as community-based, structured day programs following on from residential detox. This would help to address the likely risk of homelessness for people who want to access rehab support but will lose their tenancy in doing so. This could also benefit people who have care responsibilities (children, adults and pets) and who need to stay close to local communities of support.
- **Make out-of-area rehabs more widely available** for women who have maintained their tenancy and want to come back to their home after rehab.
- **Offer women supported emergency accommodation before** leaving rehab with fast-track pathways to re-engage in rehab. Support provided in this accommodation could be tailored to substance misuse needs.
- **Offer assertive outreach services** to all clients with multiple and complex needs, as standard. Any service that hopes to engage with clients who have MCN is likely to struggle without this approach. It is important to acknowledge that this may require less resources to implement in a city where services are concentrated compared to county-wide services.
- **Reduce waiting times** for rehab placements where a client has already received trauma stabilisation treatment, to help maximise treatment outcomes.
- **Offer more trauma stabilisation treatment** to women who want to go into residential rehab, increasing capacity for women-only spaces or women-centred services.
- **Offer trauma stabilisation group work to women in local rehabs** to continue learning and developing strategies to help manage trauma symptoms as well as prepare for further therapeutic work.

POLICIES

- **Review, adapt and make transparent** policies for alcohol & drug misuse services regarding accessible and inclusive support for clients with short or long-term limited mobility.
- **Stop putting responsibility for service capacity or confidence to support trauma onto clients** with statements about them being ‘not stable enough’ or ‘too complex’.

TRAUMA PRACTICE

- **Employ and train qualified trauma stabilisation practitioners in wider services** such as substance misuse, housing allocation, mental health, employment and benefits, and supported housing. These roles should also be supported with clinical supervision.
- **Offer trauma stabilisation as a pathway for mental health support.** Through assertive outreach, trauma stabilisation can act as a bridge to more in-depth mental health interventions (such as Phase 2 trauma treatment) and can support a range of client groups with co-existing mental health and drug & alcohol needs.
- **Offer trauma stabilisation training and qualifications** as a development pathway within support services. Working in an assertive outreach model, trauma stabilisation practitioners have the potential to offer more accessible, mobile and immediate mental health support, which often works better than traditional 'sit and talk' interventions with MCN clients. With limited availability of psychologists and psychiatric nurses, trauma stabilisation practitioners could offer an accessible choice for many clients.
- **Offer trauma-informed training** to all services to build confidence, complement existing experience and increase ability to appropriately respond to and safely support trauma symptoms.

FUNDING SYSTEM

- **De-link funding for rehab services from punitive benefits system.** People entering rehab can only claim one month's rent for both their existing accommodation and rehab services. This funding system allows little room for any setbacks, creates a situation where people can be made 'intentionally homeless' without a duty of care to be re-housed and can create a sense of 'shame' and 'failure' for many women who have experienced complex trauma. The current system fails to recognise experience on the number of attempts it takes motivated clients to achieve their goals in rehab with a naive expectation they will be able to succeed at the first attempt.

CONTACT DETAILS

This Pilot role sat within BHT Sussex and was delivered through the FLSE programme.

For further details on the work of FLSE please visit the website: **https://www.bht.org.uk/fulfilling-lives/**

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APPENDICES

APPENDIX 1: CASE STUDY – DAVINA

You haven't understood that right, that's my trauma response

Davina's story has been fraught with suicidal feelings leading to mental health inpatient admissions, spells of homelessness and cycles of binging crack cocaine and alcohol. Davina was trying to be abstinent but didn't have the tools and strategies in place to make this stick. Davina also wanted a better relationship with her daughters, her foster parents who she still speaks to, and to avoid abusive partners.

When she was nominated for the Trauma Stabilisation Pilot, Davina was in hospital in another county. Gemma called her, introduced the Pilot and asked her how she might feel safe as they started working together. When she left hospital, Davina was offered an out-of-area emergency accommodation placement. Housing services didn't want to put Davina there, but they didn't have anything more suitable and supported mental health housing wasn't an option due to her needs not meeting criteria. Davina was discharged from the mental health crisis support service because she wasn't engaging. Davina described feeling isolated and unsafe with regular knocks on her door and harassment from male residents in accommodation. As a result of not feeing safe Davina lived in a car for a few weeks. At one point Davina spoke to Gemma about her mental health diagnosis and the research she had done into suicide rates with this diagnosis, seeming to suggest this was inevitable for her also.

At the start, Davina either messaged or spoke to Gemma on the phone. Gemma realised she needed to take a gentle approach and be careful not to overwhelm too quickly with this new relationship. After a few weeks they met for the first time at a women-only service where Davina felt safe, with her substance misuse worker who she felt she could trust. Davina came across very motivated to work with Gemma and explore her trauma experience. After a short while they started meeting at coffee shops, but most of all Davina liked going to the marina. Davina explained how she liked open spaces that weren't too busy because she could be hyper vigilant. Throughout the Pilot, Davina would continue to meet with Gemma or talk over the phone as well as email back and forth. Gemma wanted to provide consistent support and avoid anything that might cause a further sense of shame, such as being critical about the way Davina chose to engage. There were times when Davina wasn't where Gemma had arranged to meet, but Gemma was able to get to where she was in town.

Several services would try to phone Davina a few times and when she didn't respond would say she's not engaging. Gemma introduced work around the 'window of tolerance' with a visual worksheet. This seemed to compliment Davina's learning style and was something they returned to a lot. Later Davina would use worksheets like this to explain her experiences to her old foster parents. It became clear that Davina couldn't always manage some of the ways services were trying to reach her, but this wasn't about motivation. Davina's attachment style meant she really struggled with face-to-face meetings, feeling overwhelmed and then shame at not being able to get through something as simple as a meeting. Davina also spent a lot of time in 'survival mode' where avoidance, disassociation and withdrawal from people was part of how she had learned to protect herself.

Davina would later explain to Gemma that she would sometimes avoid professionals because she was worried about her ability to manage her anger with them. Davina said she felt misunderstood by mental health services as they would talk about everything being part of her diagnosis, then offer medication but

not any ideas for how to manage her intense feelings. Davina often felt frustrated when meetings were focused on filling out forms or doing checks the service needed to do. This would lead to Davina feeling stressed, overwhelmed, dysregulated and eventually it would escalate into verbal conflict. As a result, Davina was labelled 'aggressive' or 'not able to engage' and this fed into feelings of shame.

Davina was curious about her diagnosis and spent a lot of time researching and trying to understand it. Davina seemed to have more of a sense of being able to make changes when she understood trauma responses as way of surviving rather than just being a 'broken' person. Davina began to recognise when she was dysregulated and, using one of the worksheets, explained to her foster parents some of the behaviours they found difficult. Davina also came up with some pre-made text messages she could send out when she was struggling, and people were asking to meet. In this way, Davina didn't have to think about writing them at the time and feeling shame about not being able to respond or causing them to worry.

There were times where Davina felt she could see how her behaviour might relate to trauma where before this was only talked about in relation to her diagnosis. With Davina's permission, Gemma talked to the other services around understanding Davina's behaviour. Gemma presented a trauma-informed perspective of what might be going on for Davina which seemed to lead to more compassion and understanding where previously they had struggled with the way Davina could sometimes come across. Gemma also talked to these services about the relationships between self-harm and addiction with attempts to sooth difficult feelings. This perspective influenced the decision not to pursue a potentially invasive assessment which allowed space for Davina to work with Gemma on options for other strategies and tools to manage what appeared to be symptoms of trauma. At the start of the Pilot Gemma would regularly get calls from the mental health service saying Davina had been shouting at them on the phone, which happened when she felt threatened. Often this led to concerns they were not able to work with Davina. Since taking this approach, they haven't reported any more incidents like this.

Davina grew up in an unpredictable home and spent some time in care. Davina's parents struggled with addiction and would only seem to come to her aid when she was in crisis. Davina was able to see a link between this and her suicidal feelings. The trust built in the relationship, to the point where Davina felt able to share experiences from her life that she hadn't shared with professionals before. Gemma had to gently put a stop to some disclosures to prevent Davina from regressing to those past feelings and becoming overwhelmed. When this happened Gemma would check in with Davina about how she was feeling. They'd use some of the grounding techniques they had been practicing helping Davina reconnect with her present feelings and environment. Gemma made sure to tell Davina this wasn't because she didn't believe what she was saying but that she wanted to keep things safe until she has tools to regulate emotions. Gemma was also aware that, oversharing without having strategies to deal with the emotions this could bring up, could be a symptom of trauma.

In the six months before she met Gemma, Davina made two suicide attempts and was involved in several emergency service callouts. Gemma started to move conversations from risk around suicidal feelings to asking what makes Davina feel safe followed by making plans that help her connect with what felt safe when she was in that place.

Gemma used clinical supervision to discuss the dynamics of this which informed her decisions to stay with

Davina when she was feeling like this. On one occasion that Davina reported feeling suicidal and hopeless, Gemma looked for a grounding technique that involved physical activity to bring Davina's energy and mood up. Gemma suggested they go to the marina, and they threw stones into the sea. This seemed to help Davina safely release feelings of anger and get back a sense of control over her emotions where she had felt overwhelmed. This was a different experience for Davina who was used to having emergency services called when she was feeling suicidal. For Gemma, this felt like a breakthrough moment. Together they went on to devise other strategies to deal with this such as getting into outside spaces (trying to be still didn't work for her), using a self-care box with fidget toys and Gemma sending little cards with affirmations and supportive messages. Davina still feels suicidal from time to time. However, now Davina sticks to plans, reaches out for support, can name things that trigger her to feel suicidal and tries to stay within what she can tolerate. Since the start of the Pilot, Davina has not had any emergency services callouts. Davina has also been able to see how she could misread expressions. Gemma was able to explore this with Davina when they met after Gemma had some difficult personal news. Davina picked up on slight change in how Gemma was and assumed it was because Gemma was annoyed with her. However, Davina felt able to bring this up with Gemma who could then reassure her it wasn't because of anything she had done.

Seeing that Davina now had much better relationships with the services around her, she was offered another place in supported accommodation. Gemma went with her to look at it twice. Although housing services said Davina had no other option but to stay there, Gemma wanted Davina to be aware of the choices she had and decide for herself. The accommodation manager listened to Davina's needs and preferences, and they tried to make sure the shared space was with a resident she might get on with. While Gemma wasn't sure how Davina would get on there, eventually she liked to meet at the accommodation because her space started to feel safe and familiar to her.

With the affirmation cards Gemma sent up on her wall, Davina has now been in stable accommodation for 6 months and is on the waiting list for a local rehab. Davina has longer periods of reduced drug use but does still self-sabotage by using, which will need further support and understanding. Over the course of the Pilot, Gemma saw how Davina's periods of avoidance got shorter and her disassociation to reduce. Davina didn't avoid her court case for drug possession and Gemma was able to provide a trauma-informed perspective to the experience of being restrained when she was arrested, which the Court took on board. The Court also listened to how much Davina had been engaging with Gemma and she didn't get a custodial sentence as she had feared. Davina has since been seen by Gemma to have the confidence to advocate for herself in meetings. Using some of the new words and ideas she had learnt, Davina told a group of professionals, 'No you haven't understood that right. That's my trauma response'.

APPENDIX 2: CASE STUDY – LUCY

It wasn't my fault, was it?

Lucy had been to detox for ten days and rehab for six weeks but struggled with her relationships with peers and staff and found it difficult to manage her emotions. Lucy avoided communal activities, struggled to talk about what she needed, found groups triggering and eventually left. Lucy's girlfriend and her family saw this as a failure and felt she didn't try hard enough. Because she kept people at a distance and came across standoffish, people would interpret this as Lucy being unmotivated or 'stuck up'. Lucy grew up in an unsafe and unprotective environment where there was neglect as well as physical and emotional abuse. As an adult Lucy was in several abusive relationships and had been in hospital multiple times because of violence against her. When Lucy reached out to her family, they didn't believe her. Lucy was now in a relationship that wasn't physically violent, but others had concerns about the negative way her partner would talk about her.

When Gemma first called Lucy, she was in hospital after an alcohol binge. Lucy did come across as closed off but as they started meeting at her home, she seemed very motivated and kept her appointments with Gemma. In-between meetings, Lucy would sometimes text or call Gemma and she liked to get emails with some information to look at before their next appointment. Lucy was very analytical and liked to make sure she really understood the topics Gemma would bring before allowing herself to engage with it emotionally; Lucy really liked the worksheets Gemma used to frame their discussions. Gemma was aware of taking things at a slow pace, so Lucy didn't get overwhelmed with this new information. Lucy seemed to particularly get something out of worksheets on attachment styles, trauma symptoms, disassociation and understanding what she might be trying to communicate through self-harm.

It started to emerge that Lucy felt comfortable in individual meetings but found groups of people to be difficult. Lucy described her standoffish presentation as protecting herself by keeping people at a distance. At first Lucy didn't see her experiences as traumatic or recognise how this might be impacting her now. As the relationship developed, Lucy became more aware of how she came across and Gemma was also able to gently bring this up. Lucy has been told she was rude, and this fed into her sense of being a terrible person.

Lucy was really drawn to talking seriously and deeply about things. Gemma spoke about Lucy's case in clinical supervision, and they came up with some ideas for playful ways to have discussions. Lucy really loved animals so Gemma asked what animal she would like to be and what traits she valued about them. Lucy chose an elephant because they look after their young for a long time, move in groups and are intelligent.

They also met in the park, at coffee shops, the substance misuse service, at hospital appointments and a women-only space in a local coffee shop. When they first met Lucy's health wasn't too bad, but she found appointments difficult and needed someone to go with her. Lucy felt anxious and that she was being judged in these environments because of her alcohol use and domestic abuse experiences.

Sometimes Lucy needed to get scans that involved several bus changes and getting to the other side of the city. On a few occasions Lucy's partner would take her to appointments but talk over her or for her. Gemma would sometimes help her get a taxi to medical appointment that she otherwise wouldn't have gone to.

After one of their meetings, Lucy began setting boundaries with her partner and challenging some of the ways she talked about her which knocked her confidence. After this, Lucy's partner said Gemma had given her a 'dirty look'. She quizzed Lucy on what she had been talking about with Gemma and for two weeks he said she didn't want Gemma to come to the house. One professional wanted to come up with a plan to get Lucy out of the relationship, but Gemma was careful not to get drawn into a confrontation. Gemma saw how this could create a 'drama triangle', pushing Lucy to feel she had to rescue her partner or Gemma. Later, Gemma assured Lucy's partner that she was not trying to end their relationship but support Lucy with her resilience. After this they met in the house again and Lucy continued to talk through her changing expectations about close relationships in her life and what she might want from them.

Lucy generally thought of herself as being a bad person and took on the blame for the traumatic things that had happened to her. As well as being avoidant and closed to people, Lucy had nightmares, was often hypervigilant, would disassociate, had an unhealthy relationship with food or exercise and would neglect her physical health. None of this was mentioned in her nomination for the Pilot and it was what Lucy had experienced for most of her life, so it felt normal to her. Now Lucy recognises a link between this and what she's been through. Lucy can say when she feels triggered, has been open up about past difficulties and recognised that she didn't feel safe to do this before. Lucy still struggles with blaming herself but has started to shift in this, asking Gemma 'It wasn't my fault, was it?'; and Gemma could reply, "No it really wasn't". Since they've been talking about rehabs, Lucy has asked to go somewhere that will help her continue to explore her trauma experience. Other signs of change Gemma observed were Lucy shutting down from communication for shorter periods of time and being able to practice some self-care when this happens.

Recently Lucy received a difficult letter about her health. Lucy spent a couple of days in bed, didn't eat anything and made herself unwell. Usually this would last for weeks but after three days Lucy got out of bed and had a hot shower. Lucy and Gemma have worked on other techniques when she's struggling with her feelings such as watching comedy shows, wrapping up in her favourite blanket and putting on the music she likes. Where before she saw crying as a sign of weakness, Lucy now used short periods of this as part of her coping mechanisms and even allowed herself to be tearful in front of Gemma. This has led to Lucy getting better practical support as well; being able to go to medical appointments by herself for the first time by using diaphragm breathing techniques to help stay grounded and visual techniques such as imagining herself as a super hero in that situation.

Lucy completed a 10-day in-patient alcohol detox but was unable to go on to rehab because of her physical health needs. Unfortunately, things have deteriorated, leaving her in more physical pain. Gemma has noticed how the pain can affect Lucy's memory and concentration, so they've sometimes done something less structured or had a more light hearted chat. While this might seem simple, Gemma hopes it also gives Lucy an experience of someone being attuned to her difficulties so that she might come to expect and look for this in her other relationships.

Lucy is now getting more medical support than she's had in a long time and is getting treatment for things that were previously neglecting. Lucy is going to appointments for neuropathy, arthritis and she's seeing a hepatologist. Gemma would have liked to do sessions out and about more, connect her with recovery services and a peer mentor. But it's not been possible and other services aren't offering outreach work to see Lucy at home. Before Lucy was being seen at home, the health issues she is now trying to address weren't being recognised by professionals - it's still not clear which service will take responsibility for this.

Lucy now has a better relationship with the drug and alcohol service where before there seemed to be a lot of misunderstanding about her behaviours. Lucy has been able to share more of what's happened to her and, when she's felt safe to, been more open and warmer with other people. Several people didn't think Lucy would be able to engage in therapeutic work because of what they observed but Gemma has been able to share a trauma-informed perspective of what might be going on for Lucy. In fact, Lucy has been one of the most consistently engaging people on the Pilot. The change in narrative around Lucy and evidence that she is motivated has led to an application for a rehab that has a focus on trauma-informed approaches. Lucy has also been able to complete an online education course and generally does now see a more positive future despite all the difficulties she still faces. Lucy really wants to continue therapeutic work and Gemma has been able to make a referral for a service that might support her where before this wouldn't have been considered. What's more, Lucy has continued to talk about setting boundaries with her partner as well as her family and showing she expects more from these relationships.

APPENDIX 3: CASE STUDY – MARI

Unstuck Thinking

Mari's housing keyworker had seen the progress she'd been making over the last year but had noticed some things kept tripping her up and felt this might somehow be about trauma. Mari had reduced some of her heroin use and had recently stopped using it with crack cocaine. The injecting sites in Mari's arms were badly damaged so she had moved to increasingly risky locations near main arteries. Mari wanted to go to rehab but her chances didn't look great; she'd been to both the local and out-of-area rehabs several times and told by one she was not allowed to return because she got into relationships, and they'd use drugs together. Another rehab said they would consider Mari coming back but they wanted to see some evidence of work to reduce the chances of this happening again.

After a phone call Gemma meet Mari at a coffee shop where she talked about how she felt misunderstood, judged and how people didn't understand how hard she was finding it in rehab. Gemma talked to her clinical supervisor about using a 'working together' agreement that set out how Mari likes to meet near the end of the day and at a coffee shop where she can smoke. Mari explained she had night terrors, would use drugs and have to exhaust herself to sleep; often not being able to sleep until the morning. Mari didn't know if these bad dreams were memories of real events, but they felt very real. At a later meeting Gemma showed Mari a worksheet on sleep and sleep apnoea. They came up with some techniques that she's still using to help get to sleep; watching travel shows and videos of cats doing funny things. They also agreed that if Mari fell out with Gemma, she would like to be given a bit of space, but also for Gemma to call her not long after to talk things through.

At first Mari struggled to talk about herself with Gemma and would chat about politics or what celebrities were up to. It took a lot of energy, but Gemma was determined and patient to bring the conversations back to Mari. As they got to know each other, Gemma introduced Mari to the idea of attachment styles. Mari hadn't come across this idea before and at times she was very tearful because she thought she was just a bad person. For the first time, Mari opened up about the difficulties in her childhood where before she would only talk about it positively. There's still a lot for Mari to explore but she was able to talk about how her step-mum would have violent outbursts and her dad had a successful career working abroad. Mari had learnt to suppress her own feelings of being unsafe with her step-mum's anger to also care for and comfort her afterwards. Later in life, Mari had a son. After social services involvement, her son was placed in Mari's father's care. Now retired, Mari struggled with seeing her father care for her son in the way he didn't care for her. Mari's son is now an adult, and she wants to have a good relationship with him, but he doesn't want to see her while she's using drugs. Mari and Gemma thought about how a lot of her behaviour was trying to comfort herself where she hadn't had this consistently in her life. They talked about Mari's relationship style being disorganised and anxious and saw how this matched the relationships she got into in rehab. This was a bit of a 'shift moment' for Mari who was able to see she wasn't just a bad person, that she was having an understandable reaction to her trauma experiences, and that these things could change.

Another of Mari's trauma symptoms was disassociation. In the past Mari would 'switch off' during groups or individual sessions and staff at one of the rehabs interpreted this as her being annoying, rude or lacking motivation. Jumping to these conclusions instead of staying curious and thinking about trauma is unfortunately something Gemma was regularly seeing with other professionals supporting the women she was working with. Soon Mari was keen to learn about trauma symptoms and share the details.

However, Gemma was concerned Mari could become overwhelmed. Gemma slowed the pace of these conversations and diverted to other topics until Mari had some tools and strategies to better regulate her emotions.

As time went on, Gemma learnt about how Mari would frequently find herself in places with no memory of how she got there. Mari was curious about how her experience might be linked to the beliefs she had about herself now, her disassociating and using drugs to avoid emotional pain. Sometimes this would weigh very heavily on Mari so Gemma would move the conversation to something else or have an activity prepared to help Mari stay in touch with her current situation.

As these conversations developed, Mari's curiosity eventually turned into insights. To protect herself, Mari would avoid connecting with other people because this made her feel anxious. That anxiety was linked to being disconnected from her own feelings of fear when she had to comfort her dad. Mari joined the dots and realised that keeping emotional distance from people meant they couldn't get to know her, so she was often misunderstood. They also talked about how Mari's difficulties reading people or recognise what it felt like to be safe in relationships might be linked to the mixed messages she got in her childhood.

Early on Mari also talked about wanting stability in her life. During the pandemic the 'Everyone In' policy led to Mari being put up in local hotels. As business returned, she would get 1-2 days' notice that she would need to move and one of the hotels was so poor it was shut down. On top of this, Mari was on edge because she knew if there was so much as a spoon lying around from drug use, she would be kicked out and facing rough sleeping. In this uncertainty, Mari kept hold of a lot of possessions, including a large collection of books, which made it harder to move at short notice. While Mari was eventually able to settle, Gemma couldn't do much trauma stabilisation work while things were being shaken up. Mari continued to struggle with her own needs and put herself at risk of getting into trouble trying to get food for others at the hotel who were going hungry.

After four months and 13 meetings with Gemma, one of the rehabs started talking to Mari about a place. By this time Mari had said a few times that it was nice to have someone that understands her, and Gemma could comfortably and regularly challenge Mari without a rupture in the relationship, saying things like, 'That's not okay but let's make sense of it'. They also did some planning around Christmas and dropping off presents which hadn't gone well as Mari was always hoping her father would invite her in despite everything. Gemma worked with Mari to come up with a plan to drop off presents with a family friend to avoid feeling rejected.

After just under 6 months and 21 meetings with Gemma, Mari walked through the doors of the rehab again. Mari was now able to see some of her triggers, including feeling judged, and manage difficult feelings with self-soothing (watching videos or distracting) and grounding techniques (naming four things she can see, feel and hear). Mari also took the worksheets Gemma had made into a workbook and a sensory box with pictures of her cats, things from her son, cards with grounding techniques and things to fidget with when she's feeling anxious in groups. What's more, Mari was using the words and language she had learnt to talk to staff about what she was going though. Mari even showed her keyworker her worksheets and what she was talking about with Gemma.

Gemma continued to meet Mari with some bumps along the way. Before going into rehab, Mari was buying books from authors she liked to read and telling herself she would be allowed to look at them when she gets to rehab. But now she's there she still doesn't feel she deserves to read them. Mari really struggled reducing her methadone for the first few weeks but managed to get from 80mg to 10mg/day with just one pause in the reduction, having never got below 30mg before.

Gemma also talked to her clinical supervisor to make sense of behaviour in rehab that she hadn't seen before. It seemed this might be about Mari feeling trapped and when Gemma explained this to the rehab, they came up with a plan for her to be more active and go out supervised walks to release more nervous energy. Now they're also talking about taking Mari to go cycling.

Mari has made it this far into rehab a few times before but this time there's a slight difference. Since she walked through the doors again 9 weeks ago, Mari hasn't got into a relationship or shown signs of becoming co-dependant. Staff who have seen her several times are talking positively about Mari and say they can see a change in her this time. But it's not all great news. Mari is waiting for the results from a drug test after she used drugs with another resident. If it's positive, she might be asked to leave. However, they're looking at the possibility of Mari being able to come back quickly based on her progress. Where before they were very cautious, now they are looking at ways to get Mari back in as soon as possible. Gemma has seen professionals change in their attitude towards Mari and they now approach her with understanding and want to make sense of her behaviour. It's no longer about Mari making the same mistakes over and over again but what those around her can learn each time to help her move on. As professionals start to get unstuck in their thinking, Mari seems to be more and more free to take the next step.