The feasibility of delivering a trauma-specific intervention to women in a UK substance misuse service

Study overview and findings

Dr Karen Bailey, Kings College London, June 2019
“I am just glad that someone is paying attention a bit more to what we have been going through....sometimes you can suffer from PTSD and not know it you know, and you think what the f**k is wrong with you, why can I not function at all....”

- Groupwork participant
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1. Background to the study

Women who experience interpersonal abuse [defined here as physical, emotional or sexual violence/abuse in adulthood and/or childhood] also experience high levels of co-occurring post-traumatic stress disorder (PTSD) and substance use (El-Bassel, Gilbert, & Hill, 2005; Gilchrist, Blázquez, & Torrens, 2012; Gutieres & Van Puymbroeck, 2006; Trevillion et al. 2012; Natcen, 2013). The high levels of psychological distress and physical health problems experienced (Reynolds et al 2005; Schafer et al. 2014; Tirado et al., 2018) bring added complexity in attempts to treat substance use.

For example, research has highlighted how mental health problems impact on alcohol relapse and treatment outcomes among women with histories of sexual abuse (Greenfield et al., 2002). The implications of this evidence base are that survivors of interpersonal abuse may require more tailored treatment approaches, which address the co-occurring issue of substance use and mental health in relation to their experiences of trauma, rather than dealing with each issue in isolation. However, in the UK, there are a lack of adequate treatment responses to address these issues in an integrated way, and a lack of robust evidence for the effectiveness of trauma-informed practice or trauma-specific interventions delivered in substance use services.

My PhD study, conducted between 2016-2018 with grants from the Economic and Social Research Council and Alcohol Change UK, determined the feasibility of delivering and evaluating an integrated trauma-specific group intervention, Seeking Safety (Najavits, 2002), within routine substance use treatment in England. The study was conducted in four phases and this briefing presents the key results from phases 3 & 4.

Detailed discussions of phases 1 & 2 can be found in the following journal publications:


Bailey, K., Trevillion, K. & Gilchrist, G. (in press) “We have to put the fire out first before we start rebuilding the house”: Practitioners’ experiences of supporting women with histories of substance use, interpersonal abuse and symptoms of post-traumatic stress disorder. Addiction Research & Theory.
Mixed methods were employed across all phases:

- **Phase 1**: a narrative systematic review of 20 international controlled trials examined the evidence base for interventions aimed at women with PTSD symptoms and problematic substance use;
- **Phase 2**: thematic analysis of 14 semi-structured interviews with UK stakeholders explored how practitioners from a range of sectors were addressing substance use, interpersonal abuse and substance use in their practice with women;
- **Phase 3**: Seeking Safety was adapted in collaboration with service users and staff, using Behaviour Change Theory;
- **Phase 4**: the feasibility of delivering the adapted Seeking Safety intervention was evaluated with groupwork participants (n=19) and facilitators. Qualitative interviews, analysed using ‘Framework’ (Richie et al., 2014), elicited their experiences of taking part. Mental health, coping skills and substance use outcomes of groupwork participants were measured post-intervention and 3-months post-intervention.

### Trauma-informed practice in substance use services

Trauma-informed practice (TIP) means instigating practice at an organisational level, as well as an individual/clinician level centred around five core principles: trauma awareness, safety, trustworthiness, choice and collaboration, and building of strength and skills (Harris & Fallot, 2001). Within the context of substance use treatment, TIP assumes experiences of interpersonal abuse are widespread and provides practitioners with a framework to avoid re-traumatisation, promote physical safety and use strengths-based practice such as motivational interviewing. This present-focused approach does not require trauma disclosure nor rely on PTSD diagnoses (Markoff et al., 2005).

The revision of UK clinical guidelines for the treatment of substance use have identified TIP as essential practice (DoH, 2017), however treatment services are likely to require support and training to enable them to do this.
Trauma-specific services

An integrated trauma-specific intervention acknowledges the link between both PTSD symptoms and substance use and involves the provision of CBT and other therapy modalities to address the symptoms concurrently in one ‘intervention’.

*Present-focused* interventions are ‘first stage’ interventions that typically focus on establishing both physical safety and stabilisation of trauma symptoms and substance use; and involve psycho-education about the impacts of trauma and links to substance use as well as the teaching of coping skills to manage PTSD symptoms, emotional regulation, and substance use triggers.

In *past-focused* ‘second stage’ interventions, the active therapy component involves revisiting the trauma memories in detail and typically follows preparation sessions involving techniques taught in present-focused interventions (Najavits & Hien, 2013).
2. Review and adaption of Seeking Safety

The Behaviour Change Wheel (Michie, Van Stalen & West, 2011) is a structured framework for illustrating the behaviour change theory behind health interventions.¹ It was used in this study to highlight the behaviour change techniques underpinning Seeking Safety, guide the selection of topics and activities, review the handout material, and chose the most appropriate service setting. This process was done in collaboration with women with lived experience of interpersonal abuse and substance use, as well as the group facilitators over a 6 month period.

The Behaviour Change Wheel provides a framework for applying theory and evidence to designing health interventions and draws on a detailed list of ‘behaviour change techniques’ (BCTs) developed by expert consensus. The model theorises that changing any incidence of any behaviour involves changing one or more of the following: capability, opportunities and motivation relating to the behaviour itself or behaviours that compete against or support it (Michie et al., 2014).

Whilst many public health interventions emphasise individual capabilities and motivations to change behaviour, the Behaviour Change Wheel also invites consideration of contextual and social factors (‘opportunities’) influencing behaviour change. For example, interventions to address a woman’s use of substances to cope with interpersonal abuse and PTSD symptoms should not merely focus on her ability to put safety strategies in place. Support is also required from external services to manage the risk from her abuser(s) and treatment services may need to change their service models (aka ‘behaviour’) in order to facilitate this.

The Behaviour Change Wheel then invites you to consider in a structured and systematic way, ‘what needs to change?’ in order to facilitate the required behaviour change (B) across the three domains of capability (C), Opportunities (O) and Motivation (M) (COM-B). (see Figure 1).

¹ [www.behaviourchangewheel.com](http://www.behaviourchangewheel.com)
The Behaviour Change Wheel then offers a suite of Behaviour Change Techniques (e.g. goal setting, action planning, reframing cognitions, modelling of coping skills, valuing identity, reducing negative emotions) that can be mapped against pre-established interventions, such as Seeking Safety or used to design new interventions or add new components to pre-established interventions. Using the various steps of the Behaviour Change Wheel resulted in the following decisions:

- **Setting**: Choice of substance use treatment service that was mixed gender, but offered a women only programme, had established procedures in place to address domestic abuse experienced or perpetrated by service users, employed a specialist Independent Domestic Violence Advisor, offered holistic wrap-around services, had a strong record of service user involvement, and provided a treatment environment that operated like a community centre.

- **Group Facilitators**: Two female practitioners with extensive experience of working with women were selected to deliver the group. One facilitator was based in the study substance use treatment service. She was joined by an external facilitator from a specialist trauma-service for women who have experienced gender-based violence, thanks to a grant from Alcohol Change UK.

- **Intervention**: A pre-orientation session + 12 sessions of 2 hour groupwork was delivered twice weekly covering the following topics: Safety, PTSD-Taking back your
Delivering a trauma-specific intervention for women in a UK substance misuse service

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- Power, Detaching from Emotional Pain (Grounding), Red & Green Flags, Self-Nurturing, Healing from Anger (2 sessions), Compassion, Recovery Thinking, Setting Boundaries in Relationships, Creating Meaning and Honesty.

- **Adaptations:** Additional mind-body strategies for ‘grounding’ were introduced: (1) women were invited to choose items based around the five senses to compose a ‘comfort kit’ (e.g. feathers, fragrances, chocolates) they could bring to each session and (2) a cleansing ritual ended each session whereby facilitators sprayed a fragrant water onto the participants’ hands.

**Seeking Safety** is a present focused intervention that does not invite women to discuss traumatic experiences. It places emphasis on optimism, possibility of change, and the use of positive praise. Specific techniques involve teaching compassion rather than self-blame and reporting on good coping at each session. There is an explicit focus on strengths rather than pathology. The programme provides a broad list of over 80 coping skills in the first session which participants are invited to try within- and between-sessions as a ‘commitment’ relating to the weekly topic matter.

As the intervention author states: “The goal is that patients will never need to believe ‘there is nothing I can do’. If one tool doesn’t work, the idea is to use another” (Najavits, 2002, p.13). Seeking Safety in its entirety consists of 25 topics that each integrate PTSD and substance use related issues. Guidance for implementation allows maximum flexibility for the number, type and delivery method of the topics, which reflect the needs of the service and participants. Topics can be delivered over several sessions. See [www.treatment-innovations.org](http://www.treatment-innovations.org).
3. Feasibility Study

Summary of findings

- An adapted 12-session Seeking Safety groupwork intervention, with additional activities to promote the mind-body connection, was feasible to deliver in a community based substance use treatment service. It required group facilitators skilled in PTSD, substance use, and interpersonal abuse, and adequate attention paid to providing training and supervision for facilitators to support their delivery.

- Of the 19 women recruited, 68% (n=13) completed at least six sessions (minimal dose) and 16% (n=3) attended all 12-sessions; with an average of 7.2 sessions. 84% (n=16) were followed-up 3-months post-intervention. There were encouraging improvements relating to PTSD, emotional wellbeing, and alcohol use.

- Group cohesion, therapeutic alliance, and session pacing were influential to the acceptability of the group for participants and facilitators; women placed high value on being with other women with similar experiences and hearing their experiences. Some of the problems reported by women and facilitators about the group could be remedied by slowing down the pace of the sessions, splitting topic content over several sessions and providing groups aimed at women in similar stages of recovery in order to tailor the material. Facilitators should be allowed to prioritise group cohesion, whilst maintaining the structured nature of the group format.

- Women valued the group-work format and the variety of coping skills taught, particularly the mind-body strategies, grounding techniques, and reframing negative thoughts using compassion.

- Providing access to 1:1 support outside of the sessions was an important component required by some participants in order to maintain their emotional safety.

- Group participants reported high levels of ongoing victimization during the study, highlighting the need for services to promote a safety-first approach and for researchers to measure ongoing victimization after baseline and incorporate into the data analysis.

- Services are encouraged to first develop trauma-informed practice in the wider organization to prepare the groundwork for the delivery of trauma-specific interventions such as Seeking Safety.
3.1 Methodology

The feasibility study involved a single group, pre-post test design and the methodology was guided by Eldridge et al. (2016). The purpose of a feasibility study is not to determine whether an intervention ‘works’ but to explore key uncertainties in the study design before proceeding to a more costly and lengthy randomised control trial. The key questions to be answered centred on the feasibility of delivering a highly structured manual by staff in substance use services (i.e. non-psychologists).

- What training and support is needed for group-facilitators to deliver the manual as it was intended?
- Are there sufficient numbers of women to recruit and retain in the group over 12 sessions?
- Do groupwork participants and facilitators find the material/content acceptable?
- What are the most appropriate measures to capture changes in women’s health, safety and wellbeing?
- What are the external factors impacting on women’s recovery?

Wide Inclusion criteria for entry to the groups: Various PTSD symptom severity and stages of substance use recovery.

Sample size: 19 women were recruited to take part across two group cycles.

Ethical approval: granted by the Psychology, Nursing and Midwifery Research Ethics sub-committee at Kings College (Ref: HR-16/17-4598).

Measures

Structured questionnaires were administered at baseline, immediately at the end of the group and 3-months later, and covered:

- PTSD (PCL-5)
- Substance use (ASI Drugs & Alcohol composite)
- Trauma Cognitions (PTCI)
- Depression (PHQ-9)
- Emotional Regulation (DERS-SF)
- Self-Esteem (RSE)
- Domestic Abuse, Childhood Abuse and wider forms of interpersonal abuse (CAS-SF & Modified Life-Stressor Checklist-R)
- Social Support (Social Provisions Inventory)
In addition, two focus groups were held (immediately at the end of each group) and all women were invited to take part in individual semi-structured interviews (n= 15 women) + staff (n=3) to explore further their experiences of the group and impact on recovery.² Adherence to the manual was assessed by myself using using a template score sheet provided by the programme author, and following online practice sessions.

3.2 Findings

3.2.1 Experiences of life-time abuse and substance use

Women reported multiple experiences of abuse in both childhood and adulthood. Seventy-eight percent³ of women (n=14) reported childhood physical abuse and 74% (n=14) reported childhood sexual abuse. Experience of any physical abuse in adulthood was reported by 94% of women (n=17) and sexual abuse by 63% of women (n=12). Women reported stalking and threats to kill or serious harm (84%, n=16), rape (68%, n=13), 37% of women (n=6) reported providing sex in exchange for money, drugs or other goods, and 21% (n=4), participation in prostitution. All women had experienced intimate partner violence.

Women reported lifetime problems with a variety of substances, most commonly heroin and other opiates or cocaine (including crack). The mean number of years of reported illicit substance use was 15.32 (SD 11.41]. The mean number of years of regular alcohol use to intoxication (more than 3 times a week) was 10.56 (SD 11.8) and 21% (n=4) reported being in treatment for alcohol use, most commonly in conjunction with other substances (16%, n=3).

Thirty-one percent of women (n=6) reported any illicit drug use in the past 30 days with a mean of 14 days of use in the past 30 (SD13.10) (range 2-30). Twenty-six percent of women (n=5) reported drinking to intoxication in the previous 30 days with an average of 13.4 days.

The majority of participants (84%, n=16) self-reported that they had received a diagnosis from mental health services, most commonly depression (58%, n=11) with another co-occurring problem such as anxiety (32%, n=6). The majority of women (95%, n=18) met criteria for a possible PTSD diagnosis⁴ although only 2 women had received prior treatment for PTSD from mental health services.

² Qualitative data was analysed using Framework Analysis (Richie et al., 2014) and quantitative data analysed using Analysis of Variance (ANOVA).
³ Based on data for 18 women
⁴ Classed as score of 33 or more on the PCL-5
3.2.2 Motivations for taking part in the group

The staff from the study treatment service played an important part in identifying eligible women and encouraging them to take part. Women were motivated to take part due to a desire to understand themselves better, specifically in relation to their trauma and PTSD:

"I have always kind of known somewhere that I had those traumatic experiences and that, I mean I wasn’t using it as an excuse to drink but you know I could maybe take the drink away, but that wasn’t the complete answer, there was all that underlying...So when this came up I thought ah that’s it all in one more or less...that’s where I fit.”

(Rachel, Group 1, 3-sessions)

“Cause I felt I had to do something, I had to get an intervention somehow cause I was killing myself, do you know what I mean, and I just really needed something that was going to explain to me my PTSD, explain to me why I do stupid things, why I make rash decisions, why can I never love myself, can’t care for myself.”

(Steph, Group 2, 9-sessions)

The service manager of the study treatment service viewed the retention rates for the group as a definition of group success and explained why:

“Well the [former] women’s programme we couldn’t retain anyone for longer than 2-3 sessions you know, the retention rates were quite good on both Seeking Safety groups.....” (Service Manager)

3.2.3 Reasons for missed sessions

For women who attended less than six sessions, the overwhelming reason given was due to substance use and/or the strong emotions evoked by participating in the group. Attendance at the pre-orientation was an important element in helping women to feel comfortable both with each other and the facilitators and promote continued attendance. However, women reporting more severe substance use at baseline struggled to attend, which they attributed to their active use.
3.2.4 Acceptability of the intervention

The group dynamic, between participants themselves and between participants and the facilitators, was one of the over-arching themes identified in the qualitative data as influential to the acceptability of the group for all involved.

Positives

The fact the group was women only was appreciated by the participants because it felt safe and comfortable but also because it was inspiring. The group bond was aided by the shared similarity of experiences of interpersonal abuse or ‘seriously big experiences’ as one participant put it:

“Because it’s woman-based only, I think in that regards I feel comfortable I really do...I appreciate being in the presence of lots of women, wonderful women, so thank you for that.”
(Sophie, Group 1, 11-sessions)

Women described how it was helpful to listen to what others had to say, whether it was related to hearing stories of what others had endured over their lives, their interpretation of the topic matter, or attempts to use coping skills. This appeared to play an important part in normalising experiences and contributing to recovery:

“What helped me get better was knowing that I weren’t the only one going through these symptoms and suffering... I thought I was going mad, you know what I mean, I thought it was the drugs they have sent me mad, but like hearing all the other ladies and their experiences and stuff like that that was a good help, yeah definitely.”
(Steph, Group 2, 9-sessions)

Others gave examples of how the group supported them emotionally, including women only attending a few sessions:

“We were all very close in there and we all did help each other. I loved the group, I did, and although I wasn’t there often I did love it.”
(Ali, Group 2, 4-sessions)
Negatives

Whilst women described a strong group alliance, women were also very vocal about the behaviour of other group members, which impacted on their positive experience of the group. Some women stated that the group was more intense when certain women were present, and this appeared to be related to the inconsistent attendance of a few women:

“All I wanted to say was that it depended on the members of the group that was in there. If certain members weren’t in the group, it was a better group. If other members were in the group it was a worst group.”

(Steph, Group 2, 9-sessions)

Facilitators were also of the opinion that the group was not suitable for those with more active substance use:

“If someone has been using and drinking they can’t do that... people who were using, you could see they didn’t come.”

(Facilitator 1)

Women described how at times they were not able to fully express themselves and felt there were discrepancies between the time allocated for each member of the group to talk. One woman described the impact of being asked by the facilitators to come back to an issue later after check-in, which is a key principle of the intervention format:

“When you are feeling that vulnerable you need to talk there and then, for someone to say, it’s sort of a slap in the face well me personally... I know it’s childish so when you do try and talk it’s not as clear, you are upset and its almost as though someone’s telling you off, shut up, well that was the impression I got.”

(Clare, Group 1, 8-sessions)

For another participant the inability to express herself was directly linked to her desire to attend the group and her ability to benefit from it:
3.2.5 Intervention content and structure

Women felt that the pace of the sessions was too fast and overly focused on getting through the content, and that this resulted in problems with the group dynamic described above. Both participants and facilitators endorsed small group sizes, and recommended spreading topics over two sessions and delivering a longer group. Despite the negative aspects, women were emphatic about the uniqueness of the group and relevance of the topics to their lives:

“All the topics delivered in the sessions were rated highly according to questionnaires completed immediately at the end of each session. The five mostly highly rated topics were: PTSD, Creating Meaning, Recovery Thinking (all cognitive topics); Honesty (interpersonal topic); and Self-Nurturing (behavioural topic). In the qualitative interviews, women identified the topics of Anger and Grounding as particularly useful. The structured format was supported, particularly the use of inspiring quotations and out-of-session activities to practice coping skills (the commitments). The introduction of the new components, the mind-body activities comprising a sensory based ‘comfort’ kit for self-soothing, and ending ritual involving a fragrant spray, were particularly valued and deemed helpful.

“I don’t think I took much from the programme. I sat here and I heard the people saying what ever they want, which is ok I am not against that, but when it was my turn I felt cut out many times.”
(Alda, Group 2, 6-sessions)

“There wasn’t one thing that was brought up and I thought that doesn’t really relate to me…it was like no I can relate to each thing and each coping mechanism.”
(Rachel, Group 1, 3-sessions)

“All I don’t say this very often but it’s unlike anything I have ever experienced this course. I know that it has changed my life and so I am sure that it has done that to some others in the same group … it’s so important that this can be experienced by so many many women…”
(Tara, Group 1, 12-sessions)
The comfort kit was mentioned on frequent occasions in response to questions about helpful aspects of the intervention, including those attending minimal sessions and in active substance use:

“I have still got them smelly little bags as well that we made, yeah still got them, so that comes in useful sometimes, the smells... to help you comfort you, you know to get you out of that bad headspace and bring you into something a bit more loving and stuff.”

(Steph, Group 1, 9-sessions)

One facilitator extolled the importance of introducing these new components in order to for women to manage states of arousal, as she believed this was lacking in the original intervention. Her overarching recommendation for improving Seeking Safety focused on a greater balance of holistic coping skills:

“I think I would put in probably more mindful practice, I would put in more physical grounding techniques, like Stephanie Covington’s work, I would do something more around basic yoga, basic breathing... more three dimensional, so it would be about working with mind-body-spirit-emotion.”

(Facilitator 2)

The provision of one-to-one discussions with facilitators outside of the group sessions was also important due to the intensity of the subject matter. Women described the group as less relevant for addressing their substance use, perhaps because they were attending other programmes alongside that were specifically focused on substance use.
Both facilitators described feeling anxious about balancing all the competing elements of the intervention whilst trying to maintain group cohesion. They required substantial preparation time for sessions, more experiential training, and ongoing coaching, and they needed the flexibility to focus on therapeutic alliance over and above other aspects of intervention fidelity.

3.2.6 Participant outcomes

Quantitative data

Eight-four percent (n=16) of women were followed-up 3-months after the group ended. Overall, improvements were recorded in the measures of PTSD, depression, emotional regulation and negative trauma cognitions immediately at the end of the group, which were sustained 3 months later. Women attending 6-sessions or more experienced steeper decreases in PTSD symptoms, compared to those attending less, although this was not supported statistically, possibly due to the small sample size. 63.16% (n=12) of group participants experienced clinically meaningful change in PTSD at the end of the group, and 68.42% (n=13) 3 months later. However, at both follow-up points more than half of the sample had scores which signified ongoing PTSD. At the end of the intervention there was some evidence for a reduction in alcohol use, but no evidence for drug use reduction. This may be reflective of the high numbers of women reporting abstinence in the past 30 days at baseline (58%) and the small sample that meant small outcome changes could not be detected in statistical analysis.

\[ F(2,36) = 16.68, p<0.001 \]
\[ F(2, 36) = 7.24, p=0.002 \]
\[ F(2, 36) = 7.84, p=0.001 \]
\[ \chi^2 (2) = 37.312, p=0.005 \]
Qualitative data

The improvements captured quantitatively cannot be attributed to participation in the group due to the absence of a study control group. However, in the qualitative data, women described improved emotional wellbeing; and those experiencing clinically meaningful change in PTSD described decreased PTSD symptoms such as flashbacks, nightmares, irritability and exaggerated self-blame, which they attributed to participating in the group. Women attending six sessions or more attributed improved wellbeing to skills developed in the groups. Techniques focused on reframing negative thoughts, compassionate self-talk, and practical grounding techniques were all valued, and numerous examples given of exactly how these had helped:

“I used to get such bad panic attacks and anxiety…I would spray like a scarf and if I feel panicky I could have a sniff and nobody knows what you are doing, but it sort of just takes you to step away from that chaos at the moment.”
(Rachel, Group1, 3-sessions)

“Every day, every time coming here on the tube, on this packed train, I would never have been able to do that before, I used to get anxiety I would take the long way… but now I can get on the tube and I use the breathing and the smells.”
(Sophie, Group 1, 11-sessions)

Women also described themselves as having improved self-esteem and adopting greater self-compassion, which were used to re-frame the negative self-talk reinforced by experiences of abuse from a young age.
Rachel described how she used to call herself a fat cow when she was eating too much and reflected on how her ex-partner used to call her this. Taking the time to step back and reframe the negative self-talk in this way made a crucial difference in managing her drinking:

> “...it [group] has just given me a bit more hope and more understanding about myself and give compassion to myself and stuff, instead of beating myself up all the time.”
> (Steph, Group 2, 9-sessions)

> “…that 5 minutes I could have been in Tesco’s buying a bottle of vodka but actually stopping and thinking, putting it in its place takes the power out of it and gives you the power.”
> (Rachel, Group 1, 3-sessions)

Whilst women provided less qualitative evidence in relation to substance use changes, some women demonstrated a greater self-understanding about the role of trauma in their substance use, which some described as supporting reductions in substance use or abstinence.

> I do think [the group] is making me aware that he is traumatising me, that is trauma that I don’t need...sometimes [before] I would be in a situation where his arguments would make me think, tomorrow when he has her [daughter], I am going to fucking go and smoke crack...”
> (Chrissy, Group 2, 9-sessions)

### 3.2.7 Contextual factors impacting on recovery

The study treatment service closed on the 31 March 2018 due to the re-commissioning of the borough substance use treatment services. The loss of substance specific and social support women experienced from the service closure contributed towards return to active substance use by some:
Other external contextual factors of importance were the ongoing interpersonal abuse experienced by women during the study; new incidents were recorded for 47% of women during the period of the group and the descriptive statistics suggested that these women experienced less improvement in PTSD, compared to women experiencing no new abuse. Although this was not supported in statistical tests, this may be down to small sample sizes.

3.3 Discussion

3.3.1 Core role of coping skills to manage emotional regulation

The aim of the intervention was to develop healthier coping strategies and thereby manage PTSD symptoms and reduce substance use. Experimenting with new strategies, combined with the belief that the new strategies can work, are linked to the promotion of self-efficacy; this is believed to play a significant role in behaviour change, including desistance from substance use (Cummings, Gallop & Greenfield, 2010; Trucco, Connery, Griffin, & Greenfield, 2007). In this study, the move towards more active coping was evident in the narratives of women who discussed using the skills of mindfulness, acceptance of emotions, grounding techniques and changes in how they made sense of the trauma. They described how this helped lessen their emotional distress. Other research has demonstrated how changes in thought processes and appraisals related to the trauma are responsible for improved PTSD symptoms (Kleim et al., 2013). For those in alcohol and opiate treatment, the targeting of negative beliefs about oneself (not necessary trauma related) have also been identified as important for helping desistance in substance use (Brotchie, Meyer, Copello, Kidney, & Waller, 2004). Other research suggests that the ability to manage emotions is key to reducing both PTSD and substance (Hien et al., 2017; Tull et al., 2015).
3.3.2 Coping skills to enhance the mind-body connection

Since interventions such as Seeking Safety were first developed, there have been vast developments in understanding the neurobiological and physiological impacts of trauma (Levine, 2010; van der Kolk, 2014). These developments have led researchers to argue for strategies that help balance the ‘emotional’ and ‘rationale’ parts of the brain (van der Kolk, 2014). Whilst Seeking Safety includes a whole topic on grounding techniques, the facilitators identified the need for more activities reliant on the mind-body connection as tools for self-soothing. Women provided tangible illustrations of how the introduction of these skills in their daily lives helped them to feel better, feel more in control and cope with life stressors in a healthier manner. When people are vacillating between extreme states of emotional–arousal due to PTSD symptoms, the part of the brain responsible for concentration, attention, and learning is compromised. It thus makes it difficult to undertake any cognitive work that involves analysing and planning (van der Kolk, 2005). Therefore, the inclusion of more mindfulness-orientated activities, and sensory-based coping skills into the Seeking Safety intervention, are key recommendations for future implementation, and skills that can be both adopted and taught by substance use practitioners, without additional training or specialist expertise.

3.3.3 Importance of attending to group process

In this study, the complexity of the group dynamic was highly influential on the acceptability of the Seeking Safety intervention for both the study participants and the facilitators. In fact, research has shown that there is a strong link between group-cohesion and positive therapeutic outcomes (Burlingame, McClendon, & Yang, 2018). In order to enhance group cohesion, researchers have recommended paying attention to activities which encourage interaction between members, positive emotional and working relationships, addressing conflict, and promoting positive affiliative statements between group members (Burlingame et al., 2018; Valeri et al., 2018). In the feasibility study, the qualitative data identified that these activities were indeed promoted by the facilitators; although the facilitators felt that their ability to focus on these aspects of group cohesion were hampered by the demands of adhering to all aspects of the intervention manual. Whilst the Seeking Safety implementation guidance allows a certain amount of flexibility for facilitators styles and preferences (Najavits, 2002), the facilitators were unsure which parts of this guidance and the hand-outs they should prioritise within the sessions, whilst observing other aspects of adherence such as balance of client/participant talk, discussing both substance use and PTSD in each session, adequate focus on hand-outs, and maintaining the group cohesion and therapeutic alliance. This no
doubt comes with experience of running the groups (Najavits, Kivlahan, & Kosten, 2011). However, the facilitator concerns re-iterate the importance of prioritising therapeutic alliance over and above strict adherence to the manual (Barber et al., 2006).

3.3.4 Importance of coaching and support for group facilitators

The findings also highlight how substance use treatment services wishing to adopt trauma-specific interventions should allocate sufficient budget for the provision of training and supervision when starting out, by someone with experience of delivering these groups (Killeen et al., 2015). As with the study participants, the facilitators also found delivering the intervention intense and emotional. Clinical supervision was funded by the study treatment service and was an important component for promoting self-care for the facilitators, and to prevent vicarious trauma (Herman, 1998). Finally, services may wish to consider delivering different groups for those in active substance use and those in abstinence; in order to tailor the content and pace to the specific needs of participants.

3.3.5 Responding to context

The study treatment service closed shortly after the end of the groups, having lost its contract as part of a re-tendering of all substance use services in the borough. This is not unusual in the current commissioning climate in England whereby constant re-tendering processes result in treatment services changing every three years, which have been described as costly, disruptive and complex, with negative effects on service users (ACMD, 2017). The study findings once against highlight the importance of continuity of care and also the lengthy process of aftercare required to maintain sobriety after ‘therapeutic interventions’ have ended (Covington, 2000; McKay, 2009). Other external contextual factors of importance were the ongoing interpersonal abuse experienced by a substantial number of women during the study. A recent literature review stressed the need for treatment practitioners to pay attention to the quality and safety of women’s social networks in supporting or detracting from both substance use and PTSD recovery (Bailey et al., 2019). Mixed-gender services need to pay particular attention to the safety of the service environment for women, particularly in regard to safety from (ex)-partners and predatory male service users, by ensuring suitable policies and procedures are in place (Galvani, 2009).
3.4 Recommendations

3.4.1 Practice – developing TIP and trauma-specific interventions

- Services wishing to deliver integrated trauma-specific interventions such as Seeking Safety should first pay attention to developing organisation wide trauma-informed practice. Checklists and guidance are now widely available to do this (see Fallot & Harris, 2014; SAHMSA, 2014). A number of UK services also now offer organisational training however, this should be seen as the first step in instigating wider-organisational change, which should be supported by a strategic programme of change (see Against Violence and Abuse and Solace Women’s Aid, 2017);

- Whilst the women only group-format provided therapeutic benefits in itself, attention must be given to ensuring group cohesion and therapeutic alliance is maintained and the topic content is delivered at the appropriate pace;

- Women valued the provision of coping strategies for emotional regulation which centred on the mind-body connection and using compassion to address negative thoughts; strategies which could be incorporated into standard group-work programmes. As well as the grounding techniques in Seeking Safety, practitioners can draw ideas from: Covington, 2016; Lee, 2012; and training on emotional regulation available from the National Center for PTSD online https://webstair.org

- To deliver integrated trauma-specific group-work interventions, substance use treatment services should consider bringing in external expertise in interpersonal abuse and PTSD to develop their practice, and for co-facilitation of trauma-specific groups, particularly in the early phases of adoption;

- Mixed-gender services need to pay particular attention to the safety of the service environment for women, particularly in regard to safety from (ex-)partners and predatory male service users, by ensuring suitable policies and procedures are in place;

- Services should adopt strong multi-agency working with local domestic abuse services and seek advice from specialist domestic abuse workers where needed (see NICE, 2104);

- Regular supervision delivered by senior clinicians with experience of delivering trauma-specific interventions, along with managerial support for self-care, should be a core part of the workforce management policy.
3.4.2 Policy

- Policy makers, commissioners and funders must ensure that vital women-only services for women facing co-occurring issues are maintained in the face of brutal funding cuts. As recommended by a recent government mental health taskforce (Dept. Health and Social Care & Agenda, 2018), service guidelines and service specifications used in tendering processes should specify how they will assess for meaningful trauma-informed practice in service delivery;

- In the USA, government funded training initiatives have supported the roll-out of TIP in substance use treatment (Capezza & Najavits 2012; SAMHSA, 2014), which would also be beneficial in the UK;

- Given the recent support by NICE for extending trauma-specific interventions to people with substance use, commissioners and funders should promote a stepped model of care; engaging working partnerships between substance use treatment services offering first stage safety and stabilisation interventions for trauma and PTSD, and mental health services offering second stage treatments, such as trauma-focused CBT and Eye Movement Desensitisation and Reprocessing Therapy (EMDR);

- Commissioners should also pay attention to the importance of continuity of care and the need for longer-term interventions for women with co-occurring issues; given the complexity of the challenges they face; in order to avoid the revolving door syndrome of service access.
4. References


Delivering a trauma-specific intervention for women in a UK substance misuse service

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