Section 4

Meeting survivors' needs

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Section outline

It can be difficult to know where to start when supporting someone who has experiences of domestic violence, sexual violence, problematic substance use and mental ill-health. The majority of survivors will have multiple needs that vary between individuals and will change with time and circumstances.

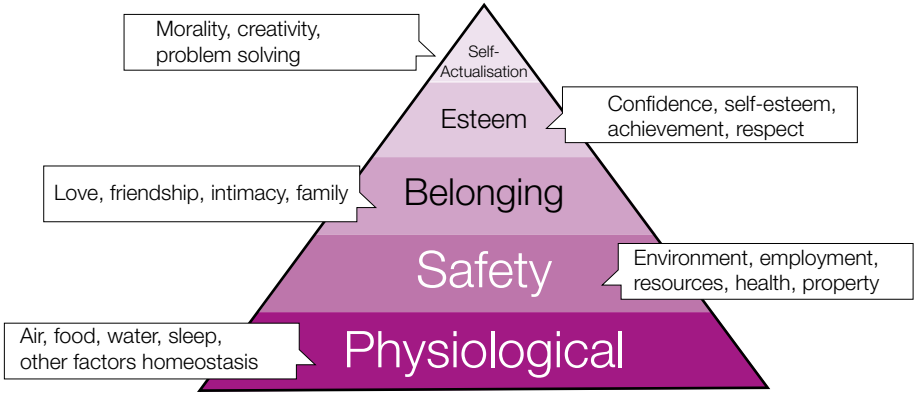
This section describes what survivors identify as their greatest needs, with an emphasis on **how** professionals offer support rather than the actual areas of assistance services can provide. Following these steps should encourage survivors to engage with services so that their needs can be met:

1. Understand the survivor's perspective
2. Treat survivors with humanity and respect
3. Enable survivors to develop life management skills
4. Promote safety and security
5. Support survivors to lead a healthy and active life
6. Consider long-term recovery options

1. The survivor's perspective

There are many models and theories about human needs. Maslow's Hierarchy of Need is one of the most well-known. According to Maslow, humans are motivated to satisfy a range of needs, starting with physiological needs (air, food, water) through to feeling a sense of belonging (a result of friendships, family, intimacy, etc.) and self-actualisation.

Figure 2 - Maslow's hierarchy of need.



The advent of outcomes- or results-based service delivery has led to the development of different needs assessment and supporting planning tools that tend to focus on varying aspects of a client's life: typically physical health, mental health, housing, finances, social networks, education/training and employment, living skills, substance use and offending.

Section 4

People who have been affected by domestic and sexual violence, problematic substance use and/or mental ill-health have similar physical, emotional and social needs to those outlined above. However, there is often a level of complexity in supporting this group of survivors as many needs require attention at the same time, and the problems are more severe.

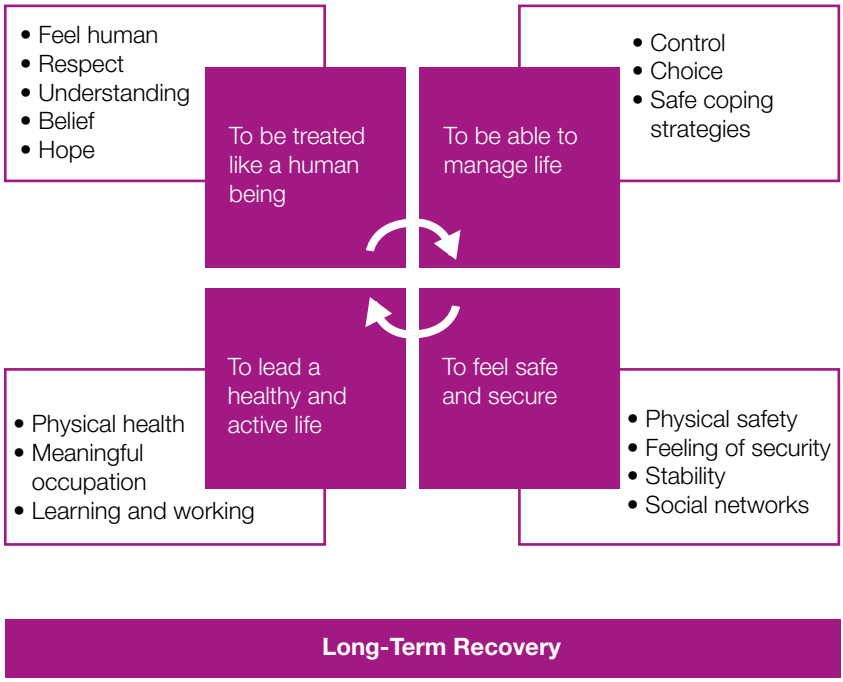
Violence, substance use and mental ill-health can all lead to homelessness, poorer physical health, and leave survivors vulnerable to further abuse. Trauma responses may be compounded by additional events such having a child removed, losing touch with family and friends, being imprisoned/sectioned, being involved in prostitution. Substance use may worsen mental health problems. Research has found, for example, that women experiencing PTSD and substance use problems have extremely high rates of co-morbid diagnoses of other disorders such as depression and anxiety. They are more likely to use 'harder' drugs such as cocaine and opiates than women who experience either PTSD or substance use problems.[1]

The consultation with survivors that was completed as part of the Stella Project Mental Health Initiative found that there are five areas of need that practitioners and services should address: being treated like a human being, being able to manage life, feeling safe and secure, leading a healthy and active life, and being able to recover in the long-term (see figure 3 for more detail).

The first two segments – treating someone like a human and being able to manage life – refer more to how practitioners behave towards survivors with additional experiences. Meeting these needs is critical in promoting engagement with services so that other needs can be met.

Each of the sections also fits in with broadly accepted principles/values that underpin models of recovery that have been established within substance use and mental health services in the UK and US. As such, the following information provides an overview of the building blocks for recovery which we can all offer survivors.

Figure 3 - Overview of survivors' needs



2. "Treat me like a human being"

"The basic essence of it is that you are worth treating. By the time I got to that point it was like I can't live with drink, I can't live without drink, I've completely screwed up my whole life, my children's life, I'm a horrible mother, nobody loves me, every one I go out with wants to beat the shit out of me, so where does that leave me? I'm nothing. And that's how I felt."

Survivor's voice

2.1 Humanity and respect

Experiencing domestic and sexual violence, problems with drug or alcohol use and/or mental ill-health often leads to feelings of self-blame, self-loathing and self-doubt. In addition to how they feel and think about themselves, survivors may also face a lack of understanding and thus stigma. They may have a strong sense of isolation and alienation.

Research with people who have experienced problems with their mental health have found that stigma and discrimination are rife, with the vast majority reporting that stigma has had a negative impact on their lives and stopped them from doing things they want or need to do.[2] Similarly, a 2010 survey by the UK Drug Policy Commissioning found that 22% of people think that those affected by problematic drug use don't deserve sympathy.[3]

People who are affected by all three issues are likely to experience multiple discrimination, with women who have problems with substance use and/or mental health reporting significantly higher levels of stigma – either as individuals or as mothers.[4]

As such, survivors of domestic and sexual violence who are also affected by substance use or mental ill-health state **their most fundamental need is to be treated like a human being.**[5]

This means you should:

1) Treat survivors with respect.

2) Take time to listen.

3) Validate their thoughts and feelings.

4) Show understanding of how abuse, mental ill-health and substance use are often linked.

5) Do not judge survivors for how they might think, feel or act.

6) 'Go the extra mile' to show that these survivors are worth helping.

Research[6] emerging from the Troubled Families programme of work has drawn similar conclusions: "Families…want to feel that they are treated as a human being, that they are listened to, and…believe the workers are dedicated to helping them and 'going the extra mile'"

Another important message from people who are affected by these three issues is for professionals to view service users as individuals in their own right, rather than solely as a person with a mental illness, a person in recovery or as a victim or survivor.[7]

"I love being able to talk to my keyworker about EastEnders. It's like I'm not just a recovering addict, I am a human being and there is something in my life other than staying in recovery"

Survivor's voice

2.2 Understanding change

Making change in life is difficult. For survivors of domestic and sexual violence who are also affected by substance use and mental ill-health, addressing each issue will often take time and require on-going support through periods of well-being and crises of different kinds.

For professionals the slow pace of change can be frustrating, particularly when it appears to be the client who is reluctant to change or take action. Understanding the process of change, and being able to anticipate some of the difficulties that survivors may come across can be useful in managing our frustrations and expectations of clients.

2.2.1 Stages of Change Model

Prochaska and DiClemente's Stages of Change (see figure 4) arose out of research into how people stop smoking, but can also be helpful in understanding the journey survivors of abuse who also experience drug, alcohol or mental health problems take. There are six stages:

Pre-contemplation. The individual does not see themselves as having a problem and are unlikely to take action. Raising awareness is helpful at this stage.

Contemplation. People become more aware of the personal consequences of their situation and spend time thinking about the problem. Providing a space to talk and reflect can be useful.

Preparation. The individual has made a commitment to make change. Professionals can have a huge impact on this stage by providing service users with full information – the positives and the possible negatives – to ensure they are best prepared to deal with the hurdles ahead.

Action. Professionals often skip to this stage, encouraging clients to make change when they have not yet decided action is needed or prepared sufficiently. Wherever possible, survivors should not be forced to make change without sufficient preparation. In some cases, for example where children are involved or a woman is being sexually exploited, immediate action may be needed and practitioners should be aware of how this may impact on the client's ability to maintain the change.

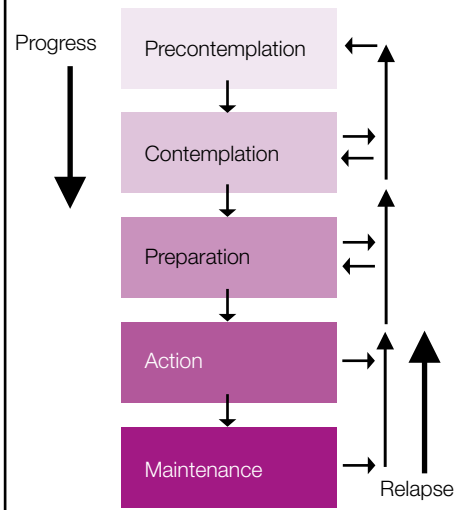
Maintenance. There is a vast array of factors that can make maintenance, i.e. not returning to the previous situation, very difficult. At this stage, enabling the person to identify short-term benefits or to use short-term rewards can help sustain motivation and promote self-confidence. They may also need support to anticipate situations which may trigger a relapse and to prepare coping strategies.

Relapse. Relapsing at least once is far more common than not relapsing at all. As practitioners, we should support service users to avoid labelling themselves as failures but help them to understand why they had a drink or used, returned to an abuser, or why mental health

problems come back. In this way, relapse can be a learning experience and an opportunity to grow stronger and consider strategies for avoiding relapse in future.

Change can come in many different forms, from acknowledging the abuse or that the substance use is problematic to leaving an abusive relationship and entering treatment for substance use. Supporting a survivor to move between any two stages is excellent progress; if a survivor does not take immediate action this should not be seen as a failure.

Figure 4 - Cycle of change

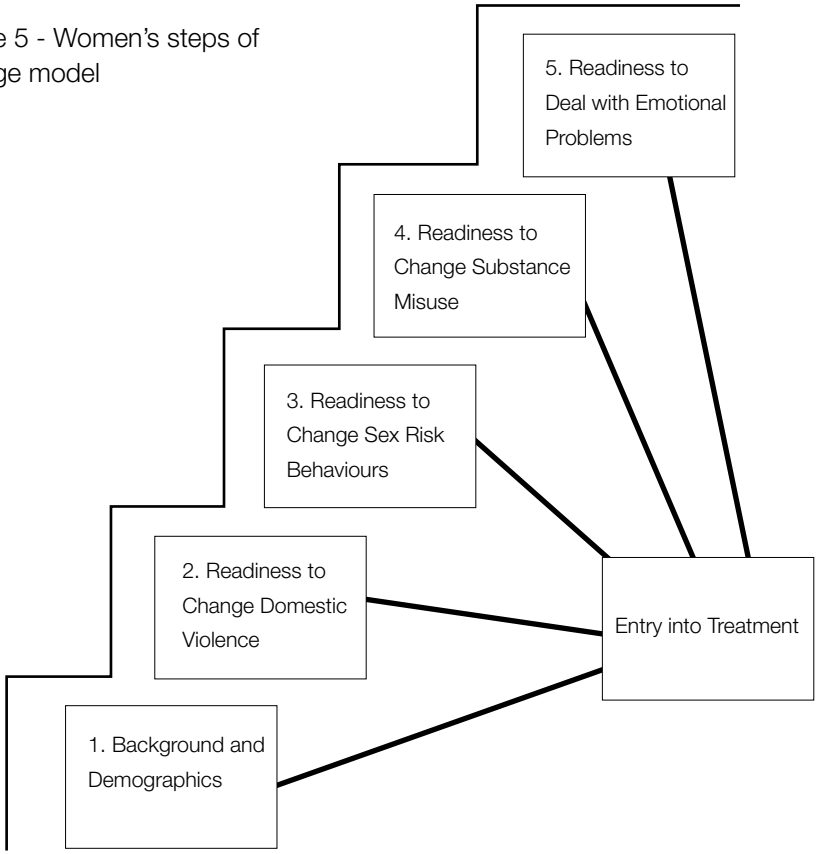


2.2.2 Women's Steps of Change Model

Professionals often ask what issue to address first. Depending on who you are asking, you will get a different answer. Practitioners may give varied answers depending on their training and theoretical beliefs. Survivors will have differing opinions which reflect their individual circumstances and needs – which issue is causing the most acute problems, which can you most easily get help for, what are the consequences of asking for help with each problem?

Limited research on the order in which survivors may approach issues such as domestic violence, substance use and mental ill-health has led to the creation of the Women's Steps of Change model (see figure 5). This model proposes that the help-seeking behaviour of women with substance use problems may reflect a hierarchy of readiness to change based on the urgency or immediacy of their treatment issues. For example, their study suggests that some women may be ready to make changes in their exposure to domestic violence or in sexual risk-taking behaviour before they are ready to change their substance use behaviour.

Figure 5 - Women's steps of change model



2.3 Have belief and hope

Survivors and professionals alike can become frustrated when change or improvements don't come easily. For people who already feel hopeless or powerless because of abuse, mental health problems or substance use, it is particularly important for professionals to have:

Belief in the client. For people lacking in self-efficacy (belief in their own ability to complete a task), it

is important to show that we have belief that they can make change in their life. You can demonstrate belief in someone by:

- telling them you believe them
- offering encouragement
- highlighting their strengths and resources
- acknowledging how they coped until now
- being realistic about what someone can achieve and not setting them up to fail by overwhelming them with tasks
- having patience, particularly when things go wrong
- not giving up - be persistent with other agencies to get things done

Hope for the future. We can suggest we have hope that the survivor's situation can improve as well as teaching them to have hope themselves. Learned hopefulness is the process of learning and utilising problem-solving skills and the achievement of perceived or actual control. Increasing perceived control (self-efficacy) helps individuals cope with stress and improves the likelihood of solving future problems effectively, which in turn generates more hope. A belief in one's self-efficacy and possessing problem solving skills are core components of resilience in an individual.[8] Engendering hope and building resilience are seen as key contributors to enabling people to recover from mental ill-health.[9]

Survivors who are affected by substance use and/or mental ill-health may need more positive and hopeful assurances than other survivors. Research has shown that problematic drinking can undermine the psychological benefits of positive life events.[10] Similarly, a survivor with depression may not glean hope for the future because one positive thing happens.

"People do not understand the consequences of not letting go. If you do not let go, your life is never going to change. That person will ruin your life forever and it will never ever change. Letting go is the bravest thing in the world. Let go and never look back."

Survivor's voice

3. Life management skills

Being able to manage in life centres around the three Cs: **control**, **choice,** safe **coping** strategies. In turn, research has shown that having a sense of control, developing safe coping mechanisms and the skills to make safe and healthy choices is also paramount to individual empowerment.[11]

3.1 Control and choice

Trauma, substance use and mental ill-health are experiences that can leave an individual feeling helpless and powerless: unable to control the occurrence of the traumatic event, to regulate trauma responses, to manage urges to use drugs or alcohol, to control how they are feeling emotionally or psychologically.

Establishing control (perceived or actual) over any aspect of our life – developing a routine for getting the children to school on time, managing money, making telephone calls, deciding when to have appointments – builds our **self-efficacy** or the belief that we are competent and able to achieve tasks. Increased self-efficacy can lead to a greater sense of control, which is understood to have a direct effect on improving an individual's mental and physical health.[12]

Being given choice is central to developing a sense of control. Being responsible for making decisions enables people to learn to trust themselves (when the outcome is positive) and to learn from mistakes (when the outcome is negative). As professionals, therefore, we should encourage clients to develop control in their life by supporting them to make decisions and complete manageable tasks for themselves.

"I had the overwhelming feeling that the worker would not suggest something I wasn't capable of doing; she took care of the essential needs like food and clothes first before talking about AA and meetings"

Survivor's voice

3.2 Coping strategies

Being able to cope with flashbacks, cravings, strong emotions and everyday stressors is also key to promoting a feeling of control.

For professionals, we should **acknowledge** how someone has coped thus far and **identify,** where needed, safer coping strategies.

There is a tendency to pathologise women who are affected by abuse, substance use and mental ill-health,[13] rather than understanding how the experiences may be interlinked and that substance use is often used as a coping mechanism.

Whilst research on survivors' resilience is limited, the available literature and practice-based evidence demonstrates that women who experience multiple negative life experiences are in fact more resilient and resourceful than other groups of vulnerable people.[14]

Survivors of domestic violence, for example, will probably have tried many strategies for managing the abuser's behaviour, from calling the police to complying or fighting back. They may also have tried to cope with the abuse by minimizing what is happening, denying the reality of their situation or dissociating during physical or sexual assaults. They may have managed the impact on their physical and emotional well-being by drinking alcohol, misusing prescribed medication, self-harming or attempting suicide.

As some coping strategies can be potentially dangerous or harmful, it is important that professionals acknowledge the ways in which survivors managed their situation (often successfully, in the short-term) as well as highlighting the potential risks and identifying safer coping mechanisms, where needed.

New coping strategies could involve writing a safety plan with a survivor currently in an abusive situation, practicing grouping exercises and mindfulness to manage anxiety or craving, or identifying activities to let out anger safely such as punching pillows. More information about safer coping strategies can be found in section 5.4.

4. Safety and security

Being the victim of trauma rocks your belief in the world as being an inherently safe place. Certainly in terms of domestic violence, perpetrators create an environment which is steeped in fear and is indeed unsafe for the survivor and their children in many instances. Experiencing abuse, as well as problematic substance use and mental ill-health, also increases the risk of being harmed in future.

Reestablishing someone's sense of safety and security requires a multi-faceted approach which addresses i) their environment, ii) their physical safety, and iii) their emotional stability.[15] The key needs to address are:

- **Living environment.** As a basic need, survivors require somewhere safe to live, and this should be addressed as a priority. This may include finding accommodation, applying for a non-molestation order from the court to stop an abuser from contacting the survivor, or offering other safety measures such as a personal alarm or additional security on the property. See overleaf for more information about housing.

- **Harm minimisation.** Supporting someone to identify safe strategies for dealing with difficult emotions and situations can make them feel more secure in themselves. The first step is raising their awareness about what danger they are in, for example exploitation from others, or possible risks of problematic substance use or self-harming.

- **Promote stability.** People affected by abuse, substance use and mental ill-health may have lived with years of chaos and uncertainty which makes the world feel unsafe. Professionals can provide stability by developing consistent, boundaried relationships with clients and helping to create routines in their lives.

- **Enable trust.** Consistency is also completely bound up with trust. Survivors of domestic and sexual violence have often had their trust violated by someone close to them. People with experiences of substance use or mental ill-health may also find it difficult to trust others. Survivors are more likely to engage with professionals who they can trust.

What engenders trust?[16]

1) Being treated like a human being.

2) Being listened to and understood.

3) Not being overwhelmed with suggestions of things to do that the survivor isn't ready for.

4) Not being judged.

5) Not being treated as though you are crazy.

6) Names and stories being remembered so information doesn't have to be repeated.

7) Workers completing actions on the survivor's behalf as agreed.

"You've got walk-in centres, I don't want to go to a walk-in centre, I want to see someone who understand what's happening"
Survivor's voice

- **Peer support.** Domestic and sexual violence, substance use and mental ill-health can leave an individual feeling very isolated and alone in their experiences. Building a network of support, including people who have similar experiences, can be highly beneficial. The decreased isolation and ability to get support from others means someone is more able to leave an abusive partner (or less likely to return) and/or may have more success in addressing their substance use or mental health problems. Furthermore, being part of a family, social network or community can provide a sense of safety.

- **Boundaries.** At the same time as supporting survivors to develop a support network, it is important to remember that people who have experienced their own boundaries being violated may also need support to establish and maintain boundaries within new interpersonal relationships.

Further information about addressing safety issues can be found in section 5, *Keeping Safe*.

Housing

Having somewhere to live is undoubtedly very important. For survivors who have drug, alcohol and mental health problems, accommodation is important because it can provide:

1) a place of safety. Professionals should, however, be aware that mixed sex hostels and B&Bs do pose risks to survivors' safety, particularly women. Women routinely report experiencing violence, abuse and exploitation within these settings and so, wherever possible, should be offered single-sex accommodation in a safe setting.

2) a sense of control. Research[17] has found that women affected by multiple issues such as domestic and sexual violence, substance use and mental ill-health yearn for a 'place of their own' over which they have control – control over what to put in the accommodation, how to arrange their own belongings, who to let in, if they let anyone in.

Therefore, where survivors are able to live independently, self-contained accommodation should be provided along with sufficient support to ensure people do not feel completely isolated:

"When they discharged me homeless [from hospital], I was in a flat, it was really bare so of course I tried to hang myself. I didn't know where the shops were, I was totally lost. I don't know [the area] very well. It's better in the hostel with people around….[although] there's people on heroin in the hostel, really bad drugs at times, people begging at times. Moving to women's hostel where I can cook for myself before moving into own flat."

Survivor's voice

What works?

The Chrysalis Project

The Chrysalis Project - a partnership between London Borough of Lambeth, St Mungo's and Commonweal Housing - provides housing and support for women who are homeless and have high support needs, including substance use, mental ill-health and experiences of trauma, abuse and sexual exploitation.

There are three phases of accommodation and support within the Chrysalis Project, each tailored to the needs of clients at the different stages of their recovery:

1) **Security, stability and intensive support.** Secure supported accommodation is provided in an 18 bed St Mungo's hostel. Intensive support, including counselling from specially trained psychotherapists, is provided to enable women to address enduring problems such as substance use and mental health problems as well as traumatic experiences.

2) **Moving towards independence.** Clients move into a St Mungo's semi-independent project to help them to develop skills to live independently, such as cooking, budgeting and engaging with local services.

3) **Living in the community.** The women are given a tenancy in one of seven one bedroom flats in South London. The accommodation is well maintained, furnished to a high standard and is designed to boost the women's self esteem and act as a motivator for further change.

An independent evaluation of the project found women have been supported to reduce their substance use, improve their mental health and live more safely. The project has helped women to avoid having their children taken into care, and supported women to re-establish connections with family. Several women have become economically more active, and all ten women who have been accommodated in phase three have maintained tenancies.

For more information, please see http://tinyurl.com/bvwx9eu.

5. A healthy and active life

5.1 Being healthy

Domestic and sexual violence, problematic substance use and mental ill-health are all associated with poor physical health.

Types of health problems

Injuries from: physical assault, sexual violence, administering drugs, self-harming

Neglect: direct neglect by abuse, not being allowed to care for self, self-neglect due to low self-esteem, substance use, etc.

Long-term conditions: impaired immune system, heart disease, liver and kidney problems, respiratory disease, gastrointestinal disorders, various cancers are associated with all three issues

The long-term health conditions associated with trauma, in particular, have been linked in part to chronically high levels of stress hormones, such as adrenaline and cortisol, in the body. Elevated cortisol levels, for example, are associated with an increased risk of obesity, diabetes, gastronintestinal problems and heart disease.[18]

As such, survivors may need access to health services to address acute injuries as well as for treatment for long-term conditions. A range of health services are available and professionals should ensure information about national and local services are easily available in their place of work:

- Accident and Emergency (A&E) department
- Minor injury unit (where available) for non-life threatening complaints. Minor injury units cannot deal with overdoses, alcohol and mental health problems.
- Walk-in centres (where available) for non-life threatening complaints. Walk-in centres are also accessible for people who are not registered with a GP, although survivors with substance use or mental health problems may be reluctant to attend as you are likely to see a different professional each time.

- NHS Direct (0845 46 47) or NHS 111 (where available) for advice on the telephone 24 hours a day. This service is run by nurses and people calling with non-urgent queries may be called back at a later time.

- GP surgery and out of hours service. The local GP surgery can provide a range of health services, including being the first port of call for someone who is experiencing mental distress.

Alternative approaches to managing stress and aiding relaxation are used variably throughout services for people affected by domestic and sexual violence, substance use and mental ill-health. Substance use and sexual violence services, in particular, are more likely to promote activities such as acupuncture, reiki, different types of massage and aromatherapy to help clients to feel both emotionally more resilient and physically better. More information about alternative therapies can be found on p.85.

5.2 Being active

The need to be **active and occupied** is consistently reported by survivors, particularly those who are also affected by substance use and mental ill-health. Being active, meeting other people and usefully occupying your time can create a sense of purpose and build self-esteem.

Whilst it may not always be possible to find meaningful ways to fill time when someone is in an abusive relationship, is heavily using or in crisis mentally, it is important to find out how survivors want to spend their time. It is often in periods of 'calm' after a crisis where boredom and restlessness can set in.

Boredom can be a trigger for substance use, as can loneliness, so having lots of things to do can be very important for people who have recently reduced their substance use, or stopped altogether.

For people who experience mental ill-health, long periods of inactivity can exacerbate symptoms. Boredom and loneliness, for example, can make depression and anxiety worse.

"The evenings [in the refuge] were when I really struggled. If they know someone has mental health issues, they need to make sure there's stuff for them, not just bring them in and do nothing".

Survivor's voice

6. Long-term recovery

Recovery is a much talked about subject and is central to the delivery of most drug, alcohol and mental health services. It is also a key concept within sexual violence services such as Rape Crisis.

The Government's mental health strategy, *No health without mental health*, for example, incorporates recovery as one of the six objectives. Recovery is described as:

"*More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates, and a suitable and stable place to live.*"[19]

Similarly, models of substance use recovery look at freedom from substances, reduction in offending, improved health and well-being, stable accommodation, improved employment opportunities and stronger social networks.[20]

"The word recovery isn't just about drugs, it's a way of life, it's recovering from [domestic violence], it's a cycle of trying to get out"

Survivor's voice

6.1 Principles of recovery

As outlined already in this section, survivors' main needs revolve around how they are treated by others and the extent to which they can regain control of their lives. These are also the building blocks for recovery:[21]

- Being treated with dignity and respect
- Being seen as an individual, not just as an illness, a survivor, an addict or as someone in recovery

- Having hope and someone to believe in you

- Having the opportunity and support to make sense of what is happening or has happened in your life and to validate how you feel

"Research has demonstrated that it is not the traumatic events in our lives that determine resiliency so much as how we make sense of those events that determine our ability to experience resiliency"[22]

- Having control and being supported to make decisions about one's life

- Developing trust in others through relationships with consistent, caring and empathic people – professionals, peers, friends and family.

6.2 Models of recovery

As domestic and sexual violence, substance use and mental ill-health are so interlinked, it is important for practitioners to consider an integrated approach which recognises that the ways in which dealing with one issue can escalate risk in other areas of the survivor's life. For example:

- Addressing experiences of trauma, for example in leaving an abusive situation or participating in psychological therapy, can result in a decline in mental health.

- Where alcohol or drugs are used as self-medication or a way to cope with trauma responses, the risk of suicide and self-harm can increase in the short-term when people begin to address the substance use.[23]

- Changing patterns of drug or alcohol use can lead to an increased risk of domestic violence if the victim appears to gain control of their life.

A core principle of supporting people through their recovery therefore is safety.

In prioritising survivors' safety, models of recovery from trauma, problematic substance use and mental ill-health all have a broadly similar framework:

1) **Assessment of presenting problem.** Severity of mental health problems, extent of substance use, future risk of being abused may be considered

2) **Crisis intervention and management.** This could include fleeing an abusive partner or being hospitalised due to a mental health crisis (see section 6 for more information).

3) **Stabilisation.** In different settings, this may include the use of medication to manage symptoms of mental health, reducing alcohol or drug use so that the individual can engage with services, or building up a survivor's internal resources so that they are more able to manage trauma responses (see section 5 for more information).

4) **Long-term interventions.** Long-term care plans may include medication, psychological therapies, support with practical matters such as housing, finances and employment and building support networks.

The rest of this section looks at different longer-term options (primarily therapeutic) available to help survivors deal with experiences of trauma, problematic substance use and mental health problems.

What works? Seeking Safety

Seeking Safety is a therapeutic model of addressing the dual issues of PTSD and substance abuse, recognising that dealing with either issue in isolation could lead to a worsening of the other issue. The author has created a manual covering 25 topics (including asking for help, setting boundaries, healing your anger, coping with triggers, grounding) that can be conducted in any order and in both group and individual settings. The core principle is to enable sufferers to be and feel safer – to be able to manage both the symptoms of PTSD and their substance use. The Seeking Safety manual is very user-friendly, with clear guidance for practitioners and handouts for survivors. Repeated reviews of the model have yielded positive outcomes for survivors. The manual can be ordered from www.seekingsafety.org.

6.3 Long-term interventions

A wide range of medical, psychological and psychoeducational interventions are used in stabilising and then supporting individuals to address substance use and mental health problems, as well as in enabling survivors to process and recover from experiences of violence and abuse.

NICE

The National Institute of Clinical Excellence (NICE) writes guidance for health professionals on a range of issues including PTSD, depression, drug and alcohol treatment and dual diagnosis. Their recommendations are based on careful research to find what works, but they exclude methods that have not been rigorously studied within the health sector. Guidance can be accessed at www.nice.org.uk.

The most common options you will come across are detailed below (in alphabetical order):

Abstinence (from substances)

An approach adopted by some drug and alcohol services, abstinence means completely refraining from the use of drugs or alcohol. Organisations such as Alcoholics and Narcotics Anonymous require abstinence as part of their self-help ethos.

Behaviour therapy

Aims to change behaviour by focusing on what the person does and teaching new skills. It is concerned with what people do, rather than thoughts or feelings, which are often influenced by actions. It may include learning ways of reducing anxiety or confronting feared situations (but not ones which are really dangerous). Clients may keep diaries and practice 'homework'. It is particularly good for anxiety or phobia and is usually short term (weekly sessions over not more than three months).

Body-oriented therapies

In relation to trauma, body therapies primarily relate to either:

- Complementary therapies such as massage, shiatsu and reiki that encourage survivors to reconnect with and honour their bodies.

- Somatic experiencing and/or sensorimotor therapy that helps survivors to recognise and process trauma-related bodily sensations and memories. More information is on p.41-44 and p.91-92.

What works?
Women and Girls Network
Women and Girls Network (WGN) is a free, women-only services providing a holistic response to women and girls who have experienced, or are at risk of, gendered violence. Women who receive individual counselling sessions are also offered six weeks of body therapies (aromatherapy massage and shiatsu). This aspect of the service particularly acknowledges the impact of violence on the body, and this can impact on the survivor's ability to heal. Body therapies offers an opportunity to reconnect and develop a positive relationship with the body and to build trust in others within a safe environment. Find out more at www.wgn.org.uk.

Cognitive Analytic Therapy (CAT)

The therapist and client work together aiming to understand how problems arose. Clients may find their usual ways of coping make difficulties worse, and will discuss with their therapist ways to improve things, using their own strengths and resources. Diagrams and written outlines of old patterns and new insights are made to help the client develop their understanding and skills. CAT uses some cognitive principles (using the client's thoughts and observations of their experiences and behaviour) and some analytic principles (including exploring unconscious or unacknowledged issues and relationship patterns). It is usually offered 1:1 for sixteen hourly meetings. See www.acat.me.uk for more information.

Cognitive-behavioural therapy (CBT)

CBT can help a survivor to process and evaluate their thoughts and feelings about a trauma. While CBT does not treat the physiological effects of trauma, it can be helpful when used in addition to a body-based therapy such as somatic experiencing or EMDR. CBT approaches are also used in substance use treatment services to help recognise, avoid and cope with triggers or relapses in their substance use. The Increasing

Access to Psychological Therapies (IAPT) programme has increased access to CBT in recent years – ask your GP for more details.

Cognitive restructuring

Cognitive restructuring teaches people how to recognise and control unhelpful thoughts and replace them with calming, more helpful thoughts. AVA's mental health toolkit, Sane Responses, includes examples of cognitive restructuring techniques and can be downloaded from the Toolkit section of the AVA website (www.avaproject.org.uk).

Complementary therapies

Common complementary or 'alternative' therapies include:

- Acupuncture: the Chinese system of healing by inserting fine needles into the body. It can increase the body's release of natural pain killers and have positive effects on the nervous system. Also used in substance use services to manage urges to use drugs or alcohol

- Aromatherapy: the use of concentrated plant oils to treat emotional or physical conditions through massage, bath water or a room vaporiser

- Creative therapies: art, drama and music therapy can help expression of feelings, provide insight and reduce isolation

- Herbal medicine: using one or more herbs, to relieve symptoms and treat the cause of a condition

- Homeopathy: taking tiny, highly diluted quantities of substances that create similar symptoms to the condition suffered, which can promote the body's self-healing efforts

- Self-development courses: local colleges and domestic violence outreach groups run short courses on self-development e.g. assertion, social skills and self-defence

- Yoga: designed to achieve balance between body, mind and spirit by encouraging flexibility, posture, improved breathing and blood flow.

The British Complementary Medicine Association (www.bcma.co.uk) covers over 75 therapies and holds a directory of therapists.

Counselling

Person Centred, Rogerian or Humanistic approaches to counselling all provide space to examine current and past issues with a counsellor as a non-judgemental listener. The client is seen as the expert with their own answers, and the counsellor a supportive listener who does not give advice. It is not structured or directed by the counsellor, which can be very supportive in cases of domestic violence but has not been shown to help in processing trauma. Counsellors may be located with a GP practice, in private practice or in voluntary organisations such as Rape Crisis. All counsellors should be accredited - check the British Association for Counselling and Psychotherapy (www.bacp.co.uk) or British Psychological Society (www.bps.co.uk) for accreditation and for counsellors specialising in abuse or trauma.

What works? Nottinghamshire Rape Crisis Centre

Nottinghamshire Rape Crisis Centre (NRCC) offers a holistic and person-centred counselling to women in Nottinghamshire who have experienced sexual violence. Person-centred counselling can assist an individual through stages of deepening experiential awareness and acceptance of self. The very nature of the approach means the therapeutic work undertaken avoids the possibility of reinforcing the trauma and fosters post traumatic growth and healing in terms of feeling more empowered, more able to exercise control, stronger sense of self, development of healthy coping strategies and improved quality of life. The client's emotional safety and well-being is paramount. Women who have used NRCC report feeling greater acceptance and healing: "*My difficulties have melted away – I can cope with anything now. I am no longer over-powered, just empowered.*" For information about Rape Crisis Centre in England and Wales, visit www.rapecrisis.org.uk.

Couples and family therapy

Couples and family therapy are based on the understanding that many problems arise in relationships and problems are often not one person's alone. Both types of therapy are common within mental health and substance use services, and survivors may request couple or family therapy as a first step to remedy the problems with their partner, **but these approaches are not recommended if domestic violence is a current issue as it can increase the danger faced by the survivor and any children.** Relate, the largest provider of relationship counselling in England, has produced guidance which clearly states that in cases of domestic violence, counselling should not be offered to the couple jointly, but each partner should be seen separately. The full guidance can be downloaded here: http://tinyurl.com/cwcsu3q.

Detoxification

Stabilistation of drug and alcohol use may begin with detoxification. For substance use problems such as alcohol that have significant withdrawal effects, detox may take place in a residential service. In in-patient services, medication may be prescribed to alleviate painful side effects of withdrawal and monitor the service user's health. Mild to moderate withdrawal as well as non-medical detox may happen in the community.

Dialectical behaviour therapy (DBT)

DBT was developed from cognitive behaviour therapy (CBT) in order to meet the emotional needs of people diagnosed with a borderline personality disorder. DBT aims to help people recognise and accept their emotions, and then teaches people to manage their emotions more effectively and find safer ways to manage with stress and difficult emotions in future.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR incorporates elements of cognitive-behavioral therapy with eye movements or other forms of rhythmic, left-right stimulation. These back-and-forth eye movements are thought to work by "unfreezing" traumatic memories, allowing you to resolve them.

Gestalt therapy

An 'experiential' approach, emphasising bodily feelings and emotions in understanding people's

experience. It can be individual or group therapy. The client and therapist typically focus on 'unfinished' past experiences which have left lingering feelings or distress about the person or event. The therapist may suggest experiments to obtain closure, such as having an imaginary conversation with a person or writing them a letter (that may not be sent).

Harm minimisation

Harm minimisation accepts that some people will choose to use drugs and alcohol and some of those people will develop problems with their substance use. It is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising the harms and hazards of drug use for both the community and the individual. This approach does not require abstinence.

Medication

Medication is the most common form of treatment for mental distress; it is also used in some types of drug and alcohol detoxification. Medication can relieve some symptoms of mental ill-health and make life easier but is not likely to resolve the problems when taken alone and is most effective when combined with other kinds of support. If misused, medication can cause its own additional problems. Common groups of medication are:

- **Anti-anxiety drugs** also known as anxiolytics or minor tranquillisers. Includes Benzodiazepines which can help people feel calm and relax in the short term but can cause dependency if used over time (longer than a month). Used to treat anxiety and sleeping difficulties.

- **Antidepressants** used in the treatment of depression, anxiety, obsessive-compulsive disorder and pain.

- **Antipsychotics** used in the treatment of psychosis (including schizophrenia) to reduce the distress caused by hallucinations and delusions. Sometimes called Neuroleptics or major tranquillisers. Some examples include haloperidol and chlorpromazine. Newer forms have fewer side-effects.

- **Depot medication** taking prescribed medication, usually antipsychotics, by injection (usually given by a Community Psychiatric Nurse), which releases the drug slowly over several weeks and prevents the need to take tablets regularly.

- **Mood stabilisers** used to control mood swings in Bipolar Disorder. The most common are Lithium and Carbamazepine.

- **Sleeping tablets** designed to help people sleep. Sometimes called hypnotics. Useful in the short term but can cause dependency; use over months or years should be avoided. Over-the-counter sleeping remedies can contain antihistamines (used to treat hay fever and colds) which may cause drowsiness well into the next morning.

Leaflets about all the aforementioned types of medication, how they are used and the potential side effects can be downloaded from the Royal College Psychiatrists website:
http://www.rcpsych.ac.uk/expertadvice/atozindex.aspx

Motivational interviewing (MI)

MI is a directive, service user-centred counselling style for eliciting behaviour change by helping service users to explore and resolve ambivalence. It is primarily used in drug and alcohol services in the UK. Compared with non-directive counselling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counsellor is intentionally directive in pursuing this goal.

Multi-systemic therapy (MST)

MST is a family and community-based therapy, often used for young people with complex problems. There is increasing use of MST with CAMHS (Child and Adolescent Mental Health Services) and in social services to deal with families who experience multiple problems. The relationships between family members are seen as the cause of problems rather than individuals and carries the same warning as other types of family therapy that this is not appropriate in cases of domestic violence as the therapy can be used by the perpetrator to further abuse the survivor and manipulate services.

Opioid substitution therapy/ methadone replacement therapy

People who are dependent on opioids (heroin) may be prescribed methadone as a replacement. Methadone is a synthetic opiate manufactured for use as a painkiller, and has similar effects to heroin but doesn't deliver the same degree of buzz or high as heroin. Prescriptions may need to be collected on a daily basis, particularly if the service user's drug use is chaotic. Methadone is partly prescribed to break the cycle of offending often associated with using heroin and to help users to reduce their use. Prescribing services are usually run in partnership between a GP surgery and a specialist drugs service.

Psychoanalysis and psychodynamic counselling

Psychoanalyis originated with the theories of Sigmund Freud. In a session, the client talks about thoughts, feelings, dreams and memories and the therapist listens, sometimes commenting on the client's patterns of thinking and behaving, with the goal of raising self-awareness.

The psychodynamic counselling approach (counselling based on the analytical approach) generally focuses on working with the inner world of the client, the unconscious and the client's past experiences. This approach can be unhelpful where there is domestic violence because:

- A focus on the past may mean that the cause of trauma – domestic violence – may not be acknowledged or understood.
- This approach may fail to recognise the perpetrator's behaviour.
- It may fail to recognise the strengths and resources of the woman which have helped her cope.
- It may create a risk to a woman's safety unless risk assessments are conducted and the reality of real danger is understood and incorporated.

Somatic experiencing and sensorimotor therapy

Somatic and sensorimotor therapy recognises the impact of trauma on the survivor's nervous system, brain and hormones. It builds on psychotherapeutic approaches to

integrating thoughts and emotions to include concentrating on what's happening in the body, getting in touch and releasing trauma-related energy and tension.

Trauma therapy

The treatment of trauma usually involves different therapeutic approaches that:

- Build the survivor's resources so that they have some control over hyper- and hypoarousal and are able to manage strong emotion which may arise during therapy
- Decondition traumatic memories and responses
- Process and integrate events and memories of traumatic events
- Help to discharge pent-up trauma-related energy
- Build or rebuild the ability to trust other people

What works? LifeWorks

Since 2008, St Mungo's LifeWorks programme has provided face-to-face psychotherapy to around 200 service users regardless of their mental health diagnosis, including psychosis and personality disorders, or active substance use. Of the LifeWorks clients willing to share their history, 66% had histories of chronic trauma including sexual, emotional and/or physical abuse as children and high levels of early loss of primary caregiver. 24% had been in care and 43% had been in prison.

Clients are offered up to 25 weekly sessions, 50 minutes each, of individual psychodynamic psychotherapy. These are 'client led', with clients talking about emotional issues (such as relationship breakdown and bereavement), rather than 'needs led' (talking about substance use and non-engagement with services).

Evaluation of the LifeWorks project has found that:

- 75% of clients showed an improvement in mental well-being

- Impact on a wide range of health and social outcomes :e.g. increased uptake of appropriate health treatment, reduced use of emergency services, and 42% of LifeWorks clients were in employment or training placements by the end of the therapy

- Higher take-up and completion rates and more recovery outcomes than the IAPT programme (Improving Access to Psychological Therapies) despite working with chronically excluded adults with complex needs.

For more information, see http://tinyurl.com/cpte2mn.