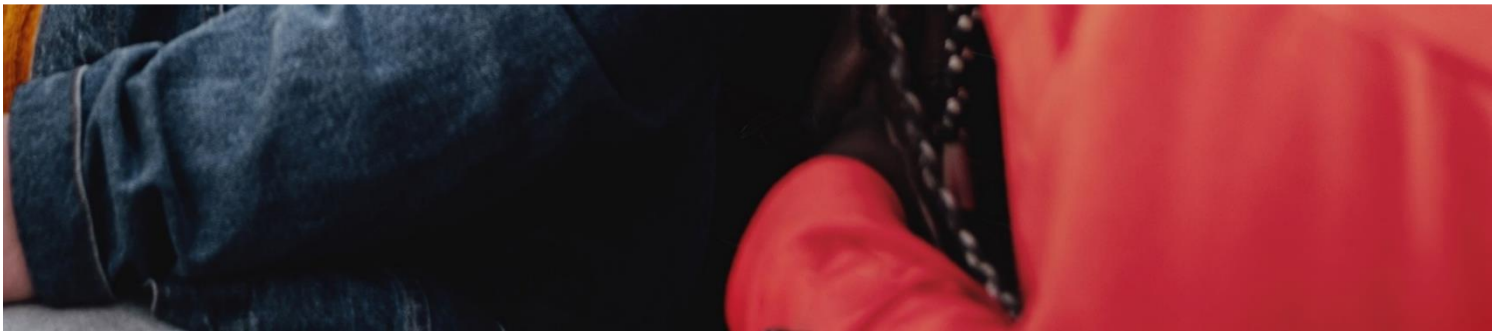
Substance use and trauma-informed approaches:

A toolkit for frontline professionals and organisations who work with people who use drugs and alcohol



ALCOHOL CHANGE UK

CAPITAL

west sussex county council

Contents

Introduction

This toolkit has been developed to provide you with the knowledge and practical tools needed to apply trauma-informed principles in your work, and to create environments that foster safety, trust, and empowerment for those you support.

Why Trauma-Informed approaches matter

Trauma is a pervasive experience that can have lasting effects on emotional, physical, and social wellbeing. A trauma-informed approach (TIA) acknowledges these impacts, and aims to provide support that avoids re-traumatisation, while promoting healing and resilience. By understanding trauma and responding with sensitivity, professionals can create supportive environments that empower people to regain a sense of control, safety, and hope in their lives.

Acknowledgement and appreciation

We are deeply grateful to the members of CAPITAL, whose invaluable contributions as *experts by experience* have played a crucial role in shaping this project. Their lived experience, insight, and dedication have been instrumental in ensuring that the content of this toolkit is relevant, meaningful, and reflective of the challenges faced by people affected by trauma. Their voices remind us of the importance of empathy, dignity, and respect in trauma-informed care.

Objectives of this toolkit

Throughout this toolkit, you will learn about key models and theories that underpin trauma-informed practice, and it has been designed to support reflective learning. Each section includes *reflection exercises and videos*, which you are encouraged to engage with both individually and within your teams. This will enhance your understanding and help you to apply the concepts to your work. The contributions of *experts by experience* serve as a powerful reminder that the voices of people with lived and living experience are central to creating meaningful, person-centred support. In applying the learning from this toolkit, you will be able to:

- Identify the signs and effects of trauma in individuals, understand how substance use is related to trauma, and be aware of how stigma and prejudice impact people who use drugs and/or alcohol.
- Implement trauma-informed principles in your everyday practice.
- Build relationships based on trust, collaboration, and empowerment, developing an understanding and empathy for people who use drugs and/or alcohol.
- Support people in developing resilience and coping strategies, helping them access specialist drug and alcohol treatment, if needed.
- Prioritise self-care to maintain your own wellbeing in trauma-informed work.

Thank you for your commitment to adopting a TIA. Together, through collaboration and understanding, we can create environments that promote healing, dignity, and hope.

Section one
Understanding trauma

Trauma can be defined as: *'an event, series of events, or circumstances that are experienced as physically or emotionally harmful or threatening, with lasting adverse effects on an individual's functioning and well-being'* [1]. Types of trauma include:

- **Acute**: results from a single event (e.g., accident, assault).
- **Chronic**: results from prolonged exposure to distressing events (e.g., domestic violence, long-term abuse).
- **Complex**: involves multiple, invasive, and interpersonal traumatic experiences, often beginning in childhood.

The three Es of trauma

The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies trauma through three elements:

1. **Event**: a distressing experience such as violence, loss, or neglect.
2. **Experience**: how the event is perceived and processed by the individual.
3. **Effect**: the long-term impact on emotional, physical, and social wellbeing [1].

Understanding trauma through this lens can help professionals avoid minimising experiences and respond with sensitivity.

Trauma and substance use and dependence

Trauma-informed care (TIC) recognises the profound impact of trauma on people, particularly those struggling with drugs and/or alcohol. Substance dependence is often deeply rooted in unresolved trauma, with people using them as a coping mechanism to manage emotional pain, stress, and past adverse experiences.

Dr Gabor Maté, a leading expert in addiction trauma, advises that *"addiction is not a choice that anybody makes; it's not a moral failure; it's not an ethical lapse; it's not a weakness of character; it's not a failure of will, which is how our society depicts addiction. What it actually is: it's a response to human suffering"* [2]. Understanding the link between trauma and substance use and dependency allows professionals to provide compassionate and effective support, fostering environments that promote healing, trust, and empowerment.

Reflection exercise

Think about someone you have worked with who may have experienced trauma. How did their experiences shape their behaviour and ability to access support and/or collaborate with services?

Trauma can stem from a wide range of experiences, such as childhood adversity, abuse, neglect, violence, systemic discrimination, and significant life disruptions. A TIA recognises the prevalence of trauma and aims to provide care and support that minimises the risk of re-traumatisation and fosters a sense of safety and empowerment.

It is crucial for professionals to understand trauma not as an isolated event, but as an experience that can shape an individual's worldview, behaviours, and interactions with people and services. By adopting a trauma-informed lens, and providing TIC, professionals can create environments where people feel heard, respected, and supported in their recovery. The next section will explore the principles of TIC.

Section two
The principles of trauma-informed care

Trauma-informed care (TIC) is based on principles that guide professionals in creating a safe, supportive, and empowering environment for individuals who have experienced trauma. These principles ensure that services recognise the impact of trauma and actively work to prevent re-traumatisation [3].

Principle one: Safety

- Creating a physically, emotionally, and psychologically safe space for individuals and staff.
- Ensuring predictable and consistent interactions to build trust.
- Being aware of potential triggers and minimising distressing environments.

Principle two: Trustworthiness and transparency

- Being honest, consistent, and clear in communication.
- Explaining policies, procedures, and decisions to individuals accessing support.
- Setting and maintaining professional boundaries to foster trust.

Principle three: Choice and autonomy

- Providing individuals with control over decisions affecting them.
- Respecting a person's right to accept or decline support without fear of punishment or exclusion.
- Encouraging informed decision-making and self-determination.

Principle four: Collaboration and mutuality

- Recognising that healing happens in relationships and that people and practitioners work together as partners.
- Valuing lived experience and co-production in shaping services.
- Encouraging teamwork and shared decision-making.

Principle five: Empowerment, voice, and strengths-based approach

- Focusing on an individual's strengths and capabilities rather than deficits.
- Encouraging people to use their own resources for healing and recovery.
- Validating experiences and promoting self-efficacy.

Principle six: Cultural, historical, and gender awareness

- Recognising how cultural and historical experiences shape trauma responses.
- Ensuring services are inclusive, anti-discriminatory, and accessible to all.

By embedding these principles into practice, public-facing professionals can create an environment that supports recovery, reduces harm, and promotes resilience [3].

Reflection exercise

Consider how each principle applies to your work setting. Discuss with your colleagues and write down one action you can take to enhance each principle in your interactions with people

To deliver TIC, it is important to understand theories and frameworks relevant to trauma and development, and the impact of childhood trauma on the brain, which will be explored next.

Section three
Trauma and development

There are well established theories and frameworks relevant to development and trauma.

Attachment theory

Attachment theory explains how early relationships with caregivers shape an individual's emotional and social development. It suggests that the quality of these early attachments influences how people form relationships, regulate emotions, and respond to stress. There are four primary attachment styles:

1. **Secure**: people feel confident in relationships, seek support when needed, and offer support to others. They typically have a positive view of themselves and others.
2. **Ambivalent**: characterised by a heightened need for closeness and reassurance, people with this style often fear abandonment and may appear overly dependent in relationships.
3. **Avoidant**: people tend to value independence, suppress emotional needs, and avoid closeness in relationships, often due to a fear of rejection or vulnerability.
4. **Disorganised**: a mix of anxious and avoidant traits, people may exhibit inconsistent behaviour in relationships, often linked to experiences of trauma or neglect [4].

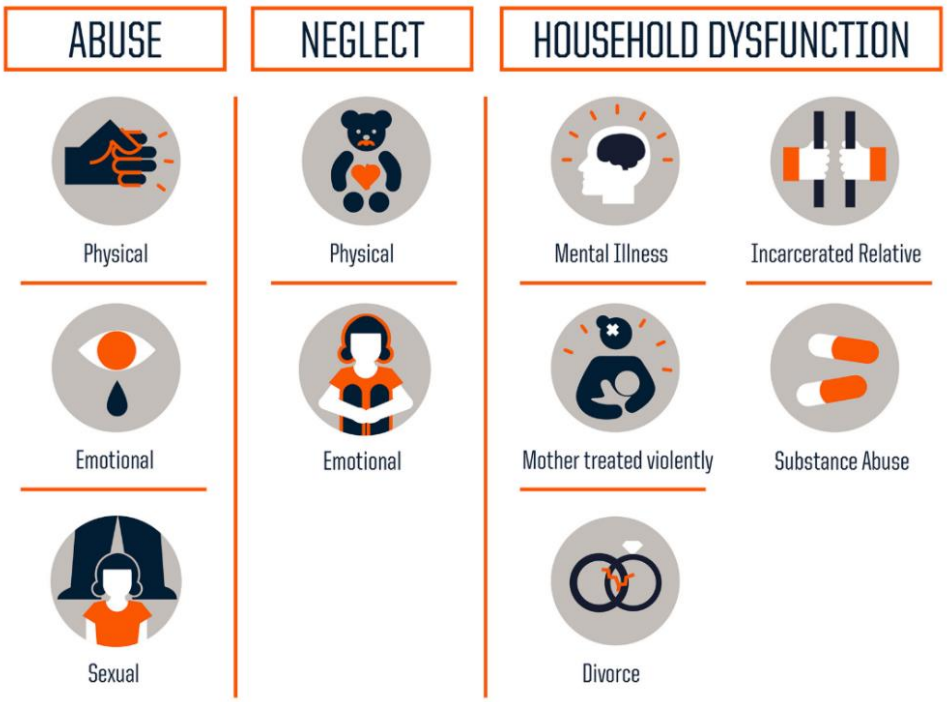
Understanding attachment styles can help us in supporting people's emotional and social well-being, and recognise behaviours linked to early experiences [5].

The Adverse Childhood Experiences framework

Adverse Childhood Experiences (ACEs) refer to potentially traumatic experiences that occur in childhood (e.g., abuse, neglect, household dysfunction). ACEs can have long-term impacts on health, behaviour, and wellbeing.

Research shows that higher ACE (Adverse Childhood Experiences) scores are associated with an increased risk of mental health conditions, substance use, and chronic illnesses. Early intervention and supportive environments can help mitigate the long-term effects of ACEs. ACEs can include a wide range of experiences such as racism, gender discrimination, witnessing a sibling being abused, witnessing violence outside the home, observing a father being abused by a mother, being bullied by peers or adults, involvement with the foster care system, living in a war zone, residing in an unsafe neighbourhood, losing a family member to deportation, and other destabilising events [6;7;8;9].

Examples of ACEs



Source: Centers for Disease Control and Prevention
Credit: Robert Wood Johnson Foundation

Case study: Jason's story [Watch the video]

Jason has a history of substance use and homelessness. He experienced neglect and abuse in childhood, leading to insecure attachments and emotional dysregulation.

Reflection exercise

How might Jason's early experiences influence his ability to trust support services?
What trauma-informed approaches could be used to support Jason?

Childhood trauma and the brain

Early, traumatic life experiences can have a profound impact on neurobiological development. Trauma, particularly in childhood, can alter how people process emotions, stress, and relationships. Three key areas are impacted:

- **The brainstem (primitive brain)** – controls survival functions like breathing and heart rate. Trauma can cause a heightened fight-or-flight response, leading to anxiety and hypervigilance.
- **The limbic system** – regulates emotions and memory. Trauma can lead to emotional dysregulation, difficulty forming attachments, and increased fear responses.
- **The cortical brain** – responsible for reasoning and problem-solving. Trauma can impair decision-making, self-control, and perspective-taking

Childhood trauma also has a profound neurobiological impact. For example, the amygdala, responsible for processing fear and emotions, can become overactive, leading to heightened stress responses and emotional dysregulation. The hippocampus, which plays a crucial role in memory and learning, may shrink and impair cognitive function and emotional regulation, and the prefrontal cortex, essential for decision-making and impulse control, can also be underdeveloped, contributing to difficulties in managing emotions and behaviour. These changes can result in long-term challenges in adulthood [10;11;12;13].

The 'window of tolerance'

People function best when they are in their "window of tolerance"—a state where emotions are regulated, and they feel in control. Trauma can push people outside this window, and into **hyperarousal** (anxiety, outbursts, impulsivity), or h**ypo arousal** (numbness, detachment, shutdown). Many people, including children and young people, use substances to manage trauma symptoms, either to calm hyper-arousal, or to feel something in hypo-arousal. However, substance use can further dysregulate emotions and prevent healing [14;15].

The 'early gifts' from caregivers

In childhood, caregivers provide fundamental 'gifts' that shape a person's emotional, psychological, and social development. These are essential experiences and interactions that create a sense of safety, self-worth, and resilience. Examples include:

- **Being welcomed into the world** (e.g., feeling valued and wanted)
- **Bonding with a main caregiver** (e.g., secure attachment and trust)
- **Consistency** (e.g., predictability in care and response)
- **Being seen, heard, and taken seriously** (e.g., feeling acknowledged)
- **Boundaries that protect, rather than restrict** (e.g., safety with freedom)
- **Emotional vocabulary** (e.g., learning to identify and express feelings).

These 'gifts' form the foundation of a person's ability to regulate emotions, build relationships, and cope with challenges. When these are absent or inconsistent due to neglect, trauma, or instability, a child may struggle with emotional regulation, which can lead to anxiety or impulsivity; develop insecure attachment styles, making relationships difficult; lack self-worth, leading to low confidence or self-destructive behaviours; have difficulty trusting authority figures or accessing support; and feel unsafe in the world, increasing hypervigilance or dissociation. Without these foundational experiences, people may turn to coping mechanisms, such as using drugs and/or alcohol, to manage distress [4;5;10;16;17].

How we can model these 'gifts' through our actions in our day-to-day roles

For people who did not receive these early 'gifts', frontline professionals and services can play a key role in providing corrective experiences through TIC. In practice, this means:

- **Being welcoming and valuing** – greet people warmly and show genuine interest in their well-being. Small acts, like remembering their name or asking how they are, can make a huge difference.
- **Providing consistency** – be reliable, clear about boundaries, and follow through on commitments. Inconsistency can reinforce mistrust and anxiety.
- **Using active listening** – make eye contact, listen without judgment, and validate experiences. Reflect back emotions to show understanding.
- **Setting protective boundaries** – boundaries should be firm but not punitive. For example, explaining why certain rules exist rather than enforcing them without discussion.
- **Encouraging emotional expression** – help people develop language around feelings. Phrases like, "It's okay to feel angry; let's talk about why," help normalise emotions.
- **Promoting safety** – ensure the environment is non-threatening, predictable, and inclusive. Ask, "What would help you feel safe today?"

By modelling these 'gifts' in day-to-day interactions, we can offer people a chance to experience relationships built on trust, respect, and empowerment—helping to heal past wounds and support long-term recovery. People who experience childhood trauma can develop specific maladaptive behavioural responses to stress in later life, including the use of drugs and/or alcohol, which will be explored next**.**

Section four
The impact of trauma on behaviour

The *fight* and *flight* responses are natural and universal survival mechanisms that are present in everyone, regardless of trauma. These responses are part of the autonomic nervous system (ANS) and are designed to help people react to perceived threats or challenges in everyday life.

The *fight* response is activated when an individual perceives a threat and reacts by confronting it. It can manifest as assertiveness, anger, or aggression, enabling a person to stand their ground and protect themselves. In everyday life, the *fight* response can appear in healthy ways, such as standing up for oneself in a disagreement, pushing through challenges, or defending personal boundaries. In contrast, the *flight* response is triggered when a person perceives danger and seeks to escape or avoid it. Physiologically, it involves an increased heart rate, rapid breathing, and heightened alertness to enable quick action. In normal life, the *flight* response can present as avoiding conflict, walking away from stressful situations, or striving for self-improvement by distancing oneself from harmful environments.

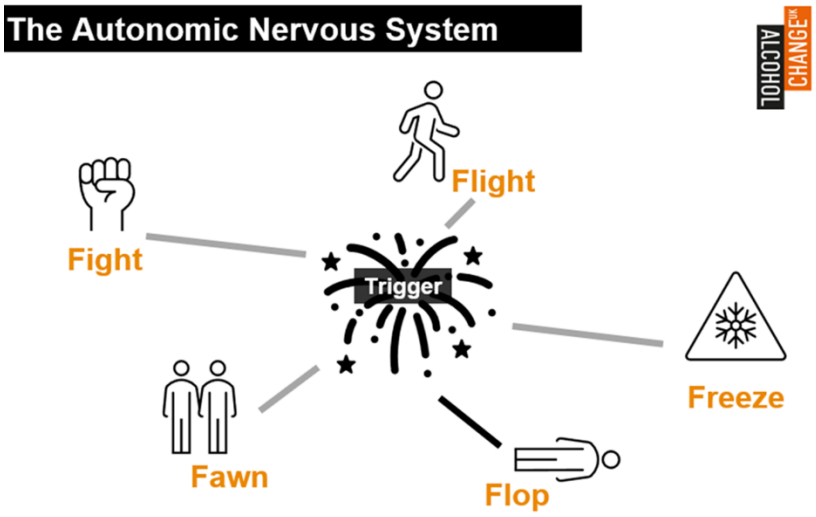
Both responses are adaptive functions that operate in everyone, not just those who have experienced trauma.

Trauma-specific responses

The *freeze, fawn*, and *flop* responses are more closely associated with trauma, and tend to occur when an individual feels overwhelmed, powerless, or trapped. These responses are involuntary and often develop as coping mechanisms in response to past traumatic experiences.

- *Freeze* occurs when the nervous system becomes overwhelmed, leading to immobility or dissociation.
- *Fawn* is a learned response to chronic stress or abuse, characterised by excessive people-pleasing to avoid further harm.
- *Flop* involves a physical collapse or submission, often seen in extreme fear situations where the body "shuts down."

Understanding the distinction between responses is crucial. The ANS plays a key role in all stress responses, and trauma-specific reactions such as *freeze, fawn,* and *flop* develop in response to extreme situations, and can have a profoundly negative impact on wellbeing [15;18;19;20].



Trauma and substance use

Trauma can significantly impact an individual's ability to regulate emotions, maintain relationships, and engage in daily activities. It is strongly associated with conditions such as anxiety, depression, post-traumatic stress disorder (PTSD), and substance dependency. Drug and/or alcohol use is a common survival mechanism for many who have experienced deep emotional wounds. Trauma impacts an individual's ability to form healthy relationships, regulate emotions, and engage in positive coping strategies, and using substances to manage trauma can lead to:

- Compounding chronic stress responses, that can perpetuate substance use and lead to dependency.
- Feelings of alienation and isolation from support systems and networks.
- Difficulty maintaining collaboration with treatment or support programmes.

Reflection exercise

Can you think of anyone you have worked with who demonstrated a freeze, fawn, or flop response? If so, how did they behave? How did you/your service respond?

Understanding the interplay between trauma and substance dependency helps us approach people with empathy and patience, avoid re-traumatisation, and offer appropriate, tailored support.

Section five
Why do people use substances to cope with trauma?

There are many reasons why people may use substances to cope with trauma, including to numb overwhelming emotions, regain a sense of control, suppress distressing memories, and to self-soothe or increase confidence. However, over time, substance use, and dependency, can exacerbate trauma by increasing vulnerability to unsafe environments, risky behaviours, and harmful relationships. It can worsen existing trauma, impair coping mechanisms, and lead to cycles of victimisation and self-destructive behaviours. Additionally, it can hinder access to support, and reinforce isolation, shame, and further emotional distress.

Case study: Tracey's story **Watch the video**

Tracey used alcohol to manage PTSD symptoms from childhood trauma. She avoided services due to previous negative experiences.

Reflection exercise

What barriers might Tracey have faced in accessing support?
How could services be more accessible and non-judgmental?

Re-victimisation

Re-victimisation occurs when people who have experienced trauma are subjected to further harm in similar or new situations. This cycle is often linked to unresolved trauma, impaired coping mechanisms, and difficulty in recognising risky situations. It can reinforce feelings of powerlessness, shame, and distress, and increase vulnerability. Institutional and iatrogenic re-victimisation occur when people experience further harm within systems meant to support them, such as healthcare, social care, and the criminal justice system. This can include neglect, discrimination, or re-traumatisation through insensitive practices. It can erode trust, deter people from seeking help, and perpetuate feelings of powerlessness and distress, hindering recovery and well-being [1;15;21;22].

What prevents people from seeking support?

For people who have experienced trauma and substance use/dependency, change is not a matter of willpower—it is influenced by complex psychological, social, and physical factors. TIC recognises that many barriers to change are rooted in past experiences, survival mechanisms, and systemic challenges.

Psychological barriers

- Fear of change – change can feel threatening, even if it is positive. Many people have adapted by using substances as a coping strategy and removing that strategy may feel unsafe.
- Previous negative experiences with services – stigma, judgment, or feeling unheard in past interactions can make people reluctant to engage.
- Mental health challenges – conditions like depression, PTSD, and anxiety can make motivation and collaboration difficult.

Physical and cognitive barriers

- Alcohol-related brain damage or cognitive impairment – this can impact decision-making, memory, and ability to engage in structured support.
- Physical health conditions – fatigue, pain, or illness (e.g., liver disease) can reduce the ability to engage with services.
- Nutritional deficiencies – poor diet can affect energy, concentration, and mood, making it harder to focus on change

Social and environmental barriers

- Peer and family influence – social circles may normalise or encourage continued substance use.
- Financial pressures – debt, housing instability, or benefit concerns can take priority over recovery.
- Ongoing abuse or unsafe environments – trauma may still be occurring, making change feel impossible.

Reflection exercise

How can you adapt your support to help someone overcome one or more of these barriers?

Shame and stigma in the context of trauma and substance use/dependency

Shame is a powerful and often hidden emotion that plays a significant role in the lives of people who have experienced trauma and substance dependence. Unlike guilt, which is about feeling bad for something done, shame is about feeling inherently flawed or unworthy. Many people who use substances to cope with trauma experience deep shame, reinforced by societal stigma, judgment from services, and internalised self-criticism. Shame can manifest in different ways, including withdrawal, defensiveness, anger, or self-destructive behaviours. It creates a barrier to seeking help, as people may fear being judged, rejected, or misunderstood. TIC aims to reduce shame by fostering trust, validating experiences, and creating non-judgmental spaces where people feel safe to engage with support.

Common shame reactions include:

- **Denying** e.g., "It wasn't that bad."
- **Withdrawing** e.g., "I can't face this."
- **Attacking others** e.g., Blaming or deflecting.
- **Attacking self** e.g. "I'm broken."

How we can reduce shame and stigma through trauma-informed care

Stigmatising people who are drug and/or alcohol dependent can increase shame and isolation, reduce someone's willingness to seek help, and can perpetuate cycles of trauma and substance use. Public-facing professionals can help by recognising shame reactions, using compassionate language, and ensuring that services empower rather than punish. Addressing shame is key to breaking cycles of trauma and substance dependency, helping people move towards healing and change. Creating service environments that reduce shame and promote trust is essential. Here are three key actions you could implement:

1. **Use compassionate and non-judgmental language**
   The words we use can either reinforce shame or help to alleviate it. Avoid labels like "addict" or "non-compliant" and instead focus on person-centred language, such as "a person experiencing challenges with drugs and/or alcohol." Acknowledge their experiences without judgment by saying things like, *"I can see how difficult this has been for you"* or *"You've been doing your best to cope.*
2. **Create a safe and trusting environment**
   Many people who feel shame have experienced judgment and rejection from services. Building trust takes time and consistency. Offer choices where possible, be transparent about processes, and respect boundaries. Small actions, like remembering a person's name and being reliable in follow-ups, can reinforce a sense of safety and reduce feelings of shame.
3. **Validate experiences and encourage self-compassion**
   Help individuals recognise that shame is a common response to trauma, not a reflection of their worth. Encourage self-compassion by reframing negative thoughts. For example, if a person says, *"I've failed again,"* you might respond, *"You're facing something really difficult, and it takes strength to keep trying."* Normalising emotions and acknowledging resilience can help reduce the power of shame.

What needs to change? Watch the video

Reflection exercise

As a team, discuss what steps your organisation has taken towards trauma-informed care?

Section six
Trauma-Informed care in practice

Amongst people who are drug and/or alcohol dependent, trauma can often present itself in ways that are misinterpreted as resistance, denial, or a lack of motivation. By understanding these behaviours through a trauma-informed lens, professionals can respond with empathy and provide the necessary support without reinforcing feelings of shame, guilt, or failure. Alongside the actions already outlined in this toolkit, here are further considerations to embed TIC into your day-to-day practice.

Understanding how our own experiences and beliefs can impact our work

Our personal experiences and beliefs shape how we perceive and respond to situations, which can significantly impact our work with individuals who have experienced trauma. If we have unexamined biases or hold judgments about substance use, for example, we may unconsciously respond in ways that reinforce stigma rather than promote trust. Similarly, if we have personal experience with trauma, we may over-identify with individuals or project our coping mechanisms onto them. A TIA requires practitioners to engage in self-reflection, recognising how our own backgrounds can influence our responses.

Being aware of personal triggers, practicing non-judgment, and actively seeking professional development helps ensure that we provide consistent, empathetic support. By fostering self-awareness, we can create safer environments, where individuals feel seen and supported rather than judged. A commitment to learning and reflection enables us to provide support that is compassionate, empowering, and free from personal bias.

Adapting our everyday language to be more trauma-informed

Traditional language used by professionals and services can often reflect judgment, blame, or a lack of understanding of trauma. By shifting to a TIA, we can promote dignity, trust, and empowerment. Here are some examples of outdated language and their trauma-informed alternatives:

- Old: “addict or substance misuser” → New: “person who uses substances”
- Old: “non-compliant, or non-engager” → New: “facing barriers to collaboration”
- Old: “resistant to change” → New: “not yet ready for change”
- Old: “lack of motivation” → New: “experiencing challenges in collaboration”
- Old: “refused treatment” → New: “chose not to access treatment at this time”

This shift acknowledges people’s autonomy, reduces shame, and encourages meaningful collaboration. Using person-first language and reframing negative labels helps foster trust and collaboration, making services more accessible and supportive.

Building trauma-informed relationships

Building relationships with a TIA requires active listening, empathy, and respect. Providing consistent, predictable interactions helps build connection over time. Trauma-informed relationships require a foundation of trust, empathy, and validation. People affected by trauma may struggle to form connections due to previous negative experiences with authority figures or support services. Establishing consistency, providing clear communication, and demonstrating reliability are crucial steps in fostering trust.

Using a strengths-based approach

Professionals should adopt a strengths-based approach, focusing on an individual's capabilities and encouraging them to recognise their own resilience and potential. Small, positive interactions can build rapport and pave the way for more effective collaboration. Key principles that underpin a strengths-based approach include:

- Every individual has strengths and the capacity for growth.
- Collaboration is key to goal setting and empowerment.
- People should be supported in identifying solutions that work for them

It can be helpful to encourage people to reflect on their past successes and use these as building blocks for future goals [25;26;27;28].

Reflection exercise

Write down three strengths you have observed in someone that you have supported recently

Building on your existing skills that support trauma-informed care

Many public-facing professionals are trained in Motivational Interviewing (MI), a person-centred, goal-oriented approach designed to strengthen an individual's motivation for change by exploring and resolving ambivalence. MI is particularly effective in supporting people with substance use and mental health challenges, and is guided by four key principles:

- **Engaging** e.g., building a trusting relationship through empathy and active listening
- **Focusing** e.g., collaboratively identifying and clarifying goals that support positive change
- **Evoking** e.g., eliciting the individual's own reasons and ability to change by exploring their values and motivations
- **Planning** e.g., helping the person develop concrete steps towards change.

The approach is underpinned by the spirit of MI, which emphasises unconditional positive regard, and the use of open-ended questions, affirmations, reflective listening, and summarising (OARS) to guide conversations. It can help individuals to build confidence and commit to positive change. MI empowers people to take control of their decisions and actions and aligns strongly with TIC [29;30;31].

Your team, organisation, and trauma-informed care

Applying trauma-informed principles requires ongoing reflection and adaptation. Professionals should continuously assess their approach and seek feedback from people and colleagues to improve practice. For TIC to be truly effective, it must be embedded within team and organisational culture. This may include ensuring that policies reflect inclusivity and promoting a culture of understanding across all levels of service provision. Embedding trauma-informed care is an evolving process that requires commitment and flexibility. Commitment to creating trauma-aware, trauma-sensitive psychologically informed environments can also embed TIC. These environments are underpinned by:

1. **Psychological awareness** – understanding how trauma, mental health, and substance use impact behaviour, informing support approaches.
2. **Staff training and support** – equipping staff with skills in TIC, reflective practice, trauma-informed supervision, and de-escalation.
3. **Relationships** – prioritising trust, consistency, and collaboration to foster a sense of safety.
4. **Environment and design** – creating spaces that feel safe, calming, and empowering.
5. **Learning and continuous development** – using reflective practice, feedback, and evidence to adapt and improve support.
6. **Access to meaningful activities** – encouraging purpose and engagement in daily life.

Organisational behaviours and practices should reflect the core principles of TIC at all levels, from frontline interactions to administrative processes. Organisational commitment to TIC can result in improved outcomes, higher staff satisfaction, and better service user experiences [32;33;34].

What does good support feel like? Watch the video

Reflection exercise

What immediate changes can your team or organisation make in your day-to-day practice to create a more trauma-informed environment?

Prioritising self-care for professionals working with trauma

Working with people affected by trauma can be emotionally demanding and may lead to vicarious trauma or burnout. It is essential for professionals to prioritise self-care to maintain resilience and effectiveness in their roles. Self-care strategies may include regular supervision, boundary setting, and mindfulness practices. Organisations should support staff by offering debriefing sessions, promoting work-life balance, and fostering a culture of peer support. It is important to reflect on and recognise the signs of vicarious trauma or burnout:

- Feeling exhausted, cynical, or detached.
- Over-identifying with clients.
- Struggling to maintain boundaries.
- Becoming emotionally numb or avoiding clients.

Key sources of support for professionals and organisations

Mind
General mental health support, information lines, local branches offering support services.
https://www.mind.org.uk

NHS Practitioner Health
A confidential NHS service for doctors, dentists and other NHS staff struggling with mental health, addiction, or trauma-related issues.
https://www.practitionerhealth.nhs.uk

BACP (British Association for Counselling and Psychotherapy)
Search for registered therapists, with filters for trauma specialisms. Often used by professionals seeking private supervision or support.
https://www.bacp.co.uk

Trauma Response Network
Specialist trauma support, including for professionals affected by work-related vicarious trauma.
https://www.traumaresponsenetwork.org

Samaritans Frontline (for health and social care workers)
Confidential support line: 0800 069 6222 (7am–11pm daily).
https://www.samaritans.org/how-we-can-help/health-and-care

Reflection exercise

As a team, discuss how you can enhance your strategies for self-care within the working environment?
As an individual, are there any self-care strategies that you could enhance or develop?

The importance of professional referral in trauma-informed care for people who use drugs and alcohol

Professional referral to appropriate services, when they are needed, is essential for ensuring a clear, effective, and well-managed trauma-informed support process for people who use or are dependent upon drugs and/or alcohol. Assuming that someone must be motivated to self-refer, or relying on signposting, can prevent people from accessing support due to associated shame, stigma, and fear of change. In addition, individuals may not fully understand the services available, or how to access them. In practice, professional referrals help to streamline pathways, reduce delays, enhance collaboration, and can ensure that people receive the right support at the right time. This can, in some instances, be lifesaving. Furthermore, they strengthen trust, consistency, and efficiency, leading to better engagement, improved safety, and a more supportive environment for individuals accessing treatment and support.

West Sussex Drug and Alcohol Wellbeing Network – Change, Grow, Live

Change, Grow, Live are the specialist drug and alcohol treatment provider for West Sussex. To refer:

Online:
Referrals - Drug and Alcohol Wellbeing Network - West Sussex | Change Grow Live

Telephone:
0330 128 1113

Email:
WestSussex.FirstStep@cgl.org.uk

Change Grow Live

Thank you for your commitment to trauma-informed practice.

Alcohol Change UK and West Sussex County Council, 2025.

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