INTEGRATING TRAUMA-INFORMED CARE INTO SUBSTANCE USE TREATMENT

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Aim: People seeking help from alcohol and other drug (AOD) treatment services report high rates of trauma, and approximately half meet criteria for post-traumatic stress disorder (PTSD). Evidence suggests that integrated treatments for PTSD and SUD are more effective in reducing symptoms of both disorders compared to a single treatment method. However, there is limited consensus on how to best manage or integrate integrate trauma/PTSD treatment in AOD settings.

This symposium contains four presentations. The first presentation presents the results of a qualitative study which investigated client and staff perceptions of the integration of trauma informed care (TIC) and specialist PTSD treatment in residential AOD treatment facilities. The second presentation reports a 3-stage whole of service plan for implementing a TIC. Presentation 3 describes the co-development and implementation of a trauma-informed model of care which incorporates individual treatment for post-traumatic stress disorder (PTSD) using Cognitive Processing Therapy (CPT), and describes the results of the training evaluation. The final presentation reports the results of a systematic review of research on the Concurrent Treatment of PTSD and Substance Use disorder Using Prolonged Exposure (COPE), and discusses the implications for practice.

PRESENTATION 1: CLIENT AND STAFF PERCEPTIONS OF THE INTEGRATION OF TRAUMA INFORMED CARE AND SPECIALIST PTSD TREATMENT INTO RESIDENTIAL TREATMENT FACILITIES FOR SUBSTANCE USE: A QUALITATIVE STUDY

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Introduction and Aims: Comorbid Posttraumatic Stress Disorder (PTSD) is prevalent among individuals seeking residential treatment for Substance Use Disorders (SUD). We

aimed to examine client and staff perceptions of the integration of trauma informed care (TIC) and specialist PTSD treatment in residential alcohol and other drug (AOD) treatment facilities.

Design and Methods: Individual semi-structured interviews were conducted with frontline staff (*n* = 20) and clients (*n* = 18) in two residential AOD treatment facilities in Queensland, Australia. Interviews were audio recorded, transcribed, and data was analysed using Thematic Analysis.

Results: There were akin perspectives between clients and staff: PTSD was perceived as an underlying cause of SUD, where AOD is used to cope with, and avoid PTSD and anxiety-related symptoms. Hence, integrated treatment of SUD and PTSD in the residential setting was perceived to enhance treatment outcomes as residential facilities provide a safe and supportive environment for clients. Both staff and clients suggested an individual clients' readiness to begin PTSD treatment was contingent on establishing coping skills. Psychoeducation on SUD and PTSD was also highlighted to normalise experiences associated with comorbid SUD/PTSD and promote help-seeking pathways for specialist PTSD treatment. Staff perceived TIC as providing a consistent service delivery with a shared language, and having an assumption that all clients may have a history of trauma.

Discussion and Conclusions: Findings suggest that both client and staff perceive that adverse experiences from comorbid SUD/PTSD in residential treatment may be overcome through integrating TIC and PTSD treatment in residential treatment facilitates for substance use. Organisational and practical implications are discussed.

PRESENTATION 2: A FRAMEWORK FOR IMPLEMENTING A TRAUMA-INFORMED CARE APPROACH IN ALCOHOL AND OTHER DRUG SERVICES

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Introduction: Trauma-informed care (TIC) within an Alcohol and other Drug (AOD) setting operates according to the assumption that the majority of individuals seeking AOD treatment have a trauma background. Hence, a best practice approach to implementing a TIC framework involves adopting a systems approach. That is, it is critical that the *whole organisation* including policies, procedures, administration, assessment, counselling and referrals systems are responsive to the trauma background of their AOD clients. TIC differs from providing a specific trauma-focused intervention, which directly target the trauma event. At times the distinction between the two has been misunderstood across health and community services. We argue that implementing a system-wide TIC framework across AOD services is essential in order to be responsive to the long-term effects of trauma in AOD clients. This paper reports on a 3-stage plan when implementing a trauma-informed care that could be widely adopted by AOD services.

Design: The overarching framework we consider includes 10 organisational areas identified within the literature. The 3-stage plan will be described in detail and examples of success and challenges will be presented. Stage 1: Staff consultation, needs analysis and dissemination of the principles of a trauma-informed care framework. Stage 2: Whole of organisation approach to dissemination, training and implementation of practice guidelines.

Stage 3: Review and refinement of approach based on evaluation and staff and consumer feedback.

Conclusions:
A systems-wide TIC approach within AOD services is critical in order that we meet the needs of clients and provide a holistic approach to treatment.

Implications for practice and policy:
This framework consists of a staged-plan that can be adopted and implemented across the AOD sector and indeed more broadly. It is based on best practice and empirical evidence and is a practical approach for services to adopt.

PRESENTATION 3: DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF A NEW TRAUMA-INFORMED MODEL OF RESIDENTIAL TREATMENT FOR YOUNG PEOPLE WITH SUBSTANCE USE DISORDERS.

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Background: Up to 90% of clients entering residential treatment for substance use disorders (SUD) report a trauma history, and 50% meet the criteria for post-traumatic stress disorder (PTSD). These comorbidities limit treatment effectiveness, where trauma-informed models of care may improve long-term treatment outcomes. We developed a novel model of trauma-informed care (TIC) for youth (aged 18-35 years) in residential treatment for SUDs.

Description of model of care/intervention: Co-developed with staff and implemented across one residential service, the new model incorporated: (i) workforce development via online training and a 2-day workshop in TIC, followed by weekly clinical supervision; (ii) reviewing the service environment and therapeutic groups for the 6-week program; and (iii) screening for trauma and PTSD in clients entering treatment, and offering individual cognitive-processing therapy (CPT).

Effectiveness: Staff foundational knowledge in TIC increased from baseline to 3-months after training (MD=0.59, 95%CI [0.45,0.72]), which was sustained by 6-months (MD=0.54, 95%CI [0.35,0.72]), as did self-efficacy to deliver TIC (MD=0.52, 95%CI [0.28,0.76], MD=0.44, 95%CI [0.17,0.71], respectively). Staff principle support increased by 3-months (MD=0.37, 95%CI [0.08,0.66]). Of 79 clients recruited so far, 92.4% (n=73) reported a trauma history, 82.3% (n=65) with positive screen for PTSD, and 68.4% (n=54) with severe symptoms. Treatment retention, adherence, and client outcomes are currently being collected.

Conclusion & next steps: Greater numbers of clients than expected are entering residential treatment with PTSD symptoms, where the new model increased staff knowledge and confidence to deliver TIC. Expanding TIC to more services may help staff address trauma in the service environment.

PRESENTATION 4: WHAT IS THE EVIDENCE BASE REGARDING THE CONCURRENT TREATMENT OF PTSD AND SUBSTANCE USE DISORDER USING PROLONGED EXPOSURE (COPE)?

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Introduction and Aims: The evidence base regarding the efficacy of integrated interventions for the treatment of PTSD and substance use has increased substantially in the last decade. An increasing number of studies point to greater efficacy among trauma-focused interventions than non-trauma focused/present centred therapies. One of the most researchered trauma-focused interventions to date is Concurrent Treatment of PTSD and Substance Use disorder Using Prolonged Exposure (COPE). This presentation aims to present a review of this research, discuss the implications of findings for practice, and directions for future research.

Design and Methods: A search of five online databases (PsycINFO, MEDLINE, Embase, Cochrane Library and Scopus) identified controlled and uncontrolled trials of the COPE treatment.

Key Findings: Seven studies have been conducted in Australia, the US and Sweden and reported primary outcomes; four of which were controlled trials. Based on these studies, a further 20 papers have been published examining secondary outcomes and moderators and mediators of treatment outcome. All studies report positive outcomes with improvements in PTSD symptoms and substance use, with some studies demonstrating significantly greater improvements among people who received the COPE treatment relative to control conditions.

Discussions and Conclusions: Evidence to date provides support for the use of the COPE treatment as an efficacious treatment for PTSD and substance use. With the exception of one study that is currently underway, all studies have been conducted among adults. It is imperative that we continue to research new and innovative interventions as no one treatment will be effective for all.

Discussion Section Following the presentations, the discussant will provide a brief summary of the implications of the symposium presentation for AOD practice. The chair will then will facilitate a panel discussion, addressing issues concerning the challenges of implementing TIC and individual treatment for PTSD in different types of AOD treatment settings. The audience will be encouraged to engage with and ask questions of the panel in relation to their findings and application.

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