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Metro North Mental Health – Alcohol and Drug Service

# Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment

Metro North Mental Health - Alcohol and Drug Service

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## Executive Summary

The majority of people accessing alcohol and other drug services (AOD) have had exposure to traumatic events (TE). In fact, high rates of comorbidity exist between substance use disorders (SUD) and posttraumatic stress disorder (PTSD) (Mills, Teesson, Ross, & Peters, 2006). In Australia, prevalence rates suggest that around 90% of individuals accessing AOD services have experienced at least one TE with most being exposed to multiple traumas (Phipps, Molloy, & Visentin, 2019). Furthermore, between half to two thirds of these clients will also have comorbid PTSD (Dore et al., 2012; Mills, Lynskey, Teesson, Ross, & Darke, 2005; Ouimette et al. 1998).

**Many people who have experienced TE find that substance use reduces their distress and helps them to manage trauma related symptoms. These people have a high risk of developing a SUD, increasing their likelihood of experiencing further TE resulting in a cycle of trauma and substance use that becomes self-perpetuating.**

When clients present to AOD services for treatment, they are not routinely assessed for exposure to TE or PTSD symptoms and the focus of treatment is on reducing SUD symptoms. This has important treatment implications for AOD services as current evidence suggests that the concurrent treatment of SUD and PTSD is more effective than the treatment of each disorder independently. **Further, SUD treatment retention and outcome are adversely affected by unidentified and untreated comorbid PTSD** (Brown et al. 2003; Palacios et al. 1999). **The cost of untreated PTSD is not limited to individual factors such as reduced life expectancy, quality of life, and lost productivity but extends to significant increases in the utilisation of medical, mental health, correctional, and social services** (MHCC, 2013).

Around half to two thirds of clients engaged in AOD treatment in Australia meet the criteria for PTSD

Until now, Queensland Government AOD services have not offered trauma informed or integrated treatment for clients with comorbid PTSD and SUD as part of standard service delivery. Clients have often been referred between AOD and mental health services, fragmenting care and increasing the likelihood of treatment drop out and poor outcomes.

Trauma Informed Care and Practice (TICP) involves both the provision of psychosocial treatment for trauma related symptoms and the adaptation of all aspects of service delivery to meet the needs of trauma-affected populations whilst minimising the risk of inadvertent treatment related re-traumatisation. **Outcome studies indicate that adopting a TICP framework within health services is not only cost effective but is associated with a range of benefits including: a decrease in trauma and mental health symptoms, reduced substance use, a decrease in the utilisation of crisis-based services, improvements in general functioning and social factors such as housing stability, improved therapeutic alliance, improved collaboration between services and providers, and improved staff morale** (MHCC, 2013).

Metro North Mental Health - Alcohol and Drug Service (MNMH-ADS) has developed the Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment (MoC-TICP) which articulates and describes the application of the current recommended principles of TICP to AOD service delivery and SUD treatment. In summary, the MoC-TICP recognises that the implementation of TICP principles to practice at MNMH-ADS will involve three critical areas:

1. **Organisational Practices**
2. **Workforce Development**
3. **Psychosocial Treatment**

## Rationale

Specialist AOD treatment services in Queensland public health settings aim to provide people with a range of accessible client-focused and evidenced based AOD interventions to reduce harms to individuals, families and the community. This includes the provision of comprehensive, specialised and effective multidisciplinary AOD assessment and treatment services (see Queensland Health AOD Services – Model of Service, Companion Document, 2016).

In response to the recognition of high prevalence rates of exposure to trauma in clients and a current gap in service provision for concurrent treatment of SUD and trauma related symptoms<sup>1</sup> MNMH-ADS has developed a MoC-TICP to outline TICP principles and their implementation in service delivery within MNMH-ADS (for further information see [Appendix A, Background: Literature and Evidence Base](#)). The adoption of TICP will guide MNMH-ADS to become better equipped to safely and efficiently respond to the high rates of trauma-related comorbidity in SUD populations and to provide evidence-based care in treatment environments that are safe for staff and treatment-seekers.

## Objectives

The aim of MoC-TICP is to provide a framework for the application of the principles of TICP in order to establish MNMH-ADS as a trauma informed tertiary AOD service. To do this, the MoC-TICP specifies a number of actions and objectives outlined in Table 1.

Table 1. *Model of Care: TICP for Alcohol and Drug Treatment: Actions and Objectives*

TICP Domain	Actions and Objectives
<b>Organisational Practices</b>	TICP Leadership
	Trauma Informed Care Service Audit
	Implementation of TIC Principles in MNMH-ADS Service Provision
	Routine Screening for PTSD Symptoms
	Organisational Support for Staff in TICP
	Embedding TICP: Sustainability Plan
<b>Workforce Development</b>	TICP Training
	Supervision
<b>Psychosocial Treatment</b>	Routine PTSD screening
	Referral, access and triage to psychosocial services
	Integrated psychosocial treatment for comorbid SUD and trauma related symptoms
	Collaboration and case-coordination

## Strategic Alignment

*The Model of Care: Trauma Informed Care and Clinical Pathway for Alcohol and Other Drug Services* aligns with the following state-wide strategies and guidelines:

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<sup>1</sup> Reference to “trauma related symptoms” refers to traumatic stress sequelae associated with exposure to traumatic events which may include but are not limited to PTSD symptoms. There is a high prevalence of AOD clients who experience disturbances in emotion regulation, interpersonal relations, attention and consciousness, and belief systems associated with complex trauma experienced in childhood. Many of these clients may meet criteria for diagnosis of Complex PTSD (Cloitre, et al., 2011).

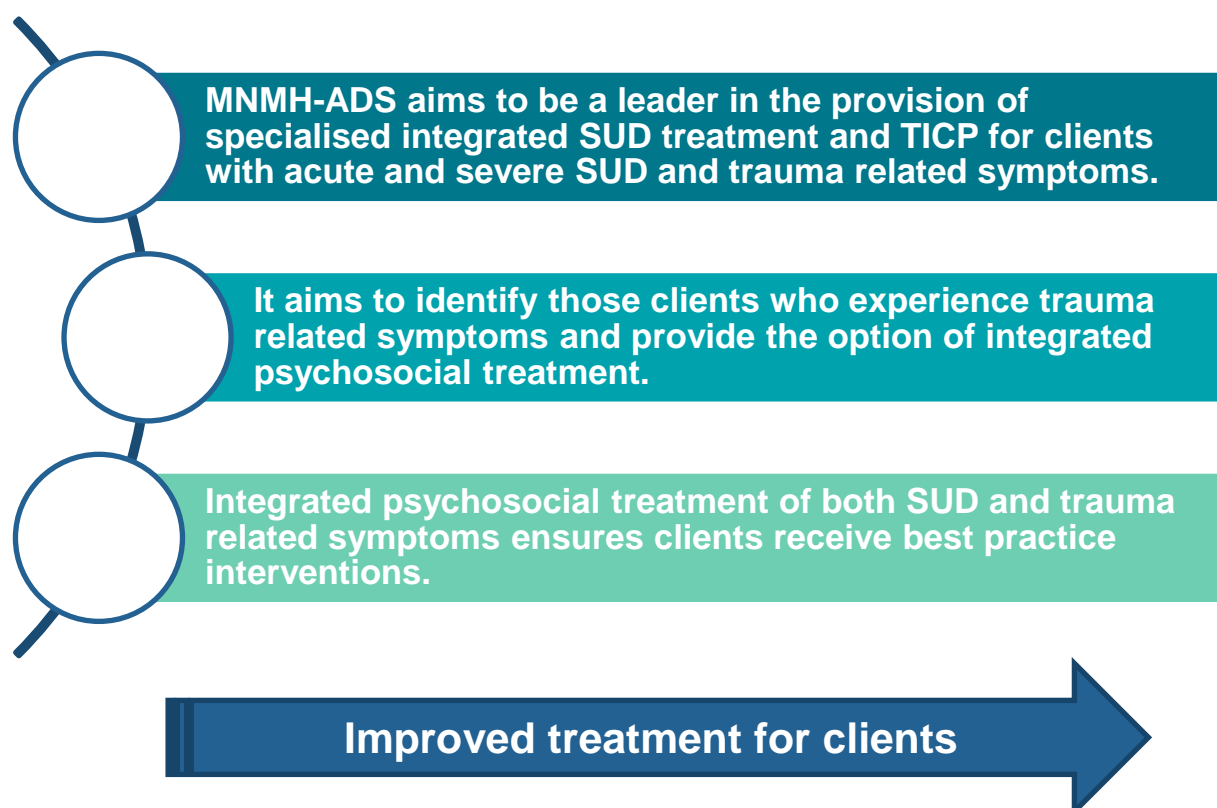
1. Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018 – 2023, Queensland Mental Health Commission (2018)
2. Queensland Health Alcohol and Other Drug (AOD) Services – Model of Service (Companion Document) 2016
3. Queensland Health Dual Diagnosis Clinical Guidelines (2010)

## Governance

Each MNMH-ADS service has a designated Director, Manager and/or Team Leader to provide operational and clinical governance within their delegation. A governance structure for the TICP project was developed that comprises senior program managers and a TICP working group consisting of representatives from psychosocial treatments, opiate replacement therapy, and withdrawal management teams from Biala, Chermside, Redcliffe and Caboolture ADS service areas.

## What Does the Service Intend to Achieve?

Specialised AOD treatment services in Queensland public health settings aim to provide people with a range of accessible client-focused and evidenced based AOD interventions to reduce harms to individuals, families and the community. This includes the provision of comprehensive, specialised and effective multidisciplinary AOD assessment and treatment services (see Queensland Health AOD Services – Model of Service, Companion Document, 2016).



## Trauma Informed Care and Practice

A TICP model has two main components –

1. **Trauma Informed Care** - a service level approach that assumes clients have a trauma history and is sensitive and responsive to their needs, and
2. **Trauma Informed Practice** - the provision of psychosocial treatment of trauma related symptoms.

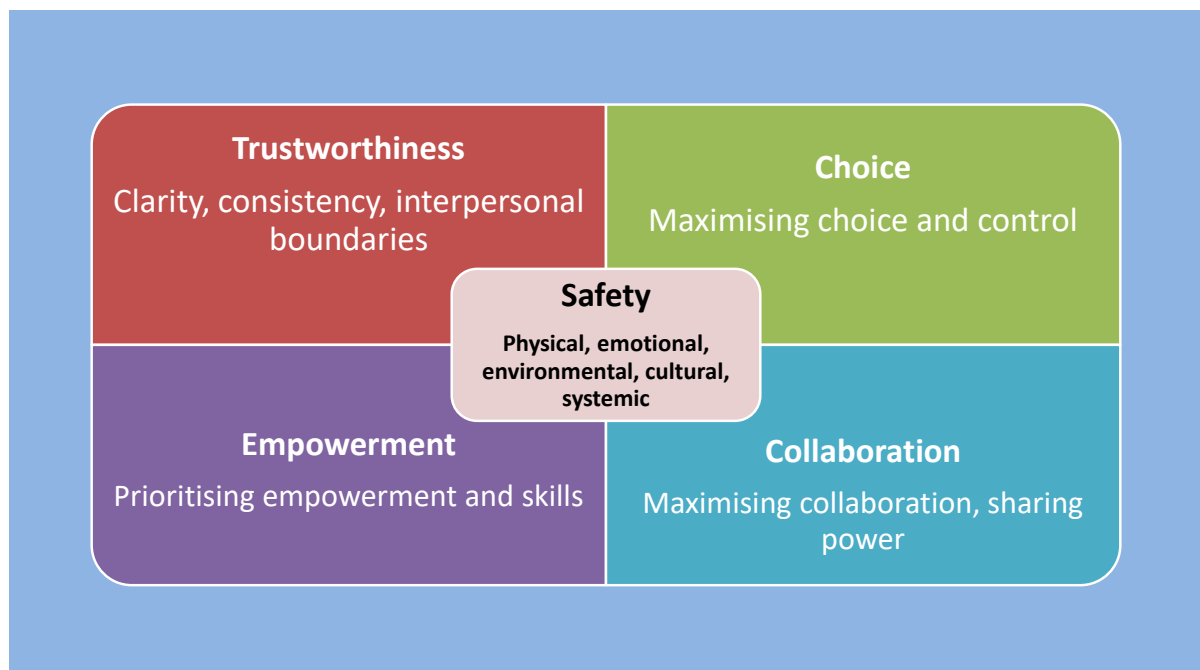
An important distinction between the two components is that *trauma informed practice* is the treatment of trauma-related sequelae whereas *trauma informed care* refers to the context in which services are delivered.

### Trauma Informed Care

Trauma informed care is based on the understanding that trauma sensitive modifications in the context in which trauma is identified, managed or treated have benefits not only for treatment-seekers who have experienced trauma but also the personnel that provide services to trauma affected populations.

In TIC, all aspects of the organisation are reoriented to reflect an understanding of the impact of trauma on survivors and to meet the needs of treatment-seekers with trauma histories. A TIC organisation will seek to accommodate the trauma-related vulnerabilities of individuals who have been exposed to trauma whilst facilitating access to treatment and managing inadvertent treatment-related re-traumatisation. Rather than a set of prescriptive practices, TIC is a framework that reflects an adherence to five TIC principles of trustworthiness, choice, empowerment, collaboration and safety.

Figure 1: Principles of Trauma Informed Care





## Trauma Informed Practice

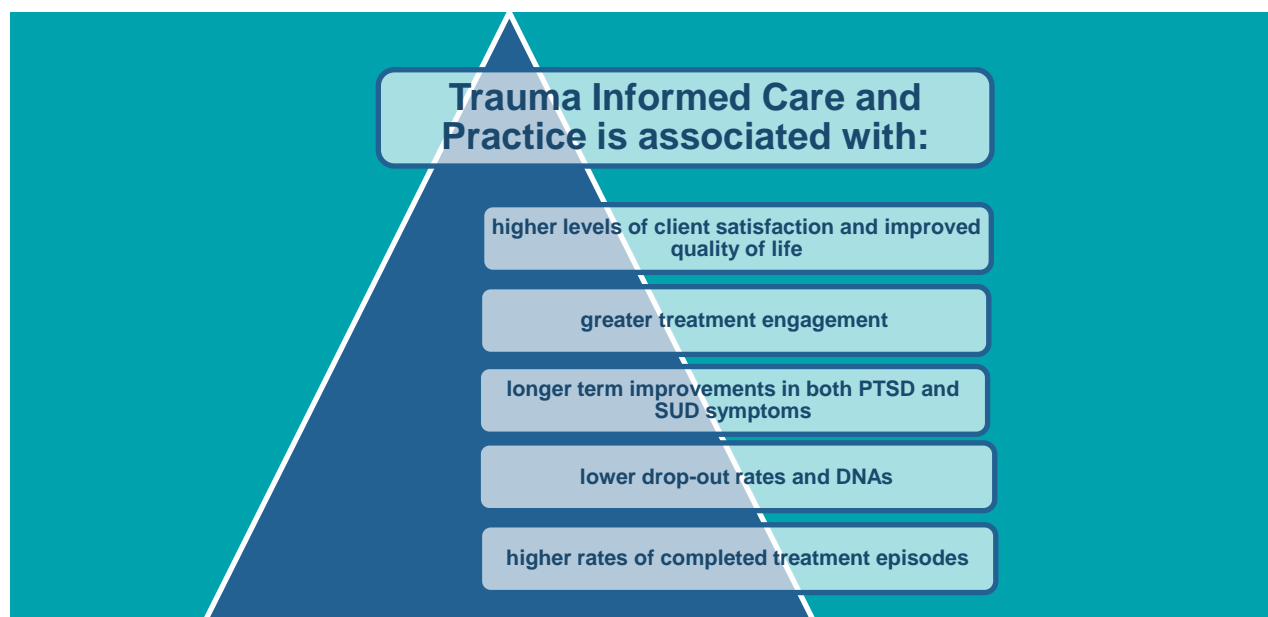
Trauma Informed Care is a service delivery approach “that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment”

(Hopper, Bassuk, & Olivet, 2010).

Trauma informed practice includes psychosocial interventions which may be *trauma focused* and *non-trauma focused* (van Dam, Vedel, Ehling, & Emmelkamp, 2012).

**Non-trauma Focused Treatment** – emphasises psychoeducation and equipping the person with coping strategies/skills to manage symptoms and improve functioning and do not require clients to revisit or reprocess trauma memories.

**Trauma Focused Treatment** – gives specific attention to trauma related symptoms and has a “past” orientation, focusing on memories of the TE and their meaning (Foa, Keane, & Friedman, 2009).



# The Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment

The Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment provides a framework for the application of TICP within MNMH-ADS services. The model does not replace clinical judgement or Hospital and Health Service specific patient safety procedures. The MoC-TICP describes the target population, a referral pathway to integrated psychosocial treatment, staff support requirements and governance of TICP within MNMH-ADS services. The aim of the MoC-TICP is to guide the implementation of TICP so that the service can provide evidence-driven AOD care that is integrated, safe and effective. MNMH-ADS recognises that the implementation of TICP to tertiary AOD services will involve three critical areas:

1. **Organisational Practices** – these are required to ensure that the service is engaged in an ongoing process of TICP development, expansion, evaluation and review.
2. **Workforce Development** – all clinical and non-clinical staff are supported to develop enhanced skills and knowledge in TICP which includes TICP training, clinical supervision and the management of vicarious trauma.
3. **Psychosocial Treatment** – phase-based integrated treatment of co-morbid SUD and trauma related symptoms.

Figure 2: Overview of Structure of Trauma Informed Care and Practice in MNMH-ADS

## MNMH-ADS Trauma Informed Care and Practice for Alcohol and Drug Treatment



# 1. Organisational Practices

The integration of TICP principles to every part of MNMH-ADS (including administration, management and service delivery) is necessary to effectively and appropriately respond to trauma affected clients. The following section outlines the organisational practices that have been developed to support the implementation of TICP to MNMH-ADS and guide the evaluation, sustainability and ongoing review of the MoC-TICP.

## Trauma Informed Care and Practice Leadership

Trauma informed leadership is necessary to ensure that the vision, values and mission of TICP are operationalised into all areas of the service. At MNMH-ADS, the TICP project manager, senior MNMH-ADS management and the TICP Working Group were responsible for integrating TICP principles into all relevant MNMH-ADS policies, procedures and practices.

Trauma informed leadership was essential to deliver key elements of the project such as:

- ✚ funding for TICP project and staff
- ✚ formation of the TICP Working Group
- ✚ systematic TIC service audit reviews and follow up of action items
- ✚ time and resources for staff TICP training
- ✚ inclusion of the TIC approach in all policy, service delivery and information materials
- ✚ the provision of a safe work environment
- ✚ overseeing the continuity of the MoC-TICP
- ✚ developing a sustainability plan
- ✚ fostering a TICP culture
- ✚ the commitment to building a TICP workforce through training, recruitment, and incentives for TICP upskilling

The TICP project has engaged the MNMH-ADS Client Advisory Committee to ensure the experiences, perspectives, and needs of clients are included in the project. Client voices are an essential component of a TICP approach and should be included in decision making about the policies, procedures and practices that they receive and are implicated in.

## Trauma Informed Care Service Audit

MNMH-ADS has engaged in a process of self-assessment measuring how the service meets standards of TIC pre and post implementation of the MoC-TICP. A Trauma Informed Care Service Audit was undertaken by the TICP working group in order to first understand and identify relevant TIC practices and then to measure current service delivery against these standards. An audit tool was adapted from established TIC self-assessment tools used in human services (Fallot & Harris, 2014; Guarino, Soares, Konnath, Clervil, & Bassuk, 2009). The audit assessed TIC standards and practices in the domains of: staff and management training, adapting and creating policies, creating a safe and supportive environment for clients, establishing a safe psychological environment, collaboration and sharing power, creating a safe and supportive environment for staff. The audit process identified key actions and objectives required for MNMH-ADS to meet the standards of a TIC organisation.

## The Implementation of TIC Principles to MNMH-ADS Service Provision

MNMH-ADS ensures that the five TIC principles of safety, trustworthiness, choice, collaboration, and empowerment are incorporated into all aspects of service provision through the following:

### Safety

#### A Safe Physical Environment

Environments that are safe from harm and reduce the risk of re-traumatisation are a vital part of TIC (Mills & Teesson, 2019). MNMH-ADS services are physically secure, well lit (inside and outside), and those entering and leaving premises can be monitored. Clear signage is used and waiting areas are comfortable to ensure there is enough space for comfort and privacy. There are sufficient staff levels to monitor behaviours that could be perceived as intrusive or harassing to other clients (Elliott et al., 2005). Youth friendly environments are provided where appropriate (i.e. Biala Youth Allied Health Service). Culturally relevant artefacts, paintings and brochures are incorporated throughout service premises.

#### A Safe Psychological Environment

Staff are sensitive to the needs of clients and attentive to signs of distress or difficulty. Staff monitor material in waiting rooms to ensure clients are not exposed to violent or sexual material (for example, magazines or television content) (Elliott et al., 2005). Staff are sensitive to cultural differences and those groups at higher risk of experiencing trauma. Organisational information is presented in culturally appropriate ways (e.g. different languages, LGBTI specific information) and different cultural groups are encouraged to share their culture (e.g. through art or displays).

### Trustworthiness

All clients are provided with clear and transparent information about services, information sharing, the limits of confidentiality, client's rights and responsibilities, and informed consent for treatment (including goals, risks and benefits). Staff aim to provide clear information about boundaries and are consistent in maintaining them. Staff endeavour to ensure reliability in service provision (e.g. following through with plans, avoiding changes in appointments and treatment providers).

### Choice

Clients are offered choices about the services they receive (when, where, what and by whom). They are given options regarding how they want contact to be made and maintained. They have control over starting and stopping services (within guidelines that are made clear to them). Clients are given the option of having a support person present. Priority is given to a person's goals.

### Collaboration

The service promotes a therapeutic relationship that emphasises 'doing with' rather than 'doing to' or 'doing for'. Clients are involved in the evaluation of service programmes and can do so in anonymous and/or confidential ways (e.g. suggestion boxes, satisfaction surveys, on-line surveys). The service has a Client Advisory Committee (composed of members who have a lived experience of SUD) that provides input to management on planning and development of service programmes.

## Empowerment

Staff are aware of the inherent power imbalance in the relationship between service providers and clients and strive to ameliorate this by looking for opportunities to empower clients. Clients are encouraged to take an active role in directing their treatment. The service builds on clients' strengths and strives to empower clients to experience a sense of self-efficacy and confidence in their own abilities. The service supports clients to increasingly take on more responsibility for choosing and carrying out personal change so that they may feel a sense of agency in their lives and believe that recovery from trauma related difficulties and SUD is possible.

## Routine Screening for PTSD Symptoms

All new clients of the service will be screened for PTSD symptoms. MNMH-ADS acknowledges that clients may experience trauma related symptoms that are not included in PTSD screening items and where possible, further identification of these symptoms are encouraged through clinical interview and additional assessment tools. Trauma related symptoms will be incorporated into the formulation, treatment planning, and psychosocial interventions provided to clients. Brief psychoeducation will be given about the rationale for screening and the relationship between trauma and substance use. Those clients who screen positive for PTSD symptoms can also benefit from developing an understanding of what trauma is, how it may have affected them and the possible connection between their experience of trauma and their SUD.

All clients who screen positive for PTSD symptoms will be offered an internal referral for integrated psychosocial treatment.

Screening enables accurate identification of trauma related symptoms and prevents misdiagnosis and inappropriate treatment.

## Organisational Support for MNMH-ADS Staff in TICP

MNMH-ADS supports an organisational environment that will safeguard the safety, health, and wellbeing of its staff. This organisational TIC culture is sustained by not only top down support by management but also bottom up input by trauma champions and clinicians.

## Vicarious Trauma

AOD clinical staff may be vulnerable to experiencing secondary traumatic stress or vicarious trauma associated with working with high volumes of clients with severe trauma related symptoms (Ewer, Teesson, Sannibale, Roche, & Mills, 2015). *MNMH-ADS Management of Vicarious Trauma Guidelines* provide information and support for staff to aid in the prevention of vicarious trauma and to provide assistance with ways affected staff may cope. MNMH-ADS will act to prevent vicarious trauma in the workforce by reducing the risk factors and enhancing the protective factors that have been demonstrated to influence vicarious trauma. Staff receive training pertaining to vicarious trauma within TIC training and through regular trauma focused group supervision. Additional support is provided to staff that experience vicarious trauma during the provision of clinical services that is individualised to the clinician and the situation.

## Supervision and Debriefing

Clinical supervision has been found to reduce the likelihood of staff experiencing vicarious trauma and increase staff satisfaction, reduce staff turnover and improve client outcomes (Ewer, et al., 2015). The MoC-TICP includes regular trauma focused group supervision for psychosocial

teams. Supervision can assist with improving levels of staff confidence and self-efficacy that can protect against vicarious trauma when working with trauma affected clients. Line managers and supervisors also support clinicians to understand and manage vicarious trauma and personal stress in response to providing trauma treatment. Clinicians providing trauma treatment will have completed training in reducing the risk of vicarious traumatisation and managing self-care. Trauma champions are identified within each psychosocial team who have expertise in trauma treatment and can consult on complex cases and treatment difficulties.

## Provision of Safe Spaces for Staff

MNMH-ADS strives to provide spaces that are both physically and psychologically safe for staff (see <https://qheps.health.qld.gov.au/csd/employee-centre/workplace-culture-and-diversity/culture>).

Policies and procedures guide staff on reporting of bullying and workplace harassment. A culture of TIC promotes a commitment to non-violent communication and resolution of conflict through mediation. Staff are encouraged to practice the principles of TIC in their interactions with colleagues (e.g. offering choice, “doing with” rather than “doing to”, empowering peers, focusing on strengths). The value of social responsibility is promoted which fosters a sense of shared responsibility for team members and ways to support colleagues and be attentive to their needs.

MNMH-ADS offer staff opportunities to engage in self-care and stress reduction practices such as regular mindfulness for staff (at those services where available).

## Embedding TICP: Sustainability Plan

A plan for TICP sustainability has been developed to promote a culture of continuous TICP related-learning and service improvement.

## Organisational Practices

- ✚ A complementary guideline, *Becoming Trauma Informed: Steps Completed, Program Evaluation and Recommendations*, outlines the steps, change management processes, and evaluation of the implementation of the MoC-TICP. Included in this guideline is a narrative of the review processes and recommended mechanisms for the sustainability of TICP at MNMH-ADS. The sustainability plan will be governed by the senior program managers, the TICP working group, the trauma champions, and the client advisory committee.
- ✚ An annual working group meeting will be held to review adherence to the MoC-TICP and identification of any barriers or issues in service delivery. The TIC Service Audit will also be conducted to monitor fidelity of MNMHS-ADS to standards of TIC.
- ✚ Routine screening for PTSD for all new clients will be measured through the chart audit process that is conducted annually. The chart audit requires that the screen has been administered and is in the client file.

## Workforce Development

- ✚ TICP focused workforce development strategies foster the active recruitment of TIC trained/motivated staff. Incentives for TIC-related professional development can assist in increasing job satisfaction, reducing staff turnover and vicarious trauma, and fostering

collaborative decision making between all levels of staff involved in TICP (Substance Abuse and Mental Health Services Administration, 2013).

- ✚ The culture of TICP is supported by maintaining a regular trauma focused supervision group to continue in-service training in trauma focused treatment, support for complex cases and discussion of TIC in service delivery. These groups will be led by trauma champions on teams who will offer leadership and guidance in TICP and vicarious trauma support for staff (see the document *Roles and Responsibilities of Trauma Champions* for further information). Staff will be expected to participate in ongoing professional development training in TICP (including both in-service, TIC in AOD training presentations and external training sources).

## Psychosocial Treatment

- ✚ Integrated psychosocial treatment is sustained by ongoing training and professional development for staff to continue consolidating and developing skills in trauma focused treatment.
- ✚ Psychosocial treatment for clients with co-morbid trauma related symptoms and SUD will be monitored through regular reviews of client progress and outcomes. These may take place periodically as determined by the clinician and every three months as part of multi-disciplinary team reviews.



## 2. Workforce Development:

The aim of workforce development is to build MNMH-ADS workforce's capacity to recognise and respond appropriately to clients who have had exposure to trauma. This is achieved by integrating TICP principles into all workforce practices particularly staff training and clinical supervision.

### TICP Training

#### Trauma Informed Care Training

All clinical, allied health, and administrative staff are provided with training in TIC in the context of MNMH-ADS service provision and new staff will be required to complete the MNMH-ADS TIC online learning module. Management also will complete TIC training and ensure that policies, procedures and support for staff in TIC are implemented and maintained. This training covers the TIC principles (see p. 6) and their implementation in MNMH-ADS service delivery.

To allow for implementation of the core principles, all staff within a service should have:

- ✚ an understanding of the five key principles of trauma informed care and how they are implemented in practice,
- ✚ knowledge of different types of trauma, their effects on a person and how to recognize trauma-related reactions,
- ✚ an understanding of the ways that trauma may affect a person's engagement in treatment and behaviours that may be associated with having a trauma history,
- ✚ confidence in screening for trauma symptoms and talking about TE and their effects on clients,
- ✚ communication and safety planning skills to support clients to prevent further trauma exposure and/or re-traumatisation (both within the service and in the community),
- ✚ knowledge of how to conduct psychoeducational interventions, and when to make treatment referrals for further evaluations or trauma-specific treatment,
- ✚ skills in supporting clients to use strategies to regulate distress,
- ✚ ability to consider trauma histories and symptoms in a client's formulation and treatment plan (Jennings, 2004; Kezelmen & Stavropolous, 2012; SAMHSA, 2013).

#### Integrated Psychosocial Treatment for SUD and Trauma Related Symptoms Training

Those staff who provide psychosocial treatments will receive regular and ongoing training in integrated phase-based treatment for trauma related symptoms in the context of treatment for SUD. This training includes specialised skills in trauma treatment provided within MNMH-ADS. Training is provided for 1.5 hours each fortnight for psychosocial treatment teams. Ongoing training will be a feature of group supervision and all staff providing psychosocial treatment are encouraged to undertake additional trauma focused training with external providers as part of their professional development.

Clinicians providing psychosocial treatments are guided by the *Trauma Informed Care and Practice Clinician Capability Framework* which outlines practice capabilities in integrated treatment for comorbid SUD and trauma related symptoms. The Framework addresses five key domains of practice: therapy knowledge and skill, dealing with complexity in therapy, scope of practice, research and education, and supervision. Four levels of skill are defined for each domain and



clinicians providing psychosocial treatment are expected to have a minimum level of competency as novice clinicians (level 2) working towards achieving experienced (level 3) and advanced (level 4) capabilities.

## Supervision

Regular and ongoing supervision is considered imperative to reinforce both trauma informed and trauma focused treatment training to ensure the sustainability of trauma informed practice standards. In addition, for clinicians providing integrated psychosocial treatment, pathways for regular individual clinical supervision will also be available. Supervision plays an essential role in the support of clinicians providing psychosocial integrated treatment, offering them an avenue to discuss, understand and manage complex cases, ethical issues, countertransference, burnout, and risk (Kezelmen & Stavropolous, 2012). Supervision is also considered important for the management of vicarious trauma by reinforcing it as a systemic issue and encouraging clinician self-care.

### 3. Psychosocial Treatment

The pathway to integrated psychosocial treatment of co-morbid SUD and trauma related symptoms involves four main areas:

- i. Routine PTSD screening
- ii. Referral, access and triage to psychosocial services
- iii. Integrated psychosocial treatment for comorbid SUD and trauma related symptoms
- iv. Collaboration and case-coordination

#### i. Routine PTSD Screening

Routine PTSD screening of all new clients to MNMH-ADS enables identification of those who have co-morbid trauma related symptoms.

#### ii. Referral, Access and Triage

- ✚ Clients who screen positive for PTSD symptoms can receive an internal referral for psychosocial treatment. These clients will be provided with information on options for psychosocial treatment, however, referral is dependent on client choice and are not made without the client's consent.
- ✚ Those clients who have accessed psychosocial treatments directly will also be screened for PTSD symptoms.
- ✚ MNMH-ADS has a policy of “no wrong door” which ensures that all clients receive appropriate treatment regardless of their point of entry to the service.

#### iii. Integrated Psychosocial Treatment for Co-morbid SUD and Trauma Related Symptoms

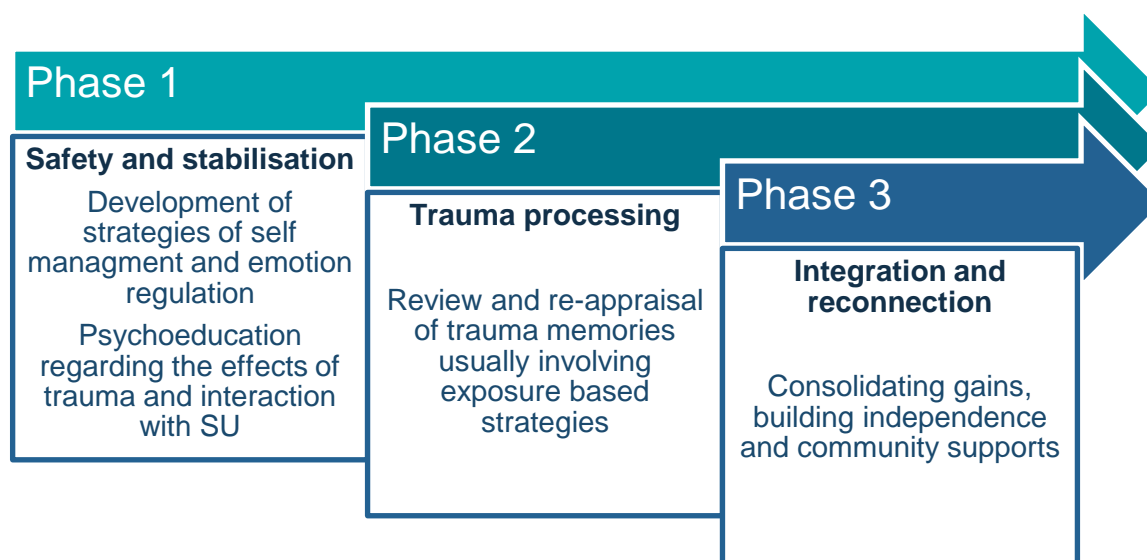
##### Treatment Types

Trauma and AOD related sequelae (and their interaction) will be incorporated into each client's formulation, treatment plan and multi-disciplinary team case review. The service will provide integrated treatment of both SUD symptoms and trauma related symptoms which may include both individual psychosocial treatment and participation in group programs.

##### Background

Psychosocial treatment may encompass both trauma-focused and non-trauma focused treatments and includes specific psychological interventions provided for trauma related symptoms for those with concurrent SUD. Treatment of trauma related symptoms may address both single incident TEs (such as those associated with PTSD) and complex trauma (which may be multiple, persistent and interpersonal). The preferred psychosocial treatment that is recognised as the “gold standard” in trauma treatment encompasses both types of trauma and is a phase based or sequenced approach (Cloitre et al., 2011, Kezelmen & Stavropolous, 2012). This involves three key

stages or phases that each play a distinct role in the overall treatment plan.



*Phase one* plays a key role in overall treatment and *Phase two* is not commenced until the person has sufficiently stabilised and has adaptive resources for coping with distress and both emotional and bodily dysregulation. *Phase two* plays a critical role in resolving trauma related symptoms. Interventions that contain an element of exposure to trauma memories have been found to have the strongest evidence base in the treatment of PTSD symptoms (Institute of Medicine, 2008). *Phase three* describes the process of consolidating gains in social, emotional and relational domains and integrating back into the community through strengthening sense of self, building safe and supportive relationships, and engagement in meaningful activities.

### Concurrent Trauma and Substance Use Disorder Treatment

There is an emerging evidence base supporting integrated psychological interventions for comorbid SUD and PTSD (Roberts et al., 2015; van Dam et al., 2012). A recent review of 14 randomised controlled trials involving 1506 participants found a small but significant effect size showing a reduction in PTSD symptom severity in those receiving psychological interventions that include a trauma-focused component in conjunction with an intervention for SUD (Roberts et al., 2015). Reviews assessing the effectiveness of comorbid SUD and PTSD interventions have been hampered by heterogeneity of treatments, measures, and study designs making it difficult to evaluate overall findings. An Australian study of 103 participants receiving either Concurrent Treatment of PTSD and SUD or treatment as usual (TAU) found those in the intervention group had a significantly greater reduction in PTSD symptom severity compared with controls (Mills et al., 2012). This study challenged conventional beliefs as participants continued to use substances throughout the study and there were more than twice as many adverse events in the control group compared to those receiving the intervention.

A study exploring clients' perceptions of the interaction of PTSD and SUD and their treatment preferences showed a preference for both phase-based treatment and concurrent treatment of both PTSD and SUD (Brown, Stout, & Gannon-Rowley, 1998). Treatment should also be client-centred and tailored to address the most prominent symptoms (Cloitre, et al., 2012).

## Phase Based Treatment for Trauma and SUD

Attrition rates are high in both PTSD and SUD treatment. It may therefore be important to allow more time to build trust, rapport and empower clients with comorbid PTSD and SUD to build a sense of safety and commitment to change prior to embarking on treatment. The first phase includes a focus on treatment engagement and readiness for change.

The main focus of treatment is Phase 1 and is aimed at assessment, formulation, psycho-education, and stabilisation. Emotion regulation difficulties and a reliance on avoidant coping styles is seen as a key area of difficulty in this client group (Roberts et al., 2015). Improved ability to regulate negative emotions is associated with better management of both trauma related symptoms and craving urges. As more adaptive coping skills are developed, there should be less reliance on avoidant coping strategies and substances to “self medicate”.

Trauma focused strategies associated with memory work conducted in Phase 2 may be used more selectively. Many clients choose not to do exposure-based trauma memory work and may still make significant gains.

Most treatment will be conducted at a Phase 1 level. Many people experience significant benefits during this phase and may choose not to engage in Phase 2 interventions.

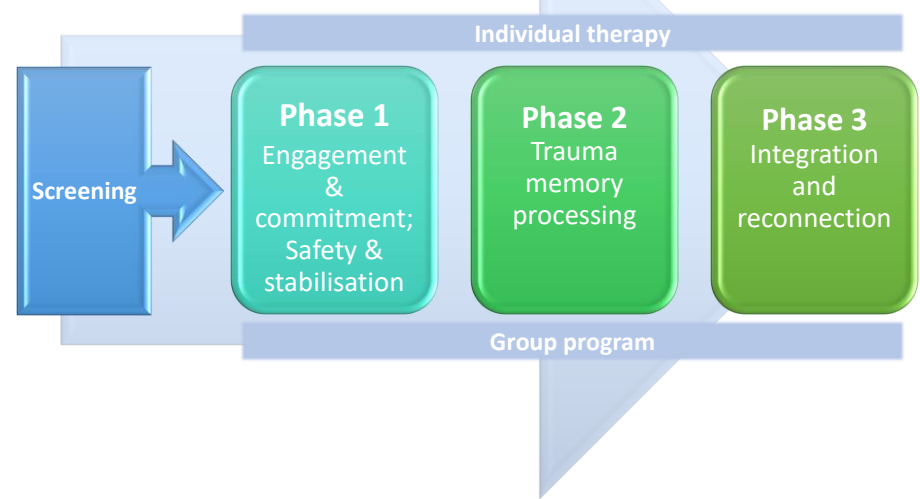
## Group Treatment for Trauma and SUD

Group therapy has been a key therapeutic modality in SUD treatment. Some of the advantages of groups are: positive peer support; a reduction in social isolation; normalisation of difficulties, skills training, real-life examples of what can help, and a sense of hope for the future (Substance Abuse and Mental Health Services Administration, 2005). There are several group treatment approaches for concurrent PTSD and SUD (i.e. Seeking Safety, TREM, STAIR-PE, and TARGET) which have been found to have small effect sizes in improvements in both PTSD and SUD symptoms (Ford & Russo, 2006). Group treatment can provide a valuable adjunct to individual therapy and can increase access to treatment in AOD services with limited capacity for regular individual counselling

## iv. Collaboration and Case Co-ordination

MNMH-ADS collaborates with other services and stake holders (both within and external to the service) in the provision of treatment. Clients with co-morbid trauma symptoms and SUD may require more complex inter-agency collaboration to ensure adequate care and complementary treatment of different areas of need. MNMH-ADS may identify and partner with other trauma informed agencies who can provide trauma-specific therapies for clients who require them. In order to provide gapless care, a system of communication and direct referral will be factored into each agency partnership.

Concurrent Trauma and SUD Psychosocial Treatment Pathway



# Appendix A

## Background: Literature and Evidence-Base

### Prevalence of Trauma in Alcohol & Other Drug Services

There is now overwhelming evidence to show that exposure to traumatic events (TE) is almost universal in clients of AOD services (Mills, 2015). One study showed at least 80% percent of AOD clients in Australia reported having experienced a TE (the most common being physical or sexual assault, witnessing serious injury or death, being threatened with a weapon, held captive or kidnapped)(Dore et al., 2012; Mills, Lynskey, Teesson, Ross, & Darke, 2005). The majority of clients have experienced multiple traumas and two thirds have met the criteria for a diagnosis of PTSD (Mills, 2015). A further 23% have been found to have subsyndromal symptoms of PTSD (Driessen, et al., 2008). Individuals with PTSD are also five times more likely to have a SUD than those without PTSD (Mills, Teesson, Ross, & Peters, 2006). In a local study of 905 young people aged 12-24 years attending the Youth Team, MNMH-ADS, 77% reported exposure to TE and 63% screened positive for PTSD (Kelly, Harrison, & Palmer, 2016). International studies have reported incidence rates of trauma exposure ranging from 89-95% in AOD clinical populations and rates of PTSD ranging from 37-39% (Gielen, Havermans, Tekelenburg, & Jansen, 2012; Reynolds et al., 2005), far outstripping the estimated 12 month PTSD prevalence rate of 4.4% in the Australian general population (McEvoy, Grove, & Slade, 2011).

### Different Types of Trauma

The prerequisite for a diagnosis of PTSD requires exposure to a TE involving actual or threatened death, serious injury, or sexual violence (APA, 2013). TEs can cause difficulties that fall into three main groups of symptoms: (1) hyperarousal, hypervigilance, and increased startle responses; (2) re-experiencing of the TE; and (3) withdrawal or avoidance behaviours and emotional numbing (Bergen-Cico, Wolf-Stanton, Filipovic, & Weisberg, 2016). While this diagnostic framework captures the significant and severe effects of trauma, this working definition of TE fails to capture the majority of trauma that can be experienced in childhood.

### Complex Trauma

Complex trauma refers to multiple or combined traumatic events which include emotional abuse, neglect, poverty, witnessing family violence, and living in an environment which is chaotic and unpredictable. This type of trauma tends to occur during childhood (although may be applied to situations of persistent family violence) and usually involves interpersonal relationships. Due to its nature, this type of trauma can be more prolonged and repeated ultimately resulting in neurological changes to the child's developing brain (Van der Kolk, 2014). The resulting adaptations can cause enduring changes into adulthood that disrupt the person's experience of safety, self-regulation, sense of self, interpersonal relationships, and self-efficacy.

Many who have experienced complex trauma adopt coping strategies to manage their distress such as suicidality, substance abuse, and self-harming behaviours (MHCC, 2013). These difficulties may meet the criteria for diagnosis of Complex PTSD which encompasses the three main groups of symptoms for PTSD and includes problems in affect regulation, negative beliefs about oneself and interpersonal difficulties (World Health Organization, 2018). This may manifest in a

range of areas including self-destructive behaviour, impulsivity, emotional reactivity, heightened perception of threat, disturbances in relationships, anger, dissociation, and feelings of shame, guilt and failure (Maercker et al., 2013).

## **Individual and Group Trauma**

In addition to the types of individual trauma noted above, there can be TE that are experienced by groups of people. These types of TE include natural disasters, war, terrorism, arson, and accidents (e.g. crashes involving transportation). The effect of natural disasters depends on variables such as the degree of devastation, the associated losses and the extent of individual and community disruption (SAMHSA, 2014). These impacts can be ameliorated by material and social supports and the degree to which normal life is able to resume following the event. Group trauma that is intentional and caused by humans may be more difficult to recover from than unintentional TE and natural disasters.

## **Vulnerable Populations, Cultural Differences and Minority Groups**

There are numerous cultural groups who are at greater risk of exposure to TE. Trauma may be experienced disproportionately by different groups according to their socioeconomic position and experience of poverty and discrimination. Furthermore, conditions of disempowerment, stress and adversity are chronic stressors that may pose a cumulative burden on these individuals and reduce their ability to cope with TE making them more vulnerable to PTSD (Hinton & Goode, 2016). Susceptibility to forms of interpersonal trauma is higher in groups that are marginalised and disempowered – including children and adolescents. Disempowerment is also a consequence of experiencing trauma and can further increase a person's exposure to physical, emotional and sexual abuse in the future.

## **Culturally and Linguistically Diverse People (CALD)**

There are cross cultural differences in what might be considered a TE and their meanings. There may be local understandings of trauma symptoms (e.g., symptoms may be attributed to local cultural syndromes), local consequences of having these symptoms (e.g., interpersonal and economic consequences) and different ways that cultural groups may treat and manage trauma related difficulties (Hinton & Goode, 2016). Migration can be a significant stressor for CALD people and impact on their ability to cope with traumatic events. Refugee populations are at particular risk for PTSD as they may have experienced traumatic events such as:

- denial of human rights
- forced separation from members of their family/family fragmentation
- witnessing family members being tortured or killed
- being tortured themselves
- exposure to violence
- physical, emotional and sexual abuse
- illness and starvation
- exploitation
- in the case of some children and young people, being forced to fight as soldiers.

(Working with people from culturally and linguistically diverse backgrounds, 2010)

## Women

Women continue to face inequality, discrimination and disempowerment that persist across cultures, age differences, and socio-economic groups. One in three women in Australia will experience sexual violence (Taylor, Pugh, Goodwach & Coles, 2012). Women experience twice the rate of PTSD compared to men as well as higher levels of Complex PTSD (Dore, Mills, Murray, Teesson, & Farrugia, 2012). Women are more likely to experience:

- gender-based violence (i.e. rape, other forms of gendered/sexual assault, intimate partner violence and stalking)
- network trauma (i.e. unanticipated illness, death or injury involving close others) (Derrick, et al., 2017).

## Aboriginal and Torres Strait Islander People

Aboriginal and Torres Strait Islander people have an elevated risk of experiencing intergenerational trauma, complex trauma and TE. Many Aboriginal and Torres Strait Islander people experience ongoing racism, poverty, violence and disadvantage which further increases their risk of experiencing TE and decreases their ability to recover. The historical trauma of forced colonisation and displacement from Country has brought numerous experiences of trauma including:

- *conflicts, massacres, and dispossession of traditional lands and resources*
- *introduced diseases and starvation*
- *undermining of traditional identity, spirituality, language and cultural practices through the establishment of missions and reserves and the government policy of assimilation*
- *forced removal of children from their kin, country and culture to institutions where they were harmed physically, emotionally and sexually*
- *destruction of Indigenous forms of governance, leadership and community organisation*
- *discrimination and racism*
- *breakdown of healthy patterns of individual, family and community life*

(Australian Indigenous Health InfoNet).

## Lesbian, Gay, Bisexual, Transgender/Transsexual, Intersex & Queer/Questioning (LGBTIQ)

Lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning people suffer extensive social and political discrimination and marginalisation.

Studies on lesbian, gay, bisexual, transgender/transsexual, intersex and queer/questioning people highlight higher rates of trauma and AOD use by LGBTIQ people, with the presence of trauma as a persistence backdrop in their lives. LGBTIQ people are more likely to:

- *experience trauma, particularly interpersonal violence, compared with heterosexuals*
- *have familial issues, including more abuse and rejection from their family of origin. This can result in ongoing limited support systems*



- *experience bullying, especially during adolescence, as well as experience or be targets of hate crimes*
- *be subjected to ongoing microaggressions, in the form of experiencing unequal civil rights, religious freedoms, political campaigns against their rights, and workplace discrimination*
- *have a mental health concern, attempt suicide or lost someone due to suicide and experience higher rates of psychological distress*
- *be marginalised by members of their own community, such as experiencing rejection and discrimination due to their HIV status or sexuality*
- *not access services for help, due to a lack of LGBTIQ specialised services and fears of discrimination within mainstream services.*

(Brown & Pantalone, 2011; National LGBTI Health Alliance, 2016).

## Young People

Childhood is the period in which complex trauma is most likely to occur. Experiences of trauma are common and international studies suggest that between half to two-thirds of young people will have been exposed to at least one traumatic event by the age of 16 years.

Children and adolescents may be more vulnerable to traumatic events due to their limited ability to protect or defend themselves and their lack of power compared to adults. Young children are highly dependent on adults for protection and survival and without a responsible caregiver, they are at risk of neglect, abuse, injuries and accidents, and family violence.

Adolescents and young adults, by their nature, are also risk takers. Engaging in risky activities, and being somewhat inexperienced, places them at greater risk of trauma exposure.

Early intervention for the impact of trauma is critical, however many young people do not disclose trauma or seek help. Reasons include financial limitations in seeking help, lack of services or awareness of services, fearing the consequences of disclosure, a lack of trust in professionals, not knowing how to disclose; or feeling ashamed or embarrassed (Bendall et al 2018).

Furthermore, children and young people who are in out of home care, under youth justice supervision, are homeless, refugees, identify as LGBTIQ or Aboriginal and Torres Strait Islander are at particularly high risk.

## Association Between Trauma Exposure and Substance Use

While exposure to TE is relatively high in the general population, only a small percentage of people will go on to develop PTSD. The relationship between SUD and PTSD is complex and multi-factorial with each one exacerbating and maintaining the other (Dore et al., 2012). There are, however, differing proposed models that attempt to explain the high level of co-morbidity between SUD and trauma related symptoms.

One of the most dominant models is the *self-medication hypothesis* (Khantzian, 1997). This model proposes that substances are a means of gaining relief from PTSD symptoms such as hyperarousal, insomnia, intrusive thoughts, and emotional distress (Dore et al., 2012). The pain-relieving and numbing effects of substances (particularly central nervous system suppressants such as alcohol, cannabis, opioids, and benzodiazepines) serve to reduce unpleasant symptoms but perpetuate and exacerbate high levels of arousal caused by withdrawal - thus maintaining PTSD symptoms and reinforcing ongoing substance use and dependence (Jacobsen, Southwick, &

Kosten, 2001). Substances may also serve other functions such as providing feelings of pleasure and social connection ameliorating emotional numbing and social detachment associated with PTSD (Ford & Russo, 2006). There is some evidence to support the self-medication hypothesis as TE have been found to precede or co-occur with substance use (Mills et al., 2006; Ouimette, Read, Wade, & Tirone, 2010).

The *high risk hypothesis* suggests that the lifestyle associated with substance use elevates the person's risk of experiencing trauma due to factors such as intoxication and engagement with dangerous environments associated with crime (Dore et al., 2012).

The *susceptibility hypothesis* considers that these individuals may struggle with higher levels of arousal and anxiety (in conjunction with ineffective coping strategies) thus placing them at greater risk for both PTSD and SUD (Jacobsen et al., 2001).

Similarly, the *common factors* rationale raises the important role of shared liabilities for both disorders such as genetic risk, personality traits such as impulsivity, and adverse environments (Roberts, Roberts, Jones, & Bisson, 2015). It is likely that all hypotheses may be relevant and apply to differing degrees depending on the person and their circumstances.

## Increased Risks and Poor Outcomes for Comorbid Trauma Exposure and Substance Use

Co-morbid PTSD and SUD have been associated with a range of poor outcomes including chronic health conditions, polysubstance use, poorer social and occupational functioning, higher rates of inpatient treatment, greater risk of relapse, more co-morbid psychiatric disorders, less effective coping strategies, non-suicidal self-injury and suicide attempts than those with SUD alone (Dore et al., 2012; Mills et al., 2006; Ouimette, Goodwin, & Brown, 2006; Reynolds et al., 2005). Furthermore, the interdependent relationship between the two disorders leads to more chronic and severe symptoms and thus higher rates of service utilisation in addition to associated difficulties such as criminal justice system interactions, medical conditions, child safety involvement, family violence, and homelessness (Mills, Ewer, Dore, Teesson, Baker, Kay-Lambkin, & Sannibale, 2014).

## Barriers to Treatment for Clients with Comorbid SUD and PTSD

Treatment of comorbid SUD and PTSD has been an under researched area due to factors such as clinician beliefs that clients with concurrent trauma symptoms and SU are more difficult to treat and differences in views on preferred approaches to treating both disorders. The belief that clients should first be abstinent before commencing trauma focused treatment has been the conventional view and presumes that treatment of trauma will lead to an escalation of SU (Flanagan, Korte, Killeen, & Back, 2016). Alternately, those clients who present for treatment of PTSD may be referred to an AOD service for detox prior to commencing treatment. There is an increased risk of exacerbation of PTSD symptoms during detoxification leading to treatment drop out with the consequence of neither disorders being treated (van Dam, Vedel, Ehring, & Emmelkamp, 2012).

This belief that a client's SUD should be treated first has been a barrier to clients accessing trauma treatment as it is unlikely that their SU will reduce while their untreated trauma is still driving their symptoms (Abel & O'Brien, 2010). Furthermore, reductions in SU may increase hyperarousal and elevate PTSD symptoms thus reinforcing SU as a symptom management strategy (Jacobsen et

al., 2001). These factors have meant that treatment for co-morbid PTSD and SUD is rarely offered and clients are referred between mental health services and AOD services, fragmenting care and increasing the likelihood of treatment drop out and poor outcomes. The interdependent relationship between SUD and PTSD indicates that treatment of both disorders should be concurrent (Flanagan et al., 2016).

There are other barriers to accurate identification and treatment of trauma related difficulties in AOD services. The majority of services do not systematically screen for exposure to trauma or PTSD symptoms (Mills, 2015). The onus is then on the client to disclose trauma and many clients may not do so due to mistrust, shame, and stigma. Furthermore, many may not understand the significance of the TE they have experienced in relation to their SU and not report these experiences. Many clients may not recognise that they have had experiences that may indeed be considered traumatic.

There is also a reluctance amongst AOD service workers to ask about trauma with many fearing that talking about it may cause further distress and exacerbation of symptoms. Consequently, clients' trauma histories remain unknown and the impact of trauma on their substance use is not taken into consideration in their formulation or treatment plan. Thus, their trauma continues to maintain their substance use, they receive inadequate treatment, and the likelihood of chronicity and poor outcomes is high. AOD services may inadvertently harm their clients by doing nothing to treat their trauma and reinforcing taboos around talking about TE. Additionally, there are ways that AOD services may retraumatise clients through subjecting them to environments that are unsafe, coercive and disempowering.

## Glossary

**Trauma** has been defined as “exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways: (1) directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental, (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (American Psychiatric Association, 2013). This definition does not acknowledge the difficulty of objectively defining what constitutes a traumatic event and has been criticised for failing to consider individual differences in subjective perceptions of threat. A broader concept of trauma refers to events or circumstances that are perceived by the individual as physically or emotionally harmful or threatening and cause intense physical and psychological stress reactions (Substance Abuse and Mental Health Services Administration, 2013).

**Complex Trauma** refers to multiple or combined traumatic events that typically are of an interpersonal nature and occur during childhood and adolescence. It may include “psychological maltreatment, neglect, physical and sexual abuse, and domestic violence...Exposure to these initial traumatic experiences – and the resulting emotion dysregulation, loss of safety, direction and the ability to detect or respond to danger cues – often sets off a chain of events leading to subsequent or repeated trauma exposure in adolescence and adulthood” (National Child Traumatic Stress Network, 2013). Complex trauma causes lasting and pervasive effects that endure into adulthood and affect a person’s identity, relationships, capacity to regulate themselves, and is associated with a broad range of physical and mental health conditions.

### Post-traumatic Stress Disorder (PTSD)

PTSD may develop following exposure to a traumatic event (see definition of “trauma”). Symptoms must have persisted from more than one month and include intrusion symptoms, persistent avoidance of stimuli associated with the trauma, negative alterations in cognitions and mood that are associated with the TE, and alterations in arousal and reactivity that are associated with the TE (American Psychiatric Association, 2013).

### Complex PTSD

Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning (World Health Organization, 2018).

## Vicarious Trauma

Vicarious trauma has been described as "...the transformation or change in a helper's inner experience as a result of responsibility for and empathic engagement with traumatized clients" (Courtois & Ford, 2009). These changes may resemble the difficulties experienced by trauma affected clients the clinician is providing services to. Some of these difficulties include common post-traumatic signs, symptoms, and relational patterns such as disturbances in cognitive schemas, avoidance, hyperarousal, numbing; relational difficulties, re-enactments, boundary problems as well as general psychological stress.

## Inter-generational Trauma

Intergenerational trauma describes a process and form of psychological trauma transmitted within families and communities without having experienced the original traumatic event (Isobel, Goodyear, Furness, & Foster, 2019). Traumatic events may become part of collective cultural knowledge and may also be individually passed on from parent to child. Families affected by intergenerational trauma may struggle with similar trauma related symptoms such as disturbances of self, emotion and arousal.

## Trauma Informed Care and Practice Treatment Definitions

Treatment Type	Definition
<b>Trauma Informed Care</b>	<p>All staff understand the 5 key principles of trauma informed care: safety, trustworthiness, choice, collaboration, and empowerment.</p> <p>All staff are aware of ways that complex trauma may influence the behaviour and engagement of clients in AOD services and ways that services may retraumatise clients.</p> <p>Clinicians are aware of different types of trauma and their effects (both single incident and complex trauma).</p> <p>Clinicians are sensitive to “at risk” groups that may be at higher risk of experiencing trauma.</p> <p>Clinicians demonstrate a willingness to ask about trauma exposure and reactions with all clients, in both trauma and non-trauma focused client presentations.</p> <p>All clinical and allied health staff can respond appropriately to disclosures of trauma.</p> <p>All clinical and allied health staff can support clients to manage and reduce distress associated with trauma and its effects.</p>
<b>Phase Based Treatment</b>	Phase based treatment is recommended as the “gold standard” for trauma treatment. This involves 3 key phases –
Phase 1 –Safety and stabilisation	This phase focuses on orientation of the client to AOD treatment, establishing rapport, and building readiness for change. Emphasis is on safety of the client and psychoeducation, building adaptive strategies and resources for coping with trauma related symptoms and reduction of SU.
Phase 2 – Trauma processing	Phase 2 addresses trauma memories directly and may involve using exposure based strategies to process and reappraise traumatic experiences.
Phase 3 – Integration and reconnection	The final stage facilitates consolidation of gains made in the previous phases. This is also a time when the focus is on the person rebuilding a sense of self and life beyond trauma. This may involve transitioning out of the service and building connections in the community. Relapse prevention is also an important focus.
<b>Trauma Informed Practice</b>	Interventions focused on direct treatment of trauma related symptoms.

Non-trauma focused interventions	Interventions that do not involve exposure to trauma memories and focus on coping strategies for management of trauma symptoms (e.g. breathing, mindfulness, relaxation, grounding, anxiety management, psychoeducation).
Trauma focused interventions	Interventions that contain a component of exposure to traumatic memories. These interventions include (but are not limited to) Trauma Focused Cognitive Behaviour Therapy, Eye Movement Desensitisation Reprocessing, Cognitive Processing Therapy for Trauma, Schema Therapy, Acceptance and Commitment Therapy for Trauma.
<b>Group Interventions</b>	<p>Additional trauma informed group based interventions (i.e. psychoeducation, understanding the effects of trauma and the role of SU as a coping strategy) that focus on building more adaptive strategies for self regulation (e.g. Managing Strong Emotions group).</p> <p>These may play an important role in Phase 1 and 2. It is expected that those clients attending group programs are engaged in individual therapy.</p>

Screening and Assessment Type	Definition
Routine screening for PTSD symptoms	Screening of all new clients for PTSD symptoms will be conducted using the PC-PTSD-CL5
Exposure to traumatic events and further assessment of trauma related symptoms	<p>Evidence based psychometrically validated assessment tools will be employed by psychosocial clinicians to measure exposure to trauma and trauma related symptoms (e.g. Trauma History Screen and Complex Trauma Inventory).</p> <p>Trauma related symptoms will be monitored to measure treatment progress during and concluding treatment.</p>

<b>Publications &amp; Resources</b>	Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment
	Becoming Trauma Informed: Steps completed, Program Evaluation, and Recommendations
	Managing Strong Emotions group evaluation
	TIC training evaluation
	Vicarious Trauma Guidelines
	TICP Clinician Capability Framework
	Managing Strong Emotions Group: facilitator manual, presentation slides, take-home client session resources
	Information resources for clients
	Roles and Responsibilities of Trauma Champions



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