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Client and staff perceptions of the integration of trauma informed care and specialist posttraumatic stress disorder treatment in residential treatment facilities for substance use: A qualitative study

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Abstract

Introduction: Comorbid posttraumatic stress disorder (PTSD) is prevalent among people seeking residential treatment for substance use disorders (SUD). We examined client and staff perceptions of the relationship between trauma and SUDs, and the integration of trauma-informed care (TIC) and specialist-delivered treatment for PTSD in residential alcohol and other drug (AOD) treatment facilities.

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 shared client and staff data was analysed using thematic analysis.

Results: Major staff and client themes emerged: PTSD was perceived as an underlying cause of SUD, where AOD is used to cope with and avoid PTSD and related symptoms (Theme 1). Residential facilities were perceived to provide a safe and supportive environment for clients (Theme 2). 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. Concurrent treatment of SUD and PTSD in the residential setting was sought after and was perceived to enhance treatment outcomes (Theme 3). Staff saw the need for implementing TIC into the organisation and perceived TIC as a multi-faceted and consistent approach of service delivery.

Discussion and Conclusions: Both clients and staff perceive comorbid SUD/PTSD as a challenge in residential treatment, that may be overcome through integrating TIC and PTSD treatment in residential treatment facilitates for substance use. Organisational and practical implications are discussed.

KEYWORDS
addiction recovery, posttraumatic stress disorder, residential treatment, substance use disorders, trauma informed care

1 | INTRODUCTION

Substance use disorder (SUD) and posttraumatic stress disorder (PTSD) are highly comorbid: adults with SUDs are 2.6 to 10.8 times more likely to have PTSD than those without one [1–4]. The prevalence of experiencing at least one traumatic event in people seeking treatment for substance use is approximately 90%, and most have been exposed to multiple traumas [5, 6]. People with comorbid SUD and PTSD have poorer general wellbeing, higher rates of symptom severity, relapse, homelessness, suicidality and chronic medical problems than people with either disorder alone [7, 8].

Several hypotheses have attempted to explain the SUD/PTSD comorbidity. The self-medication hypothesis suggests that painful affective states (i.e., intrusive memories, sleep disturbances) emerging from PTSD symptoms are relieved through alcohol and other drug (AOD) use [9, 10]. Substance use may facilitate avoidance and in turn, a lack of processing around the traumatic event [11]. Second, the high-risk hypothesis suggests that the engagement of hazardous behaviours to obtain substances may lead to a greater risk of trauma exposure [12, 13]. Third, the susceptibility hypothesis suggests that increased arousal and poorer emotion regulation due to substance use or withdrawal may increase the psychological vulnerability to develop PTSD after exposure to a traumatic event [2]. Such hypotheses point to the cyclical pattern between SUD/PTSD and each hypothesis suggests that a person-centred, system level response to trauma is needed within AOD treatment settings.

A trauma informed model of care (TIC) is an organisational-level approach that assumes a trauma history in all clients seeking its services, understands the widespread impact of trauma and provides a recovery-oriented environment that focuses on trauma-specific recovery [14]. TIC is distinct from PTSD-specific interventions and extends to organisational practises, policies and procedures that are guided by five principles: safety, trustworthiness, choice, collaboration and empowerment [14–16]. TIC has previously been operationalised across both inpatient and outpatient AOD settings as a strength-based approach to improving communication, establishing safety in the environment and facilitating stabilisation work [17, 18]. As this approach is universal across all staff and clients within the organisation, it does not require specific diagnoses or trauma disclosure.

Residential treatment for AOD use is a common recovery pathway for people with SUD and other mental health comorbidities. Services provide live-in treatment through structured programs and 24-h support in safe housing [19]. Implementing TIC in residential treatment may reduce the risk of re-traumatisation, enhance individual treatment outcomes and improve staff confidence with managing trauma [20, 21]. However, while AOD workers have identified trauma training as an area of priority [22], less than two-thirds have received it [21]. Further, limited research has examined the perceptions, knowledge and required skills of staff providing TIC in residential AOD services.

Perceptions of integrated SUD/PTSD treatment from clients accessing residential AOD services are also yet to be examined. Growing evidence suggests that integrated treatments for SUDs and PTSD are more effective in reducing symptoms of both disorders compared to a single treatment method [23]. Qualitative data also suggests that patients have a preference for integrated SUD/PTSD treatment [24, 25], ideally delivered by the same service [7, 26]. The feasibility of implementing concurrent SUD/PTSD treatment in residential treatment facilities for veterans with PTSD has been established [27, 28]. However, the evidence is rarely translated into AOD use services [29], which may result in poorer treatment outcomes and little synchronicity of care. For example, a survey of mental health and AOD treatment providers working with adolescents with SUD/PTSD showed that less than 10% used an integrated treatment approach for patients with this comorbidity, despite 91% reporting they had received evidence-based training for PTSD treatment [29].

One reason for this research-practise gap are clinician and service provider attitudes and perceived barriers towards treating SUDs and PTSD concurrently. Current findings investigating perceptions of treating SUD/PTSD have been obtained through surveys [29–31], vignettes [32] and case study designs [33, 34] from clinicians working in a variety of AOD and mental health settings. Clinicians have reported that treating SUD/PTSD is significantly more difficult than treating either disorder alone in adults [30, 31] and adolescents [29]. Some of the greatest reported challenges of working with people who have SUD/PTSD includes a high level of self-harm and suicidality, the need to balance case management with treatment, and the high intensity of care required to manage a severe substance dependence [31, 35]. Other challenges identified included limited access to evidence-based treatment guidelines for SUDs and PTSD, the lack of information available on how to integrate PTSD treatment into residential and outpatient AOD settings [30], and when to commence PTSD treatment after remission from substance use [33, 36]. This research demonstrates the importance of clinicians' perspectives in the implementation of trauma-specific services, while including patient preferences in evidence-based guidelines has also been found to improve program implementations through treatment retention and outcomes [37].

Relatively few qualitative studies have explored both clinician and client perspectives using qualitative methods to gain more detailed insights on such issues, particularly within residential AOD settings. One study interviewed clinicians on the diagnosis and treatment of PTSD in a large AOD facility that provides support through various delivery modalities [38]. Clinicians acknowledged the adverse consequences of trauma exposure on SUD, reported an issue of underdiagnosing PTSD, and did not support the integrated treatment of SUD and PTSD; which is mostly inconsistent to aforementioned quantitative findings and the evidence-base calling for integrated SUD/PTSD treatments. Another qualitative study conducted in a women-only residential AOD facility found staff and clients perceived the delivery of TIC to be impacted by the recruitment and retention of trained staff, the ability of staff to engage clients in working therapeutic relationships, and deliver TIC care in a safe and stable residential treatment environment [39]. Finally, other qualitative research has found that patients in AOD treatment acknowledge the self-medicating nature of the relationship between SUD and PTSD [25, 38, 40] and people receiving detoxification in hospital may prefer concurrent SUD/PTSD treatment due to an exacerbation of PTSD symptoms during abstinence [25].

Research is yet to investigate the perception of integrated PTSD-specific treatment and TIC among both clients and staff in the same residential AOD treatment service. This dual-approach will better inform the use of integrated PTSD treatment and TIC within AOD settings.

Our central research question was to explore the potential feasibility of integrating TIC and specialist-delivered PTSD treatment into residential AOD services. We aimed to investigate this through obtaining client and staff perceptions of: (i) the relationship between trauma and substance use; (ii) the need for; and (iii) how to best implement TIC and concurrent specialist-delivered PTSD treatment alongside AOD residential treatment.

2 | METHOD

2.1 | Setting

Recruitment took place in two mixed-gendered specialist residential rehabilitation services in Queensland, Australia. Both services run an AOD rehabilitation program predominantly comprised of group-based treatment, case management, counselling support and specialist referrals. Services offer a 6-week length of stay that can be extended to 12-weeks depending on individual client needs. The service which we recruited clients from offers treatment to young people aged 18 to 35 years.

Staff were asked about former TIC training during the interview and this was included in the thematic analysis. However, this information was not directly asked through quantitative means. The constructs of trauma and PTSD were not defined to the participants prior to the interview, as we were trying to understand client and staff's perspectives of these constructs. Both terms were used to describe the study to participants, and the terminology used by the client or staff member to refer to these constructs was adopted throughout the interviews.

2.2 | Participants

Thirty-eight participants (staff: $n = 20$; clients: $n = 18$) were recruited. Client participants (8 females, 10 males; $M_{age} = 27.89$, SD = 3.52) were receiving treatment for the following primary drugs of concern: methamphetamines ($n = 7$), alcohol ($n = 7$), cannabis ($n = 2$), alcohol and cannabis ($n = 1$), and amphetamine and gamma-hydroxybutyrate ($n = 1$) use. All staff participants comprised of AOD frontline workers (15 females, 5 males, $M_{age} = 35.80$; SD = 9.35) including: counsellors ($n = 9$), facility team leaders ($n = 3$), psychologists ($n = 3$), social workers ($n = 4$) and an administrator ($n = 1$).

2.3 | Procedure

This study was approved by the Human Ethics Research Committee at the University of Queensland, Australia (2019002695). Expression of interest from staff participants was generated through members of the research team (VM and MC) presenting the study aims at staff meetings. Selection of client participants was guided by treatment staff to minimise the risk of distress. Before approaching a client, the interviewer checked with a treatment staff member whether they were emotionally and physically stable enough to complete an interview about trauma and PTSD. The informed written consent of staff and clients was obtained, and they were debriefed after their interview. Participants were not financially incentivised. Clients were not asked whether they had ever been diagnosed with PTSD or another mental disorder. However, clients completed The Primary Care PTSD Screen for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition as part of service entry (PC-PTSD-5; a five-item measure for PTSD symptoms associated with experiencing a traumatic event; [41]). A score of three or more indicates a positive PTSD screen. The

average score for the PC-PTSD-5 for the participants from this study was 3.11 (SD = 1.94) and 13 (68%) had a positive screen for PTSD.

2.3.1 | Interview procedure

Interviews were directed by a semi-structured interview schedule informed by the literature in residential treatment [7, 23, 27]. Interviews asked participants about the relationship between trauma and substance use, if trauma/PTSD can be treated alongside substance use and how to do this. Staff were additionally asked about TIC, as well as barriers and facilitators to its implementation (interview questions available in Data S1, Supporting Information). Interviews took place from March to June 2020.

Eighteen client interviews and 20 staff interviews were conducted. Client interviews ranged from 5 to 26 minutes (M_{client} = 11.24, SD = 4.97) and staff interviews ranged from 11 to 29 minutes (M_{staff} = 17.24, SD = 5.78). Participants were asked and attempted to answer all interview questions to the best of their ability. However, the length of interviews was contingent on participant knowledge of SUD/PTSD and their level of interest in taking part. All client interviews were conducted in-person. Eighteen staff interviews were in-person and two were over the phone. Interviews were audio recorded and professionally transcribed using a confidential transcription service. Names were excluded from the transcripts to protect participants' confidentiality.

Interviews were conducted by the first author (VM), a clinically trained PhD candidate. All study authors have a background in clinical psychology an interest in the implementation of TIC and novel interventions for the prevention and early intervention of comorbid mental health conditions.

2.4 | Data analysis

Data were qualitatively analysed following Braun and Clarke's procedure of a thematic analysis [42]. A thematic analysis refines emerging topics from the data to identify themes that best capture that data [43]. All 38 interview transcripts were analysed. Valeriya Mefodeva devised an initial codebook reflecting broader contextual topics (e.g., perception of SUD/PTSD) and topics specific to answer research aims (e.g., treating PTSD in the residential setting). The data was coded and themes were identified using an inductive approach with NVivo 12 [44]. Transcripts were read and re-read by two study authors (VM and MC) and independently coded to account for a potential researcher effect (i.e., author triangulation). Inductive codes were assigned to segments of text representing new themes. Once these codes were independently identified, three study authors (VM, MC and ZW) subsequently discussed final themes from the most commonly occurring codes, and checked the analytical link to the responses, while searching for codes that did not correspond to the theme. We utilised maps, diagrams and tables to organise codes into themes and subthemes and ensure links to responses. Two separate thematic analyses were conducted for clients and staff, which were combined once similarity across the client and staff transcripts were determined. Authors agreed that thematic saturation was reached after analysis of all 38 transcripts as no new themes or major codes emerged by approximately the 10th client, and the 15th staff participant interview.

3 | RESULTS

We identified three key themes shared by clients and staff: (i) relationship between trauma and substance use; (ii) what factors can facilitate the awareness and treatment of comorbid SUD/PTSD; and (iii) the need for specialist-delivered PTSD treatment within the residential setting. We also asked staff additional questions (see Data S1) on their understanding of TIC, and the potential benefits and challenges of its implementation (Section 3.4). Themes and the subthemes are outlined in Table 1.

TABLE 1 Overview of themes and subthemes

Key themes	Subthemes
1. Relationship between trauma and substance use	1.1. Using for coping 1.2. Increasing exposure to dangerous situations 1.3. Trauma/PTSD symptoms in residential treatment
2. Facilitating awareness and treatment of SUD/PTSD	2.1. Psychoeducation on SUD/PTSD 2.2. Coping strategies
3. Specialist-delivered SUD/PTSD treatment	3.1. Treating underlying cause of using 3.2. Need for specialist support 3.3. Safety in the residential setting 3.4. Individualised readiness for PTSD treatment

Abbreviations: PTSD, posttraumatic stress disorder; SUD, substance use disorder.

3.1 | Theme 1. Perceived relationship between trauma and substance use

Participants described how they perceived SUD and trauma to be related. Both staff and clients most commonly referred to using substances as a form of 'avoidance', 'blocking' and 'self-medicating' from the trauma, that precipitated substance use. Staff, but not clients, described how substance use may expose people to high-risk circumstances which may lead to trauma exposure. Staff, but no client participants, also described a reciprocal relationship between trauma and SUD such that substance use may expose people to traumatic events and PTSD symptoms initiate substance use.

3.1.1 | Using AOD for coping with trauma

Most participants identified trauma as an underlying cause of SUD, indicating their use was a form of avoidance and detachment from traumatic experiences. AOD use was described as an effective, short-term coping mechanism for the suppression of PTSD symptoms (e.g., to deal with flashbacks).

> '*it puts a pause on every single thing in your life … you don't care about anything that's happened to you, because you're no longer on Earth and you're in some sort of fantasy land, high on drugs*.' (Client 4, Male, 25)

> '*every single client that comes in here with substance issues has had some sort of trauma … it suppresses the symptoms, and by the time they get here they've numbed those memories*.' (Staff 15, Female, 50)

3.1.2 | Increasing exposure to dangerous situations

Some staff ($n = 5$), but not clients, additionally spoke about the relationship between trauma and substance use where PTSD has caused further substance use, substance use leading to exposure to dangerous environments and substance use exacerbating PTSD symptoms [2, 4, 45].

> '*those who are in the field of consistent or chronic substance use find themself in situations or environments which expose them to events which can be traumatic both in terms of physical violence, sexual assault, or the environments that they find themself in*.' (Staff 4, Male, 28).

Although no themes emerged about specific types of traumatic events, clients ($n = 10$) and staff ($n = 8$) related a history of childhood and/or domestic violence trauma as events initiating the onset of PTSD. Some clients also mentioned the possibility of PTSD-specific treatment towards these events.

3.1.3 | Emergence of trauma and PTSD symptoms in residential treatment

Staff described a high level of emotional dysregulation within the clients during the initial period of residential treatment. This was attributed to the presence of AOD withdrawal symptoms in addition to the removal of AOD use as mechanisms to cope with distress or repressed emotions.

> '*So often we see that trauma comes up for people, because they've taken substances away, so it's then they start to kind of think about these things that have happened more in-depth … There's lots of emotion that comes out in treatment here, because, again, they don't have substances to manage and cope with those things*.' (Staff 2, Female, 44)

Clients additionally described their experiences with PTSD symptoms and other mental health difficulties emerging throughout residential treatment that they were not aware of prior to being abstinent. This included trauma reminders triggering AOD cravings and relapse in prior treatment episodes after understanding underlying problems.

> '*I have had repressed memories come to life when I have been in recovery. I had that here and before that, I really thought that repressed memories were something that people just did for attention. And then I just, like I've been doing a lot of AA work and I remembered this date rape entirely, it was a horrible thing*.' (Client 14, Female, 33)

> '*I ran away last time because I started dealing with being off the drugs, and then you start dealing with why you were on the drugs. And once I got down to the problems, I legged it back out of here and slowly relapsed*.' (Client 6, Male, 26)

3.2 | Theme 2. Facilitating awareness and treatment of SUD/PTSD

Clients and staff highlighted the importance of understanding and beginning to manage PTSD in the residential setting. Facilitating factors of this were psychoeducation around the client's experiences with trauma/PTSD and SUD, and establishing coping strategies alternative to substance use. Staff perceived this as a step to prepare the client for specialist-delivered PTSD treatment in the residential setting.

3.2.1 | Psychoeducation on comorbid SUD and PTSD

Psychoeducation may normalise the client's PTSD/trauma-related cognitions, especially during the initial period in residential AOD treatment when clients are at a higher risk of relapse. Clients spoke about having limited insight on the role of how their trauma impacts their other presenting problems, and being unaware that some of their symptoms may be PTSD 'people might not think that they're experiencing trauma'. Clients may begin to 'label' and/or 'connect' experiences that were not previously identified as traumatic or related to substance use.

> '*We don't have the best understanding of ourselves. We've neglected our own needs – psychological, and physical for a really long time. And when you're getting, you know wasted all the time, you're not really aware so you neglect a lot of things. And I think learning to recognise those things would be good because a lot of us probably can't even recognise problems we ourselves have.*' (Client 7, Male, 25)

> '*It would be important to teach our residents about trauma, so that way they can start to process how it's impacted on them.*' (Staff 10, Female, 38)

3.2.2 | Coping strategies

Learning and practising coping strategies in residential rehabilitation was identified as an important protective factor for remaining abstinent and for assisting with trauma-related symptoms. Coping strategies were also perceived as fundamental to beginning PTSD treatment among clinicians, due to the potential distress that may arise through PTSD/SUD treatment. Clients identified forms of mindfulness and distress tolerance techniques as helpful coping strategies for managing PTSD symptoms. For example:

> '*I have a history of self-harm and whatnot, to bring myself back to a physical sense. And I guess that's the same as walking – you're doing something physical as opposed to trying to work it out in your head. So, you get a bit of a respite from the trauma or the anxiety that you're dealing with.*' (Client 6, Male, 26)

> '*Clinically for me it's really around determining if they're at a place with distress tolerance and emotional regulation to do that work* [PTSD-specific treatment]. *But also explaining generally the therapeutic process with managing trauma in terms of building up that distress tolerance, the emotional regulation skills, ensuring that they've got that toolkit to manage distress before we get to that state of going through and exploring and doing that trauma work.*' (Staff 4, Male, 28)

3.3 | Theme 3. Identifying the need for specialist-delivered SUD/PTSD treatment

Both clients and staff perceived that the simultaneous treatment of SUD and PTSD is more effective than standalone SUD treatment and the implementation for specialist-delivered PTSD treatment was sought after. This was linked to Theme 1 as clients drew on their own experiences of having used a substance to reduce PTSD symptoms. Most participants (staff and clients) listed trauma/PTSD as the underlying cause of SUD and described that leaving PTSD untreated may result in a higher likelihood of relapse. Participants highlighted that there is an individualised readiness to address trauma/PTSD in therapy, which needs to be determined through a collaborative approach between the specialist and client.

3.3.1 | Treating the underlying cause of substance use

Addressing underlying trauma issues in substance use treatment was perceived to lead to a more successful recovery. Participants highlighted that treating substance use without addressing the trauma, or the 'root cause' of using, was less efficacious as the trauma may arise

throughout SUD treatment and trigger the client into relapse.

> '*If we start to treat one, the other one does get worse. So, if we take away the substance, and a person's PTSD surfaces, they don't have the coping skills because we've taken away their substance, which is their coping skill … the reverse is true if we start to treat PTSD because we're actually causing that person to go into that trauma that creates more of their stronger feelings, so they reach more for their substance. So, we would need to have a co-treatment plan for both*.' (Staff 11, Female, 29)

> '*A lot of us have used a substance for a trauma-based relationship or trauma-based thing and it* [PTSD treatment] *just gives us that chance to really find the reason why we use and get coping mechanisms, apart from the substance use … and getting the knowledge back on how to retrain our brain to not cope with the trauma and to not live with it for the rest of our lives, and knowing that there's help there*.' (Client 1, Female, 32)

3.3.2 | Need for specialist PTSD support

Clients who had the opportunity to see a psychologist for trauma-related issues during their treatment spoke about benefits of addressing trauma in recovery from substance use. Staff that had limited access to specialist psychological services for their clients described experiences of clients needing PTSD-specific treatment, and how absence of this hindered the clients recovery process.

> '*I definitely feel like people here do talk about trauma a little but not a lot. And the biggest thing for me to have become comfortable with what I've been through, has been by talking about it, getting it out there and letting it go, has been the biggest way for me to be able to step forward in my treatment, in my recovery*.' (Client 4, Male, 25)

> '*They live with trauma every day so if they don't tackle that it will be at the back of their mind all the time. And just to give you an example, I have a client now … she said, "I need to do this, I need to see a mental health worker and you won't give me one … but I have this trauma and this, I feel it every day and it's making my life here very difficult." So, we need to address that somehow*.' (Staff 18, Female, 48)

3.3.3 | Safety in the residential setting

Clients and staff perceived the residential community as a suitable environment for specialist-delivered PTSD treatment and SUD recovery through having psychological safety and support within the community. Participants placed emphasis on safety in the recovery process.

> '*This is a good environment by virtue of being around other people and getting the chance to be healthy and not adding to the trauma … I felt really safe in here … if I was in therapy, I would be addressing the past rather than acquiring new damage which is what normally happens when I try and do stuff like that*.' (Client 18, Female, 31)

> '*They can talk about their trauma and so on and then when they've finished talking about it, we can support them and keep them here … there'd be some good benefits in that*.' (Staff 6, Male, 36)

3.3.4 | Individualised readiness for PTSD treatment

Clients and staff discussed the diversity in peoples' recovery journeys and highlighted that some people were perceived at a higher risk of relapse from re-traumatisation in PTSD treatment if the client was inadequately prepared. Linked to the sub-theme above, some staff additionally suggested a need for a specialist to determine the client's readiness for treatment.

> '*It has to be approached delicately and by individual case … you don't want to push someone who's not ready because you're just going to put them in a deeper shell*.' (Client 6, Male, 26)

> '*What a specialist clinician is able to do is determine where clients are at and who's ready to do what work. It's not a one size fits all "no one should do trauma work" but a specialist who can do that targeted*

psychotherapy can then make those assessments and gauge where people are at and how deep to dive so to speak.' (Staff 1, Male, 33)

3.4 | Organisational approaches to TIC—Staff responses

Staff were asked additional questions about their understanding of TIC, and the potential benefits and challenges of its implementation (see Data S1). This differed from the thematic analysis component of the study, as it highlighted how organisational factors can contribute to the way staff work with people who have a history of trauma.

3.4.1 | A mutual approach to trauma

Staff perceived TIC as a consistent approach of service delivery—whereby the organisation provides a shared language and understanding of trauma, and assumes all clients may have a history of trauma and/or comorbid PTSD underlying the SUD(s). This included the need for a shared understanding of PTSD symptoms, how these symptoms may manifest in a client and a consistency with how trauma is communicated throughout the organisation.

'*Good TIC in a setting like this is everyone's responsibility … so by the way the kitchen staff conduct themselves with residents … to the way treatment facilitators operate … there's a shared language, a shared approach*.' (Staff 1, Male, 33)

'*TIC is being aware that the clients we have may or may not have some sort of trauma that needs to be taken into consideration during treatment*.' (Staff 15, Female, 50)

3.4.2 | Managing clients who disclose trauma

Staff also identified a concern with having to contain clients if they disclose a history of trauma and not knowing how much to explore this with clients. In a similar vein, there was a perceived need for training in containing the client with expressing trauma-related content ('opening Pandora's box') and the need for referral services that can provide PTSD-specific treatment, which are important contextual considerations for the implementation of TIC.

'*We just never know how people are going to respond when we've opened up the trauma box. Making those clicks with clients is a wonderful moment. But then potential not great things is probably just about that can of worms, and not knowing how that's going to present, and maybe not having a way to close that back up again*.' (Staff 12, Female, 24)

There were various ways in which staff reported detecting the presence of trauma/PTSD in clients. Most staff stated that they directly ask the client if they have a trauma history. Other staff spoke about attempting to detect a trauma history based on the language the client was using. Staff also mentioned using organisational outcome measures to detect trauma/PTSD. However, this was less common. Notably, some staff did not differentiate between TIC and specialist-delivered therapy for PTSD.

'*In my initial interviews, we often ask about physical abuse, sexual abuse, or any other forms of abuse - like emotional or verbal abuse*.' (Staff 7, Male, 27)

4 | DISCUSSION

We qualitatively explored client and staff perceptions on integrating TIC and specialist-delivered PTSD treatment into residential AOD services. Major themes emerged: clients and staff reported on the self-medicating and high-risk relationship between trauma and substance use, facilitating factors of PTSD-specific treatment within the residential setting, and the perceived need for specialist-delivered SUD/PTSD treatment. Staff additionally provided their insights on how to best implement TIC in AOD settings.

Staff and clients shared similar views on the relationship between SUD and PTSD, which provided important contextual information about how to best implement TIC in residential settings. For example, participants reported AOD use as a way of self-medicating for and avoiding trauma-related cognitions and physiological symptoms of PTSD [9, 25]. This is consistent with research suggesting that SUD/PTSD patients are typified by maladaptive coping styles [40] and prior reports of clients with a trauma history describing the self-medicating role of substances [25]. Further, while there are alternative hypotheses to explain the

relationship between comorbid SUD/PTSD (e.g., high risk, susceptibility and shared vulnerability theories; [11–13, 45, 46]), few participants discussed these links. Some staff discussed PTSD and SUD as having a reciprocal relationship, and even fewer raised that SUD can increase risk and susceptibility to trauma exposure.

The residential setting was perceived to provide a suitable and psychologically safe environment for SUD/PTSD treatment. However, participants did not describe the residential setting as physically safe—a crucial element of TIC [15]. Minor references that did not form a theme were made to 'being triggered' by other members in the residential community discussing their trauma history, particularly those related to domestic and intimate partner violence. Special considerations to maximise safety within mixed-gendered residential environments is therefore crucial to optimise the effectiveness of both TIC and specialist-delivered PTSD treatment, especially in survivors of domestic and intimate partner violence who may be triggered based on gender-related cues.

Within residential treatment, clients who receive concurrent PTSD treatment are able to return to a recovery-oriented environment, which has the capacity to influence treatment outcomes [39, 47, 48]. One qualitative study conducted among clients and staff in a residential AOD setting revealed that having staff available 24-h a day contributed to stress reduction and kept clients treatment-focused [47]. Another qualitative study suggested that clients needed to feel physically safe during trauma treatment to fully benefit from it [39]. Clients and staff also reflected on the unsafe environments clients lived in prior residential treatment. Residential treatment clients are in a drug-free environment that promotes a sense of psychological and physical safety, which may not be available to some clients who receive PTSD treatment in outpatient treatment settings [49, 50]. The benefits of the residential treatment setting may therefore be maximised through the implementation of TIC and integrated SUD/PTSD treatment.

Psychoeducation was perceived as a beneficial intervention for allowing clients to identify the link (if one is present) between SUD and PTSD, and to normalise the client's experiences such as their PTSD symptoms and wanting to use due to trauma related triggers. This was consistent with qualitative research that found practitioners operationalise TIC through providing psychoeducation about self-medication [18]. Brief psychoeducation interventions about trauma reactions and symptom management have previously been shown to improve PTSD symptom severity among inpatients receiving detoxification [49]. This suggests the delivery of PTSD psychoeducation interventions is likely to be beneficial in residential AOD settings.

There was an emphasis on establishing coping strategies for managing PTSD symptoms and triggers without substance use, as well as regulating strong emotions that clients had not otherwise experienced under AOD use. This was tied to the link between SUD and PTSD, where clients reported that substance use is a coping mechanism and self-medicating process to manage PTSD symptoms [9]. Among staff, teaching coping strategies was perceived as a precondition to beginning PTSD-specific treatment; thus, highlighting the need for implementing coping strategy interventions at the beginning of residential treatment or prior specialist-delivered PTSD support. Together, these factors show that TIC may look like a counselling engagement response to trauma in the residential setting, which promotes psychoeducation, normalisation of the clients' experiences and coping strategy practise [14].

The organisational principles highlighted by staff endorsed some of the policies and practises of TIC. For example, staff perceived TIC as an organisational awareness of trauma, that it may exist in any of their clients [50], and expressed the need for systemic organisational change to support it [51]. Some staff understood organisational aspects of TIC in a way that was inconsistent with the TIC literature (e.g., staff confusing TIC with PTSD-specific treatment), demonstrating how training would help with clarity on TIC. Overall, our results suggest that clinicians have the capacity to work within the TIC framework but are currently not practising aspects of TIC that can wholly benefit the residential treatment setting.

Staff recognised their abilities to provide brief interventions such as psychoeducation and coping strategies (practical TIC skills) which have previously been shown to decrease PTSD symptoms in people receiving detoxification [49]. However, listening to trauma narratives, determining readiness for, and delivering PTSD treatment was perceived as a trauma specialist role and some counsellors did not perceive themselves to have the competence to deliver PTSD treatment. Therefore, there was an overwhelming desire for PTSD treatment, but a perceived boundary between the capability of counselling staff and PTSD specialists [21].

Research has indicated that the delivery of integrated treatment for PTSD in service settings and upskilling of AOD staff in trauma management strategies may reduce secondary stress and mitigate factors associated with burnout in staff, irrespective of their professional background [21]. If PTSD treatment were to be integrated within a service, consistent communication between PTSD specialists (i.e., psychologists delivering specialist PTSD treatment) and AOD staff may facilitate better client care.

There was a need among all participants to implement specialist-delivered PTSD treatment. This was mainly linked to the reportedly high percentage of clients with a history of trauma and PTSD who enter the residential facility. Our findings contrast previous qualitative research among AOD treatment staff, which found resistance to treating PTSD in AOD settings [33, 38], where trauma was perceived to be a barrier to SUD recovery and PTSD triggers were often cited as a cause of major distress for participants. The current study reported that clients who began to address trauma during residential treatment described its importance throughout their recovery. This suggests a need to provision specialist-delivered PTSD therapy within the residential AOD setting, both to reduce PTSD symptoms and, in turn, reduce triggers of substance use and help the client remain abstinent long-term.

Most of the clients were seeking treatment for amphetamine and alcohol use, which echoes epidemiological data of Australians admitted into AOD treatment through 2011 to 2020 [52]. However, this may not capture people with problems across other substance types. Some client participant interviews were short (e.g., two were 5 minutes long) as they were dependent on client knowledge of trauma and PTSD, despite this thematic saturation was still reached. COVID-19 may have limited the quality of our interviews. Eight client interviews took place while residents were preparing to leave the treatment facility due to an unplanned lockdown. In turn, client perceptions may have been altered from elevated distress which may have created a greater perceived need for specialist support and PTSD interventions. We did not record whether staff had received former TIC training, which may have influenced their interview responses. Furthermore, to minimise the risk of distress we checked with staff whether each client was stable enough take part in the interview. This may have introduced a bias in our results as the clients most sensitive to distress (and potentially had a more severe trauma history) may have been excluded. Nonetheless, this approach was necessary to minimise the risk of participant distress.

To the best of our knowledge, this was the first study to qualitatively obtain both frontline staff and clients' perceptions of the role of TIC and specialist-delivered treatment for PTSD in AOD residential treatment services. This study revealed key themes related to trauma and substance use. Our findings suggest that both staff and clients considered the integration TIC and PTSD-specific treatment in residential AOD treatment facilities to be a positive step forward for improving the outcomes of people with SUD/PTSD. Future research should direct attention to implementing integrated PTSD treatment for this population and understand the feasibility and effectiveness of TIC alongside PTSD treatment within the residential AOD setting.

AUTHOR CONTRIBUTIONS

VM and LH conceptualised the project. VM conducted the interviews, analysed and interpreted the data, and wrotethe manuscript. MC and ZW assisted with the analysis, conceptualising the results and editing the manuscript.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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