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The feasibility and acceptability of a brief intervention for clients of substance use services experiencing symptoms of post traumatic stress disorder

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HIGHLIGHTS

- We pilot tested a brief intervention for comorbid PTSD and substance use.
- PTSD symptom severity decreased from baseline to 1-week follow up.
- Participants expressed high levels of satisfaction with the intervention.
- The brief intervention appears feasible and acceptable, and of some benefit.
- The brief intervention may be a "stepping stone" to further trauma treatment.

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ABSTRACT

Background: Trauma exposure and post traumatic stress disorder (PTSD) are common among clients of substance use services. Existing treatments for these co-occurring conditions tend to be lengthy, treatment retention is relatively poor, and they require extensive training and clinical supervision. The aim of the present study was to conduct a preliminary examination of the feasibility and acceptability of a brief intervention for PTSD symptoms among individuals seeking substance use treatment.
Methods: An uncontrolled open-label pilot study was conducted among 29 inpatients of a medicated detoxification unit in Sydney, Australia. All participants completed a baseline interview followed by the brief intervention. The intervention consists of a single, one-hour manualised session providing psychoeducation pertaining to common trauma reactions and symptom management. PTSD and substance use outcomes were assessed at 1-week, 1-month and 3-month post-intervention.
Results: PTSD symptom severity (assessed using the Clinicians Administered PTSD Scale) decreased significantly from baseline to 1-week follow up (β −10.87, 95%CI: −19.75 to −1.99) and again between the 1-week and 3-month follow-ups (β −15.38, 95%CI: −23.20 to −7.57). Despite these reductions, the majority of participants continued to meet criteria for a diagnosis of PTSD and there was no change in participants' negative post-traumatic cognitions. Participants expressed high levels of satisfaction with the intervention.
Conclusions: Brief psychoeducation for traumatised clients attending substance use services appears to be feasible, acceptable, and may be of some benefit in reducing PTSD symptoms. However, participants continued to experience symptoms at severe levels; thus, brief intervention may best be conceptualised as a "stepping stone" to further trauma treatment.

1. Introduction

There is a substantial international literature documenting the disproportionally high prevalence of trauma exposure and post traumatic stress disorder (PTSD) among people with substance use disorders

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(Gielen et al., 2012; Mills et al., 2006). Indeed, epidemiological and clinical research has shown that trauma exposure (i.e., experiencing, witnessing or being confronted with a situation placing the life or physical integrity of one's life, or that of another, at risk), is almost universal in this population, and up to 45% suffer from current PTSD (Dore et al., 2012; Gielen et al., 2012; Mills et al., 2006; Read et al., 2004). In addition to those who meet criteria for a full diagnosis, approximately 23% of substance use clients have subsyndromal levels of PTSD (Driessen et al., 2008).

The high prevalence of trauma exposure and PTSD is of significant concern to substance use treatment providers as clients with this disorder present to treatment with a more severe clinical profile (e.g., extensive polydrug use histories, poorer general physical and mental health, greater psychopathology, and higher rates of attempted suicide) (Mills et al., 2005; Najavits et al., 1999; Ouimette et al., 2006; Wu et al., 2010), and demonstrate poorer treatment outcomes across a number of domains (e.g., poorer retention in treatment, higher relapse and readmission rates, reduced time to relapse, and poorer outcomes in terms of mental health and psychosocial functioning) (Brown et al., 2003; Ford et al., 2007; Hien et al., 2000; Najavits et al., 2007). Moreover, it appears that the poorer treatment outcomes demonstrated are specific to PTSD rather than to greater psychopathology in general (Mills et al., 2007; Ouimette et al., 1999). It is therefore not surprising that clinicians perceive individuals with comorbid substance use disorder and PTSD to be more difficult and challenging to treat compared to those with either disorder alone (Back et al., 2009; Najavits, 2002).

There is consensus in the literature, and growing evidence to suggest, that the incorporation of trauma-specific interventions into substance use treatment services may improve the outcomes of clients suffering from comorbid PTSD symptoms (Back, 2010; Elliott et al., 2005; Ouimette et al., 2003). Furthermore, a large proportion of substance use clients with this comorbidity indicate that they would prefer to have the symptoms of both disorders addressed simultaneously by the same clinician (Back, Brady, Jaanimagi and Jackson, 2006.

A number of protocols have been developed to treat clients with comorbid substance use and PTSD (Back, Waldrop, Brady, & Hien, 2006). While there is growing evidence of the efficacy of these interventions (Mills, Teesson, et al., 2012; Torchalla et al., 2012; van Dam et al., 2012), they tend to be lengthy (ranging from 3-month to 2-year duration including partial hospitalisation). Many providers do not, however, have the opportunity to work with clients for several months or more, due to the nature of the service being short-term (e.g., drop-in services, detoxification, short-term residential rehabilitation). Retention in substance use treatment has also been identified as a pervasive clinical challenge, particularly in cases in which there is comorbidity (Beynon et al., 2006; Tate et al., 2011). In addition to being lengthy, existing interventions require extensive training and clinical supervision. For these reasons, many substance use treatment providers are not able, or willing, to implement these interventions in clinical practice.

In situations where more intensive interventions are not feasible, delivery of a brief intervention for PTSD symptoms may be more attractive, feasible and sustainable to both clients and treatment providers. Brief interventions are less time and resource intensive (typically comprising a single counselling session), and they may be applied across a variety of settings, by a range of clinicians, with minimal training (Heather, 2004). Furthermore, brief interventions are widely used and accepted in the treatment of substance misuse (Moyer et al., 2002).

The use of brief interventions in relation to PTSD has not been investigated previously. Research examining the use of brief interventions with respect to other comorbid mental health conditions, however, indicates that such an intervention may be effective in this population. Studies examining the efficacy of brief interventions relative to longer, more intensive psychological treatment programmes for comorbid substance use and mental health disorders, have consistently found that the improvements observed for brief interventions match those reported for the comparison treatments (Baker et al., 2005, 2009, 2010; Kay-Lambkin et al., 2010). In a comparison to outcomes across several randomised controlled trials, Baker et al. (2009) demonstrated that a one-session brief intervention produced significant and comparable reductions in alcohol use, hazardous substance use and depression over 6-month follow-up as more intensive, specialised, 10-session psychological treatments. This was true irrespective of severity of mental disorder (schizophrenia, bipolar disorder, depression) and type of substance use disorder. Together, this body of research indicates that single-session brief interventions comprising psychoeducation and self-help material, can improve outcomes for people with comorbid mental health and substance use disorders. The present study sought to extend this knowledge by conducting the first examination of the feasibility and acceptability of a brief intervention for PTSD symptoms among individuals seeking substance use treatment. More specifically, the study aimed to answer the following research questions:

- Do clients who receive a brief intervention for PTSD demonstrate improvements in PTSD symptoms and post traumatic cognitions?
- Do clients who receive a brief intervention for PTSD demonstrate improvements in substance use and severity of dependence?
- Is a brief intervention for PTSD acceptable to substance use clients (as indicated by clients' willingness to participate in the study, the attendance rate, and client satisfaction)?

2. Methods

2.1. Design and recruitment

An uncontrolled open-label pilot study was conducted to achieve the proposed aims. Ethical approval was granted by the Human Ethics Review Committees of the University of New South Wales and the Northern Sydney Central Coast Area Health Service.

Participants were recruited from an inpatient medicated detoxification unit in Sydney, Australia. One-hundred-fifty-five consecutive entrants to treatment were screened for study eligibility by clinic staff. To be eligible for inclusion in the study, clients needed to: i) be aged 18 years or over; ii) have experienced a traumatic event; iii) screen positive for PTSD (defined as scoring 6 or more on the Trauma Screening Questionnaire; Brewin et al., 2002), and iv) have no recent history of self-harm or attempted suicide (past 12 months). Fifty-three of the clients screened (34.2%) were eligible to participate. Reasons for exclusion included not having experienced a traumatic event (n = 15, 14.7%), failing to screen positive for PTSD (n = 63, 61.8%) and having a recent history of self-harm or attempted suicide (n = 24, 23.5%).

2.2. Structured interviews

Structured interviews were administered to participants at baseline (i.e., study entry), and at 1-week, 1-month and 3-month post the brief intervention. The interviews collected data on: i) demographic characteristics; ii) lifetime and current substance use (using the Opiate Treatment Index; Darke et al., 1992); iii) severity of dependence (using the Severity of Dependence Scale, Gossop et al., 1995); iv) trauma exposure and past-week PTSD symptom severity (using the Clinician Administered PTSD Scale; Blake et al., 1995); and v) post traumatic cognitions — that is, dysfunctional trauma-related thoughts and beliefs including negative cognitions about the self, negative cognitions about the world, and self-blame (using the Post Traumatic Cognitions Inventory; Foa et al., 1999). At the 1-week follow-up, participants also completed the Client Satisfaction Questionnaire (CSQ; Attkisson & Zwick, 1982).

Self-reported substance use was not validated against urine screens of other biomarkers as there is an extensive literature documenting the reliability and validity of self-reported drug use (Darke, 1998). Overall, agreement between self-report and biomarkers is high. Indeed,