FUTURE RESEARCH DIRECTIONS FOR IMPROVED RESPONSES TO TRAUMA AND ALCOHOL AND OTHER DRUG-RELATED PROBLEMS:

REPORT FROM A NATIONAL STAKEHOLDER CONSULTATION

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We would like to acknowledge the Traditional Custodians of the unceded lands on which Deakin University campuses are located: the Wadawurrung people, the Boon Wurrung people, the Wurundjeri people, and the Gunditjmara people.

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EXECUTIVE SUMMARY

This report presents findings from a national consultation undertaken in 2023 on knowledge gaps and areas for future research on trauma and alcohol and other drug (AOD)-related problems in Australia. Drawing on interviews with Australian stakeholders working in the fields of trauma-informed or AOD policy, research and treatment, the report aims to inform research that can improve policy and practice responses.

The consultation generated new insights into Australia's knowledge about trauma and AOD-related problems; knowledge gaps in understanding and implementing trauma-informed approaches to AOD treatment; and future research and knowledge translation needs to enhance responses to trauma and AOD-related problems. Interviews were conducted with 15 stakeholders (from research, policy, service provision, and peer and advocacy services) to explore their views on key issues for social research into trauma and AOD-related problems, trauma-informed AOD treatment and the current fit between research on trauma, and policy and practice (see Appendix B for the interview schedule). This report presents stakeholders' views on the integration and implementation of trauma-informed approaches to AOD treatment, and strategies for enhancing Australia's capacity to respond to trauma and AOD-related problems.

The **main findings** and **recommendations** of this report are:

1. Stakeholders expressed uncertainty about the role of trauma in AOD-related problems and the nature and extent of traumatic experiences among AOD consumers. **Further research is needed to identify the nature and scale of trauma experiences among AOD consumers and service users in Australia.**
2. People with experiences of trauma and AOD-related problems have historically been excluded from research. **Future research should include people with diverse lived experiences, and it should address the factors that shape their experiences, and their preferences for treatment and support.**
3. AOD-related problems and experiences of trauma are reported to be higher among LGBTIQA+ and Aboriginal and Torres Strait Islander peoples. **There is a need for targeted research to develop culturally specific understandings of trauma for these priority groups, and to identify targeted and responsive policy and practice recommendations.**

4. The meanings of trauma-informed treatment approaches in the AOD sector are inconsistent and unclear, with potential barriers to implementing trauma-informed approaches across different AOD treatment settings and service modalities. Stakeholders also expressed concerns about the compatibility of trauma-informed approaches with the aims of harm reduction, use reduction and/or abstinence. **Further research and evaluation on the implementation of trauma-informed approaches to AOD treatment is needed, including in relation to:**
    - The compatibility between trauma-informed treatment and existing AOD service modalities;
    - The alignment between trauma-informed treatment and AOD treatment aims, including harm reduction, use reduction and/or abstinence;
    - Identifying, monitoring and addressing unintended harms from the implementation of trauma-informed AOD treatment approaches; and
    - Funding models and system investment.
5. The AOD and mental health sectors require targeted, specialist knowledge, skills and training. **Trauma-informed policy and practice changes in the AOD sector must be supported by research to identify and address education, training, and support needs for the AOD workforce.**
6. Existing research on trauma and AOD-related problems is poorly integrated into Australian AOD policy and practice. **Future research needs to be translated into accessible forms for AOD health professionals and policymakers.**
7. **There is a need to conceptualise AOD-related problems and trauma through the lens of related social issues of gendered and family violence, racism, sexual discrimination, criminalisation, poverty and homelessness** – in that these are widely recognised as producing complex harms and stigma.

BACKGROUND AND AIMS

Despite decades of research, policymaking and treatment, AOD-related problems remain major health and social issues and are estimated to cost Australia almost $40 billion per year (Australian Institute of Health and Welfare [AIHW], 2021).

In 2019–20, approximately 139,300 clients aged 10 and over received AOD treatment (AIHW, 2021) with Australia's current investment in AOD treatment valued at around $1.26 billion per annum (Ritter et al., 2014). The AIHW reports that 57–75% of Australians will experience a potentially traumatic event during their lives and that trauma has considerable economic effects, with mental health issues (including 'alcohol and substance use disorders') representing the largest financial impact (AIHW, 2020).

Trauma is defined by the American Psychiatric Association (APA) as the psychological effects of 'exposure to actual or threatened death, serious injury or sexual violation' (APA, 2013). There are various types of trauma experiences including acute, chronic, and complex, as well as developmental, historical and intergenerational. While some research suggests a strong association between trauma and AOD-related problems, this relationship is not well understood (Thege et al., 2017). Despite knowledge gaps and limited research to guide policy and practice responses, trauma-informed approaches to AOD treatment are gaining traction internationally (Mills et al., 2015).

Trauma-informed treatment can be defined as treatment in which service delivery is influenced by an understanding of the impact of trauma on service users (Elliot et al., 2005), but what this entails is not well understood in relation to AOD treatment and service delivery. There is **an urgent need to identify key gaps in knowledge about trauma-informed AOD treatment and areas for future research, which can inform policy and service provision** in this area. To address this gap, we conducted a national consultation with stakeholders in early 2023.

Overview of consultation and aims

The aims of the consultation were to explore stakeholders' views on:

- Current understandings of trauma and AOD-related problems;
- Knowledge gaps in implementing trauma-informed approaches to AOD treatment; and
- Future research and knowledge translation needs to enhance responses to trauma and AOD-related problems in Australia.

Methods

In order to address the aims of the consultation semi-structured interviews were conducted with 15 key stakeholders working across national and state organisations in Australia. They included researchers, policymakers, service providers and peer and user group representatives involved in the design and delivery of AOD and trauma-informed policy, research and treatment. Participants were recruited across generalist healthcare, gender and sexuality-specific healthcare services, and trauma and AOD services, drawing on the investigators' networks and snowball sampling (See Appendix A for the letter of invitation to prospective participants). Participants were recruited from Victorian (n=5), Queensland (n=2), New South Wales (n=6) and national (n=2) organisations and held various roles with six in service provision (including in AOD treatment, and services specific to LGBTIQA+ and Aboriginal and Torres Strait Island peoples), four in policy, four in research, and two in peer advocacy.

A semi-structured interview schedule of eight questions was used to guide discussion and allow participants to raise issues they consider important, thereby allowing new insights to emerge (See Appendix B for the interview schedule). Interviews were conducted on Zoom and explored key issues for research

on trauma and AOD use, gaps in Australia's knowledge about trauma and AOD-related problems, the current fit between research on trauma and policy and practice in Australia, and ideas for improving trauma-informed AOD treatment and suggestions for novel research translation strategies.

Interviews were conducted by an experienced qualitative researcher (GN) and the first author (RF). They were audio recorded with participant consent and transcribed verbatim as interviews progressed so that the transcripts could be reviewed to inform subsequent interviews. To protect participants' identities, any identifying details were removed from the transcripts and pseudonyms assigned. The interviews were coded by the first author using NVivo 12 qualitative data management software. An inductive, iterative process was used to identify primary analytical themes and categories in relation to the study's key aims.

This project was conducted in accordance with the National Statement on Ethical Conduct in Human Research and was approved by the Deakin University Faculty of Arts and Education Human Ethics Advisory Group (HAE-23-009).

FINDINGS

Three main themes were identified in the interview data:

1. Gaps in knowledge about trauma and AOD-related problems;
2. Enhancing the understanding and implementation of trauma-informed approaches to AOD treatment;
3. Building Australia's capacity to generate and mobilise research in addressing trauma and AOD-related problems.

As illustrated in Table 1, several subthemes were also identified, which we detail below.

Table 1: Theme overview

1. Gaps in knowledge about trauma and AOD-related problems	2. Enhancing the understanding and implementation of trauma-informed approaches to AOD treatment	3. Building Australia's capacity to generate and mobilise research in addressing trauma and AOD-related problems
1.1 Uncertainty about the nature and extent of trauma among AOD consumers	2.1 Research on the compatibility of trauma-informed treatment and the AOD sector	3.1. Developing an integrated approach to knowledge translation
1.2 Need to foreground diverse AOD consumer experiences and understandings	2.2. Monitoring potential unintended harms of trauma-informed approaches	3.2. Research to support an interlinked approach to addressing related social issues
1.3 Relationship between trauma and AOD-related problems	2.3. Identifying and addressing workforce training and support needs	
1.4 LGBTIQA+ experiences of trauma, AODs and service needs		
1.5 Aboriginal and Torres Strait Islander experiences of trauma, AODs and service needs		

1. GAPS IN KNOWLEDGE ABOUT TRAUMA AND AOD-RELATED PROBLEMS

Participants were asked to comment about particular issues or oversights in Australia's knowledge about trauma and AOD-related problems. Stakeholders identified several gaps including uncertainty about the prevalence and scale of trauma experiences among AOD consumers and service users. They also identified other key issues for social research including the variation and diversity in AOD consumers' experiences, as well as a need for more information about the relationship between trauma and AOD consumption, and the experiences and needs of priority populations. These are detailed below.

1.1 Uncertainty about the nature and extent of trauma among AOD consumers

While some stakeholders took the view that trauma-informed approaches were needed in the AOD sector, others argued that further research was required to 'better understand the experience of trauma in the patient population' (S03, Researcher) and identify the nature and scale of trauma experiences among people accessing AOD treatment in Australia:

There's a lot of [instances] where things are assumed to be given in relation to trauma and substance use, yet there isn't necessarily as much evidence as you would hope to back it up. (S15, Research)

It's fairly clear evidence wise that there's a correlation between these two things, but I think because we have really focused on PTSD [Post-Traumatic Stress Disorder] as the primary diagnosis, it's not as broadly clear that this is an issue that affects the bulk of this population. (S09, Service Provider)

For Australia, I think one of the key issues is the gap in evidence around measuring and then treating trauma within substance use populations. This includes people in the community as well as people who are treatment seeking. We don't currently have any routine measures of trauma within treatment settings. (S11, Research)

A strong consensus emerged across the interviews that more specificity and nuance was needed in how trauma was conceptualised and diagnosed in AOD treatment services, especially in relation to experiences and presentations that did not fit the formal diagnostic category of post-traumatic stress disorder (PTSD)[1]:

> *People are often referring to PTSD and I think that that probably needs to be broadened a bit [...] I think the population that we have [accessing AOD services] will very rarely be diagnosed with PTSD.*
> (S09, Service provision)

> *Defining trauma needs to [... be based on a] broader consideration of what trauma looks like.*
> (S15, Research)

Overall, the data suggest that Australia needs a broader and richer evidence base on the experiences of people who access AOD treatment to properly establish whether trauma-informed approaches should be adopted in Australian AOD policy and treatment.

1.2 Need to foreground diverse AOD consumer experiences and understandings

Participants agreed that current policy development and best-practice approaches were limited by the lack of reliable research evidence, with several noting that consumers with lived experience had historically been excluded from research on trauma:

> *Certainly, in the area of complex trauma, many of the people who are the very subjects of [...] research are excluded because of all sorts of different criteria.*
> (S01, Policy)

> *I would be very interested to understand how those people [who have experienced trauma] see the connections, because a lot of what we've been doing is creating [... and] accessing frameworks that maybe haven't always included the voice of people in those situations.* (S03, Policy)

Participants argued that there was a strong need to centre consumer perspectives in research design and data collection to 'better understand the experience of trauma' (S04, Research) and 'the impacts of trauma on the individual and families' (S05, Service provision). Participants suggested this was especially important given the diversity of people who access AOD treatment, variation in life circumstances, and different contexts in which trauma occurs.

Other stakeholders highlighted the need for a greater understanding of consumer experiences to ensure the development of responsive and targeted policy, treatment and support services:

> *[We need a] better understanding about [whether there] are parts [...] that are more important than others in terms of the client's experience, the trauma survivor's experience, to make sure that we are focusing on the things that are most important to them.* (S10, Policy)

> *I think better understanding treatment goals for people would be interesting [...] There [are] many people who are not interested in abstinence, who see their substance use as a supportive part of their identity and they're wanting to address the harms or have controlled use or something like that.*
> (S14, Service provision)

1.3 Relationship between trauma and AOD-related problems

In addition to developing a more complex understanding of trauma, a key issue identified for further research was the relationship (if any) between trauma and AOD-related problems. Stakeholders suggested there was a need to know more about how trauma affects consumption patterns and pathways, and vice versa, including the relationships and social resources that shape different trajectories, changing habits in consumption and variation in trauma symptoms:

> *From a research perspective [... we need to know] what do those pathways looks like? How do they impact each other as far as risk and protection is concerned? What does intervention look like from a prevention, early intervention, and treatment perspective?*
> (S10, Policy)

Participants called for improved understandings of the underlying aetiology of this relationship beyond the current focus on drug use as a form of 'self-medication'.

1 The diagnosis of PTSD requires the identification of a stressor or traumatic event, at least one intrusion and re-experiencing symptom, at least one avoidance symptom, negative alteration in cognition and mood, and alteration in arousal and reactivity (American Psychiatric Association, 2013).

A lot of our work in trauma-informed care and treatments for [...] co-occurring conditions are often based on that idea of self-medication, but the evidence for self-medication is [...] still pretty thin on the ground.

(S15, Research)

> *A lot of our work in trauma-informed care and treatments for these co-occurring conditions are often based on that idea of self-medication, but the evidence for self-medication is [...] still pretty thin on the ground. There's not really any consistent findings in that space that definitely point towards that but most of our treatments [and] responses are based on it.* (S15, Research)

Peer and advocacy stakeholders in particular called for more nuanced and careful research into the diverse reasons people consume AODs, and the social relationships and contexts that shape their consumption patterns:

> *There should be [an understanding] that not everyone goes through trauma then takes drugs and alcohol [...] they [researchers] should look into it a little bit more and not just think that something traumatic has happened for [consumers] to use drugs and alcohol.* (S08, Peer worker)

> *I think focusing more so on the trauma and the factors around people's lives other than drug and alcohol [would be useful]. I think that having too much of a focus on substances themselves isn't always the answer. I think really looking into community care and protective factors for people is something we need to focus more on.* (S06 peer and advocacy)

In line with the identified need for a richer evidence base on the diversity in people's experiences, participants called for more reliable, current data on the various ways trauma and AOD consumption relate and intersect.

1.4 LGBTIQA+ experiences of trauma, AODs and service needs

There was a strong consensus among stakeholders that more detailed information on the experiences of LGBTIQA+ people, trauma and AODs is needed. In particular, they called for more research into the effects of gendered, family, and sexual violence, and ongoing discrimination and harassment in order to develop targeted responses to the AOD service needs of LGBTIQA+ people:

> *Clearly LGBTIQA populations are over-represented in drug and alcohol statistics [...] I don't think we've really thought through models of how to best treat those populations.* (S04, Research)

> *I think there is a big overlap between queer communities and people who use drugs. And I would also hedge a good bet that a lot of people who have substance abuse issues who are queer have also experienced a lot of gender-based violence and sexual violence, and that violence and abuse has directly contributed to their experiences of misusing alcohol and other drugs.* (S06, Peer and advocacy)

In particular, the experience of mainstream AOD services and cultural safety, along with preferences for specialist gender and sexuality-specific services, were identified as key gaps in knowledge, with stakeholders expressing concern about the lack of evidence in these areas:

> *I think better understanding the social barriers to seeking treatment is a really important piece here. Cultural safety in mainstream services can be really challenging, and in the family violence sector there's a presumption of a gendered nature that doesn't bear out in the LGBTIQ+ families we deal with.* (S13, Service provision)

I do think being mindful of the cultural context, and the idea of cultural safety is something that we really need to work on in order to adequately provide trauma-informed care.

(S06, Peer and advocacy)

> *I do think being mindful of the cultural context, and the idea of cultural safety is something that we really need to work on in order to adequately provide trauma-informed care.* (S06, Peer and advocacy)

> *We often hear from people who have had poor service experiences in what we would call mainstream services, so non-specialist LGBTQ services. We hear of, you know, particularly amongst our trans community, or gender diverse community [that] people feel reluctant to seek help […] based on previous discrimination.* (S07, Service provision)

Reflecting on the potential for services to inadvertently reinforce experiences of trauma, one participant noted the importance of centering the lived experiences of LGBTIQ+ people in designing appropriate responses:

> *I think […] comprehending the lived experiences of LGBTIQ+ people in the way that services and societies are constructed in ways that are sometimes inherently traumatising to queer community is worth knowing more about and thinking about in terms of providing meaningful responses.* (S14, Service provision)

Participants cautioned against services and policy approaches employing simplified models that treat AOD consumption as a pathological response to trauma. As one participant noted, this was especially important for LGBTIQ+ people whose AOD consumption was sometimes too quickly linked to their sexuality, minority stress or sexual discrimination:

> *I do think it's important not to assume that someone's substance use is related to trauma […] I think sometimes it's assumed that substance use is related to the stresses faced by someone who's gay because they're gay, or they're coming out or because they're trans.* (S07, Service provision)

1.5 Aboriginal and Torres Strait Islander experiences of trauma, AODs and service needs

There was also a strong consensus that the effects of intergenerational trauma (sometimes referred to as historical trauma) among Aboriginal and Torres Strait Islander peoples and its relationship to AOD-related problems constitute an urgent area for social research. Participants spoke about the need for Aboriginal and Torres Strait Islander-led targeted research on the effects of trauma, settler colonialism and racism on health experiences and AOD consumption:

> *I'm not an expert in Aboriginal health, but I imagine, given the very significant over-representation of Aboriginal people in drug and alcohol treatment services, and in the population surveys we have on drug and alcohol use, that that's a particular area of need. And that intergenerational trauma of dispossession and loss and racism are chronic issues facing Aboriginal people, with no great master plan to really resolve it.* (S04, Research)

> *I can only really talk from my experience in Aboriginal Health … there is nothing there. No real understanding of […] diverse communities within the Aboriginal community and not a whole lot of research looking at how trauma relates to [… identity] or AOD use.* (S13, Service provision)

> *You know, we have a fairly high percentage of Aboriginal patients and […] we can practise in a trauma-informed way but if the resources are not there to meet it at the other end, it means very little.* (S09, Service provision)

Overall, participants called for research that develops culturally specific notions of trauma and AOD consumption outside of the dominant 'diagnostic systems' (S15, Research). Some stakeholders also raised concerns that training for non-Aboriginal organisations in these areas is limited and that the existing evidence is 'not being transferred into training for staff.' (S13, Service provision)

2. ENHANCING THE UNDERSTANDING AND IMPLEMENTATION OF TRAUMA-INFORMED APPROACHES TO AOD TREATMENT

As well as being asked to comment on key issues for improving knowledge on trauma and AOD-related problems, stakeholders were asked about gaps in knowledge around trauma-informed approaches to AOD treatment. There was a strong consensus among stakeholders that trauma-informed approaches to AOD treatment are inconsistently applied and unclear in their objectives, and that implementation would be challenging.

As one stakeholder remarked, 'trauma-informed care is a really big area [...and] a really misunderstood area' (S05, Service provision). Another echoed this comment, noting:

> *I really think there has to be some sort of more concrete way of defining and implementing what trauma-informed care is. Perhaps that is the job of social research to really nut that out, because I think that people use that sort of terminology, but I'm not 100% sure that it's really clear as to what that is.* (S09, Service provision)

Participants thought there was considerable scope to identify 'where trauma-informed care isn't happening', 'where those gaps are [...], who's missing out [and] who's not getting that support' (S10, Policy). According to participants, the four most significant areas of missing information included:

- Knowledge on the development and integration of trauma-informed approaches across the AOD sector and different service modalities;
- The alignment of trauma-informed treatment with the goals of reducing AOD-related harms through harm reduction, use reduction and/or abstinence, workforce training and support; and
- The potential of trauma-informed approaches to generate harms.

2.1 Research on the compatibility of trauma-informed treatment and the AOD sector

Participants identified a need for research exploring if, where, how, and for whom trauma-informed treatment approaches might fit within AOD treatment systems. They questioned the appropriateness of trauma-informed approaches across different AOD treatment settings and service modalities that are often time-limited and episodic. Current models of government funding tied to limited episodes of care or case management were identified as an impediment to long-term relationships required to address complex trauma experiences and AOD-related problems:

> *For a state funded service, we're looking at six to twelve sessions of counselling or up to 15 hours of case management, with some capacity to re-episode people, but with waitlists what they are and funding what it is, [delivering trauma-informed care] is a real challenge.* (S14, Service provision)

> The other thing that happens in the mental health space is that trauma gets [...] taken up as this grand narrative, which then means that other sorts of meanings and explanations that people have around their distress [...] spiritual explanations, cultural explanations [...] get invisibilised.
>
> (S02, Research)

Other stakeholders raised the suitability of trauma-informed approaches across the spectrum of AOD service delivery modalities. For example, one participant questioned the delivery of trauma-informed approaches in brief harm reduction interventions:

> *With brief interventions, we have a lot of people coming in accessing needles and syringes from our needle and syringe program and you know, they're only in there for 5–10 minutes. So we just do brief interventions with them in that capacity […] I'm not a qualified counsellor to be able to counsel them, so I will recommend they go to see a counsellor.* (S08, Peer and advocacy)

As another participant explained:

> *There's been very little [research] looking at brief interventions and/or trauma among alcohol and other drug populations. Yet I feel like it's a space where so many drug and alcohol services, [have short] interactions with people […], so if there's something that people can do that is brief that would be immensely helpful.* (S15, Research)

Group-based residential settings such as detoxification services, residential and therapeutic communities were also identified as areas warranting further research. In relation to this, several participants thought residential services were potentially unsuitable for the delivery of trauma-informed treatment for a variety of reasons:

> *I'm thinking of where there is a […] heavy focus on confrontational techniques […] in some therapeutic communities. They might be thinking that those confrontation groups about calling others out about behaviours might be beneficial based on their therapeutic community model, but [they are] not from a trauma-informed care model.* (S15, Research)

The same participant noted that access to trauma-informed care is not common to individual psychologists and counsellors in group-based AOD settings:

> *In the available drug and alcohol services, there's not typically the provision of that kind of [trauma-informed] care, especially because a lot of the trauma work is one-on-one, so as soon as you get into detox or residential rehab settings, they are pretty much group therapies, opioid pharmacotherapy [as well …] Access to one-on-one psychologists or counsellors isn't really an option.* (S15, Research)

In relation to the need for more research on the suitability of trauma-informed approaches across the Australian AOD sector, some stakeholders expressed concern that 'evidence-based [AOD] practices may not always align seamlessly with trauma-informed care' (S03, Policy) and that AOD services may not be 'the best [service] to be providing specialist trauma-related treatment. (S10, Policy)

Many described mental health and AOD services as having distinct histories and different understandings of desirable health outcomes, with perceived conflicts between addressing trauma and/or reducing AOD use or AOD-related harms. For example, one participant questioned how the focus on present day 'coping skills' or crisis management in AOD counselling would align with a trauma-focused approach of 'addressing what has happened in the past' (S15, Research). Other stakeholders remarked:

> *You know you're fighting this battle to work out how to keep someone safe from now on versus kind of addressing what's happened previously.* (S12, Service provider)

> *We used to say, 'Look, we really need you to be abstinent for a period of a month or two before dealing with the trauma.' That's really hard to do if you're self-medicating. Having said that, we also need some moderation of alcohol and drug use before getting into the trauma-focused parts of treatment [otherwise] the person will just be self-medicating all the way through the treatment, and it'll be all pain for no gain.* (S10, Policy)

Pregnant women and mothers who use AODs, as well as forensic clients, were identified as particular groups for whom providing both trauma-informed and AOD treatment may be incompatible due to structural constraints and system impediments:

> *So there's all sorts of challenges with women being able to report […'experiences of violence or threats'], and the net result not being that they're referred to a Child Protection Agency. Their substance use is harder to address because they're worried about losing custody of the baby they're about to have. That's a real tension.* (S04, Research)

> *We want women to get off all this stuff, but they have this trauma history […] Even though we still practise from this harm minimisation perspective, I just think we're asking a lot of people who perhaps use […AODs] to help manage [and] regulate their emotions, their trauma […] but we kind of leave them raw with nothing [when we ask them to abstain].* (S09, Service provision)

> *I think there's always a juggle, particularly if you're working with forensic clients [… because] of goals set by external stakeholders, like the courts. Working with trauma and recognising that this sort of 'stage of change' […] in a mandated [setting], may not correspond to the moment that people are receiving treatment or there may not be enough stability in people's lives to actually address the underlying trauma.* (S14, Service provision)

2.2 Monitoring potential unintended harms of trauma-informed approaches

Some stakeholders expressed concerns about the potential of trauma-informed AOD treatment to generate unintended harms and the need for research to monitor, evaluate and document the implementation of trauma-informed approaches. Participants expressed concern that a trauma-informed framework might reduce the diversity of AOD experiences and responses that can be considered, including other innovative social policy responses. Concerns were raised that such an approach might 'individualise the problem' (S09, Service provision) through a pathologising and diagnostic focus on individual suffering, behaviour and mental health:

> *I think, in some ways, we're not talking about things like rape and violence anymore, so it's sort of become this psychological concept—something that we think about as within women, rather than within the social context.* (S02, Research)

In relation to the uptake of trauma-informed approaches in mental health, the same participant noted:

> *The other thing that happens in the mental health space is that trauma gets sort of taken up as this grand narrative, which then means that other sorts of meanings and explanations that people have around their distress, or the differences that they're experiencing—you know, spiritual explanations, cultural explanations—all of those get invisibilised.* (S02, Research)

As noted earlier, participants expressed concern about the potential for trauma-informed AOD treatment to link all AOD-related problems to trauma and potentially pathologising mental health diagnoses:

> *I still think, unfortunately, there's a fair bit of pathologising that can happen for people who are using substances, and a lack of understanding that, you know, [… AOD use] is actually an attempt to self-soothe and to cope, and actually has served them well for many, many years.* (S05, Service provision)

> *Not every client does say or think they're self-medicating, they're like, 'No, my drug use has nothing to do with my trauma' […] in which case going down some of our intervention routes that are highly based on that assumption [won't] quite fit for that person* (S15, Research)

Not every client does say or think they're self-medicating, they're like, 'No, my drug use has nothing to do with my trauma'

(S15, Research)

Overall, a common theme was that trauma-informed AOD treatment might have unintended consequences, such as diverting attention from the social or structural underpinnings of problems and harms routinely attributed to AOD use.

2.3 Identifying and addressing workforce training and support needs

There was a general consensus among stakeholders that the AOD and mental health sectors require different specialist knowledge, skills and training and that research is needed to formally identify and address training and support needs. Developing an integrated or holistic approach to the treatment of AOD-related problems and trauma was thought to produce challenges in relation to training and role clarity:

> *I guess our staffing cohort is very mixed and varied, which again is a strength in many ways, but it does probably mean that rolling out change can be a really slow process because we have a workforce with such incredibly varied training and skills.* (S12, Service provision)

I guess our staffing cohort is very mixed and varied, which again is a strength in many ways, but it does probably mean that rolling out change can be a really slow process because we have a workforce with such incredibly varied training and skills.

(S12, Service provision)

> *'What's my job?' That's what I hear a lot. Someone will be working in a sexual assault service, and they'll say, 'I'm here to work with the sexual assault stuff, but this person has AOD issues. What is my role here? Where does my role begin and my role end?' […] 'If I'm asked about drug use, do I really know what I'm talking about? Am I skilled enough? At what point should I refer on?'* (S05, Service provision)

> *As AOD clinicians we are increasingly becoming mental health counsellors, family violence counsellors […] so I know the majority of AOD counsellors dipping into the mental health side of the client's presentation is pretty small, because people really aren't trained.* (S13, Service provision)

The need to provide more information, training and support to the AOD workforce in order to offer holistic treatment for trauma and AOD issues was a strong theme across the consultation, as these comments indicate:

> *When I got to [my current organisation], it really occurred to me that the AOD sector was a little bit behind, and […] there wasn't any [trauma-informed] training for workers across [state], and there seemed to be quite limited training across Australia.* (S03, Policy)

> *We typically see some of those assessment processes in the work that we do [… as a] stepping stone, [but] not going [into too much detail] and I guess that's where training comes into it as well, being able to talk about it without trying to get into too much depth […so that] you can't handle what's coming up.* (S13, Service provision)

A key barrier to the development of an integrated approach was the existing 'siloed pathways' (S10, Policy) and models of care, in which AOD treatment was funded and delivered separately, prior or parallel to the treatment of mental health concerns and issues:

> *Traditionally alcohol and other drug use has been seen as a separate entity to experiences of trauma.* (S01, Policy)

> *What we would see usually is this kind of circular argument about what needs to be treated, you know, who needs to treat what. […There would be limited] screening for alcohol and drugs within mental health and trauma spaces and [limited] screening for trauma exposure and PTSD related disorders in the alcohol and drug space. [This has…] led to silo-based parallel treatments that weren't as integrated as they needed to be for the patients and clients and trauma survivors, for whom this is a very complex and integrated phenomenon.* (S10, Policy)

Most stakeholders expressed the view that an integrated treatment approach should be reflected across 'multiple levels' (S05, Service provision) of the organisation, including funding, management, staff training, screening and referral processes and inter-agency collaboration and communication:

> *You need resources to do it, time to create safety [and] build rapport and work with people in a safe and collaborative way, but often systems are not set up in that way. So maybe it is about looking at what systems look like [and] how they sort of speak to each other to enable effective trauma-informed care.* (S09, Service provision)

3. BUILDING AUSTRALIA'S CAPACITY TO UNDERSTAND AND ADDRESS TRAUMA AND AOD-RELATED PROBLEMS

A strong sense emerged in the data that Australia faces several key barriers to generating research and mobilising strategies for responding to trauma and AOD-related problems. Despite acknowledging the 'critical interface' between research, policy and practice and the urgent need to 'bridge the current practice to best practice gap' (S10, Policy), most participants observed that there was limited integration between research, policy and practice. There was also a perception that 'drug and alcohol research generally isn't a priority' (S04, Research) and that policy changes in the AOD sector were slow due to its status as a 'little cousin' to the mental health sector (S03, Policy). At the centre of this issue is a need to develop an integrated approach to knowledge translation and to addressing the social and political issues that shape AOD-related problems and mental health.

3.1 Developing an integrated approach to knowledge translation

A common theme across the consultation was the recognition that responding effectively to trauma and AOD-related problems requires an integrated approach to research, policy and practice development, and knowledge translation. However, participants suggested that due to the limited research and lack of guidance about implementing integrated care, specifically for trauma and AOD-related problems, 'we're only very much at the start of trying to do better'. (S04, Research)

In addition to the need for more research, there was a consensus across the interviews that the extent to which the existing research influenced policy and treatment design was limited. One participant explained, 'I don't think policy or practice really reflects [the research]' (S15, Research), while another described the relationship between research, policy development and practice change as the 'great lag' (S01, Policy). As another participant explained:

> *I'm not here to say that additional research isn't of value, but I think it's [also] about how that cascades through to people who need to put it in practice and who engage and interact with people presenting [to treatment]. So, it's about what we do with the research.* (S01, Policy)

The limited integration and knowledge translation led some participants to express concern that while the language of trauma might be becoming more prevalent in the AOD sector, it was not resulting in meaningful change in practice:

> *Trauma has become a very broad concept. It's thrown around, and so in some ways it's lost its meaning, or it's been used in quite imprecise ways [...] The risk is that the more trauma rhetoric there is, the more that it just gets taken up in this very tokenistic way, so that people learn a new language to talk about their work but haven't actually transformed much. I feel like there is a growth in awareness and acceptance that there should be trauma-informed care across services, but I feel like it's kind of slow to be adopted in any meaningful way.* (S15, Research)

Trauma has become a very broad concept. It's thrown around, and so in some ways it's lost its meaning ...

(S02, Research)

How do we unpack trauma, when someone does not have enough safety in the moment, when they're in precarious housing and precarious employment, or they're not employed and living on a minimal payment?

(S14, Service provision)

Participants described paying 'lip service' to trauma-informed approaches (S04, Research), and noted that while 'trauma-informed' 'is bandied around a lot, it is […] much harder to embody and enact' (S01, Policy). Current policy development and best-practice approaches were seen as limited by the lack of reliable research evidence, and what research did exist was poorly translated and disseminated to the AOD workforce and policymakers.

Participants took the view that developing an integrated, trauma-informed approach required local research and evaluation of current policies and practices, organisational leadership and systems-level change:

> *Over the years I've become really interested in services—how they think about trauma work and trauma-informed practice, not just in terms of what goes on in the room with a client, but how is it that staff are supported to do this work.* (S05, Service provision)

> *Where I'm working, we're creating and reviewing our entire online curriculum from a trauma-informed perspective […] We want embedded in our cases and stories and resources – choices, strengths and safety. It can be a lot of work if you're doing that with your policies and procedures, and really doing that well […] I think it then requires those in positions of power to really take that on and keep energising and promoting that as core work.* (S03, Policy)

> *To do an audit and review of what it is that they do and how they might change those things and how they might monitor those things, I think makes it really difficult for services to be able to make the changes necessary, that lack of policy or funding support to be able to do it.* (S15, Research)

3.2 Research to support an integrated approach to addressing related social issues

While trauma-informed approaches may offer opportunities to improve AOD and mental health-related outcomes for consumers, an equally important theme to emerge through the consultation was that the capacity to produce meaningful outcomes was constrained not only by knowledge translation barriers but also by narrow, siloed approaches to the causes of social suffering and problems. Many stakeholders suggested taking a broader view of the social and political underpinnings of trauma and problems commonly ascribed to AOD consumption:

> *I think [we need to better acknowledge] gender inequality and gendered violence, and its impact on people's lives. And then the ways in which systems can replicate those dynamics. So often systems will assess for interpersonal trauma—violence that has happened, you know, outside of the service—but not actually reflect on how the service has got those similar power dynamics and is also causing harm.* (S02, Research)

> *I think when considering LGBTQ+ communities and social research, it would be remiss to not [… explore] the traumatic impacts of conversion therapy that we know continues to this day.* (S07, Service provision)

> *We have a lot to do with Child Protection, which is traumatising in and of itself […] There's a lot of systems barriers and issues that don't meet the needs of trauma-affected populations […] I can practise in a trauma-informed way but I still can't make the hospital allow for [a mother's] child to stay here […] What am I doing in the event that this child can't stay – ringing*

> *up child protection […] I'm retraumatising the child and probably her parent who has just absolutely no other option.* (S09, Service provision)

> *For so many people that I've worked with […] there's a narrative of the harms of the prison system that are compounding existing traumas that make it very difficult for people to meaningfully address their [drug] use or access resources.* (S14, Service provision)

While research has tended to focus primarily on AODs, there was a consensus that Australia needed interlinked policy strategies and research approaches that address related social issues of gendered violence, racism, sexual discrimination, criminalisation, poverty, family violence, homelessness and drug-related stigma:

> *How do we unpack trauma, when someone does not have enough safety in the moment, when they're in precarious housing and precarious employment, or they're not employed and living on a minimal payment?* (S14, Service provision)

> *While people will have issues with drugs and alcohol […] it's generally not the big issue in their life […] It's living in domestic violence situations; it's being neurodiverse or having a cognitive impairment that isn't being provided appropriate support for […]. Treating alcohol and drug issues doesn't matter if someone is homeless and going to get beaten up every night […] If we don't look at supporting people through those sort of core basic needs, there's no point trying to focus on other things.* (S06, Peer and advocacy)

> *We need to really be aware of intersectionality in practice and acknowledge the higher likelihoods of harm for people that do have intersecting identities such as people of colour, people who are queer and people who have disabilities.* (S06, Peer and advocacy)

> *I think it would be about ensuring that any type of research is really mindful of cultural considerations and of the ongoing adverse effects and health issues that come from discrimination against people who use drugs. Obviously, misuse of substances in itself is a large issue, but I also think the stigma, and health issues that come directly from the stigma, is something that I don't think gets touched on enough.* (S06, Peer and advocacy)

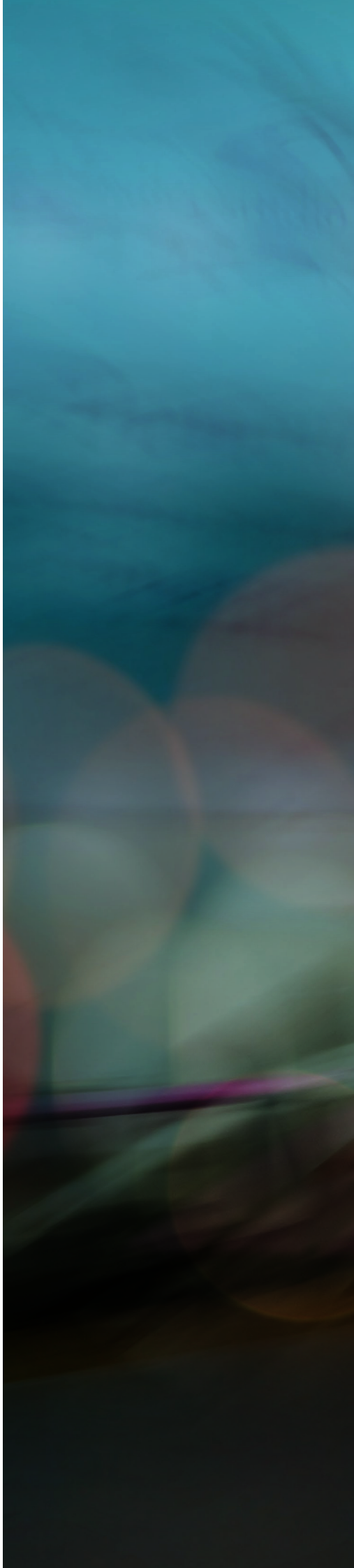
CONCLUSION

This report has outlined key findings from a national stakeholder consultation exploring key issues for social research to improve research, policy and practice on trauma and AOD-related problems in Australia. The findings are based on interviews with 15 relevant stakeholders in research, policy, service provision, and peer and advocacy services undertaken in 2023. This consultation was developed to inform future research and practice.

The consultation found there is a need for further research to develop a broader and richer evidence base on the diverse experiences of people who use AODs, including experiences of trauma, to properly establish whether and how trauma-informed approaches should be adopted in Australian AOD policy and treatment. Stakeholders took the view that existing research in these areas has not adequately been translated into practice and has to date had limited impact on Australian policy development.

Participants suggested a need for more research on consumers' lived experiences of managing concurrent AOD-related problems and trauma symptoms and how trauma differently affects AOD consumption patterns and pathways. They also identified a need for more research on the experiences of LGBTIQA+ and Aboriginal and Torres Strait Islander peoples to develop culturally specific understandings of trauma and effective, targeted responses, including cultural safety in mainstream services. Trauma-informed approaches to AOD treatment were largely considered inconsistent and unclear, and participants thought that the 'rhetoric' has not translated into meaningful practice change. They also raised concerns about the fit of trauma-informed approaches with different AOD service modalities and settings, and the goals of harm reduction and/or reducing AOD consumption. These issues were identified as requiring more research, including in relation to the potential of trauma-informed approaches to generate harms by reducing the diversity of AOD experiences and responses that can be considered. They also recommended that research identify workforce training and support needs.

Overall, stakeholders took the view that Australia's capacity to respond to trauma and AOD-related problems would be improved through an integrated approach to knowledge translation with a focus on targeted research dissemination and policy development. They also emphasised the need to approach trauma and AOD-related problems as connected to other significant structural, social and political issues, that would be best addressed through interlinked strategies and social policy approaches. These findings suggest a need for more research in these key areas and novel research translation and dissemination strategies to inform the development of future policy and practice on trauma and AOD-related problems.



APPENDIX A: LETTER OF INVITATION

Dear [insert name of invited participant]

Invitation to participate in a national consultation on new research into improving trauma-informed care for alcohol and other drug-related problems in Australia

We are a group of researchers developing a new study on trauma-informed care for AOD-related problems in Australia. We are interested in finding out about the current landscape of trauma-informed research, policy and practice in Australia, with a view to informing future research and service provision in this area.

As part of the preparation for this study, we have decided to conduct a consultation with key stakeholders, researchers and those who have made important contributions to this field. The proposed consultation will explore several matters related to trauma-informed care, including:

- The role of trauma in AOD-related problems
- Gaps in Australia's knowledge about trauma and AOD-related problems
- Successful trauma-informed care for AOD-related problems
- Key issues for improving trauma-informed care delivery
- Issues or gaps in knowledge and research that need further research

One purpose of this work is to help us shape and refine our proposed research. Please see the attached Plain Language Statement for further information.

I am writing now to invite you to participate in the consultation. We value your professional expertise and would like you to have input. Your participation is completely optional and voluntary; it is up to you to decide if you want to take part. If you agree to participate, a short confidential interview of about 30 minutes will be arranged for a time and place to suit you. Interviews are usually conducted via Zoom but can be arranged by telephone if you prefer. Attached is an information sheet on the project.

This study has received Deakin University ethics approval (reference number: HAE-23-009)

If you would like to volunteer for an interview, or have any questions about the project, please contact Dr Renae Fomiatti by phone on XXX or email her at: r.fomiatti@deakin.edu.au

We look forward to hearing from you.

Yours sincerely,

APPENDIX B: QUESTIONS FOR PARTICIPANTS

1. How would you describe your work? How does it relate to trauma-informed care?
2. What do you consider to be the key issues for social research into trauma and alcohol and other drug use in Australia, and for improving trauma-informed care?
3. Are you aware of any social research in trauma-informed care in Australia? Has any of this work been especially productive/useful to you? If so, how?
4. Are there particular issues or gaps in Australia's knowledge about trauma and alcohol and other drug consumption, and if so, what are they?
5. Trauma-informed care is increasingly used in gender and sexuality-specific services. What are the key issues for social research to improve gender and sexuality-specific policy and practice on trauma?
6. In general, how would you describe the current fit between research on trauma and policy and practice in Australia?
7. Our work is concerned with examining the link between trauma and alcohol and other drug consumption. In a new study we're planning, we aim to interview people with experiences of trauma and alcohol and other drug-related problems to learn more about how they understand the connection between trauma and AOD consumption, and their perspectives on effective treatment and recovery.
   a. FOR SERVICE PROVIDERS AND POLICY: Do you have any suggestions for enhancing the relevance of the study to your work? Do you have any suggestions for strengthening the link between the study and the key issues you have identified?
   b. FOR ACADEMICS: Do you have any suggestions for strengthening the link between the study and the key issues you have identified?
8. We plan to ensure our project effectively draws on consumer and policy and service provider expertise in designing and implementing the research and its outcomes. Can you suggest ways this would best be achieved? We're keen to consider innovative ideas to ensure the research is as widely accessible and useful as possible.

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