EXECUTIVE SUMMARY

AN INTEGRATED TRAUMA TREATMENT PROGRAM USING EMDR AND SEEKING SAFETY AS AN EHANCEMENT IN THE THURSTON COUNTY DRUG COURT PROGRAM

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INTRODUCTION

Purpose of the Integrated Trauma Treatment Program (ITTP)

The prevalence of co-occurring Posttraumatic Stress Disorder (PTSD) and Substance Use Disorder (SUD) in the criminal justice system is a serious issue for both men and women. The inattention to trauma before, during, and after involvement in the criminal justice system is problematic. Some research suggests that trauma-related disorders among those with SUD negatively affect post-incarceration outcomes (Kubiak, 2004). Therefore, from a practice and policy perspective, interventions addressing these co-occurring disorders should be made available to men and women within the criminal justice system.

Current research recommends a phased and integrated treatment approach for co-occurring PTSD and SUD. SAMHSA (2005) reports that the integration of substance abuse treatment and mental health services for persons with co-occurring disorders (COD) has become a major treatment initiative. The specific Integrated Trauma Treatment Program (ITTP) described in this report is one possible treatment approach for this challenging population. This report will outline the rationale for the ITTP

implemented in the Thurston County Drug Court Program (TCDCP) in Olympia, WA. In addition, it is hoped that results from this project will be considered when making policy recommendations for Drug Courts and other programs in the criminal justice system, as well as other public and private substance abuse treatment settings.

METHOD

Description of the Integrated Trauma Treatment Program (ITTP)

The ITTP is a new integrated treatment program developed for the comprehensive assessment and treatment of co-occurring PTSD and Substance Use Disorder. The Thurston County Drug Court Program (TCDCP) in Olympia, WA. is the first site to implement and evaluate the ITTP as a specialized enhancement to the existing Drug Court Program. The ITTP consists of a combination of two evidence-based, empirically supported treatment modalities: Seeking Safety (Najavits, 2002) and Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1989, 2001).

Seeking Safety is a "present-focused", cognitive-behavioral, manualized group treatment program designed to enhance safety and stabilization through the instruction of coping skills. Seeking Safety is not designed to directly treat individual trauma as part of its program. It is used as the first phase of treatment in this ITTP prior to a second phase of individual trauma treatment with EMDR. Seeking Safety was a *required* group in the TCDCP for those assessed with trauma histories. It is believed that safety and stability can be maximized without sacrificing individualized trauma treatment by conducting the ITTP as a phased intervention. Just as Drug Court Programs are based on phases, so too is the ITTP model of treatment. The model presumes that after Seeking Safety,

participants will be better able to address and resolve distressing individual trauma memories with EMDR, thereby ultimately reducing the risk for relapse in the future.

Seeking Safety is comprised of 25 possible topics, but for this ITTP 15 topics were selected for the education and preparation phase prior to offering individual trauma treatment. The authors (licensed clinicians) and the Drug Court Administrator collaboratively selected the topics to be used from Seeking Safety based on the assessed treatment needs of the participants in this particular Drug Court Program as well as time, staff and other resource considerations. Other Drug Court Programs might require a different set of topics, or a different amount in order to tailor the program to their specific participant needs, or to avoid replication with other existing program elements. Programs can be evaluated for this type of treatment intervention on an individual basis.

EMDR is an empirically supported individual treatment approach for PTSD and other trauma-related disorders. This second, individualized phase of the ITTP was *voluntary* only after the specified 15 topics of Seeking Safety were completed. Eligible participants in the TCDCP could receive up to 20 EMDR sessions of 60-90 minutes in length. EMDR has not yet been proven to be effective with SUDs in controlled research, however, anecdotal evidence suggests that the use of EMDR with co-occurring SUD and trauma disorders may enhance overall treatment outcomes (Shapiro et al., 1994; Vogelman-Sine et al., 1998; Zweben & Yeary, 2006). The hypothesis of this pilot study was that the combination of these two specific treatments would produce positive outcomes for this population. To date, there has not been a program like the ITTP implemented in a Drug Court model.

Design

Initially, the ITTP was to be conducted as a controlled and randomized study. With this design, Drug Court participants with trauma histories, defined as those who reported at least one Criterion A event based on the DSM-IV TR (2000) as assessed by the Clinician Administered Posttraumatic Stress Scale (CAPS), would first complete the 15 Seeking Safety groups selected for the first phase of the ITTP. They would then be randomly assigned (on a voluntary basis) to receive EMDR treatment (second phase) or continue to attend the rest of the traditional Drug Court Program as usual (PAU). The PAU included every treatment intervention already provided to the TCDCP participants with the exception of EMDR.

However, after several months of this randomized approach, an ethical dilemma arose: The Judge, the EMDR participants and the Drug Court Administrator began to notice marked clinical improvement in the participants receiving EMDR treatment. In addition, other participants began to become upset if they were not randomly assigned to EMDR, knowing it was available, but not being given the opportunity for individual trauma treatment. Based on these developments, the authors, Drug Court Administrator, and Judge jointly decided to terminate the randomization process and continue the ITTP as a pilot demonstration project. Therefore, all individuals who had experienced a Criterion A event and had completed the Seeking Safety modules were subsequently offered EMDR on a voluntary basis. Some participants signed up for EMDR, some did not.

Participants

Of the 91 people who were screened for Drug Court, 77 were enrolled in either the PAU or the ITTP. This report analyzes information collected from the 77 people who make up this study's population. The mean age was 32 years (SD=8.72) and the sample was predominantly Caucasian (87%). The most commonly endorsed drug of choice was methamphetamine (58.4%), and more than half of the sample (69.7%) identified as unemployed. For additional rates of demographic information see Table 1.

In order to be eligible for this pilot study, a person needed to have experienced a "Criterion A" traumatic event. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) defines a Criterion A event as: "(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror."

Procedures

Drug Court participants were screened for trauma histories upon entry into the TCDCP by the Master's level Drug Court Administrator trained to administer the screening assessments for this program. Additionally, participants were assessed for depression, dissociative tendencies, and levels of self-esteem. Seeking Safety groups were facilitated by paraprofessionals (e.g. chemical dependency counselors, support staff) trained by the authors. The Seeking Safety manual states that the most important characteristics for selecting group facilitators are: 1) a wish to work with this population,

2) willingness and ability to use a manual-based treatment, and 3) familiarity with the subject of both trauma and substance abuse (Najavits, 2002).

Licensed Mental Health clinicians, who have received formal training in EMDR and are certified in the treatment approach, conducted the EMDR sessions. An EMDR Institute Trainer independently assessed fidelity to the EMDR protocol through audio-taped review prior to the start of this study. Fidelity to the standardized protocols and procedures of EMDR predict better treatment outcomes (Maxfield & Hyer, 2002). The EMDR-trained clinicians used in this program were contracted as an outside treatment source in Olympia, WA to provide EMDR for the TCDCP participants after they completed Seeking Safety.

Table 1. Background characteristics

Background variables	Full population (n= 77)	PAU (n=27)	ITTP (n=50)	*p*
Gender (%)				
Female	24 (31.2%)	3 (11.1%)	21 (42%)	.004
Male	53 (68.8%)	24 (88.9%)	29 (58%)	
Age (mean ± SD)	32 ± 8.72	30 ± 8.35	33 ± 8.72	*ns*
Race n (%)				*ns*
Caucasian	67 (87%)	24 (88.9%)	43 (86%)	
Hispanic	4 (5.2%)	2 (7.4%)	2 (4%)	
Asian/Pacific Rim	3 (3.9%)	1 (3.7%)	2 (4%)	
Native American	2 (2.6%)	0	2 (4%)	
African American	1 (1.3%)	0	1 (2%)	
Education (mean ± SD)	11th grade±1.92	12th grade±1.71	11th grade±2.03	*ns*
Employed full-time n (%)				*ns*
Yes	23 (30.3%)	10 (37%)	13 (26.5%)	
No	53 (69.7%)	17 (63%)	36 (73.5%)	
Drug of choice (%)				*ns*
Methamphetamine	45 (58.4%)	12 (44.4%)	33 (66.0%)	
Marijuana	18 (23.4%)	10 (37%)	8 (16%)	

Cocaine/Crack	4 (5.2%)	1 (3.7%)	3 (6%)	
Alcohol	4 (5.2%)	2 (7.4%)	2 (4%)	
Opiates	3 (3.9%)	1 (3.7%)	2 (4%)	
Heroin	3 (3.9%)	1 (3.7%)	2 (4%)	
Trauma status (%)				
No trauma reported	27 (35%)	27 (100%)	0	.001
No PTSD symptoms	3 (3.9%)	0	3 (6%)	
Sub-threshold PTSD	27 (35%)	0	27 (54%)	
PTSD	20 (26%)	0	20 (40%)	

Measures

The Clinician Administered Posttraumatic Stress Scale (CAPS; Blake et al., 1995) was administered to assess for trauma history and eligibility for the ITTP. A local licensed clinical psychologist provided supervision for the CAPS assessment, acting as a clinical consultant to the Drug Court Program for the implementation of the ITTP. In addition, participants were given the Beck Depression Inventory-II (BDI-II; Beck et al., 1961), the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), and the Index of Self Esteem (ISE; Hudson & Ricketts, 1993), all of which are self-report screening tools.

The BDI-II includes 21 items that are based on a four-point scale. These can be computed into a raw score, which indicates different levels of depressive symptoms. For example, raw scores of 0-13 indicate minimum levels of depression, 14-19 mild, 20-28 moderate and 29-63 indicate severe levels of depression. The DES is made up of 28 items that address a variety of dissociative experiences. The higher a person's score on the DES the more likely they are to have a significant dissociative disorder, which is a contraindication for EMDR treatment. A cut-off score of 30 is generally used to determine appropriateness for EMDR and was used as such in this study. The ISE is a 25-

item measure where scores above 30 suggest that there are clinically significant problems with self-esteem. All four measures were given both pre and post ITTP treatment (defined as completing both Seeking Safety and EMDR) as well as at the end of Seeking Safety for those who declined the EMDR portion of the program.

Statistical Analysis

Frequency statistics were used to calculate and observe the breakdown of certain categorical background characteristics of ITTP participants and descriptive statistics were conducted for continuous variables. In addition, independent t-tests and chi-square analyses were conducted to determine whether there were significant differences between the treatment groups on key demographic variables. Paired sample t-tests were used to compare changes in outcome measures on depression, dissociative experiences, self-esteem and trauma symptomatology before and after the ITTP. Comparative outcome measures were conducted for those who completed the ITTP, and those who declined EMDR (but completed Seeking Safety). See Tables 2 and 3 for these specific results.

RESULTS

Sample Description

Among the 50 participants who were eligible for the ITTP, 40% (n=20) met criteria for probable current PTSD based on the CAPS, 54% (n=27) met criteria for sub-threshold PTSD (having some symptoms but not all, in the clusters of re-experiencing, avoidance or hyper-arousal symptoms), and 6% (n=3) reported experiencing a Criterion A event but no current symptoms. Of those eligible, 21 participants completed the ITTP (referred to as completers). Completion was defined as having finished the selected 15

topics of Seeking Safety in addition to individual EMDR trauma treatment sessions (60-90 minutes in length, up to 20 sessions). 13 participants (3 of whom have missing post-data) completed Seeking Safety but declined to continue with EMDR. These participants are referred to as decliners, since they declined the second phase of the ITTP. Nineteen (19) potential ITTP participants (38%) terminated early from the Drug Court Program prior to completing all of Seeking Safety.

As can be seen in Table 1, only gender and trauma status were significantly different between those in the PAU and ITTP treatment groups. Eligibility requirements explain the difference between trauma status among those in the PAU and ITTP, as only those people who had experienced a Criterion A event could participate in the ITTP. There were significantly more female participants in the ITTP than in the PAU. Those who completed the ITTP graduated from Drug Court at a rate of 90%, whereas those who declined EMDR and only completed Seeking Safety groups graduated at a rate of 31%. Graduation is achieved by fulfilling certain requirements with examples including, but not limited to: obtaining a GED or high school diploma while in the program (if not acquired before entry), becoming employed full-time in a W-2 tax-paying job or enrolling full-time in school, payment of all restitution and program fees, and 180 days of consecutive clean and sober days as measured by urinalysis and breathalyzer tests. A complete list of TCDCP graduation requirements can be found in the TCDCP Handbook. Drug Court Program completion and graduation are the strongest predictors of lower post-program recidivism rates (NIJ, 2006). Treatment outcomes for those completing the ITTP showed statistically significant improvement on all four assessment scales

measuring PTSD symptoms, depression, dissociation and self-esteem as shown in Table 2. Treatment outcomes for those declining the EMDR portion of the ITTP were statistically significant on the ISE and CAPS measures as shown in Table 3. However, there were not statistically significant changes noted for ITTP decliners on the BDI-II and the DES.

Table 2. Comparison of outcome measures at pre and post-treatment for ITTP completers (completed SS & EMDR; n=21)

	Pre-treatment Mean (SD)	Post-treatment Mean (SD)	t(df)
Assessment measures			
BDI-II	16.76 (12.30)	4.62 (5.57)	4.94 (20)***
DES	14.47 (10.4)	7.41	3.24 (20)**
ISE	31.93 (14.0)	19.76 (12.34)	5.17 (20)***
CAPS	53.05 (37.55)	6.33 (6.87)	5.93 (20)***

*p< 0.05, **p< 0.01, ***p< 0.001

Table 3. Comparison of outcome measures at pre and post-treatment for ITTP decliners (completed SS only; n=10)

	Pre-treatment Mean (SD)	Post-treatment Mean (SD)	t(df)
Assessment measures			
BDI-II	8.30 (6.02)	5.40 (5.40)	1.57 (9)
DES	6.82 (3.98)	5.51 (3.39)	1.34 (9)
ISE	28.10 (5.45)	21.32 (3.78)	2.28 (9)*
CAPS	28.0 (26.1)	8.60 (12.61)	3.68(9)**

*p< 0.05, **p< 0.01, ***p< 0.001

DISCUSSION AND FUTURE RECOMMENDATIONS

The ITTP is a Stage I formative study based on two characteristics: 1) ITTP is an innovative program design, incorporating two empirically supported treatment modalities; and 2) the intervention is being implemented as an enhancement to the

existing Drug Court model. The goal of a Stage I research program is to establish sufficient efficacy and effectiveness to progress to Stage II and conduct clinical trials, or to test it in similar program environments.

The post-treatment outcomes of the ITTP *completers* described in this report showed statistically significant symptom improvements on all four measures used to assess incoming Drug Court participants who reported a history of serious trauma. However, two factors make it impossible to make any clear statements about the additive effects of EMDR to Seeking Safety in this study. First, there were significant group differences in baseline scores of the ITTP completers (higher intake scores at initial assessment) and decliners (lower intake scores at initial assessment). Second, outcome measures were not taken between Seeking Safety and EMDR for those who went on to receive individual trauma treatment. Additionally, the unavailability of the participants after leaving the program, made follow-up assessments difficult beyond the end of their tenure in the Drug Court Program. It would be useful to make more rigorous attempts to do follow-up assessments at 3-month, 6-month, and 1-year intervals in the future, if possible, in order to evaluate whether or not treatment gains are sustained over time. There is, however, research to support EMDR's post-treatment gains being sustained over time in other published studies (Van der Kolk, et al., 2007; Power, et al., 2002).

As research and clinical experience suggest, the incidence of co-occurring disorders in the criminal justice system (Kubiak, 2004 and SAMHSA, 2005) as well as the more ubiquitous substance abuse treatment centers across the nation, indicates the need for specialized treatment programs designed to address this challenging population.

Research has also strongly indicated that those who do suffer from this COD have worse treatment outcomes, worse relapse rates, and possibly higher levels of recidivism in criminal justice (Najavits, 2002; Ouimette et al. 2002; Kubiak, 2004). These are critical areas of exploration for future research. The personal, family, social, health and economic consequences to society as a result of failing to treat these individuals at all possible doors of entry has been unfortunate and seems remediable.

The authors believe that this ITTP model could be replicated in multiple types of criminal justice settings as well as other treatment centers serving COD clients with specific challenges, such as domestic violence or post-combat PTSD. These treatment settings could develop and implement an ITTP tailored to meet the specific needs of the clients they serve. This can be accomplished by: 1) utilizing screening tools to measure the specific types of behaviors or traits they are seeking to improve (e.g. trauma symptoms, depression, self efficacy, self-esteem, coping resources, relapse, or family patterns of behavior); 2) designing the treatment intervention phases in accordance with the specific needs of the assessed population.

The screening instruments used in this pilot program were chosen because of their recognition in research for this population. However, there are other screening tools available that do not require one to have certain levels of clinical training in order to administer the measure. It would not be difficult to identify, acquire and utilize those measures most fitting to a particular treatment setting, given that setting's available resources such as staffing, time, training and client needs. The authors believe that staff

education and cross training is imperative for effective program development and implementation.

Recommendations For Starting an ITTP in a Drug Court or Other Related Setting

1. Obtain cross training for all staff in the co-occurring disorder of PTSD and Substance Abuse to familiarize the treatment team members with this subject.
2. Obtain an individualized 'Needs Assessment' for each Drug Court or other similar agency setting. No program is a "one size fits all".
3. Individual assessment is based on size of program, participant types, staff resources available to conduct the program, funding needed to support objectives, and setting realistic goals.
4. Identify appropriate screening and assessment measures for the types of participants being served.
5. Acquire referral sources for the EMDR portion of trauma treatment.
6. Set up data collection procedures. If positive treatment outcomes are shown and tracked, there is a greater likelihood of continued funding to sustain a trauma treatment program.

Author's Note

The most compelling outcomes of the ITTP were the ongoing personal stories that the participants shared about their healing and the marked functional improvements in their daily lives. Some of the participants who went through the program reported that this experience of recovery had followed numerous failed attempts at treatment and that

the difference was the education about trauma, the coping skills learned, and the individualized trauma treatment they received with EMDR during the course of the ITTP. These are sufficient reasons to ensure that others obtain effective integrated treatment for this co-occurring disorder at the earliest possible opportunity, with the understanding that "there is no wrong door" for the introduction of treatment. More rigorous replicated research is recommended specifically for the use of EMDR with populations that suffer from co-occurring disorders.

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