Table 1. **ESTSS expert recommendations for the assessment and psychological treatment of PTSD with comorbid substance use disorder (SUD)**

Recommendation	**Source(s) of recommendation**	**Supporting publication(s)**
Assessment		
1. Individuals with suspected PTSD require a thorough assessment which should include relevant history, including trauma history; exploration of PTSD features and related disorders using appropriate assessment instruments (such as the Clinician Administered PTSD Scale for DSM-5 (CAPS-5)); general psychiatric status; physical health; marital and family situation; social and occupational functioning; quality of life; strengths and resilience; previous treatment and the patient's response to this.	Practice recommendation based on expert opinion	Australian PG ISTSS PG NICE
2. Clinicians assessing and treating individuals with PTSD, should recognise that SUD and other comorbidities are common and should routinely assess for them, using appropriate assessment instruments (such as the Alcohol Use Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST)), during the evaluation and treatment for PTSD.	Practice recommendation based on multiple clinical studies	Australian PG VA/DOD
3. Clinicians assessing and treating individuals with SUD should recognise that trauma exposure is common in this population and should routinely assess for trauma history and symptoms of PTSD during the evaluation and during treatment for SUD.	Systematic review based on multiple clinical studies	Roberts et al, 2022

4. Current and past alcohol and drug use patterns for individuals with PTSD or reported trauma histories should be assessed routinely to identify possible substance misuse or dependency.	Practice recommendation based on expert opinion	VA/DOD
5. Clinicians should seek to understand the development of PTSD symptoms and drug and alcohol usage over time, both pre- and post-traumatic event(s), so that they can fully understand the relationship between traumatic events, symptom development, and maintaining factors to formulate a treatment plan appropriate to the individual's needs.	Practice recommendation based on expert opinion	ISTSS PG
6. Any associated risks, such as suicidal intent, serious self-harming, and potential threat to others, should be assessed and addressed in treatment planning. High-risk concerns where a person is in imminent danger of harm to themselves, or others should normally be the priority for intervention.	Practice recommendation based on expert opinion	VA/DOD ISTSS PG
7. Assessing clinicians should note both the presence and severity of SUD and other comorbidities in their assessments and consider their implications in the treatment plan.	Practice recommendation based on expert opinion	Australian PG
8. When PTSD-SUD comorbidity is indicated health care providers should consider whether treatment can be safely and effectively delivered in primary care or a general mental health setting, or whether referral to a specialist service is required. Factors that might influence decisions about where treatment should take place include the availability of appropriate	Practice recommendation based on expert opinion	VA/DOD

clinical expertise to deliver the required intervention effectively within the provider service, as well as broader case management and risk management need.		
9. Assessment and monitoring should continue throughout treatment and if the individual is not making adequate progress, the clinician should revisit the treatment plan and consider reassessment and reformulation.	Practice recommendation based on expert opinion	Australian PG ISTSS PG
Treatment planning 10. Clinicians should develop a collaborative care treatment strategy to address comorbid health concerns, such as SUD, simultaneously with PTSD symptoms.	Practice recommendation based on expert opinion	VA/DOD
11. Information on PTSD and strategies to deal with PTSD symptoms should be provided to individuals with SUD who are seeking to reduce their drug or alcohol use, as PTSD symptoms may worsen during substance use treatment due to acute withdrawal or loss of substance use as a coping mechanism. Addressing PTSD early in treatment may help to optimize long-term outcomes. Clinicians should also consider providing such information to family or loved ones, as well as the individual, with their consent, in order to strengthen social support.	Practice recommendation based on expert opinion	ISTSS PG Australian PG
12. Evidence suggests that drug and alcohol misuse should be dealt with from the start of treatment, alongside interventions which aim to promote understanding and initial behavioural management of an individual's PTSD symptoms. This approach recognises that frequent	Practice recommendation based on expert opinion	Australian PG

alcohol and drug usage often functions as a form of self-medication which the individual has used to address their PTSD symptoms.		
13. The presence of co-occurring disorders such as SUD should not prevent or exclude individuals from receiving established evidence-based/ guideline recommended treatments for PTSD and individuals should not be excluded from treatment solely on the basis of comorbid drug or alcohol misuse. Readiness to engage in evidence-based treatment should be evaluated on an individual basis.	Practice recommendation based on data from two systematic reviews[19, 22] and at least two RCTs[27, 28].	NICE VA/DOD ISTSS PG
14. For people with PTSD and co-occurring alcohol or drug misuse, the treating clinician/ team should help the individual manage any circumstances which provide a barrier to them engaging with trauma focused therapies. Common barriers include difficulties with travel, treatment related costs, perceived service stigma, motivational issues, and fears about potential negative effects of treatment.	Practice recommendation based on expert opinion	NICE
15. For those with complex needs, a case management approach is often required to plan and coordinate a response to primary needs. Common case management issues might include housing problems, health related and medical needs, involvement with the criminal justice system and management of acute serious risks.	Practice recommendation based on expert opinion	ISTSS PG
16. Some individuals may require a period of time to focus on developing a trusting therapeutic relationship with a clinician, service or team in order to facilitate engagement in evidence-	Practice recommendation	ISTSS PG

based treatment.	based on expert opinion	
17. Psychoeducation, adapted to the individual's level of understanding, and motivational interventions are often an important part of the engagement process.	Practice recommendation based on expert opinion	ISTSS PG
18. There is evidence that the majority of patients with PTSD-SUD comorbidity prefer integrated treatment.	Practice recommendation based on single study[29]	ISTSS PG
19. There is some evidence showing the benefits of combined or integrated substance misuse and PTSD treatment for adults on PTSD and SUD symptoms. Sequential models of treatment have not been widely tested. Further studies investigating the differential effects of sequential vs integrated or combined treatments are needed.	Systematic review and meta-analyses from independent groups	Hien et al, 2023; Roberts et al, 2022 APG; Simpson et al, 2021
20. Current evidence for adults is that those receiving combined and integrated PTSD-SUD treatment make similar progress to those receiving SUD only based interventions in reducing drug and alcohol use.	Systematic review and meta-analyses from independent groups	Hien et al, 2023; .Roberts et al, 2022

21. Current evidence for adults is that trauma-focused psychological intervention based on prolonged exposure, combined with treatment for SUD is the most effective treatment for PTSD symptoms. Average treatment gains are smaller than they are for individuals without SUD comorbidity and there is a higher level of treatment drop-out.	Systematic review and meta-analyses from independent groups	Hien et al, 2023; Roberts et al, 2022;
22. The benefits of trauma focused psychological therapy for individuals with AUD, in terms of reduction in PTSD severity and alcohol misuse appear to be stronger when trauma focused therapy is delivered in combination with alcohol targeted pharmacotherapy.	Systematic review and meta-analysis based on data from 2 studies	Hien et al, 2023
23. For adults there is weaker evidence of PTSD symptom improvement from integrated cognitive behavioural therapy (ICBT), also with a higher level of drop-out than typical seen for individuals without SUD comorbidity.	Evidence from meta-analysis in one systematic review	Roberts et al, 2022
24. Current evidence for adults is that present focused therapies such as Seeking Safety are not more effective than SUD only treatments at improving PTSD symptoms. However, there is evidence that present focused treatment and treatment for SUD only demonstrate small to medium improvements in PTSD and SUD symptoms. In the absence of access to trauma focused psychological intervention these interventions may therefore be of benefit to some individuals with PTSD-SUD comorbidity.	Systematic review and meta-analyses from independent groups	Hien et al, 2023; Roberts et al, 2022; Simpson et al, 2021

25. The current evidence base is not yet sufficiently developed to make treatment recommendations for children and young people.	Evidence from one systematic review	Roberts et al, 2022
26. Integrated and combined trauma focused treatment is usually characterised by a brief period of psychoeducational and symptom-focussed cognitive behavioural interventions for both disorders prior to the introduction of trauma-focused interventions. Normally this would take up to three or six sessions, depending on need. The provision of psychoeducation should not unnecessarily delay trauma-focused treatment when the individual is ready to engage in this.	Practice recommendation based on expert opinion	Australian PG
27. Patients presenting with co-occurring PTSD-SUD should be offered integrated treatment or evidence-based treatment for PTSD without waiting for abstinence. However, the trauma focused component of treatment should not commence until the individual demonstrates the capacity to manage treatment related distress without recourse to prolonged, therapy interfering substance misuse. Decisions about readiness to begin trauma focused intervention should be undertaken collaboratively and some planning for the management of cravings related to exposure related reminders should be undertaken before the onset of trauma processing.	Practice recommendation based on expert opinion	ISTSS PG Australian PG
28. For individuals with complex presentations and needs it may be necessary to increase the duration or number of therapy sessions according to the individual's needs.	Practice recommendation based on expert opinion	NICE

29. There is emerging evidence from one study that incentivisation with shopping vouchers may reduce drop-out from trauma-focused CBT based intervention.	Evidence from one study[27] included in a systematic review	Roberts et al, 2022
30. Therapists should work with the individual to plan any ongoing support they will need after the end of treatment (e.g., residual PTSD symptoms, continuing substance misuse, other mental health difficulties, relapse prevention).	Practice recommendation based on expert opinion	NICE

Australian PG = Australian PTSD Guidelines; ISTSS PG = Effective Treatments for PTSD: Practice Guidelines from ISTSS, 2020; NICE = UK NICE PTSD Guidelines 2018; VA/DOD = USA Department of Veteran's Affairs/ Department of Defense PTSD Guidelines, 2023