

Patient and Provider Perspectives on Treating Substance Use Disorder and Co-Occurring Anxiety and Posttraumatic Stress Disorders in the Veterans Affairs Healthcare System



RESEARCH

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ABSTRACT

Co-occurring substance use disorder (SUD) and posttraumatic stress disorder (PTSD) or anxiety disorders are related to compounded impairment relative to anxiety or PTSD and SUD occurring alone. Despite these problems, treatment for this comorbidity can vary widely; and care is often fragmented across separate clinics and providers. The objective of the study was to understand the perspectives of veterans who navigate the treatment system and providers who care for these veterans. This study used qualitative interviews conducted with 9 veterans with SUD and co-occurring PTSD and/or anxiety disorders and 7 Veterans Health Administration mental health providers. Participants completed a semistructured interview that was recorded and transcribed. Interview data were examined through matrix analysis, a rapid qualitative data-compilation technique to organize domains of responses. Results showed that veterans believe that SUD and PTSD and/or anxiety symptoms are linked, and that treatment for both SUD and the disorders simultaneously could be beneficial. Interviews with providers found that factors of the healthcare system such as siloed clinics serve as barriers to optimal treatment and that co-occurring disorder treatment requires unique skill, training, and dedicated time to treat. Results of these interviews inform gaps in the delivery of care for co-occurring SUD, PTSD, and anxiety disorders and potential avenues to improve care delivery, including transdiagnostic interventions and system-focused innovations.

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Substance use disorders (SUD; including alcohol, cannabis, stimulants, sedatives/hypnotics, and opioids) commonly co-occur with anxiety (e.g., panic disorder, generalized anxiety disorder, social anxiety disorder) and posttraumatic stress disorders (Driessen et al., 2008; Grant et al., 2004; Lai et al., 2015; Marmorstein, 2012; Murphy et al., 2019; Vorspan et al., 2015). The co-occurrence of these disorders has been reported as high as 30% among those with SUD (Agosti et al., 2002; Driessen et al., 2008; Lai et al., 2015; Mackenzie et al., 2014; Stinson et al., 2006). Although there are similarities in theoretical underpinnings and treatment approaches for anxiety disorders and PTSD (Foa & McLean, 2016), the Veterans Health Administration (VHA) has targeted efforts to improve treatment for veterans with co-occurring PTSD/SUD but not anxiety/SUD. This is problematic because anxiety disorders and PTSD commonly co-occur among veterans, and the presence of anxiety disorders contributes to greater severity of PTSD symptoms (Knowles et al., 2019). Co-occurrence of SUD and anxiety disorders or PTSD can lead to increased clinical complexity and poorer treatment outcomes than SUD, anxiety, or PTSD alone (Buckner & Carroll, 2010). Understanding how patients and providers view current treatment models and practices for anxiety or PTSD when it co-occurs with SUD can inform next steps to improve care.

TREATMENT FOR CO-OCCURRING DISORDERS

SUD is prevalent among veterans, with 1.5 million veterans diagnosed with a SUD in the past year (Substance Abuse and Mental Health Services Administration, 2015). Further, 21% of veterans with anxiety disorders or PTSD are also diagnosed with SUD (Petrakis et al., 2011). Although there are no such guidelines for anxiety disorders, current VHA policy states that veterans with co-occurring PTSD and SUD should receive evidence-based treatment for the co-occurring disorders (e.g., concurrent or integrated care) and that co-occurring SUD does not disqualify veterans from receiving treatment for PTSD (US Department of Veterans Affairs, 2017). Co-occurring SUD did not bar veterans from PTSD treatment generally (Mansfield et al., 2017), but there were barriers to receiving care for both PTSD and SUD, including lack of coordination between services and stigma (Browne et al., 2016; Ness, 2014). Although stigma does not necessarily prevent veterans with PTSD from seeking treatment (Sharp et al., 2015), individuals with co-occurring mental health and SUD experience stigma related to both mental health conditions and SUD, even within treatment settings (Matsumoto et al., 2021). Adding another barrier,

PTSD has not been consistently assessed in SUD treatment (US Department of Veterans Affairs, 2010). Some providers in SUD settings report that discussions of trauma can trigger substance use and that there are limitations in effectively treating the co-occurring conditions (e.g., little time available for treating PTSD) (Gielen et al., 2014).

STUDY AIMS

Understanding how patients and providers view current treatment models and practices for anxiety or PTSD when it co-occurs with SUD can inform next steps to improve care for co-occurring mental health disorders broadly. It is critical to also understand how providers view the treatment for co-occurring anxiety disorders and SUD in addition to PTSD and SUD to improve mental healthcare for veterans experiencing these disorders.

Better understanding factors that influence receiving such care, from providers and veterans, may help improve veterans' access and uptake of this treatment approach. The aim of this study was to better understand the perceived needs, barriers, and facilitators of mental health care for individuals with co-occurring SUD and PTSD or anxiety disorders and clinicians who provide services in this population.

METHOD

PARTICIPANTS AND PROCEDURE

Study procedures were approved by the Baylor College of Medicine Institutional Review Board and the VHA Research and Development Committee. All participants provided informed consent. Veterans were recruited through two distinct pathways in a large southwestern VHA medical center. In one pathway administrative data from veterans entering mental health treatment from April–June 2017 were used to identify veterans with anxiety and related disorders, (i.e., panic, social, generalized, and unspecified anxiety disorders, or PTSD) and a co-occurring SUD enrolled in VHA mental healthcare, through International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) mental health diagnostic codes.

Identified veterans received a packet with an invitation to participate in the study or opt-out. Of 137 veterans' records reviewed, 33 veterans were eligible based on diagnoses and were sent opt-out letters and invitations to participate, and 6 completed interviews. In the second pathway veterans could respond directly to advertisements posted throughout the medical center. Seven veterans

responded to study advertisements and were eligible, and 3 completed interviews. Veterans were compensated \$30 for their participation. A doctoral-level psychologist (author AHE) and a research coordinator conducted interviews. Interviews were conducted in person ($n = 6$) or via telephone ($n = 3$) in private clinical spaces (for phone interviews the interviewer was in a private office). Interviews were audio recorded and transcribed.

VHA mental health providers ($N = 7$) were recruited through advertisements in VHA mental health clinic meetings, emails to clinics, and purposive sampling. Providers (i.e., psychologists and social workers) were from three sites, two large southwestern VHA medical centers and one community-based outpatient clinic. Most worked in PTSD specialty clinics (which also treat anxiety and SUD), one worked in a SUD clinic, and one worked in a community clinic treating mental health (including anxiety and PTSD) and SUD broadly. Demographic information was not collected for providers to preserve professional privacy and anonymity, given the small sample size.

Interview guides (see Appendix A and B) were developed by authors AHE and NH. For veterans interview guides (see Appendix A) asked about veterans' anxiety and related disorder history, SUD symptom histories, mental health and SUD treatment histories, barriers and facilitators to receiving treatment for co-occurring disorders, preferences for treatment, and suggestions for improving treatment. Providers (see Appendix B) were asked about their training in treating anxiety and related disorders and SUD, their experiences treating veterans with co-occurring SUD and PTSD or anxiety disorders, perceived barriers and

facilitators in treating those veterans, and suggestions for improving care for veterans with co-occurring SUD and PTSD or anxiety disorders. Semistructured queries allowed interviewers to ask follow-up questions while providing a framework of standard interview items refined during the study for clarity. One interview was conducted per participant. Interview lengths ranged from 15 to 40 minutes.

DATA ANALYSIS

Matrix analysis, a rapid qualitative data-analysis technique (Averill, 2002; Hamilton, 2013), was used to compile responses to interview queries. This analytic approach was chosen given its emphasis on organizing and summarizing data based on areas of inquiry determined prior to interviewing rather than interpretation. This approach has been used successfully to understand healthcare barriers and facilitators (Abraham et al., 2021). In this analysis each item on the both interview guides (see Appendix A and B) queried a particular domain (e.g., treatment history, barriers); with paraphrased and synthesized participant responses for each domain assembled in columns. These domains were formulated a priori, and the interview guides were designed with queries that centered around these domains. These columns were reviewed by first and senior authors for trends or differences among respondents. To enhance analytic validity, template content was illustrated with verbatim quotations from participants (Creswell & Miller, 2000). Key responses are provided in Table 1 (below). Findings from veterans are discussed first, followed by findings from providers.

RESPONSES	VETERAN	PROVIDER
Simultaneous treatment is beneficial	6	5
Sequential treatment is a barrier	2	7
Veteran choice is important factor in decision of simultaneous vs. sequential	1	1
Barrier: Separate clinics for Anxiety/PTSD/SUD	1	2
Barrier: Crowded VA spaces	1	1
Barrier: Clinician stigma related to SUD treatment	NA	1
Barrier: Lack of SUD training, discomfort treating SUD	NA	4
Barrier: Patient factors including suicide risk, self-harm, or risky behaviors	NA	4
Facilitator: Integrated PTSD/SUD services	4	NA
Facilitator: Patient factors such as consistent attendance and taking action towards change	NA	5
Facilitator: Social support	NA	1
Facilitator: Manualized therapy for co-treatment of PTSD/Anxiety and SUD	NA	5

Table 1 Veteran and Provider-Endorsed Factors Related to Treatment of Co-Occurring PTSD/Anxiety and SUD.

RESULTS

VETERANS' BACKGROUND

The total number of participants (both veterans and providers) was 16 (veteran $n = 9$; provider $n = 7$). Demographic data was obtained through the electronic medical record and presented in Table 2 (below). Most veteran participants were male and African American. Veterans reported histories of experiencing anxiety and trauma-related symptoms from 9 to over 40 years. Most veterans had lifetime diagnoses of PTSD, two had lifetime diagnoses of an anxiety disorder, and all were diagnosed with at least one type of SUD. Three noted anxiety symptoms, including panic attacks that began even before serving in the military. All veterans interviewed also reported relatively long histories of substance use and SUD symptoms, with several using substances consistently for over 10 years. Veterans' self-reported drugs of choice included alcohol, cannabis, cocaine, heroin, synthetic opioids, methamphetamine, and gamma hydroxybutyrate (i.e., GHB). All but one veteran interviewed reported that their drug use was at least in part motivated by a desire to dampen or reduce anxiety and/or PTSD symptoms.

Most veterans noted long treatment histories within and outside VHA, with many reporting having been treated with multiple treatment modalities (e.g., pharmacotherapy, individual therapy). Veterans noted several reasons to seek or stay in treatment, including legal consequences (e.g., court mandate), resolving family problems, reducing anxiety and PTSD symptoms, and reducing SUD symptoms.

DEMOGRAPHICS/DIAGNOSES	N (%) OR MEAN (SD)
Male	7 (77.8)
Age	55.1 (11.2)
Race	
African American	5 (55.6)
White	2 (22.2)
Other	2 (22.2)
Hispanic	4 (44.4)
Posttraumatic Stress Disorder	7 (77.8)
Anxiety Disorder	2 (22.2)
Alcohol Use Disorder	6 (66.7)
Cannabis Use Disorder	3 (33.3)
Cocaine Use Disorder	4 (44.4)
Sedative Use Disorder	1 (11.1)
Opioid Use Disorder	2 (22.2)

Table 2 Demographic and Diagnoses of Interviewed Veterans.

VETERANS' NEEDS AND CARE PREFERENCES

Sequential Treatment Barriers

Veterans noted experiencing difficulties related specifically to co-occurring anxiety, PTSD, and SUD, with many citing beliefs that addressing co-occurring disorders simultaneously is beneficial. In contrast, many reported experiencing external requirements for abstinence before being allowed to receive PTSD or anxiety treatment or sequential treatment.

Simultaneous Treatment

Seven veterans noted that they believed addressing anxiety and related disorders and SUD simultaneously was more beneficial. "[I]t can't be one or the other; it has to be both." Six reported being open to integrated treatment, in which anxiety and related disorders are treated simultaneously by the same provider, with one stating, "I don't ever see you accomplishing one without the other." One noted that the choice should lie with the veteran whether to engage simultaneously or sequentially.

Veterans also noted that sequential approaches add assessment burden, and that they would avoid multiple assessments, "Because I'm tired of telling my story over and over again to someone different." Despite participating in programs with such requirements, several veterans noted beliefs that addressing mental health and substance use simultaneously would be beneficial: "I like doing them at the same time. I don't like kind of splitting them up like that." Preference for simultaneous treatment was not universal, as one noted a preference for sequential treatment, stating that stopping substance use makes it easier to then address PTSD and other mental health concerns.

Treatment Barriers and Facilitators

Several veterans described experiencing external motivators (e.g., court-ordered abstinence) or treatment program requirements that encouraged or required abstinence before receiving treatment for other mental health symptoms. Veterans interviewed reported several types of barriers to care: "You've got to wait, you know, another week to get a consult to see the doctor, then another month to actually work on your problem and then just getting appointments and stuff is a real hassle."

Other barriers were specifically related to care for co-occurring disorders, including care housed within separate clinics. One veteran mentioned anxiety about being in crowded VHA spaces, stating "having to face all these people. I'm already a wreck by the time I get in there." More general barriers included transportation, travel time, and family care responsibilities. Regarding treatment facilitators, veterans noted several general facilitators.

One such facilitator was assistance with transportation. Of particular relevance to the cotreatment of SUD and anxiety/PTSD, two noted that integrated SUD and anxiety and related disorders services (e.g., PTSD screening in SUD clinic) helped them find helpful treatments.

PROVIDERS' TRAINING AND BACKGROUND

All providers ($N = 7$) reported being trained in cognitive behavioral therapy (CBT). Five reported training in VHA evidence-based practice (EBP) rollouts (e.g., Prolonged Exposure, Cognitive Processing Therapy), and six reported specific training in anxiety-focused CBT. All reported at least some training in motivational interviewing, and three reported training in CBT for SUD. Five reported some experience treating co-occurring mental health disorders and SUD. Most providers (including those working in a PTSD specialty clinic) noted that treating anxiety was within the scope of their work; one provider described that their job required them to refer anxiety disorders to other providers within the facility.

PROVIDERS' NEEDS AND PREFERENCES

Simultaneous Treatment

Providers considered combinations of motivational interviewing—skills-based cognitive-behavioral interventions for SUD, anxiety disorders, and PTSD—and exposure-based interventions for anxiety and PTSD to be the most appropriate psychotherapies for veterans with co-occurring disorders. Providers described that integrated and transdiagnostic treatment approaches were favorable for use with co-occurring disorders, especially for situations when “one size does not fit all.” Quotes from two providers illustrate this: “I think it’s helpful for providers to feel that they have an approach that addresses more than one dimension of the person”; and “that is the ideal, an integrated model no matter what you’re treating to look at the whole person and who they are and what they’re struggling with.”

All providers reported a belief that requiring abstinence from substances before engaging patients in mental health treatment impedes patient recovery. Providers believed such restrictions to be arbitrary (e.g., requirements for negative urinalysis, 30 days of abstinence). Despite the overall support for opportunities for cotreatment of disorders, one provider related an experience in which a veteran had difficulty using CBT for anxiety skills due to continued cannabis use:

“A person I worked with who used marijuana a lot to manage anxiety and just really struggled with never able to not rely on marijuana and always used that instead of any strategies or anything that we came

up with and that’s what limited her from being able to engage in treatment.”

Stigma, Training, and Patient-Level Barriers

Providers also described clinical and structural barriers to increasing access to such care. Four providers described beliefs that many other clinicians, especially those not in SUD settings, are uncomfortable treating SUD. Providers also noted that in some cases SUD itself adds barriers to mental health treatment (e.g., such as cognitive impairment due to SUD, more complex treatment and case management needs), complicating delivering concurrent and integrated treatment.

Providers described several patient factors that they believe would impact their decision to treat or refer SUD patients with concurrent treatment for anxiety and related disorders, including high suicide risk, being unwilling to quit or cut down substance use, and SUD symptoms that interfere with therapy (e.g., coming into sessions under the influence). To illustrate, one described the criteria regarding referring to SUD-focused treatment versus PTSD treatment: “[I]f they’re not able to take care of themselves, having thoughts of suicide. So if they’re just engaging in highly risky behaviors.” Further, all but one described patient motivation and taking action towards (e.g., consistently attending sessions) addressing SUD as indicators that a patient is “ready” for concurrent therapies aimed at addressing anxiety or trauma.

Clinic Policy Barriers

Most providers described barriers at the system or clinic level, with one provider noting the barrier of abstinence-only clinic policies. Difficulty coordinating care was cited as a problem: “I don’t think that like [the substance use clinic] and [the PTSD clinic] work a lot together or at all together. I haven’t really observed much overlap.” Further, speaking to difficulty coordinating care, providers described siloed mental health and SUD clinics, “We have setup our own sort of silos and ways that people can receive treatment that may not be the best fit for everybody.”

Treatment Content Barriers

Providers described a need for concrete protocols that address both disorders: “Probably the thing that would get me thinking about it starting to integrate more would be a protocol that incorporated it.” One provider noted SUD stigma among other providers (i.e., not those interviewed) as a barrier, and four providers noted lack of training or comfort treating SUD among mental health providers as a barrier. To illustrate, one provider noted: “I don’t think a lot of providers feel comfortable treating patients with

substance use. So, I don't think a lot of people get that type of training."

Treatment Facilitators

Providers noted several potential facilitators of integrated treatment including the need for increased training and awareness to work with veterans who have SUD, reduction of abstinence-based treatment models, increased facilitation of social support, and more intensive case management. We asked providers whether integrated CBT that simultaneously treats anxiety and SUD could address co-occurring disorders, and all reported that such treatment would benefit veterans. Several noted that such a program would need to be protocol driven, easy to use, and easily integrated into day-to-day practice. Providers noted that delivering the VHA EBP rollout therapies for PTSD (i.e., Prolonged Exposure, Cognitive Processing Therapy) leaves little time or flexibility to address SUD: "I feel like I really don't have time to integrate other stuff in, so I feel like it's not a huge focus, though maybe it probably should be more of one." One provider mentioned that a solution, other than distinct protocols for co-occurring SUD and anxiety, would be a brief SUD treatment that could be standalone or paired with VHA EBP rollout treatments.

DISCUSSION

Through qualitative interviews with veterans and VHA mental health providers, this study illuminates factors affecting treatment for veterans with co-occurring SUD and PTSD or anxiety disorders. Overall veterans noted that treatment for co-occurring disorders that occurred simultaneously could be beneficial, with some caveats (i.e., choice should ultimately lie with the veteran). Extending prior work finding that providers identified gaps in training or experience with co-occurring disorders (Priester et al., 2016), providers in the current study identified healthcare system factors such as siloed clinics as barriers. In general providers viewed co-occurring SUD and anxiety or PTSD treatment as requiring unique skill, training, and dedicated time to treat; and these barriers could be reduced by structured approaches to treating these conditions.

Veterans largely preferred treatment settings and treatment approaches that made efforts to integrate, or at least simultaneously provide, care for co-occurring disorders. This aligns with prior quantitative work finding that patients prefer co-occurring disorder care that is concurrent or integrated (Back et al., 2014). Extending Back et al.'s (2014) survey findings and prior work demonstrating the impact of logistical elements on treatment utilization

(Johnson & Possemato, 2019), the qualitative findings of the current study suggest veterans' preferences were in part driven by logistical and comfort elements, such as avoiding disclosure to multiple providers and reduced time and travel burden of multiple sessions for different disorders. An emerging body of work is finding that integrated cognitive-behavioral approaches for anxiety and related disorders with co-occurring SUD can reduce symptoms of both disorders in a single treatment program (Mills et al., 2012; Najavits et al., 2010). These approaches use a single treatment program with key elements of CBT for anxiety and related disorders and SUD in each session of a course of therapy. However, such protocols have yet to be extensively investigated with veterans, especially for anxiety disorders. Future work focusing on these protocols' effectiveness in veteran populations could further extend these findings.

Providers cited beliefs that optimal treatment for co-occurring disorders involves making treatment for both classes of disorder available. Providers also noted that several barriers prevent such approaches from becoming more common in standard practice. VHA has implemented the requirement that each facility have a dedicated PTSD/SUD clinician who interfaces between the programs (Ness, 2014). However, further systematic effort may be needed to help ensure veterans with both conditions receive integrated treatments, and healthcare systems (i.e., non-VHA) without such programs may benefit from systematic integration of mental health and SUD treatment provision. Providers also noted that clinician education may also be a factor influencing coordination of SUD and mental health care for anxiety and related disorders. Supporting current study provider participants' perception of potential stigma or training gaps, a prior survey study of VHA providers found relatively high endorsement of "myths" (e.g., abstinence from substances essential to begin trauma treatment; Najavits et al., 2010). Prior work from a community setting (i.e., non-VHA) has found that brief provider-facing educational interventions can improve providers' confidence in working with patients with SUD (Iheanacho et al., 2020). Identifying education and implementation needs among those who have inaccurate or unscientific beliefs or policies will be an important next step in improving treatment for veterans with co-occurring anxiety/PTSD and SUD in large healthcare systems.

In contrast with prior qualitative work finding provider beliefs were barriers to implementing concurrent treatments (US Department of Veterans Affairs, 2010); providers interviewed in this study described a need for concurrent treatment (although some providers interviewed thought that there may be stigma or other barriers that

prevent veterans from receiving it). Most respondents, both providers and veterans, discussed a need for more integrated care when SUD co-occurs with PTSD or anxiety disorders; however, this preference was not universal across patients and situations. Notably, one veteran preferred to address substance use in treatment before other mental health symptoms. Additionally, providers noted several situations in which simultaneous treatment would be ruled out in their practice, largely centering around safety risks (e.g., suicidality). Taken together these findings illustrate the role of patient preference and clinical judgment in providing care for co-occurring disorders.

Care coordination for SUD and mental health care emerged as an important topic for both veterans and providers. That is both veterans and providers described bridging administrative and clinical gaps between clinics and/or providers involved in mental health and SUD care. Transdiagnostic treatments that address SUD and co-occurring PTSD or anxiety disorders simultaneously, such as integrated CBT protocols or Acceptance and Commitment Therapy (ACT), can address care-coordination problems by reducing the number of sessions and therapists involved in care (Buckner et al., 2019; Buckner et al., 2014; Gloster et al., 2020; Mills et al., 2012). One such treatment for PTSD and SUD, Concurrent treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE; Back et al., 2015) has shown promise for reducing both PTSD and SUD symptoms (Back et al., 2019; Ruglass et al., 2017). However, research on implementation of those approaches, especially those targeting anxiety disorders, has been limited (Berenz & Coffey, 2012). Other care-coordination approaches, such as the VHA PTSD/SUD program, could be applied for co-occurring anxiety disorders and SUD, given the complexity of managing these conditions (Burnam & Watkins, 2006; Minkoff, 2000).

LIMITATIONS AND FUTURE DIRECTIONS

A limitation of the study is that interviews did not include individuals in VHA administrative roles outside the specialty clinic. That is professionals who shape policy on a medical center and regional level may have different perspectives on providing mental health care for veterans with co-occurring disorders. Including such leaders in future work would improve understanding of how to manage competing demands for the healthcare system in treating veterans with co-occurring disorders. Another limitation is the relatively low number of veterans representing marginalized and underrepresented groups, and lack of comprehensive demographic data (e.g., sexual orientation, gender

identity). Future work would benefit from assessment of information beyond the medical record and recruitment of diverse samples.

This study identifies factors that influence mental health and SUD care for veterans with co-occurring disorders from the perspectives of veterans and providers in VHA mental health treatment settings that serve them. Findings underscore the need for innovations in future research, clinical practice, and policy in improving treatment for complex mental health needs, including providing education and training in treating co-occurring disorders, studies that aim to better understand of the effectiveness and implementation of transdiagnostic psychotherapies, and improved coordination of care.

ADDITIONAL FILE

The additional file for this article can be found as follows:

- **Appendixes.** Appendix A to B. DOI: <https://doi.org/10.21061/jvs.v9i1.403.s1>

ETHICS AND CONSENT

Study procedures were approved by the Baylor College of Medicine Institutional Review Board (H-40449) and the VHA Research and Development Committee (17D08.H).

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COMPETING INTERESTS

The authors have no competing interests to declare.

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