Addressing trauma in substance use disorder: a critical gap in service amplified by COVID-19

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While much has been written about the connection between substance use disorder (SUD) and post-traumatic stress disorder (PTSD), little has been done to meaningfully address it. Solutions to the overdose epidemic have focused on pharmacological therapies and decriminalization of drugs, which are essential but not sufficient. As overdose deaths rise across the country amid the COVID-19 pandemic, it is increasingly unacceptable to ignore this gap in service.

Among people with SUD, prevalence of current PTSD (in the last month) ranges from 15% to 42%,[1] which is more than ten times than that of the general population.[2] Trauma often precedes SUD, as individuals with PTSD may use drugs to alleviate distressing symptoms. Having a SUD, particularly while drug use remains criminalized, also increases one's risk of exposure to violence and trauma. Having both SUD and PTSD equates with significantly worse clinical outcomes, including higher rates of relapse, overdose and suicide.[1]

Effective psychological and pharmacological treatments for PTSD exist,[1,3] such as trauma-focused cognitive behavioural therapies and Eye Movement Desensitisation (EMDR). In spite of this, and the obvious intertwining of SUD and PTSD in people's lives, the majority of patients with SUD and PTSD have historically received treatment for SUD only.[1] This is because the majority of addiction treatment in this country is provided by primary care physicians,[4] who are not trained in trauma management. To date, all of the empirically validated treatments for PTSD require a system of highly trained mental health professionals: psychiatrists, psychologists, and specialized trauma therapists. Unfortunately, mental health specialists' costs, highly scheduled models of service, and long wait times make them inaccessible to many patients with severe SUD. As a result, some of the most traumatized patients with SUD have the least access to the help they need.

There is consensus in the literature that an integrated approach that addresses both disorders (SUD and PTSD) at the same time, by the same practitioners, is more effective[1] and often preferred by patients.[5] Despite this evidence, few substance dependence clinics or treatment centers have implemented an integrated approach. Frequently cited barriers include provider education deficit or limited awareness of PTSD resources and treatment, time constraints, physician discomfort addressing violence and of "opening Pandora's box," high case management needs, as well as lack of organizational resources to provide training and ongoing supervision.[6]

The omission of PTSD treatment sets many patients with SUD up for failure. The majority of patients report that their PTSD symptoms worsen after ceasing substance use, making it difficult for people to maintain abstinence.[7] Treatment that targets SUD only is associated, in individuals with comorbid SUD and PTSD, with worse recruitment, retention, outcomes and shorter periods of abstinence post-treatment.[1]

The consequences of not addressing trauma have been amplified by the COVID-19 pandemic and the need for self-isolation. Many people with SUD and underlying trauma already felt segregated before COVID-19. They relied on services which are now limited or unavailable. The most marginalized often do not have phones. A commonly-held belief in the addiction field is that the opposite of addiction is not sobriety, but rather connection. Isolation can worsen PTSD,[8] exacerbating the risk of substance use. Combine this with the greater contamination of the drug supply due to border closures,[9] and the increased risk of overdose when using alone, and the result is a recipe for disaster. On May 29, Canada's Chief Public Health Officer, Teresa Tam, noted that jurisdictions across Canada are reporting increases in overdose deaths. Toronto Paramedic Services reported the highest number of illicit opioid-related fatalities in a month since September 2017. British Columbia recorded its highest ever number of overdoses ever in a single month in May 2020. In speaking to this grim revelation, Dr. Bonnie Henry, B.C.'s Provincial Health Officer said: "It has to do with pain, whether it's physical pain, psychic

pain, whether its emotional pain. And unless we connect with people we don't have an opportunity to address those underlying causes."

So, where do we begin?

There is a paucity of literature when it comes to detailing concrete, affordable ways to integrate trauma and substance use services. This is particularly true for primary care settings. Despite increased awareness of, and motivation toward, the integration of services, community-based treatment providers have lacked specific policy and practice guidelines. The following are three broad areas of improvement through which we will move toward an integrated approach to treating SUD and PTSD.

First, continuing medical education and resident training around trauma-informed care, and PTSD recognition and treatment should be developed and delivered. Family doctors should understand the physiological impacts of trauma on development, be able to recognize PTSD, be aware of the spectrum of psychological and pharmacological treatments available to patients, and know when and where to refer them.

Second, there is an urgent need to develop, validate, and disseminate trauma-focused therapies for PTSD in primary care. Research examining trauma-specific interventions for substance use clients has thus far been mostly restricted to intensive interventions of at least 3-month duration, which are not practical in primary care settings. A precedent exists in SUD for brief interventions. Studies looking at brief interventions for comorbid PTSD and SUD have been promising,[10] and research on innovative resources and methods of delivery must be supported.

Third, we must establish greater integration of mental health and primary care services. One possible approach is collaborative care models, where case managers coordinate care by primary care clinicians and mental health specialists. Another approach involves more mental health specialists embedded within primary care settings. In addition, primary care clinics could offer group therapy to patients with SUD and PTSD employing evidence-based manualized therapy like Seeking Safety, designed for people with both conditions. It is imperative that we develop less onerous pathways of referral to trauma specialists for patients with more severe PTSD.

Providing trauma treatment to people who frequently distrust health-care providers, have limited access to technology, varying degrees of education, and chaotic lives will be challenging. People with lived experience may be an enormous asset in this endeavor. The benefits of peer-delivered services are well documented.[11] Peer-led initiatives have the potential to reach some of the most marginalized clients who avoid or struggle to access the traditional health system, as well as being cost effective and contributing to improved self-determination for a population frequently subjugated by stigma, poverty, and incarceration. Studies on peer recovery support for individuals with SUD show increased treatment retention, decreased drug use and involvement with the criminal justice system, and reduced rates of relapse.[11] Studies focused on peer-delivered trauma treatment are limited but the evidence suggests that, with training and professional supervision, peer providers can play a role in helping communities meet the demand for trauma-specific treatment.[12]

Finally, addressing trauma in SUD must include a conversation about decriminalization and regulation of drugs. Without this, drug users will continue to be stigmatized and face the dangers associated with the illicit market, both of which contribute to worsening trauma and decreased likelihood of seeking help. The role of trauma in the overwhelming loss of lives due to overdose is incontestable and growing more dire. Creative approaches to PTSD treatment are needed to help people suffering from the dual public health emergencies of the overdose crisis and COVID-19. Just as we will not be freed from the grips of coronavirus until a vaccine is found, so too will people with SUD and PTSD not be freed of addiction until they can address the psychological pain driving their drug use.

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References

1. Roberts NP, Roberts PA, Jones N, Bisson JI. Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: A systematic review and meta-analysis. *Clinical Psychology Review*. 2015;38:25-38.

2. Van Ameringen, M., Mancini. C., Patterson, B., & Boyle, M. H. Posttraumatic stress disorder in Canada. CNS Neuroscience & Therapeutics, 2008:14:171-181.

3. Ipser, JC, & Stein, DJ. Evidence-based pharmacotherapy of post-traumatic stress disorder (PTSD). International Journal of Neuropsychopharmacology. 2012;15:825-840.

4. McEachern J, Ahamad K, Nolan S, Mead A, Wood E, Klimas J. A Needs Assessment of the Number of Comprehensive Addiction Care Physicians Required in a Canadian Setting. *J Addict Med*. 2016;10(4):255-261.

5. Back SE, Killeen TK, Teer AP, et al. Substance use disorders and PTSD: An exploratory study of treatment preferences among military Veterans. Addict Behav. 2014;39:369-73.

6. Killeen TK, Back SE, Brady KT. Implementation of integrated therapies for comorbid posttraumatic stress disorder and substance use disorders in community substance abuse treatment programs. *Drug and Alcohol Review*. 2015;34:234-241.

7. Reynolds, M., Mezey, G., Chapman, M., Wheeler, M., Drummond, C., & Baldacchino, A.(2005). Co-morbid post-traumatic stress disorder in a substance misusing clinical population. Drug & Alcohol Dependence, 77(3), 251-258.

8. Charuvastra A, Cloitre M. Social bonds and posttraumatic stress disorder. Annu Rev Psychol. 2008;59:301 328.

9. Mustian J, Blieberg J. Coronavirus pandemic is causing pandemonium in global illicit drug trade. The Globe and Mail. Apr 19,2020.

10. Mills KL, Ewer P, Dore G, et al. The feasibility and acceptability of a brief intervention for clients of substance use services experiencing symptoms of post traumatic stress disorder. *Addictive Behaviors*. 2014;39:1094-1099.

11. Bassuk EL, Hanson J, Greene RN, Richard M, Laudet A. Peer-delivered recovery support services for addictions in the United States: a systematic review. Journal of Substance Abuse Treatment. 2016;63:1-9.

12. Crisanti AS, Murray-Krezan C, Reno J, Killough C. Effectiveness of peer-delivered trauma treatment in a rural community: a randomized non-inferiority trial. Community Mental Health Journal. 2019;55:1125-1134.