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## Substance Use Best Practice Tool Guide

### VETERANS

Division of Clinical Leadership in Collaboration with the  
Division of Substance Abuse Services

## Veterans

Substance use has long been an issue of concern for the military, just as for the U.S. population. Veterans often encounter challenging experiences during their service and some of them turn to substance use as a way to cope with those experiences (Substance Abuse and Mental Health Services Administration [SAMHSA]/CBHSQ, 2015). There have been reports of detailed effects of alcohol on troops dating as far back as the Revolutionary War, and the Civil War saw the addiction of military personnel to opium prescribed for pain. In fact, addiction became known as the ‘soldier’s disease’. Substance issues for military personnel have shifted from decade to decade, but the problem still continues to be a major area of concern today. The all-volunteer military has endured long periods of deployment and re-deployment in highly demanding and taxing environments. Thus, it is not surprising that substance use, as well as posttraumatic stress, suicide, and traumatic brain injury are also at very high levels (IOM, 2013).

Many veterans diagnosed with mental illness also have a substance use disorder (SUD). There are reports that between 21-35% have this co-occurring problem. The highest rates of substance use co-occur among those with schizophrenia and bipolar disorder (Wiley-Blackwell, 2011). SUDs and mental disorders resulted in more hospitalizations among U.S. troops in 2009 than any other cause (SAMHSA, 2014b). Younger adult veterans, ages 18 to 25 years, were more likely to have substance use and other mental health problems than older veterans (NIDA, 2013). The Department of Defense (DoD) strongly discourages substance use by members of the military, largely because of the well-known detrimental effects and negative health consequences on military discipline, levels of performance, and readiness (IOM, 2013).

One of the most prevalent substance use problems for military personnel is alcohol use. Treatment Episode Data Set (TEDS) 2013 data showed alcohol (65 percent) as the most commonly reported primary substance of admissions by veterans, followed by 11 percent for heroin and six percent for cocaine. The 2013 substance use reports for veteran admissions differed from those of nonveterans, who had 37 percent reporting alcohol as the primary substance of use and 21 percent reporting heroin. Veterans were further less likely than nonveterans to report marijuana as the primary substance of use, six percent versus 13 percent (SAMHSA/CBHSQ, 2015).

A study involving Army soldiers screened within three to four months after their return from deployment to Iraq showed that 27 percent met criteria for alcohol use and were at increased risk for related harmful behaviors such as illicit drug use and drinking/driving (NIDA, 2011; Seal et al., 2011). Nearly one in eight veterans returning from Afghanistan and Iraq are referred to counseling for alcohol use. Gender statistics reported in the National Household Survey on Drug Abuse (NHSDA) showed that male veterans were more likely than their female counterparts to report alcohol use, binge drinking, and heavy use of alcohol.

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| <b>Alcohol Use:</b> Male Veterans 56% versus Female Veterans 41% |
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| <b>Binge Drinking:</b> Male Veterans 23% versus Female Veterans 14% |
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| <b>Heavy Drinking:</b> Male Veterans 7% versus Female Veterans 2% (NCADD, n.d.). |
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However, heavy drinking is an accepted custom, part of the military work culture. Alcohol is often used to reward hard work, ease interpersonal tensions, and promote camaraderie and cohesion within units. Alcohol is available to service persons at reduced prices at military installations and especially during ‘happy hours’. The easy access and availability of alcohol on military bases, due in part to cheaper costs, may also have played a role in its increased use (IOM, 2013).

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Illicit drug use and nonmedical use of prescription drugs became popular in the military because they reduced pain, alleviated fatigue, and/or helped in coping with panic or boredom that accompanies battle. Heroin and opium were widely used by service members during the Vietnam War, as well as marijuana. It was estimated that nearly 43 percent of service members who served in Vietnam used these drugs at least once, and half of those who used were dependent on them at some time (IOM, 2013).

Substance use among active military personnel surfaced dramatically with operations in Afghanistan and Iraq, after approximately two decades of decline (Golub, Vazan, Bennett, & Liberty, 2013; ONDCP, 2010; Seal et al., 2011). Military personnel that had seen combat were at particular risk for substance use disorders (SUDs) (ONDCP, 2010). Research suggested that the unsettling surge in substance use by veterans was driven almost exclusively by the steep rise in the misuse of prescription drugs, especially pain relievers (ONDCP, 2010; VA, 2013). Prescription drug misuse in the military was associated with increases in the number of prescriptions for these medications written to alleviate chronic

pain among service members that had sustained injuries during the continuous events of war. The key driver of prescription drug misuse in the military was linked to having a prescription. Military personnel with prescriptions for pain medications were found to be almost three

times more likely to misuse prescription pain relievers than those who did not have a prescription (Bray et al., 2009; Bray, Pemberton, Lane, Hourani, Mattiko, & Babeu, 2010); IOM, 2013).

According to a Journal of the American Medical Association Internal Medicine report, 15 percent of post-deployment U.S. military use opioids, compared to about four percent of the general population (NIH, 2014). Service members may experience extreme difficulty readjusting to civilian life and turn to substances to help them cope (VA, 2012). In the 18-64 age group, the percentage of women and men reporting prescription drug misuse in all military services combined was more than twice that for the civilian population, 11.5 percent compared to 4.4 percent (ONDCP, 2010). Female veterans tended to use prescription drugs to a greater extent than alcohol (NCADD, n.d.). In fact prescription drug use among women on active duty was more than four times that for civilian women (13.1 percent versus 3.2 percent). Moreover, service women, except those in the Marine Corps, were more likely than their male counterparts to use illicit drugs. Women in the Army were more than twice as likely as men in the Air Force, Navy, and Coast Guard to have used illicit drugs, including prescription drugs used nonmedically, in the past month (ONDCP, 2010).

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## Screening

A Web site titled My HealtheVet offers online screening tools amid other information for substance use as well as mental health conditions for veterans, military personnel, persons concerned about veterans/military personnel, and providers. This site has a plethora of resources, but the number of available resources makes access somewhat arduous to maneuver. The user needs to be patient and have sufficient time to actually navigate the site. For example, screening tools are not in plain sight. A person has to search and seek them out. The user should go to <https://www.myhealth.va.gov/index.html>, and then under Veteran's Services, Health & Well-Being, choose Mental Health. A new window will open and then go to the local navigation links on the left side of the page, select Conditions, then Substance Use. The last click should open the following page: <http://www.mentalhealth.va.gov/substanceabuse.asp>. Scroll down slightly to see the link to an “assessment”. The screen asks about experiences using various substances including tobacco across the lifetime and in the past three months.

The My HealtheVet Web site is an educational and informational site as well. Veterans/military personnel and/or those concerned about them or who work with them can also find out about the numerous services that are available through the United States Department of Veterans Affairs. Veterans can further manage their healthcare needs through the site.

There is a Self-Check Quiz that veterans/military personnel or those concerned about them can take online by accessing <https://www.vetselfcheck.org/Welcome.cfm>. Scroll down to see the link to the quiz. It provides a safe and easy way to find out whether there might be issues related to depression and/or stress. This quiz was developed collaboratively by the Department of Veterans Affairs, National Suicide Prevention Lifeline, and American Foundation for Suicide Prevention.

## Recommended Treatments

Six manualized treatments have demonstrated efficacy in treating SUDs in veterans. These are (1) **motivation enhancement therapy** (MET), (2) **cognitive-behavioral coping skills therapy**, (3) **community reinforcement approach**, (4) **behavioral couples therapy** (BCT), (5) **contingency management** (CM), and

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(6) **twelve-step facilitation**. MET employs motivational interviewing along with assessment and personalized feedback. It is designed to help the veteran resolve ambivalence regarding

his or her use of substances. Identification and alteration of thoughts and behaviors that promote the substance use is the focus of cognitive-behavioral coping skills therapy. The veteran is educated about the model, collaborating with the therapist to identify and use different thoughts and behaviors and using role plays and behavioral rehearsals. Homework opportunities are typically provided through this model as well. The community reinforcement approach is a comprehensive cognitive-behavioral approach that focuses on aspects of the veteran’s environment that either supports or hinders his or her substance use. Many techniques are incorporated including teaching new coping skills, involving significant others, and conducting a functional analysis of the substance

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use. These techniques are designed to assist the veteran in creating a reinforcing sober lifestyle. BCT has a two-fold purpose—reducing the substance use while improving the marital relationship. The veteran’s partner is involved to help reinforce abstinence, reduce the risk of relapse, and improve communication. Behavioral incentives are used in CM to help maintain sobriety. Incentives can consist of vouchers for goods and/or services or money. Sobriety is objectively measured via toxicology screens. Finally the twelve-step facilitation works to engage or increase engagement of the veteran in 12-step programs such as AA. These treatments have demonstrated efficacy across various substances. However, the veteran’s motivation and current life situation, provider training/expertise, and the extent of available resources factor into delivery and potential for success (Borsari et al., 2011).

In addition, many veterans in the United States have a co-existing mental health disorder. Moreover, being young places a veteran at higher risk for serious psychological problems and/or co-occurring disorders. There is evidence that one third of veterans from the wars in Iraq and/or Afghanistan have psychiatric problems, with 20 to 40 percent in need of treatment. Post-traumatic stress disorder (PTSD) and SUD tend to co-occur very frequently in veterans. Research supports integrated versus sequential or parallel care approach to treating veterans. This approach has been shown to be more sensitive to the needs of the veteran service recipient, more cost effective, and to result in more successful outcomes. Further, the simultaneous treatment of co-occurring disorders through the integrated approach is preferred by service recipients and hence promotes better treatment adherence. *Seeking Safety* is an effective manualized program developed for use in the treatment of co-occurring PTSD and SUD and has been used with veterans. The intervention has demonstrated efficacy in reducing PTSD symptoms as well as substance use. *Seeking Safety*’s success with the veteran population is emerging but recent pilot studies involving veterans of the Iraq and Afghanistan wars showed significant difficulty with treatment engagement and retention (Borsari et al., 2011).

Among the strategies for delivery of SUD treatments include stepped care, step-down treatment, and extended monitoring. Stepped care may be necessary for veterans who do poorly during or following the first step of treatment. They would then be introduced to a more intensive level of treatment, preferably in an individual setting with the same treatment provider each time. The goal of stepped care would be to increase treatment adherence and satisfaction while providing the right dosage of care. Step-down treatment might then be an effective way to discontinue treatment. It would allow for a gradual way to reduce the level of care intensity as opposed to abruptly ending with high-dosage treatment. Extended monitoring is then recommended to minimize the potential for relapse. The VA’s telehealth technology system can serve as a valuable resource for extended monitoring services (Borsari et al., 2011).

A 2010 study utilizing these strategies with participants in intensive outpatient therapy for alcohol dependence found them to be an effective and efficient way to maintain gains made 18 months following treatment. As more veterans enter the system, a wealth of data will continue to be available for better understanding and improvement of the lifelong course of substance use and predictors of relapse for this population (Borsari et al., 2011).

## Other Treatment Issues

Irrespective of the approach or program, there are several issues that must be addressed when working with veterans.

1. Monitor the veteran's sobriety to the extent possible (Borsari et al., 2011).

Drug testing should be conducted throughout treatment to help encourage sobriety during sessions. Additionally, assist the veteran in creating a safety plan in the event sobriety is compromised.

2. Educate the veteran on his or her SUD (Borsari et al., 2011).

The veteran should be educated about his or her substance(s) of choice and how it affects the body. It may also be necessary to educate the veteran about the impact of his or her substance use on treatment and the ability to achieve treatment goals.

3. Address short-term distress associated with treatment (Borsari et al., 2011).

Sometimes treatment involving co-occurring substance use and mental health disorders in veterans lead to an increase in distress, thereby making substance use more appealing. Clearly explaining the possibility of short-term distress early during treatment will help prepare the veteran for the occurrence. In addition, alternate coping strategies should be discussed to offer options outside of substance use

4. Involve significant others in treatment to the extent possible (Borsari et al., 2011).

Research has shown inclusion of a concerned significant other in SUD treatment increases the probability that change will take place, especially if the veteran has a dependence on alcohol. Inclusion is encouraged early in treatment, e.g., during the first or second session. This allows for delivery of psychoeducation to the veteran and his or her family member/partner as well as an opportunity to assess relationship functioning. These individuals can also be sources of valuable information about the veteran's substance use. Assessment of relationship functioning will be critical to identify which, if any, significant other(s) should be included into treatment.

## Treatment Facilities

A large number of veterans use the Veterans Health Administration (VHA), the healthcare system within the Department of Veterans Affairs (VA), when seeking treatment for substance use. Fortunately, the VHA has an extensive record-keeping system containing all data from lab work to session notes, so clinicians working with veterans should initially encourage the veteran to obtain these records. Of course, appropriate release of information forms must be completed so that coordinated care can be provided. It is further imperative that veterans be encouraged to report all medications they are currently taking. Any resistance to obtaining the data should be explored. The clinician and veteran should also address concerns that his or her involvement in treatment will be disclosed to officers to whom the veteran reports and/or fellow veterans early on, as well as over the course of treatment. Limits to confidentiality should further be clearly defined (Borsari, Capone, Mastroleo, & Monti, 2011).

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Other veterans and military personnel may seek treatment from community based services. Many fear of discrimination or harm to their military career or that of their partner if treatment is received through Veterans Affairs (VA). Community-based care is typically the choice of National Guard and Reserve troops who have served in Iraq and Afghanistan, as well as their families, despite their eligibility for services through the VA (SAMHSA, 2014b). Of veterans in community-based treatment, slightly more than 20 percent were identified as homeless. However, homelessness was more prevalent

among older than younger veterans in treatment (25 percent versus 14 percent)

(SAMHSA, 2014a).

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Of course, there are veterans who are aware of their need for treatment but refuse to seek it. For some veterans/military personnel, admitting the need for help is inconsistent with the mental toughness prized in the military (Golub et al., 2013).

## **Sample of Additional Resources for Veterans**

- Veterans Crisis Line

<http://www.veteranscrisisline.net/>

800-273-8255

Press 1, chat (<http://www.veteranscrisisline.net/ChatTermsOfService.aspx>) or text 838255

- American Red Cross and Armed Forces Emergency Services (AFES)

<http://www.redcross.org/find-your-local-chapter>

- Military Support Groups and Centers

<http://www.military.com/spouse/military-life/military-resources/military-support-groups-and-centers.html>

- Military OneSource

<http://www.militaryonesource.mil>

- National Veterans Foundation

<http://nvf.org/>

- Vet Centers

<http://www.vetcenter.va.gov/>

- Warrior Care Blog

<http://warriorcare.dodlive.mil/>

The Rural Health Information Hub (RHIhub, n.d.) also provides information regarding access to health care for rural veterans since a disproportionate number, including veterans with service-related injuries, live in rural American.

## Conclusion

Research on substance abuse and associated problems among this country's military personnel, veterans, and their families is ongoing. NIDA, in collaboration with the U.S. Department of Veterans Affairs and other Institutes within the National Institutes of Health (NIH), continues to enhance and accelerate research on the epidemiology/etiology, identification, prevention, and treatment of tobacco, alcohol, and other drug use and abuse, including prescription and illicit drugs, as well as associated mental health problems among recently separated or active-duty military troops and their families. Much of the research is focused on veterans returning from wars in Iraq and Afghanistan (NIDA, 2011). A wealth of information and resources for service providers working with veterans and other military personnel can be found on the SAMHSA Web site (SAMHSA/CBHSQ, 2015).

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