A Basic Guide to Assisting Veterans with Substance Use Disorders

NYASAP

Alcoholism and Substance Providers of New York State, Inc. (ASAP) Veterans Committee

The ASAP Veterans Committee seeks to enhance the quality of prevention, treatment and recovery services designed to meet the needs of veterans. Our committee seeks to help promote and educate service providers on best practices to ensure that the special needs for veterans are met. We also help coordinate and promote networking and collaboration opportunities between providers that offer veteran services.

Unfortunately, Veterans often experience severe physical and/or emotional stress that puts them at risk for developing trauma-related conditions like Posttraumatic Stress Disorder (PTSD), tobacco use, alcohol abuse, and other substance abuse as one means of coping with the physiological and/or psychological distress they endure. Indeed, evidence indicates that Veterans are significantly more likely than their non-Veteran counterparts to use and abuse alcohol, while prescription abuse is on the rise among both active-duty military personnel and Veterans alike.

Fortunately, as a result of the Veterans Access to Care through the Choice, Accountability, and Transparency Act of 2014, Veterans have more options related to where they can receive care for their substance use and mental health conditions. Regardless of where it is offered, however, this care should be culturally sensitive and tailored to the specific needs of military Veterans and their families. Evidence suggests that people experience better treatment outcomes when they are provided coordinated assessment and intervention for both PTSD and Substance Use Disorder (SUD), and when families are involved in the recovery process.

- About 10% of military Veterans meet diagnostic criteria for SUD
- Nearly a third of Veterans seeking treatment for SUD also have PTSD
- Over a quarter of Veterans who are identified with PTSD also have SUD

A range of valid and reliable screening and assessment instruments are available for helping detect SUD and PTSD. Some of these are available to the public and can be completed privately and confidentially, self-scored, and then shared with a healthcare professional. Links to some of these screening and assessment tools can be found at the ASAP website: www.asapnys.org

Alcohol Use Disorders Identification Test Consumption Questions (AUDIT-C)

- A 3-item alcohol screen with a score of 4 or higher indicating possible misuse, and a score of greater than 7 indicating possible dependence. If a respondent scores greater than 4, further evaluation, referral and/or intervention is/are warranted.

Single-Item Alcohol Screening Questionnaire (SASQ)

- A single-item alcohol screen with a score of 0 to 1 indicating lower-risk drinking, and a score of 2 to 4 indicating higher-risk drinking. If a respondent scores greater than 2, further evaluation, referral and/or intervention is/are warranted.

The CAGE Questionnaire

- A 4-item alcohol screen with an answer of "Yes" to one or more of the questions indicating that further evaluation, referral and/or intervention is/are warranted.

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

- An 8-item structured interview with overall scores ranging from 0 to 31 for tobacco and 0 to 39 for other substances. The higher the score, the greater risk the current pattern of substance use poses to the respondent's functioning in terms of health, finances, social and legal relationships.

Brief Addiction Monitoring (BAM)

- The Brief Addiction Monitor (BAM) is a 17-item measure to assess substance use and related risk and protective factors, as well as progress in treatment programs. These factors can be measured over the past seven days (BAM-IOP) or the past 30 days (BAM-R).

Beck Anxiety Inventory (BAI)

- A 21-item anxiety screen with overall scores ranging from 0 to 63. The higher the score, the greater degree of anxiety the respondent likely experiences.

Posttraumatic Stress Disorder Checklist (PCL-5)

- A 20-item screen utilized to measure criteria components to begin to detect presence and severity of PTSD symptoms. The screen can assist in quantifying symptoms toward making a provisional diagnosis or monitor symptom change over time. The PCL-5 is not a stand-alone measure, but instead indicates whether further evaluation, referral and/or intervention is/are warranted.

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

- A 30-item structured interview that can be used to either diagnosis PTSD and/or assess PTSD symptoms over the past week.

Generally, evidence-based intervention paradigms for assessing, diagnosing, and treating dual-diagnoses should involve offering early transitional assistance for Veterans separating from military service, while also normalizing and reinforcing adaptive core military values and emphasizing self-efficacy and hope.

EVIDENCE-BASED TREATMENTS

Substance Abuse Disorders (SUD)

- Individual, Couples, and Group Cognitive Behavioral Therapy
- Motivational Enhancement
- 12-Step Facilitation
- Harm-Reduction
- Relapse Prevention
- Pharmacological/Medically-Assisted Treatment

Post-Traumatic Stress Disorder (PTSD)

- Individual, Couples, and Group Cognitive Behavioral Therapy
- Cognitive Processing Therapy
- Prolonged Exposure Therapy
- Acceptance and Commitment Therapy
- Eye Movement Desensitization and Reprocessing Therapy

Despite the range of empirically-supported treatments and resources available, not all Veterans whose symptoms warrant treatment will seek or receive it due to implicit and explicit access obstacles. Fortunately, we are aware of some of these barriers , and some of the ways toward overcoming them.

- **Barrier:** Lack of awareness about availability or eligibility criteria for services

  Solution: Publicize and distribute a comprehensive, coordinated SUD treatment locator.

- **Barrier:** Lack of SUD providers who are also Veterans and/or who are aware of military culture.

  Solution: Hire qualified Veterans and/or military-affiliated staff (e.g., National Guard/Reserve) and engage all staff in military culture sensitivity training or cultural immersion programming.

- **Barrier:** Negative perceptions of VA and/or lack of access to VA-based facilities.

  Solution: Highlight clinically-supported usefulness of engaging Veterans Health Administration hospitals and clinics for care and link all Veterans with local, state, and federal Veteran Outreach Centers.

- **Barrier:** Military discharge type might render a potential client ineligible for some services/service sites.

  Solution: Support Veterans is correcting service records and link all Veterans with local, state, Veteran Outreach Centers and clinics.

ASAP VETERANS COMMITTEE MEMBERS

Roy Kearse, LCSW, Chair
Samaritan Daytop Village

Diane Gonzalez, CEO, MSW, Chair Queens Village Committee for Mental Health for JCAP, Inc.

Katie Burbee, LMHC
Horizon Village, Inc.

Ricky Cottingham, MSW, CASAC, CRCT

Danny Eglowitz
Dynamic Youth Community, Inc.

Samuel Hall, MA, MAC, CASAC, CCTP
St. Joseph's Addiction Treatment and Recovery Centers

Carolyn T. Jackson, PhD
Syracuse VAMC/Rome CBOC

Nicholas Jefferson, LMSW, CASAC-G, FDC, SIFI
VIP Community Services

Sherry LaFountain
Alcoholism & Substance Abuse Providers of NYS

James McFarlane, LMSW
Samaritan Daytop Village

Christal Montague, MSW, LMHC, CASAC, CARC
VIP Community Services

Wilfredo Muniz, Jr., MS, MHC
VIP Community Services

Paul Noonan
NYS OASAS

Zachary Randolph, MA, MAC, CASAC, CAMS-1
St. Joseph's Addiction Treatment and Recovery Centers

Jessica Shuren, LMSW, CASAC
Outreach

Julia Floyd Ventura, CASAC
Phoenix House

ASAP Veterans Committee

11 North Pearl Street, Suite 801
Albany, New York 12201

518.426.3122
518.426.1046 fax

www.asapnys.org