

This Practice Guidance focuses on men and women, who have served in the US military, so that providers may be better able to identify and engage these individuals in treatment.

I. RATIONALE

Bureau of Substance Addiction Services (BSAS) [Principles of Care](#) highlights the understanding that vulnerability to substance use disorders can be affected by individual experiences, personal characteristics, life stage, environment, and health, among other factors. Effective treatment responses must be guided by understanding the experiences, strengths, and needs of the individual. To engage veterans, two broad areas of understanding are key: diverse experiences and characteristics and military culture.

Diverse Experiences and Characteristics: Each era of service has different hallmarks. In terms of substance use, for example, the Vietnam War saw an increase in use of heroin and opiates,¹ while the post-9/11 military has seen a tripling of prescription drug abuse.² Many veterans and active duty service members have served multiple tours, resulting in high rates of behavioral health issues³. SAMHSA reports that 11% of those serving in OEF-OIF (Operation Enduring Freedom [Afghanistan] and Operation Iraqi Freedom [Iraq]) have a diagnosed substance use disorder.⁴ This estimate is probably low since it is based only on those who seek help through the Veterans Administration (VA) healthcare system. Some veterans may be reluctant to seek help, while others who have not been honorably discharged are ineligible for VA services.

The population of service personnel is diverse in other ways. Even the word ‘veteran’ is understood differently among those who have served, as well as among the general population. For example, some who have served but received an other-than-honorable discharge may not think of themselves as ‘veterans,’ even when their discharge resulted from consequences of service experience such as combat-related Post-Traumatic Stress Disorder (PTSD) episodes of violence. Others who served but were not in a combat area may hesitate to apply the term ‘veteran’ to themselves. And still others, who saw combat and were honorably discharged, avoid identifying themselves as such, possibly to avoid questions. Therefore, BSAS recommends using the phrase ‘ever served in the U.S. military’ in intake and assessments to encompass the full population.

Experiences and needs also vary by era. The post-9/11 era is the longest period of war in U.S. history, waged by a volunteer armed services, including National Guard and Reserve Units. Subject to multiple deployments and separations from family, friends, and community, men and women are exposed to an extraordinarily high number of combat episodes¹, including individuals in non-combat roles. Many survive severe injuries that in previous eras would have been fatal⁵, often leaving individuals in chronic pain. It is estimated that at least 20% of those who served in combat areas have suffered traumatic brain injury (TBI), where symptoms may be slow to emerge, or may go undetected, and thus untreated. Veterans Affairs healthcare system reports that between 37% and 50% of OEF and OIF forces have been diagnosed with a mental health disorder, most commonly PTSD and depression.⁶ Suicide among active duty and discharged personnel is a growing concern.

¹ Institute of Medicine (IOM) *Substance Use Disorders in the US Armed Forces*, <http://www.iom.edu/Reports/2012/Substance-Use-Disorders-in-the-US-Armed-Forces.aspx>

² ibid

³ <https://www.recoverymonth.gov/sites/default/files/toolkit/2016/military-veterans-families.pdf>

⁴ SAMHSA *Behavioral Health Issues among Afghanistan and Iraq U.S. War Veterans* <http://store.samhsa.gov/product/Behavioral-Health-Issues-Among-Afghanistan-and-Iraq-U-S-War-Veterans/SMA12-4670>

⁵ PEW Research *For many injured veterans a lifetime of consequences*

⁶ Behavioral Health Issues etc. SAMHSA

The VA reports⁷ that in 2014, an average of 20 Veterans died by suicide each day and the risk for suicide was 22 percent higher among Veterans compared to U.S. civilian adults. In distinguishing by gender, the suicide rate among male Veterans was 19 percent higher, and among women 2.5 times higher than the general population.

Vietnam-era (1964 – 1975) personnel demonstrate the reality that care for those who serve can span decades; this group currently comprises the largest portion of surviving seriously injured veterans (33%).⁸ Those who served were largely a conscripted military, in a war with widespread popular opposition, a powerful factor in inhibiting ability to seek help. This population, including women, defined and described PTSD, and are still teaching us about its long-term effects: 26% of men and women who served in Vietnam combat areas had PTSD symptoms, and four out of five of those are still symptomatic decades later. There are key clinical precautions, for example due to significant evidence of increased risks associated with chronic benzodiazepine use in patients with PTSD and addiction^{9,10}, the VA's practice guidelines for PTSD recommend against the use of benzodiazepines for treatment of PTSD (see resources below).

Between the end of the Vietnam War and 9/11, the U.S. military saw action, including combat, in areas such as Lebanon, Granada, Panama, Somalia, Bosnia, Haiti, and Desert Storm in the Persian Gulf—each characterized by different experiences of violence and different long-term effects.

While women officially served in combat roles only as of 2013, they have frequently served in combat areas as support and medical personnel. As a result, they also experience PTSD, TBI, and severe physical injuries, especially in OEF-OIF-OND (Operation New Dawn), despite their non-combat status. As Vietnam veterans taught us about PTSD, women are teaching us about Military Sexual Trauma (MST), which includes sexual assault and threatening sexual harassment. This betrayal, most often perpetrated by fellow unit members, occurs within an organization that places a high value on loyalty, teamwork, strength, and self-sufficiency—values that compound the trauma and inhibit help-seeking. Experienced by both women and men,¹¹ these veterans are three times more likely to receive a mental health diagnosis than their peers.

Women and men along with their families and communities experience the effects of deployment and combat exposure: traumatic separations, disrupted relationships, and a bewildering array of injuries and traumatic symptoms.

Military Culture: The second key factor in engaging veterans is understanding the culture of the military. This is critical in building relationships that are clearly safe and trustworthy, so a 'cultural competency' approach is useful. This means, for example, treatment personnel's understanding that reluctance to engage in open sharing of experience is evidence of ingrained training in combat readiness (Battlemind)¹² rather than evidence of resistance. In other words, it is important to understand military cultural values of toughness, skill, and endurance; sharing information on a 'need to know' basis only; and loyalty to unit. These values may contribute to what recent research has spotlighted as 'moral

⁷ *Suicide Among Veterans and Other Americans 2001-2014*

<https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>

⁸ Pew Research Center, *For many injured veterans, a lifetime of consequences:*

<http://www.pewsocialtrends.org/2011/11/08/for-many-injured-veterans-a-lifetime-of-consequences/>

⁹ PAIN: *March 2018 - Volume 159 - Issue 3 - p 407-408* doi: 10.1097/j.pain.0000000000001128

Commentary

¹⁰ Benzodiazepines and PTSD: https://www.ptsd.va.gov/public/treatment/therapy-med/benzodiazepines_ptsd.asp^B

¹¹ Based only on VA Health Administration identifications, 23.6% of women and 1.2% of men receiving VA health care.

¹² Often referred to as 'battle mind.' See the Department of Defense Post Deployment Health Resources pamphlet available at <http://www.ptsd.ne.gov/pdfs/WRAIR-battlemind-training-Brochure.pdf>

injury:¹³ the transgression of deeply held beliefs and values, for example making a mistake, failing to prevent loss of life, or taking a life. This injury compounds shame, further inhibiting the ability to share and seek help. This culture also complicates return to civilian life, adding stressors on the veterans and their families, friends and communities, who expect a return to previous openness and interactions. Understanding ‘Battlemind’ (an outcome of military training and combat experience) will go a long way toward understanding service members’ responses.

Military service sets these individuals apart from their peers in other ways. For example, younger men and women often carry substantial responsibility, including command, in the military; but find few such opportunities upon return to civilian life. Challenges and frustration of everyday life can seem insignificant and petty to veterans, exacerbating alienation both within a treatment setting, and in their community of family and friends.

Understanding these factors can support substance abuse treatment providers in engaging those who have served in the military, to identify risk of conditions such as PTSD, TBI, or chronic pain; and in drawing on the array of resources available so that they can quickly connect individuals to needed help.

II. GUIDANCE

A. Organization

Policy:

- Policy states agency’s affirmative commitment to engage veterans.
- This commitment is demonstrated by Qualified Service Organization Agreements (QSOAs) supporting:
 - Active collaboration with veterans’ services.
 - Established linkages with veterans’ peer organizations.
- Agency assesses whether discharge policy adversely affects veterans, for example whether policy requires discharge for the specific behavior that prompted treatment or that requires referral for treatment.
- Policy states agency’s commitment to engage family, in broadest terms, i.e. including same or opposite sex spouses and partners, friends, parents, grandparents, and children.

Operations:

- Case management services are able to connect veterans with a broad array of formal and informal services, including resources for those with ‘other-than-honorable discharge.’
- Case managers are knowledgeable about military culture and language.
- Residential programs are alert to respond supportively to nightmares and sleeplessness.
- Agency staff assess potential environmental triggers, such as nearby loud noises.

Supervision, Training & Staff Development:

¹³ Moral Injury in the Context of War, National Center on PTSD, https://www.ptsd.va.gov/professional/co-occurring/moral_injury_at_war.asp

- Agency reviews trauma training to ensure inclusion of:
 - Service-related trauma (both for veterans and their families).
 - Grief.
 - Moral injury.
 - Vicarious trauma (for staff, as well as veterans and their families); and
 - Interaction of physical injuries and of co-occurring conditions.
- Agency engages veterans' service organizations for cross training, and for training and consultation in military culture.
- Supervisors are knowledgeable about vicarious traumatization.
- Agency takes a 'cultural competency' approach to understanding culture of military and is sensitive to veterans as 'minorities' in the agency's treatment population.
- Supervisors and agency training prepare staff to respond to veterans in groups, e.g. differences in 'war stories,' impatience with complaints perceived as 'petty.'
- Agency ensures staff are trained in assessing suicide risk.

B. Service Delivery and Treatment

Engagement:

- Screening and intake procedures ensure everyone is asked 'have you ever served in the U.S. military;'
- Agency establishes a 'sticky-fingers' approach for anyone who answers the question 'ever served in the U.S. military' affirmatively; i.e. keeps the individual engaged while assessing the best service match;
- Staff are alert to cues for those who may avoid being identified: history gaps, hesitation in answer 'ever served in the U.S. military' question;

Assessment - Staff:

- Assess for co-occurring disorder and history of injury.
- Assess suicide risk.
- Identify family, friendship, and community relationships and assess current status of these relationships.
- Are sensitive to service-related losses, for example, friends and unit members.

Case Management - Staff:

- Are able to connect veterans to:
 - Local veterans' services organizations and other peer organizations.
 - Resources to pursue educational benefits.
 - Assistance in translating military experience to civilian employment terms.
- Actively engage, and advocate for, veterans who are reluctant to seek help, so that they may obtain needed resources.

Engaging Families:

- Agency defines family broadly, including same or opposite sex spouses and partners, children, friends, siblings, and parents (of adults).
- Staff acknowledge family's trauma, can refer families to needed resources, and assist family in understanding veterans' experiences and needs.
- Staff acknowledge the important role of caregivers and can connect to needed resources specific to the needs of caregivers.

Education:

- Staff educate individuals about interaction of physical injuries and of co-occurring conditions.

III. MEASURES

- Agency conducts periodic surveys of individuals served to assess responsiveness to those who served in the military;
- Agency conducts periodic surveys of staff regarding experiences in engaging those who have served.

IV. RESOURCES

Massachusetts:

Department of Veterans Services: <http://www.mass.gov/veterans/> Offers comprehensive information and services regarding benefits, resources, education and employment and services for veterans. The DVS has established regional Statewide Advocacy for Veterans Empowerment (SAVE), and local Veterans' Services Offices. Among many resources available are information and links for:

- Health Care: <http://www.mass.gov/veterans/health-and-well-being/healthcare/>
- Outreach: <http://www.mass.gov/veterans/health-and-well-being/outreach-centers.html>
- PTSD & Military Sexual Trauma: <http://www.mass.gov/veterans/health-and-well-being/ptsd-and-mst/>
- Traumatic Brain Injury: <http://www.mass.gov/veterans/health-and-well-being/tbi/>
- Domestic Violence: <http://www.mass.gov/veterans/health-and-well-being/domestic-violence-resources.html>
- Families: <http://www.mass.gov/veterans/health-and-well-being/family/>
- Women veterans: <http://www.mass.gov/veterans/women-veterans/>

MassVetsAdvisor: This organization can help veterans and their families identify and advocate for needed resources: <http://www.massvetsadvisor.org>

New England Center for Homeless Veterans: A service center for veterans who are at risk of becoming, or who are homeless. <http://www.nechv.org>

RAND Corporation: [Interactive Resource Tool](#)

Guide to Veterans Law and Services: A compilation of state benefits in the areas of education, employment, housing, motor vehicles, property taxes, and medical assistance. <http://www.sec.state.ma.us/cis/cisvet/vetidx.htm>

Peer Organizations:

Disabled American Veterans Massachusetts Department: <http://www.davma.org/>

Vietnam Veterans of America: <http://www.vva.org>
Veterans of Foreign Wars <http://www.vfw.org>
American Women Veterans: <http://americanwomenveterans.org/home/>
Iraq and Afghanistan Veterans of America: <http://iaava.org>
American Veterans: <http://www.amvets.org>
American Legion: <http://www.legion.org>
Military Order of the Purple Heart: <http://www.purpleheart.org>

SAMHSA:

Military, Veterans, and Military Families: Support for Those Who Serve |
<https://www.recoverymonth.gov/sites/default/files/toolkit/2016/military-veterans-families.pdf>

Military Families:

<http://www.samhsa.gov/militaryfamilies/>

Meeting Needs of Veterans and Military Service Members in Access to Recovery Projects:

https://www.eiseverywhere.com/file_uploads/8386aa0f0119d03c3417fc5018773d5d_TAPackag_e_MeetingNeedsOfVets.pdf

SAMHSA Advisory: Treating Clients with Traumatic Brain Injury:

<http://store.samhsa.gov/product/Treating-Clients-With-Traumatic-Brain-Injury/SMA10-4591>

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

<http://store.samhsa.gov/product/SMA09-4381>

VA and Department of Defense:

[US Department of Veterans Affairs](#)

VA Crisis Line: 24/7 response line for veterans in crisis: 1-800-273-8255.

Center for Women Veterans: <http://www.va.gov/womenvet/>

[Community Provider Toolkit](#)

GI Bill: <http://gibill.va.gov/benefits/>

Education and career counseling: http://gibill.va.gov/support/counseling_services/index.html

PTSD: Benzodiazepines and PTSD https://www.ptsd.va.gov/public/treatment/therapy-med/benzodiazepines_ptsd.asp

Walter Reed Army Institute of Research: *Battlemind Training: Transitioning from Combat to Home*: a brochure describing the 'battlemind' and the challenges of transition.

<http://www.ptsd.ne.gov/pdfs/WRAIR-battlemind-training-Brochure.pdf>

National Center for PTSD Resources:

<https://www.ptsd.va.gov/>

Agent Orange:

VA Agent Orange Website:

<http://www.publichealth.va.gov/exposures/agentorange/>

Benefits (for those who served in Korea and Vietnam):

http://www.benefits.va.gov/compensation/claims-postservice-agent_orange.asp

VA Reports on Veterans and the General Population:

http://www.va.gov/vetdata/veteran_population.asp

Other Resources:

Battlemind Resources:

U.S. Army Medical Department Resilience Training:

<https://www.army.mil/readyandresilient/>

Department of Defense Post Deployment Health Resources pamphlet available at

<http://www.ptsd.ne.gov/pdfs/WRAIR-battlemind-training-Brochure.pdf>

Training Materials: <http://fhp.osd.mil/pdhrainfo/battlemind.jsp>

Center for Deployment Psychology:

<http://deploymentpsych.org/learn-now>

Environmental Health Registries:

<https://www.publichealth.va.gov/exposures/benefits/registry-evaluation.asp>

Gulf War Syndrome: Summary of current findings:

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0063903>

Institute of Medicine:

Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families

<http://nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>

Substance Use Disorders in the US Armed Forces:

https://www.nap.edu/resource/13441/SUD_rb.pdf

Invisible wounds of war: A study of PTSD, major depression and TBI:

http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf

National Council for Behavioral Health:

<http://www.thenationalcouncil.org/topics/veterans/>

Resources for Caregivers:

VA Caregiver Support: <https://www.caregiver.va.gov/>

VA's Caregivers Support Line: 1-855-260-3274

VA Registry:

<https://www.publichealth.va.gov/exposures/benefits/registry-evaluation.asp>

Military and Veteran Caregiver Network:

<https://milvetcaregivernetwork.org/>

Hidden Heroes Caregiver Community:

<https://hiddenheroes.org/>

Elizabeth Dole Foundation:

<https://www.elizabethdolefoundation.org/>

Training Resources:

PsychArmor or Institute: <https://psycharmor.org/>

Uniformed Services -Center for Deployment Psychology: <http://deploymentpsych.org/psychological-training>

War-Related Illness and Injury Research Center:
<http://www.warrelatedillness.va.gov/WARRELATEDILLNESS/index.asp>

BSAS welcomes comments and suggestions. Contact: BSAS.Feedback@state.ma.us.

ⁱ Keane, T.M. (2013) Recent advances in the psychological treatment of PTSD. National Center for PTSD, Presentation at Massachusetts School of Professional Psychology.