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Alcohol and Drug Use in Military Veterans

Center for Deployment Psychology

Uniformed Services University of the Health Sciences

Disclaimer

The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Learning Objectives

1. Describe common trends in alcohol and drug use amongst civilian and military populations.
2. Identify strategies for screening and assessing civilian and military clients for substance use disorders.
3. Discuss evidence-based treatments for substance use disorders.

Presentation Outline

- New Military, DOD, and VA Guidelines (IOM, 2013)
- Prevalence of Substance Use and Problems
- Active Duty Health-Related Behaviors Survey and Use Among Veterans
- DSM-5 SUD Criteria and Symptoms
- Comorbid Conditions with SUDs and Challenges
- Brief Screening Measures and Interventions to Assess SUDs

Presentation Outline (con't)

- Obtaining Accurate Self-Reports
- Using a Motivational Interviewing Style and Motivational Strategies
- General Trends in SUD Treatment and Stepped Care: Adapting Treatment to Problem Intensity
- Evidence-Based Treatments for SUDs
- Managing and Preventing Relapses
- Medications to Assist in Treatment of SUDs
- Additional Resources

New Military, DoD and VA Guidelines (IOM, 2013)

IOM 2013 Report: Far Reaching Committee Charge

- Substantial and expansive charge involving several areas and subpopulations
- Collected information from several sources
- Compared all information with best practices and modern standards of care in scientific literature

Institute of Medicine (2013)

Committee Offered Many Recommendations for DoD, Service Branches, and TRICARE

- Use of **evidence-based practices** in SUD care integral to ensuring that individuals receive effective, high-quality care
- Policies of DoD and individual branches should promote **evidence-based diagnostic and treatment processes**
- Best practices for SUD treatment should include use of agonist and antagonist medications
- DoD should **conduct routine screening** for unhealthy alcohol use, together with brief alcohol education interventions

Institute of Medicine (2013)

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Prevalence of Substance Abuse and Problems

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What Substances Are Used?

Same as civilians, but military members seem to gravitate more toward:

- **Alcohol**
  Legal (used to self-medicate)
- **Marijuana**
  Most used illicit drug lifetime, past 12 mos., & 30 days
- **Cocaine, other stimulants and synthetic stimulants**
  Can be used to stay alert

National Institute of Drug Abuse

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What Substances Are Used?

- **Opiates**
  Vicodin and OxyContin
  Becoming more widespread;
  Used to self-medicate
- **Synthetic Marijuana** (e.g., Spice)
- **Synthetic**
  Cathinones/Amphetamines (e.g., Bath Salts)

National Institute of Drug Abuse

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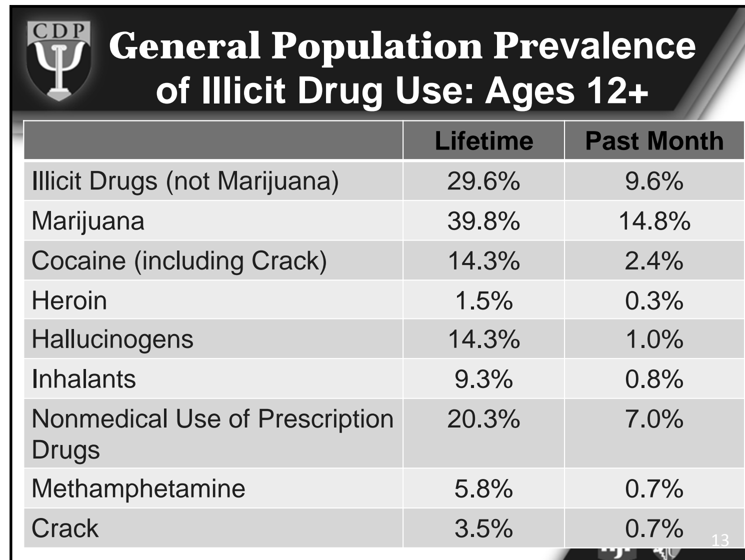
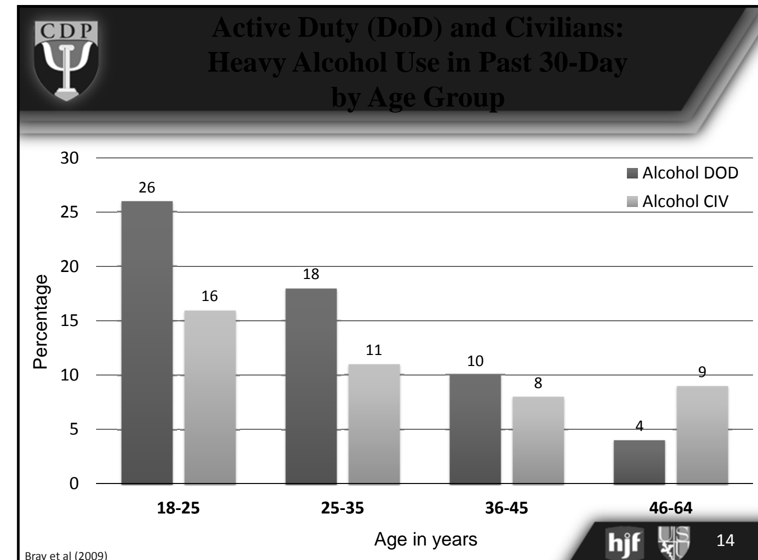
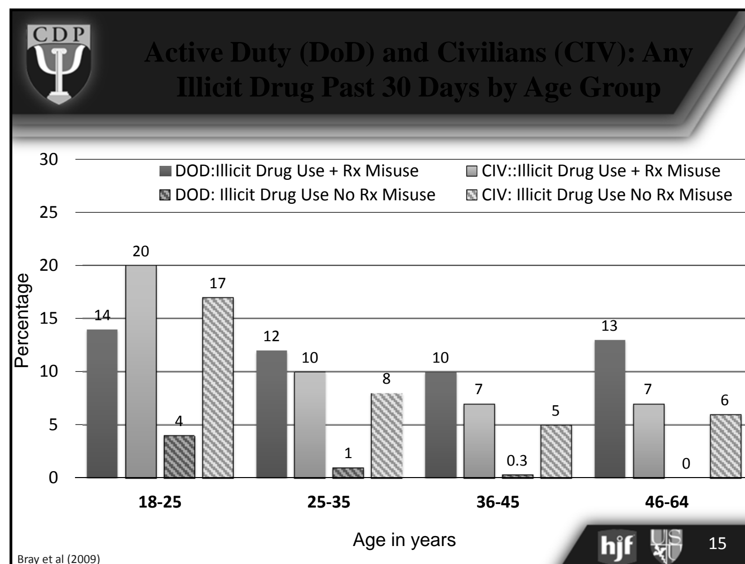


General Population Prevalence of Illicit Drug Use: Ages 12+

	Lifetime	Past Month
Illicit Drugs (not Marijuana)	29.6%	9.6%
Marijuana	39.8%	14.8%
Cocaine (including Crack)	14.3%	2.4%
Heroin	1.5%	0.3%
Hallucinogens	14.3%	1.0%
Inhalants	9.3%	0.8%
Nonmedical Use of Prescription Drugs	20.3%	7.0%
Methamphetamine	5.8%	0.7%
Crack	3.5%	0.7%





Substance Use Among Veterans and Comparable Non-veterans

Variable	Veterans	Non-Veterans
Alcohol Use past 30 days	57%*	51%*
Binge Alcohol Use	23%	22%
Heavy Alcohol Use	8%*	7%*
DSM-IV Alcohol Abuse/Dep	6%	6%
DSM-IV Alcohol Dep	3%	3%
Illicit Drug Abuse	2%	1.4%
Substance Use Tx past year	0.8%*	0.5%*

Wagner et al (2007)

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Active Duty Health-Related Behaviors Survey and Use Among Veterans

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Active Duty: 2011 DOD Health Related Behaviors Survey Definitions

- Abstainer
- Former Drinker
- Infrequent/Light Drinker
- Moderate Drinker
- Heavy Drinker
- Binge Drinker

Dept of Defense (2013)

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Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey

- 40% of current drinkers reported binge drinking
- 12% active duty had **AUDIT** scores ≥ 8 (suggestive of alcohol problem)
- < 1% reported being in treatment or would seek treatment in next 6 months

Dept of Defense (2013)

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Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey (con't)

- **Top 3 reasons for drinking:**
  1. To celebrate (50%)
  2. Enjoy drinking (46%)
  3. To be social (33%)
- Only 11% said they drank to forget problems and 14% when in a bad mood

Dept of Defense (2013)

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Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey (con't)

- **Any illicit drug use reported past 30 days:**
  - < 1% past 30 days
  - 1% past year
  - 28% reported use lifetime

Dept of Defense (2013)

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Combat Experience

Having combat experience is associated with increased substance abuse problems

Could be related to:

- Coping with stress/trauma
- Loneliness
- Deployment culture
- Lessen fatigue

*Bray et al. (2009); Jacobson et al. (2008); IOM (2013)

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Barriers to Treatment

"Service members commonly reported concerns related to stigma as barriers to treatment, particularly concerns related to their military career, functioning, and relationships with command and peers."

Institute of Medicine (2013)

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DSM-5 SUD Criteria and Symptoms

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DSM-5 SUD Criteria

"A problematic pattern of alcohol or other drug use leading to clinically significant impairment or distress, as manifested by at least 2 of 11 symptoms occurring within a 12-month period."

American Psychiatric Association (2013)

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DSM-5 Substance Use Disorder Symptoms

In the past 12 months:
• Have often used in larger amounts or over longer periods of time than intended
• Have often wanted or tried to cut down or control use
• Have spent a lot of time either using, trying to obtain, or recovering from the substance
• Gave up or reduced involvement in important social, occupational, or recreational activities because of substance use
• Continued to use despite knowing it likely caused or made worse psychological or physical problems

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DSM-5 Substance Use Disorder Symptoms (con't)

In the past 12 months:
• Had to use greater amounts to get desired effect, or affected less by same amount
• Experienced withdrawal symptoms, or used to avoid or relieve withdrawal symptoms
• Did not fulfill major obligations at work, school, or home due to substance use
• Repeatedly used substance in situations that were physically hazardous
• Experienced strong desires, urges, or cravings to use the substance
• Continued to use despite persistent or recurrent social or interpersonal problems caused by or made worse by use

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Comorbid Conditions with SUDs and Challenges

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Comorbidity Caution

High prevalence of comorbidity with SUDs

Co-occurrence does not mean causality

- Drug abuse can cause one or more symptoms of another mental heath problem
- Mental health problems can lead to substance use disorders

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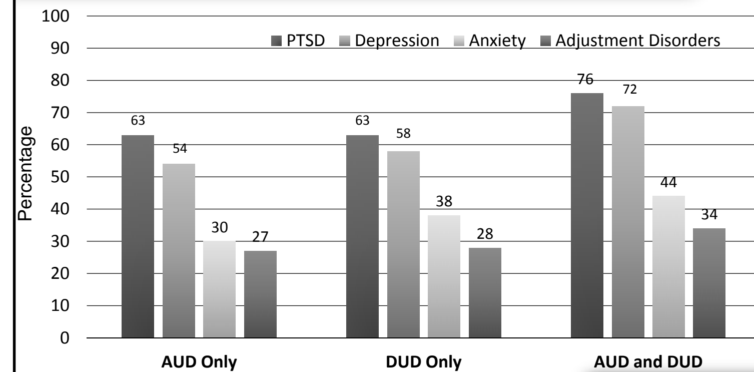
Prevalence of Comorbid Military Service Mental Health Problems Associated with Alcohol (AUD) and Drug (DUD) Use Disorders in Iraq and Afghanistan



Seal et al (2011)

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Comorbidity in Veterans

"…having PTSD is associated with a higher prevalence of problems with alcohol, pain, and sleep."

Stecker et al. (2010)

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Challenges to Working with SUDs and Other Psychiatric Problems

Three General Treatment Approaches

- **Parallel**: Strong support for concurrent (in ≥ 2 programs, MH & SUDs)
- **Integrated**: Both disorders in one program; difficult to implement - requires staff skilled in both problems
- **Sequential:** In second program after first (SUD then PTSD); issue - can one problem be placed on hold?

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Brief Screening Measures and Brief Interventions to Assess SUDs

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% Alcohol Content by Volume 1 Standard Drink =

Alcohol Type	% Alcohol Content	Number Ounces	Total Oz. Alcohol
Beer	5%	x 12	= 0.6 oz.
Wine	12%	x 5	= 0.6 oz.
Hard Liquor (e.g., gin, whiskey)*80 proof	40%	x 1.5	= 0.6 oz.

1 standard drink = 14 gm. absolute ethanol

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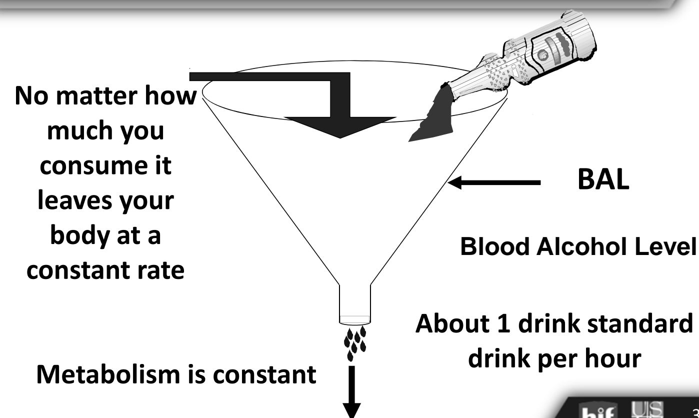
Alcohol Metabolized at Constant Rate in Healthy Adults



Multiple references

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Why Use Brief Screening Measures to Assess Alcohol, Drug, & Nicotine Use?

Most measures ....

- Have been lengthy and time consuming to administer and score; thus, cannot provide immediate feedback to patients
- Not sensitive to the full continuum of those with SUDs (e.g., young problem drinkers)
- Consequently, most substance use assessment measures not well-integrated into standard clinical care

Sobell, Sobell & Robinson (2013); Sobell & Sobell (2003); Maisto, Connors & Dearing (2007); Earlywine (2009)

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Brief Alcohol Screening Measures

- Alcohol Use Disorders Identification Test (AUDIT-10)
- AUDIT-C
- Quick Drinking Screen (QDS)
- Single Binge Drinking (SBD) Question

Note: Participants have handouts of all these screens.

Brief Drug Screening Measures

- Drug Abuse Screening Test (DAST-10)
- Opioid Risk Tool (ORT)

Note: Participants have handouts of these 2 screens.

Obtaining Accurate Self Reports

Where Do We Get Most Information About Our Patients?

- **Answer:** Self-reports, regardless of the SUD
- In addictions field, long-standing distrust by many clinicians - that is, you cannot trust SUD patients' self-reports.
- **Question:** Is this accurate? **Answer:** No!
- **How do you know?** 60-plus research studies from '70s on have shown that on a group basis SUD patients report accurately about their alcohol and drug use.
- **So why the distrust?** It might relate to how some practitioners interact with their patients.
- **Accurate information can be obtained from patients when** they're guaranteed confidentiality, substance use free, and when asked in a clinical or research context.

Connors et al (2003); Babor et al (2000); Sobell et al (1992)

Why Don't Substance Abusers Report Accurately Sometimes?

Stigma: Single biggest reason why substance abusers say they avoid or delay entering treatment

- Most individuals with SUDs do not see themselves as severely dependent and they are not
- A motivational approach can be successfully used to help motivate patients to consider changing

IOM (2013); Oleski et al (2010); Klingemann & Sobell (2007)

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Using a Motivational Interviewing Style and Motivational Strategies

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What is Motivational Interviewing?

- Often thought of as an intervention, but it is NOT a treatment
- Communication skills that are motivational rather than judgmental in nature
- Uses principles and techniques based on models of therapy and behavior change techniques
- Designed to help patients explore their ambivalence about changing

Multiple references

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Benefits of Using a Motivational Interviewing Approach

- Significantly reduced health care costs
- Increased compliance with medication and treatment recommendations
- Improved outcomes
- Greater patient satisfaction

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1

Motivational Interviewing

Different Way of Talking with People that Uses a Specialized Set of Communication Skills

Does not use stigmatizing language
(e.g., alcoholic, drug addict, you have a problem)

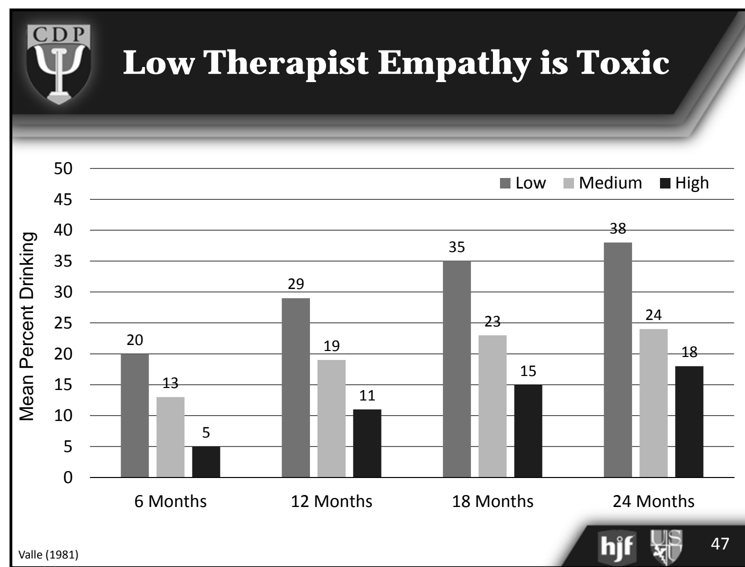
Conversational and empathetic

Avoids being judgmental
Instead of: *"How many years have you had an alcohol problems?"*
Ask: *"Do you mind if we talk about your alcohol use? What concerns you most?"*

Empathy: Key Feature In Motivational Approach

- **WHY?** High levels of empathy associated with positive outcomes
- Key to expressing empathy through **Reflective Listening**
- Listening in a reflective manner demonstrates an understanding of patients and validates their concerns

Moyers et al (2013)



Self-Efficacy

- Self-efficacy is positively associated with SUD treatment outcomes.
- For most patients, substance use is situational, and they have low self-efficacy for handling those situations without using substances.
- *Brief Situational Confidence Questionnaire* is a short easy psychometrically sound way to identify high risk situations.

Sobell & Sobell (2011); Witkiewitz & Marlatt (2004); Breslin et al (2000)

Slide 45

1	Paula Domenici, 1/3/2014

Main Types of High-Risk Situations

Typology first developed by Marlatt and now supported by other researchers:

- Unpleasant emotions
- Physical discomfort
- Conflict with others
- Testing control
- Urges and temptations
- Pleasant emotions
- Social pressure
- Pleasant times with others

Breslin, Sobell, Sobell & Agrawal (2000); Connors, Maistro, Donovan (1996); Marlatt & Gordon (1985)

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READINESS RULERS
Assess Readiness to Change

Definitely NOT Ready To Change

Definitely Ready To Change

On a scale of 1-10, how ready are you **at the present time** to change?

MI Scaling Tool to Build Self-Efficacy

Multiple references

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General Trends in SUD Treatment and Stepped Care: Adapting Treatment to Problem Intensity

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General Trends in SUD Treatment

- Use brief interventions, brief assessments, and stepped care approach
- Use outpatient treatments before intensive options
- Use a less confrontational and more empathic motivational style to interact with patients
- Integrate pharmacotherapy with psychotherapy

Multiple references

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General Trends in SUD Treatment (con't)

- Provide SUD interventions in primary care
- Combine psychiatric and SUDs treatments
- Quitting smoking now addressed with other SUDs
- Use of web-based social networks and gaming approaches to facilitate engagement

See list for references

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Treatment Needs To Be

- Attractive
- Accessible
- Affordable
- Effective

Incorporating *patient preference* and *good customer service* are essential principles for this new system of care.

Multiple references

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Services and Alcohol Problem Intensity

Institute of Medicine (1990)

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STEPPED CARE

Multiple references

Evidence-Based Treatments for SUDs

Evidence-Based Treatments for SUDs

- Brief and Web-based Social Media Interventions
- Cognitive Behavioral Therapy (CBT)
- Motivational Enhancement (MET)
- 12-Step Facilitation (TST)
- Contingency Management
- Community Reinforcement and Family Training (CRAFT)
- Behavioral Couples Therapy (BCT)
- Family Systems Approach
- Methadone Maintenance

Dept of VA & DoD (2009); Institute of Medicine (2013); Miller & Wilbourne (2002)

Brief Interventions

Not a single treatment but a collection of interventions

- **Primary Goal:** Reduce alcohol and drug use below risk levels
- **Primary Focus:** Increase motivation to change by weighing the pros and cons of the substance use
- **Intervention Time Varies:** Self-change materials, apps, 5-min discussion with a health care practitioner, one or a few outpatient sessions

Multiple references

Web-based Social Media Interventions

- **iSelfChange App:**

https://itunes.apple.com/us/app/iselfchange/id761033899?ls=1&mt=8

Evidence-based app for problem drinkers (21-35) based on promoting self-change studies.

Mirtenbaum et al. (2013)

iSelfChange Screenshots and Menu

Home

1. Intro to iSelf-Change app
2. My use of alcohol in the past 60 days
3A. Where does your drinking fit in? Men
3B. Where does your drinking fit in? Women
4. AUDIT score
5A. Decisional balance introduction
5B. Decisional balance exercise
6. Tips for changing your alcohol use
7. Tips for quitting smoking cigarettes
8. Weekly log

Where does your drinki...

Drinking Levels For Men

From the 2010 National Alcohol Survey (N=7,969) Alcohol Research Group, Berkeley, CA.

Decisional balance intro...

THINKING ABOUT CHANGING YOUR DRINKING

WEIGHING DECISIONS

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Cognitive-Behavioral Therapy (CBT)

- Empirically supported in multiple RCTs and has consistently been superior to most other interventions
- Focuses on modifying thinking and/or behavior for substance use and other areas of life functioning
- Central features
  - o Brief time limited
  - o Functional analysis of substance use
  - o Coping skills training
  - o Cognitive restructuring

Multiple references

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Motivational Enhancement Therapy (MET)

- Similar to motivational interviewing but with a more directive approach to increase awareness of ambivalence about change, promote commitment, and enhance self-efficacy
- More structured than motivational interviewing

Project MATCH Research Group (1988)

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Behavioral Couples Therapy (BCT)

- Focus is on the dyadic relationship
- Goal is to decrease substance use and improve overall marital satisfaction for both partners
- Sobriety Contract is used
- Positive feelings, shared activities, constructive communication are factors conducive to sobriety

Epstein & McCrady (1998); Walitzer & Dermen (2004)

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Contingency Management Approach

- Incorporates substance users' social system into the treatment plan
- Uses rewards for specific behavioral recovery goals
- Core of contingency management is reinforcement of abstinence
- Effective with drug abuse to establish early recovery and continuous abstinence

Community Reinforcement And Family Training (CRAFT)

- Goal is to rearrange multiple aspects of one's life so sober lifestyle is more rewarding than one with alcohol and/or drugs
- Focuses on environmental factors that impact and influence patients
- Uses family, social, recreational, and occupational events to support sobriety

Family Systems Approach

- Members are interdependent
- Patterns of interaction in the family influence the behavior of each family member
- Interventions target and provide practical ways to change patterns of interaction
- 8-24 sessions

Earlywine (2009); Kaufman & Kaufmann (1992); Miller et al (2005)

12-Step Facilitation Treatment

Developed for NIAAA's Project MATCH

- Manualized 12 sessions of individual outpatient therapy
- Although based on the 12-Step principles of AA emphasizing surrender and turning oneself over to a higher power, this is a psychotherapy It is not AA.
- Encourages participation in AA and completing the first 4 steps

Project MATCH Research Group (1998)

Managing and Preventing Relapses

Marlatt's Relapse Prevention Model

- Hypothesizes that in presence of high-risk situations, if people don't exercise effective coping response, self-efficacy will be reduced.
- Combined with expectation of short-term positive effects from substance use, this can lead to lapse or slip and becoming a full relapse if patients view a slip as indicating inability to control behavior.

Witkiewitz & Marlatt (2004)

Managing Relapses

- **Stop slip as soon as possible** to minimize consequences and risks
- **View slip as learning experience**; i.e., Why did it occur then? What could be done to avoid a similar slip in the future?
- Do not ruminate. **Take long-term perspective on recovery** and view the slip as a bump in the road rather than the end of the road

Sobell & Sobell (2011)

Identifying High Risks Situations Related to Relapse

Identifying these types of situations can lead to developing treatment strategies.

Examples:

- For persons whose high-risk situations involve negative affect, focus on managing feelings and realistic ways of reducing stress (e.g., being assertive)
- For persons whose high-risk situations involve social pressure, focus on how to reduce pressure or avoid those situations

Witkiewitz & Marlatt (2004)

Harm Reduction Approach with SUDS

- Meet patients where they are; seek to attract patients who otherwise would not get treatment.
- For patients not willing to commit to abstinence, negotiate reduction in use and develop plans to minimize risks.
- Reduced use means reduced risks and helps keep patients in treatment.
- Avoid high risk settings.

Marlatt (1998); Tatarsky & Marlatt (2010)

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Medications to Assist in Treatment of SUDs

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Role of Medications in Management of SUDs

- Detoxification
- Relapse Prevention
- Maintenance (harm reduction)

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Role of Medications in Detoxification of SUDs

Reduce intensity of withdrawals by tapered (gradual) reduction of dose

Ameliorate withdrawal symptoms

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Role of Medications for Detoxification of Alcohol Withdrawal

Benzodiazepines

- Cross-tolerant with alcohol
- Minimize withdrawal symptoms
- Some (e.g., Valium) have anti-convulsant properties

Kosten & O'Connor (2003)

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Role of Medications for Detoxification of Cocaine Withdrawal

- No proven pharmacologic treatment
- For symptom reduction some use of desipramine, amantadine, and propanolol

Wee Kosten & Connor (2003)

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Role of Medications for Detoxification of Opioid Withdrawal

- **Buprenorphine** (Subutex) taper
- **Methadone** taper
- **Naloxone** (naltrexone, narcan): antagonist for rapid detox over 12-24 hours and for relapse prevention
- **Clonidine** (antihypertensive) reduces symptoms

Wee Kosten & Connor (2003)

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Role of Medications in Relapse Prevention of SUDs

- **Naltrexone** (Revia, Vivitrol; for alcohol): Reduces high, suppresses craving
- **Acamprosate** (Campral; for alcohol): Used mainly in Europe; reduces high, suppresses craving
- **Antabuse** (disulfiram, for alcohol): Interferes with acetaldehyde metabolism causing toxic reaction which is like systemic allergic reaction
- **Naltrexone** (for opiates)

Renner (2012)

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Role of Medications in Maintenance of Heroin Addiction

- **Methadone**
  - ✓ Longer half-life
  - ✓ Can overdose by taking other opiates
- **Suboxone**
  - ✓ Longer half life
  - ✓ Agonist-Antagonist

Renner (2012)

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Additional Resources

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Major Websites

National Institute on Alcohol Abuse and Alcoholism
http://www.niaaa.nih.gov
National Institute on Drug Abuse
http://www.drugabuse.gov
Substance Abuse & Mental Health Services Administration (SAMHSA) http://www.samhsa.gov
Web of Addictions
http://www.well.com/user/woa/
Medline Plus (National Library of Medicine)
http://www.nlm.nih.gov/medlineplus/drugabuse.html
Center for Substance Abuse Research
http://www.cesar.umd.edu/cesar/drug_info.asp
World Health Organization
http://www.who.int/topics/substance_abuse/en

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Key Website Publications and Resources

- Institute of Medicine. (2013). Substance Use Disorders in the U.S. Armed Forces. Washington, DC: National Academy of Science (400 page report)
- Southeastern Consortium for Substance Abuse Treatment (SECSAT)

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Key Website Publications and Resources

- Allen, J. P., & Wilson, V. (2003). *Assessing alcohol problems (2nd ed.)*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.htm
- **NIAAA:** Resources and publications on alcohol use and alcohol-related problems http://www.niaaa.nih.gov/publications
- **NIDA:** Resources and publications on drug use and drug-related-problems http://www.drugabuse.gov/publications/media-guide/nida-resources

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Key Website Publications and Resources

- National SBIRT ATTC Suite of Services http://ireta.org/toolkitforsbirtRethinking
- Rethinking Drinking: Alcohol and Your Health http://rethinkingdrinking.niaaa.nih.gov/
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) Clinician's
- Guide http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- SAMHSA publications http://store.samhsa.gov/facet/Substances
- *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*, by the Rand Corporation, 2008. http://www.rand.org/multi/military/veterans.html

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Key SUD Books

- Earlywine, M. (2009). *Substance use problems*. Cambridge, MA: Hogrefe.
- Maisto, S. A., Connors, G. J., Dearing, R. L. (2007). *Alcohol use disorders*. Cambridge, MA: Hogrefe.
- Peterson, A. L., Weg, M. W. V., & Jaén, C. R. (2011). *Nicotine and tobacco dependence*. Cambridge, MA: Hogrefe.
- Shaffer, H., LaPlante, D. A., & Nelson, S. E. (2012). *APA addiction syndrome handbook. Volume 1* (1st ed.). Washington, DC: APA.
- Shaffer, H., LaPlante, D. A., & Nelson, S. E. (2012). *APA addiction syndrome handbook. Volume 2* (1st ed.). Washington, DC: APA.

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CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

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Online Learning

The following online courses are located on the CDP website at:

http://www.deploymentpsych.org/content/online-courses

NOTE: All of these courses can be take for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

How to Contact Us

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