RESOURCE LINKS
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SPECIAL ISSUE

Substance Use Disorders and the Veterans Population

NORTHEAST attc
The Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

OVERVIEW

By Thurston Smith

Reports indicate that each year 18 - 20 million people in the United States require treatment for alcohol and other substance use disorders; however, only 3.5 million people receive the care they need (NSDUH, 2003). In 2000, almost two million veterans (six percent of the U.S. population of veterans) reported using illicit drugs and approximately 324,000 Veterans Administration (VA) patients had substance use diagnoses (NSDUH, 2003). In 2000, the number of veterans admitted to addiction treatment exceeded 55,000 admissions (TEDS, 2000)—a growing concern.

"Substance abuse disorders remain one of the top three diagnoses in the VA system," says Dr. Richard T. Suchinsky, Department of Veterans Affairs (DVA), Associate Chief for Addictive Disorders. Research continues to suggest the increased need for evidenced-based treatment strategies, enhanced clinical practices and improved programming within the VHA.

The Challenge of the Veterans' Health Administration (VHA)

Among America's estimated 750,000 homeless, approximately 250,000 - 270,000 are veterans. Likewise, chronic homelessness has been a recurring problem in the U.S. for decades and a major undertaking for the Veterans Health Administration. Ongoing research in this area suggests that those veterans who are at greatest risk for homelessness today are those who served during the late and post-Vietnam eras. Of those veterans, approximately 45 percent suffer with mental illness, while over 70 percent suffer from chronic substance use disorders (Cooney, 2003). These conditions often occur because homeless individuals are not accessing the necessary medications and/or appropriate counseling services.

The American Psychiatric Association (APA) Task Force on Homelessness stated in their June 20, 2001 testimony before the House Veterans' Affairs Health Subcommittee on Veterans' Affairs Mental Health, Substance Abuse, and Homelessness Programs:

. . . alcohol and other substance use disorders continue to be a major national health care problem. Numerous studies show that rates of alcohol and other drug use disorders are high among veterans within the VHA health care system. To its credit, VHA made significant progress during the past three years in screening all primary care patients for alcohol misuse, which has resulted in identifying additional patients in need of specialized treatment services.*

Seemingly, the collaborative efforts of varying federal agencies, including the Department of Veterans Affairs, may help reduce the number of homeless substance dependent persons across the country. The 34th Annual Meeting of the National Advisory Committee on Rural Health, held on February 7, 2000, included a discussion on homelessness and substance use disorders in rural communities. The committee found that:

These problems are not just in urban areas but in rural areas too. The VA is the leading provider of hands-on care to the homeless in the United States and possibly for addiction treatment as well. There are initiatives in rural areas in conjunction with States, such as the Homeless Grant Per Diem Program. Under this program, the VA helps build facilities and provides per diem for vets who use these facilities. For addiction treatment, the VA strives to deliver mental health services through primary care services, which are available through the community-based outpatient clinics.

With the VA being the largest single provider of addiction treatment and mental health care treatment in the U.S., and with at least one third of America's homeless population being veterans, it's reasonable to suggest the VA take a lead role in addressing the disparaging connection between our homeless, mentally ill, and addicted populations. Although the VHA's effort to systemically identify, admit, and treat its troubled population of homeless/mentally ill/addicted veterans has been a priority, access to treatment and benefit eligibility continue to be a concern for the future health of today's service men and women.

Summary

With substance use disorder prevailing as America's #1 public health problem, along with the additional challenges of homelessness, unemployment and global terrorism, our active duty personnel and veterans, who have given much sacrifice for our well being, now require our committed service to them. Justin Cohen, Association for Addiction Professionals (NAADAC) Director for Public Relations, summarizes the challenge succinctly:

The numbers of veterans who suffer from addictive disorders is added impetus for eliminating the stigmas, misconceptions, and sometimes misguided policies that surround the disease. Addiction is a medical condition-a chronic disease-not a character flaw. Even the bravest among us, our nation's veterans, develop the disease, and in fact, in some cases they may be at higher risk. It's incumbent upon us to make quality, evidenced-based addiction treatment services readily accessible as part of veterans' care. Treating addiction may have many secondary benefits, such as easing the difficult transition to civilian life, encouraging positive ways of coping with the horrific traumas endured and helping veterans become healthier members of their families and communities. Veteran health care physicians should always perform screenings and be prepared to consult with an addiction professional. America's addictions-focused professionals stand ready to do their part.

FOOTNOTE: On April 1, 2004 VA Secretary Anthony Principi became chair of the U.S. Interagency Council on the Homeless. This council was reactivated to help focus attention on and coordinate efforts to eradicate homelessness and address the mental health and addiction needs of veterans.

Thurston S. Smith, is a Mental Health Care Coordinator for the Veterans Health Administration and is the Southeast Regional Vice President for NAADAC, The Association for Addictions Professionals.

Clinical Considerations in the Treatment of Veterans with Substance Use Disorders

By Wendy Merrill, Psy.D.

Veterans receive specialty care services for substance use disorders (SUD) at 153 VA medical centers nationwide. The Center for Treatment of Addictive Disorders (CTAD) at the VA Pittsburgh Healthcare System (VAPHS) treats over 560 veterans annually in residential rehabilitation and another 1500 annually in the center's outpatient clinics, which include a clinic dedicated to the treatment of co-morbid SUD and Post Traumatic Stress Disorder (PTSD), and an opioid substitution therapy clinic.

FACT:

■ Veterans accounted for 65,000 admissions at publicly funded substance abuse treatment facilities in 1999 (Office of Applied Studies [OAS], 2001)

For both veterans and non-veterans, addiction is a chronic disorder requiring ongoing management and treatment. Periodic exacerbation and relapses are not uncommon, and treatment adherence and motivation often fluctuates. Veterans share many issues common to those with addictive disorders; however, there are demographic differences and clinical concerns which are unique to this population, and which have important implications for treatment.

Age

Compared to non-veterans, veterans seeking treatment for SUD tend to be older. Nationally, 54% of veterans are age 50 and older (Office of Drug Control Policy [ONDCP], 2001). Although ranging in age from 23-79, the average veteran seen in CTAD is 47 years old, with the vast majority (71%) concentrated between the ages of 41-55. Forty percent are 50 years or older. When age is factored into veterans' drug of choice patterns, significant distinctions emerge, revealing greater frequency of alcohol dependence, followed by combined alcohol and poly-prescription dependence (e.g., pain medications and anxiolytics) among those 60 and older.

As older clients in recovery, veterans present with different social and occupational adjustment concerns which relate to treatment focus and which relapse prevention must target selectively. Noting the greater relative age, and hence more years and greater progression towards addiction, veterans are also likely to experience an accumulation of functional losses. Veterans are also more likely to present with complicating medical conditions, often directly associated with their addiction (Moos, Brennan, and Mertens, 1994), and frequently present with chronic pain conditions which complicate addictions treatment. Management of recovery stressors associated with phase of life transitions and accumulated losses associated with social or physical functioning are frequent priority treatment targets. Coordination and continuity of care within primary medical and specialty medical care settings are imperative elements for an effective recovery system.

Drug of Choice Patterns

Nationwide, 33% of veterans enrolled in VA addiction service treatment programs present with alcohol abuse only (OAS, 2000). For veterans seen in publicly funded facilities this figure doubles to 68% (OAS, 2001). Among veteran patients at VA facilities with drug use disorders, 50% abuse cocaine, and 34% abuse opioids (ONDCP, 2001). Substance use patterns observed in CTAD grossly parallel those for veterans nationwide, but also reflect substance use trends in the surrounding referral community. Alcohol dependence alone accounts for 32% of all admissions at the center, although an additional 45% of enrolled veterans endorse alcohol as a substance of abuse. Combined alcohol and crack cocaine addiction is patterned by 16%, while abuse of opiates, primarily intravenous heroin, is evident in another 17% at admission. Polysubstance use is observed in 17% of all veterans admitted for rehabilitation, most frequently presenting as combined use of alcohol, crack cocaine and marijuana (9% of all admissions). Drug of choice patterns have significant implications in the assessment of beneficial treatment options, and in the selection of treatment interventions, education and therapy targets.

Co-morbidity

Psychiatric co-morbidity is commonly observed in SUD. Nationwide, 15% of VA clients with SUD are estimated to also have additional psychiatric diagnoses (McKellar, et al., 2002), although some estimates are significantly higher (Moos, Finney, Federman, et al., 2000). In CTAD 58% of clients seen are dually diagnosed, partly attributable to clinic structures that specifically target PTSD (22%) and other dual disorders (36%). Combat trauma, unique to the veteran population, can trigger or complicate a substance use disorder. Drug or alcohol use disorders may reflect efforts to self-medicate PTSD symptoms such as anxiety, intrusive recollections, sleep disturbance and affective arousal. While providing some short-term relief, self-medication may initially mask symptoms, preventing appropriate treatment. Ultimately self-medication efforts are likely to compound PTSD associated sleep disturbance, avoidance, numbing and irritability. Exacerbation of PTSD symptoms is not uncommon following discontinuation of alcohol or drug use (Meisler, 1996). Treatment planning that anticipates and specifically targets such concerns may help to diminish reluctance to enter treatment and reduce relapse vulnerability for these clients. Education is vital to helping such veterans understand the interplay between PTSD symptoms and substance use disorders.

How veterans perceive their substance use disorder may also impact whether they will seek treatment and where they ultimately present with a SUD. Seventy-seven percent of the veterans at VA facilities who meet diagnosis of SUD, but who are not seen in specialty treatment for addiction, present in primary care clinics (McKellar, et al., 2002). Critically, this stresses the importance of assessment processes which identify SUD in these settings and referral structures which functionally support continuity of care between primary care and SUD services for these veterans.

Social, Cultural and Economic Factors

The context in which SUD presents, is cued, re-triggered, or reinforced, has ramifications for assessment, treatment planning, intervention strategies and relapse prevention. The vast majority (96%) of veterans receiving SUD treatment are men. Seventy-five percent are not married, and 37% are members of an ethnic minority. Thirty-one percent have service-connected medical or psychiatric disabilities (ONDCP, 2001). Forty-nine percent served during the Vietnam War era (McKellar, et al., 2002). For many combat exposed veterans, addiction began in the military or arose in the context of war; this appears to be particularly significant in the case of opiate addicted Vietnam veterans (ONDCP, 2000).

FACT:

■ In VA settings, 485,100 veterans meeting criteria for a substance use disorder (SUD) received some type of VA care in FY02. Ninety-two thousand (19%) of those veterans received specialized substance abuse care (McKellar, Che-Chin, & Humphreys, 2002).

To be meaningful and realistic, treatment planning must actively consider both the availability of supports and the unique relapse liabilities faced by client, in context with concerns related to access, economics, interpersonal relationships, day to day living environment, and cultural and historical factors surrounding the addiction.

Twenty-three percent of all homeless adults are veterans, compared with 13% for non-veterans (Burt, Aron, Douglas, Iwen, Lee, and Valente, 1999). The provision of services to indigent and homeless veterans is a high priority in the overall mission of Veterans Affairs. Accordingly, a larger proportion of veterans seeking treatment present with housing concerns. At CTAD, 60% of veterans admitted to the rehabilitation program are homeless or marginally housed. Contract halfway houses along with VA addiction and homeless domiciliaries are critical bridges in reducing the relapse risk of these clients when transitioning between rehabilitative treatment and return to the community. National VA studies indicate that patients receiving extended residential care through these referrals were less likely to be readmitted for addiction treatment or psychiatric care and had better psychosocial and substance outcomes at one year than similar patients discharged directly to independent living (ONDCP, 2001). Additionally, care between the VA and public system often becomes a special challenge if the individual is to be best served.

Dr. Merrill is the Director for the Center for Treatment of Addictive Disorders at the VA Pittsburgh Healthcare System.

The Center for Treatment of Addictive Disorders (CTAD) provides a range of services available to all veterans who are eligible for treatment at the VA Pittsburgh Healthcare System (VAPHS). Services include the CTAD Outpatient Rehabilitation and Education (CORE) Program, the Recovery and Aftercare Clinic (RAC), the Substance Use PTSD Team (PTSD) and the Opioid Substitution Therapy Clinic (OSTC).

Contact: 412-365-5011

"The enormously stressful conditions our troops face while protecting our freedom can be difficult to overcome even after they have returned from their tours of duty.

FACT:

■ Of the 357,800 veteran outpatients with SUD who received no specialty care for substance abuse in FY 02, 77% presented in primary care settings

(McKellar, et al., 2002).

Current research indicates that almost 17 percent of those who fought in Iraq and 11 percent who served in Afghanistan reported symptoms of major depression, severe anxiety or post-traumatic stress disorder. Based on these findings, and the ongoing deployment of our troops abroad, it is critical that we are prepared to provide the necessary care for them upon their return.

A recent study in the New England Journal of Medicine indicates that a significant number of our troops returning from the Middle East show symptoms of Post-Traumatic Stress Disorder (PTSD). They believe the numbers will rise dramatically as the length of service has been extended. Many of these service men and women are National Guard and Reservists who never expected, nor were trained for, long periods of combat. Presently, many of our Homeless Vets suffer PTSD as a result of service in Vietnam, Bosnia, Somalia, and the first Gulf War. Post-Traumatic Stress Disorder affects not only the troops themselves, but their loved ones, as well, and can lead to alcoholism and substance abuse disorders. We need to be prepared clinically to address this issue. The term "Homeless Vet" is an oxymoron. No Vet should ever be homeless—the nation they sacrificed for is their home.

Under Governor Pataki's leadership, the New York State Office of Alcoholism and Substance Abuse Services is committed to providing quality prevention and treatment services, and any other necessary support, for the men and women fighting to protect our way of life."

Commissioner William A. Gorman, Ph.D.
Single State Authority
New York State Office of Alcoholism and Substance Abuse Services

Co-occurring Post-Traumatic Stress Disorder and Substance Use Disorders

By Robert W. Hazlett, Ph.D., C.A.C., C.C.S.

When assessing the treatment needs of PTSD clients, the initial assessment should include a functional analysis. This is a required tool when utilizing cognitive-behavioral-therapy (CBT) as your treatment modality. It will assist you in establishing strengths and weakness of the client, triggers for existing behaviors, etc. and will aid in the formulation of the treatment plan. The functional analysis can also assist in exposing triggers that are factors in developing alcohol or other drug (AOD) treatment for relapse. If through the assessment phase your client is in need of detoxification from AOD, detoxification then becomes part of the first phase of treatment.

During the first phase of treatment it is important not only to educate your client and his/her family about how PTSD is acquired and its effects not only on the client, but the whole family. It must be explained to the client and family that PTSD is an anxiety related disorder that occurs in normal individuals under extremely stressful conditions. The client and family should be educated on how AOD is used in most cases to help the client self medicate and that establishing knowledge of the triggers that set off reactions of PTSD and the desire to use AOD, is essential for successful treatment. During this first phase specific treatment modalities are used to deal with common elements of PTSD such as feelings of guilt (survivors), shame, and anger.

Another step in the first phase of treatment is to teach the client to cope with post-traumatic memories and to adjust to reactions that were normal in unorthodox situations, but are now abnormal by environmental and societal standards. An example would be a combat veteran that in combat would run for cover when hearing a gunshot, and now at home runs for cover whenever he/she hears a car backfire or a roar of thunder. What is needed in any phase of treatment is modalities that can help the client regain control of his/her life by learning coping skills to assist him/her to return to normal functioning.

Cognitive-Behavioral-Therapy (CBT) has been found to be very effective in treatment of PTSD. It not only focuses on the disordered thoughts of the client, but also the behaviors. Using guided imagery to expose the trauma in a safe controlled context helps the client to face and gain control of his/her fears and distress that was overwhelming during the trauma.

When using Cognitive Behavioral Therapy for PTSD the following areas should be addressed:

a. Anxiety

b. Negative thoughts

c. Anger issues

d. Stress reactions

e. Future trauma symptoms

f. Triggers for urges to use AOD when trauma occurs

g. Relapse prevention

h. Communication

Pharmacotherapy (medication) can be used to reduce the anxiety levels of your clients. Depression and insomnia are often experienced with PTSD and medication can assist in reduction or total relief from symptoms. However, the person prescribing the medication must be aware of the clients' SUD issues.

Eye Movement Desensitization and Reprocessing (EMDR) is a relatively new treatment to deal with traumatic memories. It involves elements of exposure therapy and CBT combined with techniques such as; eye movements, hand taps, sounds, etc., that create an alteration of attention back and forth across the person's midline. This may facilitate the accessing and processing of traumatic experiences.

FACT:

- **Of the 86,300 SUD veterans who received specialized outpatient substance abuse treatment in the VA in FY02, 15% were also diagnosed with a co-morbid psychiatric disorder (McKellar, et al., 2002).**
- **Of veterans seeking treatment for PTSD in 1967, 68-80% also met diagnostic criteria for alcohol or drug abuse (Meisler, 1996).**

Group treatment is used with inpatient and outpatient treatment. An ideal setting for a veteran is at the Vet centers that often offer PTSD support groups. Empathy, safety, and cohesion provided by other PTSD survivors are a vital factor that aid in healing the veteran. As the group members bond, they share how they cope, prepare, and have survived, as well as sharing their successes in the treatment phase. Support groups can aid in providing support and strength to the veteran to participate and complete other PTSD treatments that they are pursuing. Most vet centers have updated their philosophies and have incorporated addressing the substance use, misuse and dependency issues along with the PTSD.

Anger Management Groups utilizing CBT can be effective in having clients attach their distortions and the behaviors that are associated with their anger as well as the triggers associated with their substance use disorders. It is helpful to have clients use a feeling log to help them in discovering possible triggers and thoughts that need to be addressed either in an individual or group session.

Brief psychodynamic psychotherapy focuses on emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. This can only happen after appropriate rapport is established with the therapist. The client with PTSD must sense that the therapist can handle whatever they may say in session without being judgmental. The therapist must be calm, empathic, and compassionate.

Relaxation Therapy focuses on relaxing the mind, thus relaxing the body. In cases where the client with PTSD has experienced certain headaches, backaches, or other similar somatic issues, deep relaxation techniques can diminsh or relieve somatic symptoms. In the addiction services field anxiety is a contributing factor in relapse. Introducing the client with PTSD to relaxation therapy, teaching them that they can control their thoughts, thus controlling their body, is an essential element for success when used in conjunction with other treatment modalities.

Further information on the treatment of PTSD and SUD with Veterans is available by contacting the National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs. www.ncptsd.org/

Relapse Prevention must be addressed for the PTSD issues as well as the SUD. As cravings for using substances can cause relapse, PTSD symptoms can return as well. In order to develop an appropriate relapse plan, the client must be willing to look at their plan as a contract for life. A relapse prevention plan must be looked at as a contract and a way of life that has to be accepted, adorned, and must become a daily thought ritual just like the thought that it is time to awake, go to sleep, or to eat. The relapse prevention plan should address the following:

a. Understand the dynamics of failure.

b. Identify and anticipate high-risk situations, triggers or cues.

c. Develop coping plan and strategies.

d. Practice strategies by client and therapist role playing.

e. Try out plan in real life.

f. Evaluate and make improvements if needed.

Robert W. Hazlett, PhD, CAC, CCS, is currently a Certified Addictions Counselor and Clinical Supervisor through the Pennsylvania Credentialing Board. He is currently working for IRETA as the Clinical Educator for Pennsylvania's Screening, Brief Intervention, Referral, and Treatment Initiative Project.

"Our veterans and our returning military will present new challenges for our system to be responsive to their needs for screening and potentially treatment for both PTSD and possible substance use. We must plan now."

Gene R. Boyle, Director
Department of Health, Bureau of Drug and Alcohol Programs

Provider Focus. . .

The Substance Abuse Detection and Early Intervention Program (SADEIP) at the VA Pittsburgh Healthcare System is a specialized clinical program established in 1991 through competitive Department of Veterans Affairs funds. The original mission of the SADEIP program was to identify cases of alcohol and drug use disorders among inpatient and outpatient medical and surgical patients, and to provide brief interventions for mild-moderate alcohol or drug problems, or to refer patients to more specialized treatment if their problems were more severe. SADEIP, which began seeing patients in October, 1992, has two arms: The Substance Abuse Assessment Team (SAAT), which is concerned with evaluation of physician-referred inpatients, and the Health Improvement Clinic (HIC), which provides evaluation, referral, and brief intervention services for physician-referred primary care outpatients.

SADEIP is unique in that it is entirely administered out of the department of medicine. SADEIP patients are typically assessed by the medical or surgical service from where they originated using a brief screen such as the CAGE or the AUDIT. SADEIP then performs an evaluation including a diagnostic assessment for alcohol or drug use disorders (abuse or dependence) and stage of change. Patients are also evaluated for potential withdrawal risk. Currently all patients undergoing medical detoxification from alcohol or drugs on the medical or surgical service are managed by SADEIP.

Dr. Joseph Conigliaro is the Director of the SADEIP Program and a Motivational Interviewing (MI) certified trainer. Much of the brief interventions delivered by SADEIP are based on the principles of MI where the patients' medical or surgical problem is used as a motivator for change. Current SADEIP staff consists of Dr. Adam Gordon, an internist with extensive expertise in the medical treatment of alcohol and drug withdrawal, Marypat Acquaviva PA a certified physician's assistant and Lola Wells, MS a clinical addictions specialist. In addition to the early treatment of alcohol and drugs, SADEIP now provides both group and individualized smoking cessation counseling. Please refer all questions regarding SADEIP to Dr. Conigliaro at joseph.conigliaro@med.va.gov.

"[Speaking to medical staff at Walter Reed]:

"You're saving the lives of liberators. You're healing the defenders of our country. You're comforting the champions of freedom. For that, every single person who works here has the respect and the gratitude of our entire nation."

President George W. Bush
(Washington Post, 12/19/03)

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Education Benefits	1-888-442-4551
Life Insurance	1-800-669-8477
Debt Management	1-800-827-0648
Mammography Hotline	1-888-492-7844
Telecommunication Device for the Deaf	1-800-829-4833
CHAMPVA	1-800-733-8387
TRICARE	1-888-DOD-CARE (1-888-363-2277)
Gulf War & Agent Orange	1-800-749-VETS (8387)
Health Eligibility Center	1-800-929-VETS (8387) or 1-404-235-1257

VHA RELATED LINKS AND RESOURCES	
VA Home page	www.va.gov
VA Consumer Affairs	www.va.gov/customer/conaff.asp
Compensation & Pension	www.vba.va.gov/bin/21/
Health benefits & services	www.va.gov/vbs/health/ or www.va.gov/1010ez.htm
Education benefits	www.gibill.va.gov/
TRICARE	www.tricare.osd.mil/ or www.tricareonline.com/
TRICARE for Reservists	www.tricare.osd/mil/reserve
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CHAMPUS	www.victorious.com/Tricare/group.htm
DoD	www.ha.osd.mil/

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EDITOR:
Michael T. Flaherty, Ph.D.
CO-EDITORS:
Victor Barbetti, Ph.D.
Janice Pringle, Ph.D.
ASSISTANTS:
Amanda Brodt, M.P.P.
Holly Hagle

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

Voice: 412-258-8565
Fax: 412-391-2528

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SUBSTANCE USE DISORDERS AND THE VETERANS POPULATION
POST-TEST

You are eligible to receive two (2) Continuing Education (CE) credits by completing this quiz based on this issue of Resource Links. INSTRUCTIONS: Indicate the best answer to each of the following questions and return the completed test and application form (on back) with a check for $20 to The Institute for Research, Education and Training in Addictions.

1. CTAD stands for:
   a) Center for Treatment of Alcohol and Drugs
   b) Center for Treatment of Addictive Disorders
   c) Counselors for Treating Alcoholic Disorders
   d) Center for Treatment of Addictive Disabilities

2. As compared with non-veterans, veterans with addictions could be described as all of the following EXCEPT:
   a) more likely to present with complicating medical conditions
   b) greater in age and with a lesser progression towards addiction
   c) more likely to present with chronic pain conditions that complicate addictions treatment
   d) more likely to have experienced an accumulation of functional loss

3. Which of the following disorders is unique to the veteran population?
   a) PTSD
   b) combat trauma
   c) additional psychiatric diagnoses
   d) co-morbidity

4. PTSD is associated with all of the following EXCEPT:
   a) irritability
   b) avoidance
   c) enhanced sleep
   d) numbing

5. In comparison with the non-veteran population, veterans have a lesser propensity to be homeless.
   ❑ True ❑ False

6. Pharmacotherapy can be used to reduce which of the following?
   a) insomnia
   b) depression
   c) anxiety levels
   d) all the above

7. Eye Movement Desensitization and Reprocessing may:
   a) facilitate the accessing of traumatic experiences
   b) facilitate the processing of traumatic experiences
   c) both of the above
   d) none of the above

8. Which of the following is not a vital factor in aiding fellow PTSD survivors?
   a) hostility
   b) safety
   c) cohesion
   d) empathy

9. Relaxation therapy can:
   a) relax the mind
   b) diminish or relieve somatic symptoms
   c) reduce anxiety levels
   d) all of the above

10. In order for clients to develop appropriate relapse plans, they must:
    a) see their plan as a contract for life
    b) make their plan a daily thought ritual
    c) none of the above
    d) both of the above

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2 Continuing Education Hours for $20

You are eligible to receive (2) Continuing Education (C.E.) credits by completing a post-test based on this issue of Northeast Addiction Technology Transfer Center (NeATTC) – Resource Links, Volume 3, Issue 1, Summer 2004. Return the completed post-test and a $20 check for processing fee to the Institute for Research, Education and Training in Addictions (IRETA). Please make check payable to IRETA. A passing grade for the post-test is 80%. Applicants that receive an 80% or above will receive a certificate by return mail stating that he/she has been awarded 2 CEs. Credits are issued by the National Association for Addiction Professionals (NAADAC).

—REGISTRATION FORM—

SUBSTANCE USE DISORDERS AND THE VETERANS POPULATION

NAME AND DEGREE AS YOU WISH THEM TO APPEAR ON YOUR CERTIFICATE (PLEASE PRINT):

NAME: _____ DEGREE: _____

ADDRESS: _____

_____

PHONE #: _____ FAX #: _____

E-MAIL ADDRESS: _____ LICENSE #: _____

I confirm that I personally have completed the above test, and I am submitting it for evaluation and certification

SIGNATURE: _____ DATE COMPLETED: _____

Evaluation: Overall, this issue of Resource Links: Substance Use Disorders and the Veterans Population (circle appropriate response)

PROVIDED INFORMATIVE UPDATES	5	4	3	2	1	WAS NOT INFORMATIVE
EXPANDED MY KNOWLEDGE	5	4	3	2	1	DID NOT EXPAND MY KNOWLEDGE
PROVIDED USEFUL RESOURCES	5	4	3	2	1	DID NOT PROVIDE USEFUL RESOURCES
WAS APPROPRIATE FOR MY TRAINING LEVEL	5	4	3	2	1	WAS NOT APPROPRIATE

NORTHEAST attc

ireta

IRETA | Regional Enterprise Tower | 425 Sixth Avenue | Suite 1710 | Pittsburgh, PA 15219