# Meeting the Needs of Veterans And Military Service Members In Access to Recovery Projects

## Contents:

**What's in this TA Package?**

### Goals of SAMHSA's Strategic Initiative for Military Families

- Improve military families' access to community-based behavioral health care through coordination among the Substance Abuse and Mental Health Services Administration, TriCare, the U.S. Department of Defense, and Veterans Health Administration services.

- Improve the quality of behavioral health prevention, treatment, and recovery support services by helping providers respond to needs within an understanding of military culture.

- Promote the behavioral health of military families with programs and evidence-based practices that support their resilience and emotional health.

- Develop an effective and seamless behavioral health service system for military families, coordinating policies and resources across Federal, national, State, Territorial, Tribal, and local community organizations.

To meet SAMHSA's goal of providing comprehensive and effective behavioral health and recovery support services to military members, veterans, and their families, the Access to Recovery (ATR) program has made recruiting, retaining, and serving the military population a priority. However, if ATR is to provide effective support for military members and veterans, it is critical that everyone working with these men and women have some understanding of:

- The military culture and military experience

- The behavioral health needs of military members and veterans

- What it takes to engage and retain military members and veterans

To facilitate that understanding for civilian clinicians and recovery support service providers, ATR has developed this technical assistance (TA) package. It includes the following sections:

Each section offers resources, checklists, tools, and/or information to help ATR programs prepare for and support service members, veterans, and their families seeking behavioral health and recovery support services. This TA package concludes with two case studies to support service planning and

implementation. Each of the case studies describes the experiences of an early ATR project that served military clients during ATR 2 and ATR 3.

## Introduction

Less than 1 percent of Americans answer the call to serve in uniform, but for those who do, they bear 100 percent of the burden for our nation's defense and freedom. Currently more than 2.2 million people make up the all-volunteer U.S. Armed Forces. Since September 11, 2001, more than 2 million men and women have been called to duty in Iraq and Afghanistan. More than 5,900 Americans have paid the ultimate price, sacrificing their lives for their country. Nearly 45,000 have been wounded, leaving many with the physical, mental, and emotional battle scars that will remain for a lifetime.

As a nation we have made tremendous strides in meeting the unique mental, emotional, and physical needs of military members and veterans since the days of the Vietnam and Korean wars. However, we still have work to do to ensure that every past, present, and future member of the military and his or her family receive the support and assistance they deserve as defenders of our nation.

It is this commitment to the millions of men and women who have served our nation's military that has compelled President Barack Obama and First Lady Michelle Obama "to make the care and support of military families a top national security policy priority." In support of the President's and the First Lady's call to action, SAMHSA has made the support of military members and their families the focus of one of its eight strategic initiatives.

▶ **SAMHSA's Strategic Initiative #3: Military Families**

Supporting America's service men and women— Active Duty, National Guard, Reserve, and Veteran—together with their families and communities—by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

—SAMHSA, www.samhsa.gov/militaryfamilies

## Part I: Key Areas of Learning for ATR Providers

The best preparation for providing effective treatment and recovery support to service members and veterans is a learning process. There are several important areas of study for ATR providers. Part I of this package provides an introduction to the scope of learning that is essential to effective, culturally competent services and focuses on these key areas:

1. The military

2. The military culture

3. Challenges on return from deployment

4. Impact of deployment stress

### 1. The Military

For most Americans, what they know about the U.S. Armed Forces is limited to what they see on television, in the movies, or read in books. Few outside the military understand the culture, the values, or the people who make up the most powerful military force on earth. Like any institution with a long history steeped in tradition, the U.S. military has its own culture, language, and methods. For civilians with little or no firsthand exposure to the military, the Armed Forces may seem overwhelming or incomprehensible. However, for ATR grantees to understand, work with, and help those who serve or have served in the military, it is necessary to have a general understanding of:

• What the military is

• Who serves

• What it means to serve

• The military family, whose members also serve

The information presented here provides a brief snapshot of important aspects of the military institution and its unique culture and people. It is not necessary for ATR grantees to try to comprehend (nor should they) all the details and nuances of the Armed Forces. Rather, a basic understanding will help service providers connect with members of the military, veterans, and their families, and will demonstrate an active interest in the experiences and challenges they face.

This in turn will help providers identify their best options for addressing their needs through the ATR program.

### The U.S. Armed Forces

There are five branches of the Armed Forces:

- Army

- Navy

- Air Force

- Marine Corps

- Coast Guard

The Army, Navy, and Air Force are managed by their respective departments within the Department of Defense (e.g., the Department of the Navy). The Marine Corps falls under the Department of the Navy. The Coast Guard is a Homeland Security force in peace time and a Department of the Navy asset during wartime. Military members are more likely to relate to fellow service members from their sister services than they are to relate to civilians with no military experience. However, the shared experience of being in the military is where the similarities end. There are clear, service-specific distinctions among the five branches. Each service is unique in its traditions, culture, rank, job titles, uniforms, missions, and language.

### Military Components

There are two components of the U.S. Armed Forces—the active and the reserves. Active component personnel are full-time military. They are assigned to posts, bases, and camps all over the world. Personnel in the active component spend every day in uniform planning, preparing for, or conducting military training exercises or combat operations. Active component personnel who are not deployed are at "homestation," preparing to deploy. "Deployment" refers to any operation, location, command, or duty beyond their normal duty assignment, often to a war zone like Afghanistan or Iraq. Training exercises take active component members away from home for days or weeks at a time, so the concept of being "at home" is a misnomer. Rather,

for personnel in the active component, "being at home" means they are not deployed in a combat theater.

The term "reserve component" collectively refers to two organizations, the Reserves and the National Guard. The Reserves is a Federal reserve force that augments the active component as personnel requirements dictate. The Reserve force is controlled by the President and can be "mobilized" to meet the Federal needs of the nation. Each of the five services has a reserve force. As of September 2009, there were approximately 1.2 million individuals serving in the reserve component in all five services. Members of the Reserves serve in a part-time capacity—generally one weekend a month and two weeks a year—unless they are mobilized to serve in a full-time capacity.

Like the Reserves, National Guard members serve part-time—one weekend a month and two weeks a year. As of 2009, approximately 500,000 individuals served in the National Guard, in either the Army National Guard or the Air National Guard. Each State, territory, and the District of Columbia has its own National Guard, as provided in the U.S. Constitution.

The National Guard has a Federal mission and a State mission. Primarily the Guard supports the States in times of natural and man-made disasters. Guard units in each state can be mobilized by the governor to provide support within the state or, under certain conditions, across state lines. The Guard responds to all types of emergencies, including snowstorms, tornados, fires, hurricanes, and floods. The Guard also supports local officials and emergency first responders in times of flu epidemics and chemical, nuclear, or biological attacks or accidents.

In addition to the Guard's state mission, the President has the power to mobilize National Guard units for Federal service in whole or in part, to support the nation in times of emergency, in response to national disasters, or in times of war.

### The Reserves and National Guard in Iraq and Afghanistan

The National Guard and Reserves have played a role in every major U.S. armed conflict since the Revolutionary War. However, since the inception of

U.S. involvement in Operation Enduring Freedom (OEF) in Afghanistan in 2001 and Operation Iraqi Freedom (OIF) in 2003, the National Guard and Reserves have been deployed at a rate and in numbers not seen since World War II.

This increase in deployments has multiple implications for reserve component soldiers. Many enlisted in the Guard and Reserves to serve their country, but not to serve in a full-time capacity. Frequent deployments pose significant challenges for Guard and Reserve service members and families as they attempt to deal with the unexpected time away from home, family, and jobs. In addition, multiple deployments increase the likelihood that service members will develop mental health issues, use alcohol or other drugs, engage in increased high-risk activities, and report chronic physical pain and other health challenges.

The fact that reserve component service members and their families live in the civilian community, separate from daily contact with the military culture, structure, and support, adds a degree of isolation that can aggravate both service members' and families' psychological challenges. This is important for ATR grantees to note, because it is most often the Reserve and National Guard members who will seek services through ATR programs.

## 2. The Military Culture

### The Personnel

The U.S. Armed Forces constitute an all-volunteer force. Despite the threat of long deployments to combat zones, people continue to commit their lives and the lives of their families to the military on a volunteer basis.

People join the military for many different reasons:

- Patriotism and a sense of duty to something beyond the individual (commitment—a belief that it is important not to fail others)

- A desire to belong to something greater than the self (selflessness)

- Friends in the military (loyalty)

- Money (the military is a means to an end)

- A way out of a bad home life, of a small town, or a big town

Individual reasons for joining the military are as distinct as the people who join. Service members make up a diverse population, the majority coming from working class, middle America. The military life is not easy. It is physically, emotionally, and mentally demanding at all times, and in combat those demands are multiplied many times. Members of the military are expected to place themselves, their values, and their individuality second to the greater demands of the military. According to one military member, "You are expected to take who you are and stuff it into a duffel bag … you are still you, you are just in a duffel bag."

Despite the high stress and high-demand environment, a large percentage enjoys the work and the lifestyle and continues voluntary service for 20 years or more.

### Military Values

The military is a values-based culture. The values differ from service to service, but they all describe a warrior ethos: loyalty, duty, courage, honor, commitment, selflessness, and integrity. From the earliest point in the military career, these values are ingrained and are expressed in every decision and every action.

Service members value one another more than their own lives. Whether they are a part of a small "fire team" of 5 or a large brigade of 4,000, reliance on "your buddy to your left and your right" is entrenched from the first moments at basic training. Service members will sacrifice their own lives to save the lives of their buddies or to retrieve their remains from the field of battle. For those in uniform, the mantra "Leave no one behind" is sacrosanct. It underscores the value that members of the military place on the importance of the people with whom they serve.

### The Combat Experience

The combat zone is a place of confusion, uncertainty, danger, fear, great loss, grief, guilt, death, injury, intense physical exertion, sleep deprivation, and pain. Service members can experience all of these emotions

simultaneously and for long periods of time. Tactical pauses can occur in which everything stops, yet it remains impossible to relax. The uncertainty of the environment means that even when it seems safe, it is not. Danger can appear without warning, requiring service members to remain tactically alert and hypervigilant at all times. With little time to truly decompress, service members have few outlets for their physical stress. This can have strong negative effects on their overall physical and emotional health.

For many women in the military, there are additional areas of stress related to their gender. For example, some women feel as if—or are treated as if—they have more to "prove" than their male counterparts. In cases of military sexual trauma, or MST (which includes a range of experiences from sexual harassment to rape), the perpetrator is often a unit member or someone in a command position. The unit is very much like a family, and sexual harassment or assault within the unit carries the kind of betrayal and psychological stress that children experience in incest. This violation of basic trust can destroy one of the most important protective factors against combat stress: the sense of unity, camaraderie, and deep friendship that often develops within the unit.

### The Military Family

For active component military family members, the military is a part of everyday life, and the family is viewed as an integral part of the total force. Active component personnel and their families live on or near military installations, where they can remain for as little as one year or as long as five years or more, before the military determines they are needed elsewhere and they move again. Duty stations are determined by the needs of the military, with little or no input from the service member or the family. ATR programs that serve adolescents are likely to see some children of military families. Service providers' understanding of the family circumstances can benefit all family members.

An active component family's experience in the military is driven by their ability to cope with uncertainty and change. The strongest military families are those that build resilience over time and are capable of

managing day-to-day life without one or both parents. Repeated deployments, in some cases as many as five in 10 years, take parents out of the home and out of the family structure for long periods of time. This requires transition and adjustment before and after each separation. Uncertainty is a fact of life in today's military family. That uncertainty is aggravated by repeated moves, where they must adjust to new schools, new jobs, new friends, and new homes. The greatest strength of the military family is its members' ability to adjust and to rely on one another in the difficult times.

Reserve component families often struggle more with the changes and transitions associated with the repeated deployments of today's military service because most did not expect a full-time life in the military. Reserve service members' families are not connected to the military structure in the way active families are. They live and work in the civilian community, and in many cases they have little understanding of or experience with military life.

Since September 11, 2001, the military has expanded its support for military families, connecting family members with a wide range of support structures to help them manage the stress of military life. Military leaders recognize that family members who are not prepared for their parents' or spouses' service, who are unable to cope with a deployment, or who are incapable of adjusting to life in the military jeopardize the overall readiness of the force. When there are problems at home, those problems can manifest in a service member's inability to focus on his or her job. In some cases, this lack of focus can jeopardize mission success or result in the injury or death of a service member.

## 3. Challenges on Return From Deployment

Entering and sustaining recovery can have profound effects on many areas of life. However, as ATR grantees know, until recovery takes hold, life stress can create significant challenges for recovery. For people who have recently returned from deployment in war zones, a number of challenges can affect the process of becoming engaged or "reintegrated" back into family and a civilian lifestyle. Of course, these are added

to the "normal" load of stress that we all carry. Some more common reintegration challenges include:

- A sense of numbness and fatigue after the "rush" of battle is over

- Insomnia, a common condition after living on brief, intense, and infrequent periods of sleep in the war zone—and taking in high levels of caffeine on a daily basis

- A constant state of vigilance, "tactical awareness," or readiness to react—a state that is life saving in a war zone but can be exhausting and problematic in the civilian world

- A sense of being overwhelmed, especially in crowded public places, and confusion in trying to conduct everyday tasks or make choices

- A sense of disconnection from the civilian culture and community, where most people have not shared their experiences and cannot understand the depth of those experiences

- Anger or other difficulties in responding to unfortunate questions and comments from well-meaning civilians

- A sense of disconnection from close friends and family members, especially after the intense closeness of war zone friendships, and loss of many of the ways they related before deployment

- A sense of disappointment in marriage, each spouse having formed ideal expectations during their wartime separation

- Anger, frustration, or lack of understanding that the spouse had to take on their duties while they were away; a feeling that they are no longer needed or would easily be replaced

- Loss of a sense of purpose after losing the intensity of the military mission—often made more difficult by unemployment or underemployment

- Intense feelings of grief and/or "survivor's guilt" following the death of a comrade in arms

In addition to these and other psychological and social challenges, there may be challenges related to injuries, particularly those that have limited people's ability or mobility, changed their appearance, and/or require assistance in meeting basic needs

## 4. Impact of Deployment Stress

Working with a population at high risk for posttraumatic stress, ATR providers need a basic knowledge of the posttraumatic stress effects that some people bring back from deployment in a war zone. This is important even if staff are primarily focused on substance use disorders. An understanding of the possible impact of deployment stress will:

- Make substance use patterns more understandable

- Help staff avoid saying or doing things that will make stress effects more troublesome

- Help staff identify the need for referral to mental health or trauma-specific services

- Improve staff's ability to provide effective treatment and recovery support services

There is a tendency to think of all post-deployment stress effects in terms of posttraumatic stress disorder (PTSD) or traumatic brain injury (TBI). However, there are many types of stress effects—for example, depression, cravings for mood-altering substances, and the urge to self-medicate—and each effect can occur at many levels of intensity. So, along with their understanding of substance use disorders, ATR staff also need an understanding of:

- The wide variety of deployment stress effects

- Ways in which these effects might affect service members' and veterans' well being

- Ways in which these effects might affect people's relationship with alcohol and other drugs, and success in recovery

- Things they can do to help, within the scope of their roles in ATR

Staff need to learn about basic trauma-related screening tools (see Page 19) and to build effective referral

and coordination relationships with trauma-specific mental health resources. The standard of care includes integrated, strength-based, recovery-oriented, trauma-informed mental health and substance use treatment and recovery support. ATR programs can add much to the nation's efforts to live up to that standard.

*It is crucial that therapists and other ATR providers know how to teach self-soothing strategies to ensure that they develop competence in using them before they advance too deeply into PTSD.*

*– ATR grantee staff*

Staff also need a basic understanding of the physiological roots of traumatic stress effects—something that might sound a little daunting but is in fact easy to understand. For service members and veterans who have these effects, this will help them bring some basic but empowering messages:

- "You're not 'crazy.' What's happening in your body and your mind really does make sense as a response to the things you've experienced."

- "There are concrete things you can do to get back in balance."

- "There are many kinds of help and support."

- "You're not alone."

It is often said that posttraumatic stress effects are normal reactions to abnormal experiences. That message has much more power if it is accompanied by some basic information, and by the provision of skill training in ways of controlling and managing stress reactions.

## Part II: Important Approaches for ATR Programs

Many of the approaches described here are common to trauma-informed services in general, and customized for this population. When a service is "trauma informed," it is designed and delivered in ways that respect and address the needs and circumstances of people who have experienced trauma. The following pages examine the need for and benefits of implementing five measures:

1. Focus on strength and resilience

2. Address the barriers to help seeking, engagement, and retention

3. Provide contact with service members and veterans

4. Create safety within ATR programs and services

5. Create choice and control within ATR programs and services

## 1. Focus on Strength and Resilience

In any clinical or recovery support effort, it is essential to focus on the individual's strengths, resilience factors, and resources. This creates a more powerful belief that success is possible and brings more energy and commitment to the recovery process. For example, assessment of strengths should be well underway before any assessment of challenges begins. To lay this foundation of hope is a vital part of successful recovery. Language should be based on strengths and individual qualities and experiences, rather than on problems and diagnostic categories. This is particularly important in serving the military culture, a culture that is focused on strength, power, and control. An approach that emphasizes strength and ability will be more acceptable than a pathology-focused approach, and bring higher levels of engagement and retention.

## 2. Address the Barriers to Help Seeking, Engagement, and Retention

When service members and veterans need clinical help or recovery support, a number of factors can keep them from seeking assistance, including:

- Lack of confidence in the effectiveness of clinical and support services

- General disconnect between the military culture and the therapeutic/recovery culture

- Stigma toward post-deployment stress effects and help seeking

### Building Confidence

The strength-based approach described above can go a long way toward increasing confidence in the outcome

of services. In addition, the more services and service providers become compatible with the military culture and values, the more hospitable your service settings will feel to service members and veterans.

### Connecting With Treatment

Differences between the military culture and the therapeutic culture can make it harder for service members to believe that services will be effective for them. This lack of confidence might reduce help-seeking, engagement, retention, and successful outcomes. Along with the education about the military culture described above, ATR programs might consider framing some of their services in terms that are more compatible with that culture. For example, though therapeutic and support services may be viewed with suspicion within the military culture (too "touchy-feely"), training is valued very highly. Many clinical and recovery support services can accurately be described as skill training (e.g., "recovery training" or "resilience training"). This emphasis might make marketing services toward military members more effective as well.

### Connecting With Recovery Support

Some service members and veterans may also have difficulty engaging in civilian recovery support services. They might feel frustrated trying to connect with people who do not share their experiences, have never served in the military, or are of the same age but have not been matured by war and trauma. They can feel significantly "different" from their peers. Some people in the community might say well meant but inappropriate things, such as: "Did you kill anyone?" or use service members and veterans as sounding boards for their political opinions. This is a fairly common—and frustrating—experience for service members and veterans, but it takes on greater importance in settings that might make them more emotionally vulnerable. ATR programs can train their recovery support staff well and can connect people with groups that contain more military members or veterans, or support their efforts to start such groups.

Twelve-Step-oriented recovery support services—with the admission of powerlessness as the first step toward recovery—might raise another challenge for some people whose cultural emphasis is on strength, power, and control. Recovery support staff can help them understand that the First Step is concerned with powerlessness over alcohol or drugs, and with learning to tell the difference between the things one can control and the things one cannot. Having those insights does not make one helpless. It actually increases one's power, brings more success in training and recovery, and makes room for additional resources.

### Connecting With Civilian Staff

Some service members and veterans may also have trouble engaging with civilian personnel in treatment and recovery support settings. They may believe that people who have not deployed to a war zone cannot truly understand their deployment experiences—and that perception is correct. War is like no other experience. However, providers can help bridge the gap by respecting the fact that they cannot and will not understand these experiences at depth, acknowledging the limits of their experience, and being willing to listen and learn.

### Overcoming the Stigma

Even more than the civilian culture, the military culture still stigmatizes the effects that many people experience after exposure to intense stress and threat in the war zone—and stigmatizes their efforts to seek help. Some military members still characterize people who have these effects as weak, cowardly, or "defective," leading to a sense of shame and self-stigma among people who are experiencing these effects. The military has been working hard to change this element of its culture, but a large and long-lived system is difficult to change. Many people still fear the loss of advancement opportunities and the loss of their peers' and their commanders' respect and confidence. Unfortunately, in some cases these fears are accurate. ATR staff can help reduce self-stigma by emphasizing the individual's strength and resilience. They can also "normalize" post-deployment effects through non-stigmatizing terminology and basic

> *It helps to have people with military experience and experience working with substance use disorders on the ATR and providers' staffs.*
>
> *– ATR grantee staff*

information about the physiological roots of these effects (see Pages 4–5).

## 3. Provide Contact With Service Members and Veterans

The bonds of friendship and commitment that grow among fellow service members in the war zone can be stronger than the closest family ties. Losing those bonds on return to civilian life can create a gap that no civilian relationships can fill. ATR staff can help by:

- Acknowledging the depth of this loss when service members and veterans express it

- Supporting their efforts to find and connect with other service members and veterans in a number of places, including:
  – ATR programs (in military-specific groups)
  – Their communities
  – Their units
  – On-line communities of service members and veterans

Wherever possible, ATR programs should hire qualified service members and combat veterans to work in clinical and recovery support roles. The input of these staff members can enhance organizational understanding and help service members and veterans engage and feel more comfortable in treatment and support settings. Having other service members or veterans involved helps give "permission" to trust the program and/or the people running the groups.

## 4. Create Safety Within ATR Programs and Services

For anyone who has lived through heavy stress, threat, and trauma, the issue of safety takes on great importance. For people steeped in the military culture—even people who have faced death with steel nerves—the sense of vulnerability that often occurs in treatment and recovery support settings can feel so dangerous that they want to do anything to avoid it. Settings that are not trauma informed can also hold many elements that actually are not safe for people who have had these experiences. ATR programs and providers can make their environments, services, and service

recipients safer in many ways. For example, providers might:

- Cultivate a culture of respect within the organization and its practices

- Ensure that service members and veterans are assigned to staff who have been trained in, and are comfortable with, the elements described earlier in this package

- Help people identify elements in their home environments (e.g., abusive relationships, easy access to alcohol or drugs) that might be addressed to increase safety

- Screen for risk of suicide and/or harm to others (see Page 19)

- Build service members' and veterans' skills in managing their stress reactions early in the treatment or support relationship to reduce the danger of relapse, escalation of post-deployment stress symptoms, or "shutting down" to avoid escalation

- Avoid placing service members and veterans in situations where they are encouraged or pressured to talk about painful experiences, instead letting them discuss their experiences when they choose and with whom they choose

- Work with service members and veterans in individual sessions or in military- or veteran-only groups, rather than in group settings with general populations

- Collaborate with clients, primary care providers, and psychiatrists to monitor the effects, side effects, and interactions of medications

## 5. Create Choice and Control Within ATR Programs and Services

For anyone who has lived through traumatic experiences, the need for choice and control can feel like a matter of life or death. For people from a control-oriented culture like that of the military, this sense of need can be all the more powerful. Anything ATR programs can do to increase client choice and control

will increase engagement, lower defensiveness, and promote stronger recovery.

- Create and sustain truly collaborative partnerships with treatment and recovery support staff

- Start with the service member's or veteran's own goals and priorities, building motivation from that point

- Allow as much choice as possible in service and recovery planning, choice of practices, choice of recovery support services, etc.

- Provide skill training—including stress management training—that increases people's control over their bodies and reactions and gives them more options in their lives and relationships

- Help people identify their own capabilities and the many resources within their families and communities

- Help people in 12-Step-oriented programs and services reframe concepts of powerlessness so that they promote empowerment rather than hopelessness

## Part III: Collaboration and Engagement

The U.S. military is a huge system with many rules and resources, most of them a mystery to the civilian community. Knowing a little about this system can make ATR providers more effective in their efforts to identify and recruit partners, and to secure needed services and reimbursement for individuals and families. Before you provide behavioral health or recovery support services to members of the military, veterans, or their family members, it is important to know:

1. The military policies regarding alcohol and drug use in the military

2. The existing health and behavioral health systems available to military members, veterans, and their family members

3. The best techniques for identifying, engaging, and retaining military members, veterans, and their families

## 1. Military Regulations Regarding Alcohol and Drug Use

The abuse of alcohol, or the use of illicit drugs, is inconsistent with the values of the military. It compromises the performance standards, discipline, overall fitness, and readiness of the U.S. Armed Forces.

### *Alcohol*

Alcohol consumption is legal and often included in military ceremonies and activities where the consumption of alcohol is approved. However, the military does not condone the misuse or abuse of alcohol, alcohol use is not permitted during duty hours, and underage drinking is prohibited. Military members who consume alcohol are expected to behave in ways consistent with the professionalism and values of the Armed Forces. A service member identified by his or her chain of command as clinically dependent on alcohol will be "command directed" to receive medical treatment/detoxification through the military treatment systems. The service member may be processed for discharge, unless his or her chain of command determines that there is potential for continued service in the military after completing treatment. Individuals processed for discharge are referred to Veterans Health Administration (VHA) hospitals or civilian programs for continued treatment.

National Guard members involved in alcohol-related misconduct such as drinking on duty, impairment on duty, or operating a motor vehicle while impaired will be:

- Counseled by the unit commander for possible enrollment in a state-certified, community-based alcohol or other drug counseling and rehabilitation service within 45 days of being identified for possible alcohol abuse

- Considered for administrative separation and/or disciplinary action

### *Illegal Drug Use*

Active component military members whose urinalysis is positive for illegal drugs will be command directed to military substance abuse programs. They will be processed for disciplinary action under the Uniform

Code of Military Justice (UCMJ) and/or processed for discharge, unless it is determined that the individual, upon successful completion of treatment, remains an asset for future military service. Service members who are retained and are enrolled in a military treatment program—but fail to comply or complete treatment—will also be processed for discharge.

When National Guard members are identified as illegal drug users, several processes begin simultaneously:

• They are counseled by the unit commander for possible enrollment in a state-certified, community-based alcohol or other drug counseling and rehabilitation service within 45 days of verified positive drug test.

• They are processed for administrative separation within 45 days of receipt of the verified positive drug test. The recommendation for separation is forwarded to the separation authority, who makes a determination to keep or discharge the service member. Guard members may also be considered for disciplinary action prior to separation.

Reserve members identified as illegal drug users will be:

• Counseled by their commander for enrollment in the Reserve substance abuse program

• Barred from any favorable actions, e.g., promotions, awards, reenlistment, etc.

• Processed for administrative separation and possibly considered for disciplinary action under UCMJ

### Limited Use Policy

The Army recognizes that treatment for drug and alcohol use/abuse will be more effective if soldiers can admit to drug use without this information being used against them. The limited use policy is intended to: (1) facilitate the identification of people abusing alcohol or other drugs, by encouraging identification through self-referral, and to (2) facilitate treatment and rehabilitation for those who demonstrate the potential for recovery and retention in the service. Under the limited use policy, soldiers are protected when they present information to Army counseling staff or the chain of command as a part of the process of voluntary

enrollment in the Army Substance Abuse Program (ASAP). The policy does not cover future use; use not self-reported to the chain of command; possession of illegal drugs with the intent to sell or distribute; or actions related to alcohol or drug use, such as an accident while under the influence. If the chain of command becomes aware of drug use independently from the information provided to the ASAP counselor, administrative action (including discharge) is possible.

Discharge is mandatory for all personnel involved in two serious incidents of alcohol-related misconduct within 12 months, and for all personnel involved in trafficking, distribution, possession, or sale of illegal drugs.

### Confidentiality

The release and/or discussion of information within the Armed Forces concerning a service member's abuse of alcohol and other drugs is governed by the restrictions contained in U.S. code and the U.S. Health Insurance Portability and Accountability Act (HIPAA). Such information will be made known to those individuals within the U.S. Armed Forces who have an official need to know. The restrictions on release of service members' information outside the U.S. Armed Forces are prescribed by the laws regarding confidentiality of drug and alcohol abuse counseling records and information.

Military substance abuse programs are "command programs." This means that commanders of individuals seeking services through military substance use disorder treatment programs will be notified. It is a commander's responsibility to ensure the readiness and fitness of his or her units. Counseling and treatment services through the military system assist commanders in monitoring unit readiness and fitness. However, only in specific need-to-know cases do commanders have access to clinical and session notes.

### Referral of National Guard Members to Civilian Service Providers

When Guard members are voluntarily or involuntarily identified as alcohol or other drug abusers, they are counseled, and the commanders are required to provide each individual a list of certified and/or approved

agencies within a commuting distance that is reasonable for the service member. Guard members must be evaluated at the civilian agency within 30 days of the counseling session. The service member is responsible for any and all costs associated with his or her treatment and should be encouraged to explore various financing options, including insurance, sliding-scale fees, etc. National Guard members must sign a consent statement that allows treatment personnel to share necessary treatment information with the unit commander or designee. Service members must request that treatment personnel provide monthly updates in writing to unit commanders, who must be kept informed regarding the progress of rehabilitation. Methadone maintenance and mandatory Disulfiram (Antabuse) treatment do not meet the Guard requirement for successful recovery. Guard members may refuse to sign the consent statement. However, it may be determined that they are not participating sufficiently in rehabilitation, and a refusal to sign may result in their being processed for discharge for rehabilitation failure.

## 2. Health and Behavioral Health Systems Available to Military Members, Veterans and their Family Members

Active component and reserve members, veterans, and their family members have a host of healthcare and behavioral healthcare options available to them.

### TriCare

TriCare is the health care program for military service members, veterans, and their families around the world. TriCare covers active component personnel and their dependents, and National Guard and Reserve members activated for more than 30 days and their dependents. Retirees and their family members, and traditional, non-active Guard and Reserve personnel and their dependents, can enroll in TriCare for a monthly premium. TriCare, like any other healthcare program, provides health coverage and health plans, including dental options, pharmacy benefits, behavioral health services, and other programs for a monthly premium. For those service members seeking to continue behavioral health services through an ATR

provider after their vouchers expire, TriCare may be an option to cover continued services.

Important notes for ATR providers:

• It will be important for the ATR provider to know if an individual has TriCare or another type of insurance that will cover ongoing services.

• It will also be important for the provider to know what the individual's benefit package contains, in order to assist him or her in accessing ongoing coverage without out-of-pocket expenses.

• National Guard and Reserve members, retirees, and family members are not automatically enrolled in TriCare. It will be important to ask about coverage, rather than to assume they have TriCare benefits.

Like other health plans, TriCare has approved networks and providers and requires referrals for many services. It will be important to know whether or not the provider chosen by the military service member is an authorized TriCare provider, and whether or not a referral is needed. Active component family members no longer require a referral from their primary care manager to seek behavioral health services.

TriCare provides six months of free post-deployment coverage to National Guard and Reserve members and their dependents.

### Active Component Healthcare

Most active component members access military treatment facilities (MTF) via TriCare for their health and behavioral healthcare services. The majority of active component installations have some level of health and behavioral health services available to active duty service personnel stationed in the immediate vicinity. Active component personnel are required to receive all medical treatment at military treatment facilities, unless there are extenuating circumstances. National Guard and Reserve personnel who work full-time for the military, or who have been activated for a period exceeding 30 days, also use the nearest MTF. If there is no MTF in the vicinity, active Guard and Reserve members use their TriCare benefits to access health and behavioral health services in the local community.

*The Veterans Health Administration (VHA)*

The VHA provides health benefits to veterans.

The following criteria distinguish those who may qualify for healthcare coverage under the VHA:

- They have served in the active military.

- They were discharged or released under conditions other than dishonorable.

- They include Reservists and National Guard members called to active duty (other than for training only) by a Federal order, who completed the full period for which they were ordered to active duty.

Eligibility is determined by the VHA. If an individual thinks he or she may be eligible for coverage by the VHA, he or she should contact the VHA directly. ATR personnel may be able to assist in making the connection to a local or regional VHA office.

VHA coverage:

- Provides five years of routine healthcare for veterans returning from a war zone

- Provides disability rating (if requested for review), which determines eligibility for health benefits

- Provides healthcare for veterans without disability rating, with potential co-pay

- Provides coverage for most physical and behavioral health concerns

The VHA has regional offices, hospitals, and clinics all over the country. ATR providers can work to develop relationships with local VHA offices and personnel, so that individuals may be connected with services not covered by the VHA.

## 3. Engaging and Retaining Military Clients

The information presented up to this point describes the unique experiences and needs of military personnel, veterans, and their family members. Because of their experiences and the environments in which they live and work, this population may not be comfortable working with civilian staff who have little or no experience with the military. Engaging and retaining this population may require that organizations make some minor adjustments in their staffing patterns, or in the organizational processes and procedures. (Part IV of this package includes a checklist that providers can use to assess their organization's readiness to receive military members, veterans, and their families.)

*Recruitment Strategies*

ATR providers who have focused on service members and veterans have reported some challenges attracting and recruiting the individuals in need of services. The list below gives some general suggestions.

*Collaborating with the National Guard*

Because Guard members live and work in the civilian communities where ATR services are provided, providers can develop linkages between ATR programs

▶ **ATR Military Client Recruitment Strategies**

- **Communicate with local military installations; meet clients where they are.** Staff in these sites will help get the word out about the availability of ATR services. Once military personnel learn about ATR, they are likely to give their blessing.

- **Design an ATR web site.** A well-designed web site targeting military members will help with client recruitment. Consider including testimonials from military clients and a section that offers education targeted to potential military clients.

- **Create outreach and marketing materials that are military specific.** Designing outreach and marketing materials specific to military members will allow staff and providers to incorporate terminology and other information that illustrates the ATR system's competency concerning the behavioral health needs of military members.

and local Guard units, with ATR services supporting the overall Guard mission of a ready and capable state military force.

### National Guard Counterdrug Program

The National Guard Counterdrug Support Offices (CDSO) operate in all 50 states and four U.S. territories. The Counterdrug offices support both a supply-reduction and a demand-reduction mission. In many states, CDSOs also provide prevention programs for youth. Part of the CDSO's demand-reduction mission is ensuring a drug-free military force through drug-testing of Guard members and referrals to treatment.

ATR coordinators can work closely with State CDSO directors to provide education and referral sources for Guard members seeking treatment and recovery support services. In addition, CDSO directors can serve as a conduit to develop a memorandum of understanding (MOU) between ATR providers and the Guard.

### National Guard Prevention, Treatment, and Outreach Initiative

Within Counterdrug Support Offices, many states have implemented the Prevention, Treatment and Outreach (PTO) initiative. The PTO initiative has been established by the "Office of the Secretary of Defense to provide prevention training, outreach to military families, and treatment resources to Guard members in an effort to increase military discipline, individual performance, and combat readiness" (more information at http://ngbcounterdrug.ng.mil/programs/Pages/SubstanceAbuse.aspx). PTO programs collaborate with internal assets such as family readiness groups, chaplains, and reintegration services to assist Guard members and their families with reintegration and transition issues. Prevention coordinators also provide resources to help Guard members and their families build capacity and minimize deployment-related stressors and other mental, physical, and emotional challenges.

In states that have prevention coordinators, ATR program staff can serve as the coordinators' connection to community providers. This can be a mutually beneficial relationship, in which the greatest benefit is increased access to services for Guard members and their families.

### Other Opportunities for Working with the National Guard

The Single State Authority (SSA) can work closely with the State Adjutant General, the highest ranking Guard member in each state. He or she has the authority and responsibility to implement mutually beneficial strategies that support the goal of a drug-free and prepared State military force.

Another resource available to ATR grantees is the National Guard Bureau liaison at SAMHSA. This

## ▶ Collaborating with the National Guard

- **Work with SAMHSA's National Guard Counterdrug Liaison.** The National Guard Bureau has assigned an individual to serve as a liaison to SAMHSA. This individual is assigned specifically to work with States to support National Guard collaboration. ATR project officers can provide information on this resource.

- **Encourage collaboration between the Adjutant General of the State and the Single State Authority.** The Adjutant General is the highest ranking military individual in the state. This relationship can support collaboration across the state.

- **Identify and work with Guard prevention coordinators.** Many States have Guard prevention coordinators whose task is to work with communities to respond to the needs of National Guard members.

- **Work with counterdrug coordinators.** Counterdrug coordinators support both supply- and demand-reduction missions. One component of the demand-reduction mission is drug testing. The counterdrug support officers can assist in building relationships in communities where there are Guard armories. He or she can also assist in the development of an MOU.

individual is a National Guard member who has been specifically identified to work with States to build collaboration between the Guard and substance use disorder prevention, treatment, and recovery service providers.

A note for ATR providers: When working with the National Guard, avoid requesting (or the appearance of a request for) an endorsement of any service or program. The Guard legally must avoid any perception of a commercial endorsement of any kind.

## Part IV: Information and Tools

Part IV of this TA package presents information, tools, and templates that will assist you in planning service provisions for military clients, or strengthening

current systems to ensure successful client outcomes. This information is organized in the following areas:

1. Assessing system and provider strengths

2. Choosing screening instruments

3. Integrating trauma-informed services

## 1. Assessing System and Provider Strengths

In preparing to serve military clients, staff are encouraged to look at the current system of care and practices within that system, and outline strengths, challenges, and opportunities for enhancing services to military members. The tools below can be used as a starting point for looking at existing resources, competencies, and facilitating factors.

## Assessing ATR System Strengths for Military Clients

| Assessment Question | Recommended Elements | What Exists in Our System? What is Needed? |
|---|---|---|
| 1. In what ways does our care coordination process support the integration of military clients? | ❏ Care coordinators and/or recovery coaches are knowledgeable about military culture.<br>❏ Former or current military members or family members serve as recovery coaches.<br>❏ Processes offer greater client choice and control—beyond what may be standard.<br>❏ Providers ensure availability of accessible treatment services based on TriCare, VHA, or other applicable provider network. | |
| 2. Which of our providers have military competency? Does our program include staff members who are culturally competent in military services? | **Knowledge of Military Culture**<br>❏ Providers understand military culture, military family life, and relationships, and understand the experiences of service members.<br>❏ Staff are knowledgeable about approaches toward earning military members' trust and overcoming stigma and other barriers to service access.<br>❏ Providers understand the range of post-deployment stress effects, and military factors that can affect resiliency and vulnerability.<br>❏ Providers understand the unique experiences of female military members and include access to female service providers.<br>❏ Providers have partnered with veterans who provide peer-to-peer services and can serve as recovery coaches if needed.<br>❏ Providers can connect individuals with mental health providers and other clinicians who are knowledgeable about service members' and veterans' issues.<br><br>**Knowledge of Specific Recovery and Treatment Competencies**<br>❏ Providers and staff understand deployment-related trauma effects and have knowledge of treatment/recovery protocols for individuals struggling with trauma.<br>❏ Providers and staff understand the relationship between trauma and substance use disorders, and the effects of trauma within any substance abuse treatment program.<br>❏ Providers are aware of evidence-based and promising practices for treating veterans, including considerations in assessment and treatment planning.<br><br>**Knowledge of Critical Recovery-Oriented Tasks**<br>❏ Providers integrate a strengths-based approach linked to a recovery plan.<br>❏ Staff can practice, train, and coach service members/veterans in ways of modulating their stress responses<br><br>**Knowledge of and Diversity in Services**<br>❏ Providers have multiple RSS and treatment models that address the unique needs of military members. Staff and providers are knowledgeable about available resources for military families and are able to connect clients with them.<br>❏ Staff and providers are knowledgeable about local resources serving female military members, and able to connect clients to them. | |

## Assessing ATR System Strengths for Military Clients (continued)

| Assessment Question | Recommended Elements | What Exists in Our System? What is Needed? |
|---|---|---|
| 3. Does our program have linkages with key military stakeholders? | **Key Stakeholders have partnered with or developed agreements with:**<br>❑ Appropriate local active duty personnel (substance abuse program coordinators, etc.)<br>❑ National Guard State prevention and counterdrug coordinators<br>❑ TriCare representative<br>❑ VHA representative<br>❑ Veterans' centers/clinics<br>❑ Local veterans organizations (VFW, American Legion, Vet Centers, etc.)<br>❑ Drug Courts, Veterans' Courts<br>❑ Recovery centers | |
| 4. Does our system facilitate collaboration with treatment providers, mental health providers, and other clinicians needed to support military clients? | ❑ Yes     ❑ No<br>❑ Written agreements, MOU<br>❑ Resource directories<br>❑ Opportunities to discuss emerging  trends (e.g., collaborative meetings, learning communities, advisory committees, etc.)<br>❑ Formalized referral processes | |

## Checklist: Staff Strength Inventory

Use the list below to conduct an inventory on the strengths available amongst staff or providers.

| | Provider | Staff |
|---|---|---|
| **Military Competence** | | |
| Understands military culture and works with service members and veterans | ❑ | ❑ |
| Understands the similarities and differences between the military and behavioral health cultures | ❑ | ❑ |
| **Procedures, Protocols, and Services** | | |
| Is able to provide or tailor service members' and veterans' services in individual sessions or in military-specific and/or gender-specific groups | ❑ | ❑ |
| Regularly reviews and adjusts procedures, protocols, and services to provide the maximum level of psychological safety and respect | ❑ | ❑ |
| Uses procedures that allow each client the maximum amount of choice and control | ❑ | ❑ |
| Follows established clinical guidelines and treatment approaches for serving military members | ❑ | ❑ |
| Has peer-based RSS available | ❑ | ❑ |
| Provides and refers to safe, respectful, and culturally appropriate services and service settings for military members and veterans, including women who have experienced MST | ❑ | ❑ |
| Has grief management, acceptance training, and family support services | ❑ | ❑ |
| Provides or refers to one or more of the following alternative RSS: Acupuncture, yoga, and/or meditation | ❑ | ❑ |
| **Supporting Competencies** | | |
| Has ability to acknowledge resilience and risk factors that contribute to people's strengths and challenges | ❑ | ❑ |
| Understands stress effects and interactions among these effects | ❑ | ❑ |
| Understands the impact of reintegration challenges (in family, friendships, community, workplace, school, etc.) that might be contributing to stress and affected by post-deployment stress | ❑ | ❑ |
| Understands existing treatment approaches, the evidence that supports their effectiveness, the populations they have been tested with, and the specific symptoms they address | ❑ | ❑ |

## 2. Choosing Screening Instruments

*Screening for the Need for Trauma-specific Services*

Although the ATR provider's role is focused on substance use disorders (SUD) treatment and recovery support, ATR staff also play important roles in identifying challenges that should be assessed and/or treated by mental health professionals. This is particularly important with a population that has been exposed to the levels of stress that many service members and veterans have endured.

As mentioned on Page 6, people experience many kinds of post-deployment stress effects, at many levels of intensity. However, the high end of that scale includes a number of clinical challenges, including depressive disorders, PTSD, other anxiety disorders, MST, and substance use disorders. These can be complicated by the presence of traumatic brain injuries (TBI), with even the mild TBI conditions often referred to as "post-concussive syndrome." Post-deployment stress effects can also raise the risk of suicide.

Although service members are screened in military settings after they return from deployment, two factors in particular can compromise the results of that screening:

- The symptoms of post-deployment challenges like PTSD or depressive disorders might not appear right away. Someone who screened negative soon after deployment might show more symptoms in a few months, or even longer.

- Service members who are wary of the effects of military stigma toward post-deployment challenges might not endorse symptoms—or symptom severity— in military screening processes. They might be more likely to reveal more in civilian settings.

As mentioned earlier, ATR programs should develop strong collaborative relationships with mental health providers. These relationships should include:

- Cross-training that includes training for ATR staff in trauma-informed services

- Staff training on the choice and use of brief screening instruments for PTSD, MST, depression, and the risk of suicide

- Coordination of care for people who need both mental health and SUD treatment

- Wherever possible, truly integrated trauma and SUD treatment and recovery support services

If a service member or veteran "screens positive," that does not mean that he or she necessarily has PTSD, MST, etc., but it does mean that he or she should be referred for trauma assessment by a mental health professional.

## List of Trauma and PTSD Screening Instruments

The Screening Instruments listed below are described in greater detail at:
http://www.ptsd.va.gov/professional/pages/assessments/list-screening-instruments.asp
That site also has information on obtaining copies.

| PTSD Screening Instrument | Description | Number of Items | Time to Administer |
|---|---|---|---|
| Please note: Anyone who screens positive on any of these scales should then be assessed by a mental health professional using a structured interview for PTSD and/or MST. | | | |
| Beck Anxiety Inventory (BAI-PC) | This seven-item self report screens for anxiety, depression, and PTSD. | 7 | 3 min |
| Primary Care PTSD Screen (PC-PTSD) | This four-item screen is used to screen for PTSD in veterans at the VA. | 4 | 2 min |
| Short Form of the PTSD Checklist | This six-item screen, designed for use in primary care settings, includes suggested items from the longer PTSD checklist. | 6 | 2 min |
| Short Screening Scale for PTSD | This seven-item screen, designed for all trauma survivors, is to be administered after people have been assessed for trauma exposure. | 7 | 3 min |
| SPAN | The SPAN is a four-item self-report screen derived from the Davidson Trauma Scale. Its name is an acronym for the four symptoms assessed (startle, physically upset by reminders, anger, and numbness). | 4 | 2 min |
| SPRINT | This eight-item self-report measure assesses the core symptoms of PTSD. It can serve as a reliable, valid, and homogeneous measure of PTSD illness severity and of global improvement. | 8 | 3 min |
| Trauma Screening Questionnaire (TSQ) | This 10-item symptom screen, based on the PTSD Symptom Scale– Self Report, is designed for use with survivors of all types of traumatic stress, and should be conducted 3 to 4 weeks post-trauma. | 10 | 4 min |

### *Screening for the Risk of Suicide or Harm to Others*

Few questions are more haunting than those that form after someone we knew has taken his or her own life, or the life of another, out of a sense of pain, hopelessness, and desperation. Assessment for suicide or harm to others is outside the scope of many ATR providers' roles. However, a basic knowledge of suicide screening questions is an important tool for anyone who works with vulnerable populations. The risk is higher for service members and veterans—before, during, and after deployment—for a number of reasons, including the following:

- Military life holds high levels of stress—even higher in and after deployment to a war zone

- The symptoms of conditions such as PTSD, MST, depressive disorders, substance use disorders, and TBI can be highly painful and frightening

- These symptoms—and their effects on family and close friends—can make suicide seem like the only way to relieve their loved ones' burdens

- If past and current forms of treatment have not relieved the symptoms, hopelessness can build, and suicide can seem like the only solution

- Challenges in reintegration can increase the sense of isolation that makes suicide more likely

- The high levels of adrenaline and anger that were so necessary in the field of battle can raise the risk of harm to self or others

- The distance an individual must cross to actually consider suicide or the death of another may be significantly shorter for a military member or veteran, because the concept of death may have been a daily presence in the war zone

- High percentages of service members and veterans have purchased firearms—and know how to use them

This again is an area in which ATR programs and staff should receive guidance from mental health professionals. They should become familiar with their states' laws around the Duty to Warn and the Duty to Protect. These concern the responsibility of a counselor or therapist to notify the proper authorities, and anyone whose life may be in danger, if there appears to be a risk of suicide or harm to others. They should also seek mental health professionals' help in examining the impact of these laws on recovery support providers, and ways in which these laws can be reconciled with confidentiality laws and policies.

Simple suicide screening tools are available, such as the pocket-sized card called "Assessing Suicide Risk: Initial Tips for Counselors," available from SAMHSA. These tools generally ask basic questions to find out if people:

- Are having thoughts or ideas about suicide

- Have developed suicide plans

- Have made a decision to take their lives in the near future

- Have access to guns, pills that can be lethal at certain quantities, or other tools that can end their lives

All threats of suicide or harm to others should be taken seriously. According to the SAMHSA assessment tool, there is no evidence that "no-suicide contracts" prevent suicide. Instead, these contracts might create a false sense of security that leads counselors to overlook important signs.

A form for ordering the SAMHSA tool is posted at http://store.samhsa.gov/product/SVP06-0153.

## Screening for Sleep Disturbances

If stigma or fear of reprisal makes a client reluctant to talk about post-trauma effects or substance use, challenges with sleep may not be regarded with the same level of stigma or risk. Service members and veterans may be more motivated to promote better sleep than to address the effects of trauma or substance use. The following table shows some signs of sleep disturbances that clients might identify and want to address.

## *Potential Stress Effects from Sleep Disturbances*

| | |
|---|---|
| ❑ Mood and motivation changes | ❑ Exaggerated feeling of physical exertion |
| ❑ Impaired attention and concentration | ❑ Lack of insight into impairment |
| ❑ Memory loss for recent events | ❑ Failed oral communication |
| ❑ Variable and slowed responses | ❑ Social discomfort |
| ❑ Illusions/hallucinations | ❑ Increased health and mental health problems |
| ❑ Failure in routines | ❑ Use of substances |
| ❑ Impaired task performance | |

Of course, many of these may also be signs of PTSD, depression, TBI, etc., though only full assessment by a mental health professional can determine this with clinical certainty. However, discomfort with sleep patterns and their effects may motivate people to consider screening for underlying causes, or to begin to build relationships with service providers that will lead over time to appropriate referral, assessment, and treatment.

## 3. Integrating Trauma-informed Practices

The following table recaps a few of the concepts discussed in this TA package and provides a framework for system- or organizational-level introspection and self-assessment.

## Opportunities for Integrating Trauma-Informed Services.

| You can use the questions below to discuss ways in which your ATR system integrates effective trauma-informed clinical treatment services for military members. | |
|---|---|
| *Discussion Question* | *Responses and Strategies for Building Capacity* |
| How widespread, accessible, and comprehensive is training and technical assistance in trauma-informed care within our system? | |
| To what extent have administrative policies and procedures been reviewed and updated for adherence to trauma-informed care principles? | |
| What screening and assessment tools and processes do we have to identify the range of military members' challenges in need of intervention? Are we familiar with the screening instruments noted in the table above? | |
| In what ways can we customize interventions to the specific needs, goals, and choices of military clients experiencing PTSD? | |
| In what ways are staff equipped to determine when clients with post-traumatic stress effects need to be referred to clinical resources outside our systems? What are our guidelines for knowing when such referral is necessary? Are referral pathways to these resources in place? | |
| What providers in our system are trauma-informed? Do we have formal collaborative relationships with mental health systems and providers? | |
| What processes are in place to monitor and evaluate elements of trauma-informed care within our system, including safety issues for people who have experienced trauma? | |
| In what ways does our system interact with and refer military clients to primary care providers, mental health services, social services, and other systems (e.g., housing, employment, or family and children services)? | |

## Part V: ATR Models and Implementation Strategies

ATR programs can learn from current and previous grantees that have experience providing services to military members. Two examples are included, representing approaches and implementation strategies from New Mexico (ATR 2) and Indiana (ongoing, in ATR 3).

### 1. New Mexico

New Mexico's approach to providing services to military clients recognizes the need to tailor services across the continuum. Their approach integrates the following strategies:

- **Modifications to central intake.** Intake services are tailored to identify and address the needs of military clients. Central intake personnel ask additional questions related to military experience. Intake staff request more detailed but appropriate background information about trauma specific to military events. At intake, individuals are asked open-ended questions about their experiences throughout their military career, including basic training and deployments, and any experiences with sexual trauma. Intake personnel avoid asking intrusive questions such as "Did you kill anyone?" but they show an openness to subjects that military members choose to disclose. Baseline assessments are made to determine the presence of depression and anxiety.

- **Adjustments to service patterns.** Contacts with military personnel are often more formal than those with other clients. The language used with members of the military is more scientific, because it helps people understand that they are not "going crazy," and that the psychological, biological, and neurological processes occurring in their brains are all normal reactions to their experiences. Hugs and physical contact are avoided, unless it is an extraordinary situation and the staff member senses that such contact is appropriate and needed.

## ▶ New Mexico ATR Experience

**Approach:** Tailored intake and service provision

**Target population:** National Guard, active-duty members, and veterans with access to clinical treatment and recovery support services

**Successful Strategies:**

- Modifications to central intake

- Adjustments to service patterns

- Integrating an understanding of rank and structure

- Adjusting protocols for provider access

- Integration of alternative therapies

- **Integrating an understanding of rank and structure.** Staff and volunteers, including recovery support service providers, speak with the clients about their experiences as members of the military hierarchy. Intake specialists and providers ask about clients' rank and ask how they earned the rank. Military personnel are addressed as "sir" or "ma'am," or by their rank. Once enough trust is built, the goal is to get past rank and move on to feelings.

- **Adjusting protocols for provider access.** Service members and veterans use the option of contacting a therapist directly if they are in crisis. When military clients call in crisis, the therapist discusses skills they can use to help them regain control over their situations. In many cases, the knowledge that they can make that call directly to the therapist empowers them to help themselves.

- **Integration of alternative therapies.** Military health systems have used alternative therapies in the treatment of personnel for years. Studies have shown the effectiveness of acupuncture and herbal

## ▶ New Mexico Lessons Learned

- **Civilian providers are sometimes preferred.** Military clients sometimes appreciate having a civilian therapist with some understanding of military culture. They like the idea of "working outside the system" on their issues and problems.

- **It is important to ask military clients about their jobs.** Military clients like the fact that therapists in the New Mexico provider organizations take the time to ask about their jobs (e.g., "What did you do in Iraq? What is it like?"). They are often asked to draw a map to show where they were deployed and provide details about life in Iraq. This helps them understand that the therapist cares and understands their issues. It also creates a space in which they can discuss memories that no one else wants to hear about.

remedy protocols in working with service members and veterans who experience PTSD symptoms. The New Mexico ATR project refers to Doctors of Oriental Medicine,* who work effectively with military clients. Because the client and acupuncture practitioner do not need to discuss all aspects of the client's condition or details of his or her issues, such remedies are particularly acceptable to and beneficial with military clients.

- **Educating military personnel about treatment and recovery.** Military personnel are often afraid to disclose their military status at intake, making it difficult to treat the individual most effectively. In response, New Mexico ATR staff members are educating military personnel about the effectiveness of treatment and the possibility of recovery. The New Mexico ATR project is also exploring the use of peer specialists with military backgrounds for outreach and recovery support services.

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\* Doctors of Oriental Medicine have special qualifications as a result of their participation in the Acupuncturists Without Borders Military Stress Recovery Project trainings.

## 2. Indiana

Indiana's approach toward providing services to military clients takes into consideration the service member's experience and strengths and focuses on helping ATR providers understand the military culture. This approach integrates the following strategies:

- **Modifications to central intake.** Intake services are tailored to identify and address the needs of military clients through an eligibility and strengths assessment. The intake is important and can set the overall tone for the military member's continued engagement in case implementation. This is a good point to begin to identify options and reinforce individual strengths that support engagement and retention. It is important to adjust intake questions to focus on military service rather than limiting it to military status (e.g., "Have you ever served in the military?" rather than "Are you a veteran?"). Many service members do not identify themselves as veterans.

- **Operation Immersion.** Indiana has implemented an Operation Immersion training, in which they "immerse" their civilian staff in the military culture and fundamental aspects of military life. Soldiers provide official briefings, but some of the highest-impact learning opportunities come from the casual conversation and down-time discussions with the soldiers.

▶ **Indiana ATR Experience**

**Approach:** Tailored intake and service provision; implemented Operation Immersion

**Target population:** National Guard, active-duty members, and veterans with access to clinical treatment and recovery support services

**Successful Strategies:**

- Modifications to central intake

- Learn the language and the lingo

- Know the resources and be able to make swift referrals to military resources

- Trust your instincts

- **Learn the lingo**. Military members have a language all their own, and to many unfamiliar with this language, it is completely foreign. Indiana staff are encouraged to learn the language—not necessarily to be able to use it, but at least to understand it. Staff are encouraged to accept the language, not be put off/offended by its use, and at a later time to ask someone other than the client what it means.

- **Know and be able to access military resources.** ATR providers must have the available military resources at their fingertips and be able to make an immediate referral to Yellow Ribbon, Military Family Life Coaches (MFLC), Military OneSource, etc. The ability to connect an individual swiftly demonstrates informed care.

- **Attracting military clients to ATR.** Word of mouth works best. ATR providers speak with recruiters, unit leaders, and Counterdrug Support Officers.

- **Trust your instincts.** Clinicians must remember to trust their instincts in the engagement process. Clients may be addicts and/or alcoholics, and they are military. Clinicians must trust their clinical instincts if they suspect trauma or other clinical indications.

- **Suggest additional services.** There may be a need to suggest other services (e.g., "Although YOU may not need it, your family may need.…" or "We have sexual assault, trauma, providers that are available to all our clients.…"). Where it is appropriate, these suggestions may be repeated as people's insight grows.

▶ **Indiana Lessons Learned**

- Women may be more forthcoming in individual settings. Women are more likely to disclose personal information in individual settings than in group settings.

- Women are also more likely to be open in discussions that take place in "informal" settings, e.g., knitting circles or jewelry making classes.

- **Stay with it.** It may take a few times before the service member is willing to hear what is being said or recommended. The following statement comes from a woman suffering from PTSD and military sexual trauma: "How do we tell you doctors to 'keep asking us?' Sometimes it takes a few times before we are willing and/or 'hear' you; we are trained to not need anything."

- **Become familiar with battlemind training.** Service members and families receive battlemind training at the end of deployment. This is a good reference point to bring the discussion back to information they have heard before.

## Part VI: References and Additional Resources for Serving Military Clients in ATR

### 1. Federal Government Resources

- **Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment,** SAMHSA TIP 50, SAMHSA's Treatment Improvement Protocol for Substance Abuse Counselors and Supervisors. http://kap.samhsa.gov/products/manuals/tips/pdf/tip50.pdf

- **ATTC Clinician Site for Serving Veterans** The ATTC Network Web site contains information on topics that are critical to the safe and effective treatment of returning veterans who have substance use disorders (SUD), post-deployment stress effects, and/or other related challenges (e.g., depression, anxiety). http://www.attcnetwork.org/learn/topics/veterans/forclinicians.asp

- **The Veterans Spotlight CD** is a compilation of print and online links and training resources to assist clinicians who provide substance abuse and mental health services to veterans, particularly OEF/OIF returning veterans. The CD can be ordered free of cost: http://www.attcnetwork.org/regcenters/productdetails.asp?prodid=516&rcid=14

- **Defense Centers of Excellence for Psychological Health and Brain Injury** includes a number of Centers funded by the Department of Defense. Its Web site provides information and resources on traumatic brain injury, psychological health issues, and combat stress specifically tailored to health care professionals. The Web site contains information on treatment options for PTSD and tips for civilian health care professionals treating military patients. http://www.dcoe.health.mil/ForHealthPros.aspx

- **Deployment Health Clinical Center (DHCC)** is one of the Centers in the U.S. Department of Defense's Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Its Web site is designed to assist clinicians in the delivery of post-deployment health care services. The Web site contains a wealth of resources, including post-deployment Health Clinical Practice Guidelines and a resource library specific to Reserve Component Personnel. http://www.pdhealth.mil

- **Management of Traumatic Stress Disorder and Acute Stress Reaction** are the U.S. Department of Veterans Affairs guidelines that provide clear and comprehensive evidence-based recommendations for practitioners throughout the Department of Defense and VA Health Care systems. The guidelines are intended to improve patient outcomes and local management of patients with these diagnoses. http://www.healthquality.va.gov/Post_Traumatic_Stress_Disorder_PTSD.asp

- **National Center for PTSD,** the U.S. Department of Veterans Affairs, is the center of excellence for research and education on the prevention, understanding, and treatment of PTSD. The Web site contains materials on the psychological effect of trauma and tools to help providers with assessment and treatment of PTSD. http://www.ptsd.va.gov

- **The National Center for Trauma-Informed Care** is SAMHSA's technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. http://www.samhsa.gov/nctic

- **Office of Tribal Governmental Relations, a Web site of the Department of Veterans Affairs,** outlines strategies that the VA will employ to work with Tribal veterans. http://www.va.gov/tribalgovernment

- **Post Deployment Health Evaluation and Management (PDH)** includes the U.S. Department of Veterans Affairs guidelines and provides clear and comprehensive evidence-based recommendations for practitioners throughout the DoD and VA Health Care systems. http://www.healthquality.va.gov/Post_Deployment_Health_PDH.asp

- **Substance Abuse and Mental Health Services Administration (SAMHSA)** includes resources, program information, and data pertaining to the needs of military members and their families. http://www.samhsa.gov/MilitaryFamilies

- **Recovery and the Military: Treating Veterans and Their Families** is a DVD of a Webcast produced by SAMHSA that explores alcohol and drug addiction among veterans, post-traumatic stress disorder and other contributing stressors, and the effect of addiction on families. http://store.samhsa.gov/product/DVD251

- **The Returning Veteran's Journey: Where Trauma and Substance Abuse Intersect,** an article from the Northwest Frontier ATTC's newsletter, Addiction Messenger, discusses the effects of PTSD in combination with alcohol use problems for returning veterans. http://www.attcnetwork.org/userfiles/file/vol%20%2011%20issue%208%20new.pdf

## 2. Private and Not-for-profit Resources

- **The Addiction Technology Transfer Center of the New England Distance Learning Program at Brown University's CAAS** provides continuing education courses in addiction treatment and prevention to health care professionals, including addiction treatment providers, counselors, social workers, nurses, psychologists, and physicians. The site includes a calendar and description of training opportunities. http://www.browndlp.org/index.php

- **ATR Services and the Military: Preparing Your ATR Staff and System Webinar,** SAMHSA's Access to Recovery Program, a Webinar produced for ATR grantees, discusses SAMHSA's strategic priority for addressing the behavioral health needs of service men and women and includes basic information relative to military culture and terminology. It also includes highlights of the TriCare, DoD, and VHA military health programs. http://altarum.adobeconnect.com/p38091937

- **The Center for Deployment Psychology** trains military and civilian behavioral health professionals to provide the highest quality deployment related behavioral health services to military personnel and their families. Resources and information regarding various in-person and Web-based training opportunities are available on the site. http://www.deploymentpsych.org

- **Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol** and its accompanying CCTIC Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs. http://www.annafoundation.org/CCTICSELFASSPP.pdf

- **The Emotional Stages of Deployment, Hooah 4 Health** is an online article that discusses the emotional cycle of an extended deployment, six months or greater. Each stage is characterized both by a timeframe and specific emotional challenges, which must be dealt with and mastered by each of the family members. http://hooah4health.com/deployment/familymatters/emotionalcycle.htm

- **Expert Consensus Guidelines on the Treatment of PTSD** are guidelines on the diagnosis of PTSD and common co-morbid conditions, on selecting the overall treatment strategy, and on level of care issues. The guidelines include recommendations for preferred psychotherapy techniques and medications for treating specific types of target symptoms and co-morbid conditions. http://psychguides.com/sites/psychguides.com/files/docs/ptsdgl.pdf

- **Finding Balance** is a series of materials designed to help service members, veterans, and families understand post-deployment stress effects, build resilience, and learn to de-escalate their stress reactions. The series includes workbooks for service members, veterans, and military families, a pocket-sized "quick book," and materials for clinicians and facilitators. All materials are free for download from Human Priorities, a site managed by Pamela Woll, a Chicago-based author, ATTC consultant, and developer of the Finding Balance series. You can download it at https://sites.google.com/site/humanprioritiesorg/home/resilience-101

- **Grace After Fire** is an organization in Texas that provides services for women veterans, and their loved ones, to connect with one another and with professional partners, to find resources, to learn and to get involved. http://www.graceafterfire.org

- **Healing a Broken System: Veterans Battling Addiction and Incarceration** is a policy brief by the Drug Policy Alliance highlighting some of the less-discussed but deeply troubling issues affecting veterans and proposes proven, commonsense, and cost-effective ways to improve the health and reduce the likelihood of accidental death and incarceration of service men and women. http://www.drugpolicy.org/sites/default/files/DPA_IssueBrief_Veterans.pdf

- **Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery** is a report that discusses the Rand Corporation's assessment of the post-deployment health-related needs associated with post-traumatic stress disorder, major depression, and traumatic brain injury. http://www.rand.org/pubs/monographs/MG720.html

- **Iraq War Clinician Guide, Second Edition** is a report by the National Center for Post-Traumatic Stress Disorder and the Walter Reed Medical Center containing a wealth of information on issues specific to military personnel that served in the Iraq War and includes a chapter on substance abuse in the deployment environment. http://www.psychceu.com/war/iraq_clinician_guide_v2.pdf

- **Military OneSource** is intended as a one-stop shop for a variety of services ranging from assistance in filing income taxes to obtaining counseling. Twelve counseling sessions can be obtained for any "issue," such as spousal difficulties, sleep problems, or a mental health problem. www.militaryonesource.com

- **Military Suicide Risk Assessment** is a tool created by the Deployment Health Clinical Center for use in primary care settings (through its RESPECT-MIL screening and brief intervention project). It is available at http://www.pdhealth.mil/guidelines/downloads/Suicide_Screening.pdf

- **Military Teens Toolkit** is a toolkit created by the National Military Family Association to give critical people in military teens' lives a way to help them manage stress and affirm the positive aspects of military life. http://www.militaryfamily.org/publications/teen-toolkit

- **National Alliance on Mental Illness Veterans Resource Center** contains a number of links to resources for veterans and their families including information specific to women in the military and multicultural issues. http://www.nami.org/Template.cfm?Section=Veterans_Resources&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53242&lstid=877

- **National Coalition for Homeless Veterans** is a nonprofit organization that serves as a resource and technical assistance center for a national network of community based service providers and local, State, and Federal agencies that provide emergency and supportive housing, food, health services, job training and placement assistance, legal aid, and case management support for homeless veterans. http://www.nchv.org/service.cfm

- **ONE Freedom** is a nonprofit organization that offers service members, veterans, and military families a framework of education and training to build strength, resilience, and a clearer understanding of how to maintain balance in the face of military deployments and other lifestyle challenges. http://www.onefreedom.org

- **PTSD 101** is an extensive web-based curriculum that offers courses related to PTSD and trauma. The goal is to develop or enhance practitioner knowledge of trauma and its treatment. This curriculum is offered free of charge on the site of the National Center for PTSD, at http://www.ptsd.va.gov/professional/ptsd101/ptsd-101.asp

- **PTSD Combat: Winning the War Within E-Journal** is the online journal of Ilona Meagher, a veteran's daughter and author of Moving a Nation to Care: Post-Traumatic Stress Disorder and America's Returning Troops. The blog focuses solely on combat-related PTSD. http://www.ptsdcombat.blogspot.com

- **Veterans Helping Veterans: Utilizing Peer Support/Peer Recovery Models in GDP Programs** is a presentation that discusses how veteran-to-veteran case managers can improve and expand the services provided to veterans and explains the structure, benefits, and limitations of these interventions. http://www.chepinc.org/public/597.pdf