



A Military Culture Approach to SBIRT for LGBTQ Veterans & Active Duty Personnel

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Presentation Outline

- Part 1: A Taste of Military Culture
- Part 2: Substance Abuse Prevalence
- Part 3: Intro to SBIRT
- Part 4: The SBIRT process
- Part 5: Case Examples
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Part 1: A Taste of Military Culture



A Taste of the Culture

- The military is unlike any other career and the demands of military life create a unique set of pressures on service members and their families.
- For most civilians, your job is what you do; in the military it is who you are.
- It is our community with clearly defined rules and expectations.

Exposure and risks

- Military service exposes those who serve to stresses and hazards that have no civilian equivalent (Veterans Benefits, 2013).



- Upon entering military service the civilian identity is transitioned to a military identity through boot camp, however no transition from military to civilian life is provided for soldiers, airmen, sailors, or marines (Demers, 2011).

Traumatizing Experiences in the Military

- Injury to self or others
- Threat of death (IED blast)
- Death of others
- Witnessing human suffering
- Seeing/handling mutilated bodies
- Killing others
- Military Sexual Trauma

Resultant considerations

- Polytrauma
- Moral Injury
- Hazardous exposure
 - Agent Orange, Nerve agents, Toxic fallout , Burn Pits
- Chronic Pain
 - 44% current military after combat deployment,
 - 50% veterans, 85% with Polytrauma, & 35% with PTSD
- Traumatic Brain Injury (TBI)
 - Increase due to technology improvements

(Johnson et al.,
2013)

Resultant considerations

- Post Traumatic Stress Disorder (PTSD)
8-36% of male veterans, 20% women
- Military Sexual Trauma (MST)
 - 1 in 4 women & 1 in 100 men reported experiencing MST
- Risk for self- harm and suicide
- Substance Use Disorder (SUD)

(Johnson et al.,
2013)

LGBTQ Service Members and Veterans





Part 2: Substance Abuse Prevalence



Substance Abuse in the Military

Though illicit drug use is lower amongst military personnel when compared to civilian populations heavy alcohol, tobacco, and prescription drug abuse are much more prevalent and are on the rise.



(NIDA, 2013)

Risk Factors

Those with combat exposure and multiple deployments are at greatest risk.



(NIDA, 2013)

Combat Exposure

- Cumulatively, deployment duration and frequency have been associated with higher rates of heavy alcohol use among active duty service members.
- Unhealthy drinking rates and alcohol-related consequences are also correlated with intensity of combat exposure, specifically among Reserve and National Guard personnel and younger service members.

(Larson et. al, 2012)

Risk Factors: Multiple Deployments

- More apt to engage in new-onset heavy weekly drinking and binge drinking
- More likely to suffer alcohol- and other drug-related problems
- Greater prescribed use of behavioral health medications
- More likely to start or relapse to smoking

(NIDA, 2013)

Alcohol Misuse

Alcohol use is higher among men and women in the military service than among civilians.

- 47% of active duty service members reported binge drinking in 2008.
- Also, in 2008, 20% of military personnel reported binge drinking every week in the past month.
 - With higher reported rates (27%) among those with combat exposure.

(NIDA, 2013)

Tobacco Use

In 2008, 30 percent of all service members were current cigarette smokers (comparable to civilian rates).

- Though once again rates were higher among those exposed to combat.



(Larson et. al, 2012)

Tobacco Use

During deployment, service members report smoking helps cope with stress, boredom, and sleep problems.

- They also endorse a belief that the dangers of smoking are insignificant compared to those of combat and perceive smoking as socially acceptable in military culture.

(Larson et. al, 2012)

Prescription Misuse

Abuse of prescription drugs is higher among service members than among civilians and as of 2013, was on the rise.

- In 2008, 11% of service members reported misusing prescription drugs, up from 2% in 2002 and 4% in 2005.
 - Opioid pain medications were the most abused.



(NIDA, 2013)

Mental Health and Substance Abuse

In one study, one in four veterans returning from Iraq and Afghanistan reported symptoms of mental or cognitive disorder.

- One in six reported symptoms of Post-Traumatic Stress Disorder (PTSD).
 - Disorders such as PTSD are strongly associated with substance abuse.

(NIDA, 2013)

Young Veterans: At Risk

According to a report of veterans in 2004 – 2006, a quarter of 18 to 25 year old veterans met criteria for past-year substance use disorder, which is more than double the rate of veterans aged 26 – 54 and five times the rate of veterans over the age of 55

(NIDA, 2013)

Suicides and Substance Use

Suicide rates in the U.S. Army began to increase in 2004 and had surpassed the civilian rate by 2008.

- The 2010 report of the Army Suicide Prevention Task Force found that 29% of the active duty Army suicides from fiscal year (FY) 2005 to FY 2009 involved alcohol or drug use.
- In 2009, prescription drugs were involved in almost one third of them.

(NIDA, 2013)

LGBTQ: Substance Use



Tobacco: LGBTQ

Studies have found that lesbians are between 1.5 and 2 times more likely to smoke than heterosexual women.



Tobacco: LGBTQ

Additionally, many studies indicate that gay men use tobacco at much higher rates than straight men – reaching nearly 50 percent in some cases.



(SAMHSA, 2012)

Tobacco: LGBTQ

Bisexual men and women seem to have the highest smoking rates of any subgroup for which data are readily available.

- States that have collected data on bisexuals via surveys found that smoking rates within the population to be between 30 and 40 percent.

(SAMHSA, 2012)

Tobacco: LGBTQ

High rates of tobacco use, specifically cigarettes smoking, have also been found among transgender people.

- Some studies suggest tobacco use rates can range from 45 to 74 percent.

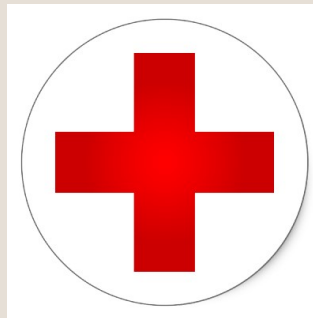


(SAMHSA, 2012)

Special Issue: Tobacco use amongst Transgender individuals

It is critical for prevention specialists and healthcare providers to note that, in transgender women who take estrogen, smoking greatly increases the chances for blood clots.

In addition, transgender men who take testosterone increase their risk of heart disease, and smoking further increases that risk.



(SAMHSA, 2012)

Alcohol: LGBTQ

A number of studies have also suggested that lesbians are significantly more likely to drink heavily than heterosexual women.



(SAMHSA, 2012)

Alcohol: LGBTQ

Data have shown that bisexual adults exhibit significantly higher rates of binge drinking (22.6 percent) than their heterosexual counterparts.

- Additionally, Bisexual women report more hazardous drinking than heterosexual and lesbian women.

(SAMHSA, 2012)

Other Drug Related Issues: LGBTQ

Some studies have shown that gay men use substances, including alcohol and illicit drugs, at a higher rates than the general population.

- Not just in larger communities such as New York, San Francisco, and Los Angeles.



(SAMHSA, 2012)

Part 3: Intro to SBIRT



What is SBIRT?



SBIRT stands for...

Screening: Universal screening for quickly assessing use and severity of alcohol; illicit drugs; and prescription drug use, misuse, and abuse

Brief Intervention: Brief motivational and awareness-raising intervention given to patients at risk for substance use issues

Referral to Treatment: Referrals to specialty care for patients with substance use disorders

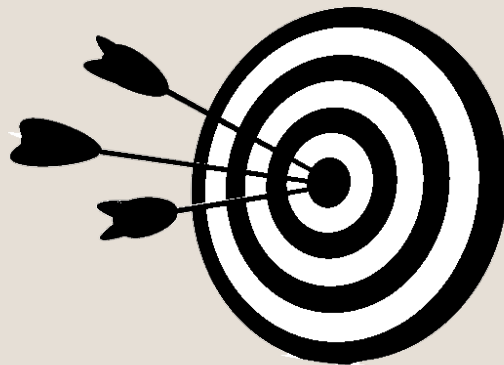
- NOTE: Treatment may consist of brief treatment or specialty AOD (alcohol and other drugs) treatment

What does the SBIRT approach aim to accomplish?



SBIRT aims to...

Identify and effectively intervene with those who are at moderate or high risk for psychosocial or health care problems related to their substance use.



Why is the SBIRT approach important?



Missed Opportunities

Most patients (68-98%) with alcohol abuse or dependence are not detected by physicians.

- Physicians are less likely to detect alcohol problems:
 - When screening tools are not used universally
 - In patients who they do not expect to have alcohol problems: Whites, women, and those of higher SES

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

Is the SBIRT approach effective?



Effectiveness of SBIRT

Meta-analyses and Reviews

- More than 34 randomized controlled trials
 - Focused mainly on at-risk and problem drinkers.

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

SBIRT Cost Savings Example

Fewer hospitalizations and ER visits

- Screening & Intervention cost per pt.:
\$177
 - Cost savings per patient: \$1170
 - » Benefit/cost ration: 6.6/1

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

Making a Measurable Difference

- Since 2003, SAMHSA has supported SBIRT programs, with more than 1.5 million persons screened.
- Outcome data confirm a 40 percent reduction in harmful use of alcohol by those drinking at risky levels and a 55 percent reduction in negative social consequences.
- Outcome data also demonstrate positive benefits for reduced illicit substance use.

Based on review of SBIRT GPRA data (2003–2011)

Effectiveness of SBIRT Example

If you see on average, 40 patients per week...

– 4 to 8 of these patients are at risk for experiencing substance misuse related issues (10 to 20%).

- With brief intervention 1- 3 patients weekly, are likely to lower their risk.

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

How do I make the transition from “business as usual” to SBIRT?



Making the Transition to SBIRT

- Routine and universal screening
- Validated screening tools
 - AUDIT and DAST
- Alcohol and drug use as a continuum (as opposed to the traditional dichotomous view)
- Patient-centered approach (as opposed to directive/advice giving)
 - Motivational Interviewing

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

SBIRT: Things to keep in mind



Part 4:

The SBIRT Process



Screening Step #1

Front desk gives patient a health and wellness screen with imbedded single question pre-screens.



Prescreening Strategy

Use brief yet valid prescreening questions:

- Alcohol:
 - The NIAAA Single-Question Screen or the AUDIT C
- Drugs:
 - The NIDA Single-Question Drug Screen

Negative

- Based on previous experiences with SBIRT, screening will yield 75% **negative** responses.

Positive

- If you get a positive screen, you should ask further assessment questions.

Questions

- Do you sometimes drink beer, wine, and other alcoholic beverages?
- Do you sometimes use tobacco products of any kind?
- Do you sometimes use drugs and/or prescribed drugs for non-medical reasons?

NIDA Quick Screen

In the past year, how many times have you used the following?

Never
Once or Twice
Monthly
Almost Weekly
Daily or

Alcohol (For men, 5 or more drinks in a day; for women, 4 or more drinks in a day)					
Tobacco Products					
Prescription Drugs for Nonmedical Reasons					
Illegal Drugs					

Screening Step #2

Staff member then reviews screen and administers the AUDIT or the DAST (if necessary).

- Positive?
 - Patient asked to complete AUDIT and/or DAST
- Negative?
 - No further activity



Screening Tools

- AUDIT: Alcohol Use Disorders Identification Test
 - Ten questions, self-administered or through an interview; addresses recent alcohol use, alcohol dependence symptoms, and alcohol-related problems
- DAST: Drug Abuse Screening Test
 - Shortened version of DAST 28, containing 10 items, completed as self-report or via interview. DAST(10) consists of screening questions for at-risk drug use that parallel the MAST (an alcohol screening instrument)

Prescription Drug Misuse

Although many people take medications that are not prescribed to them, we are primarily concerned with—

- Opioids (oxycodone, hydrocodone, fentanyl, methadone)
- Benzodiazepines (clonazepam, alprazolam, diazepam)
- Stimulants (amphetamine, dextroamphetamine, methylphenidate)
- Sleep aids (zolpidem, zaleplon, eszopiclone)
- Other assorted (clonidine, carisoprodol)

Key Points for Screening

- Screen **everyone**.
- Screen **both** alcohol and drug use including prescription drug abuse and tobacco.
- Use a validated tool.
- Prescreening is usually part of another health and wellness survey.
- Demonstrate **nonjudgmental, empathic** verbal and nonverbal behaviors during screening.
- Explore **each** substance; many patients use more than one.

Screening: Things to keep in mind



Brief Intervention

Practitioner reviews results of screening tool and delivers brief intervention.



Brief Intervention Step #1

Raise the Subject:

“Would it be ok with you if we discussed the results of the screening you filled out today?”

- Asking permission makes it a collaborative process.

Brief Intervention Step #2

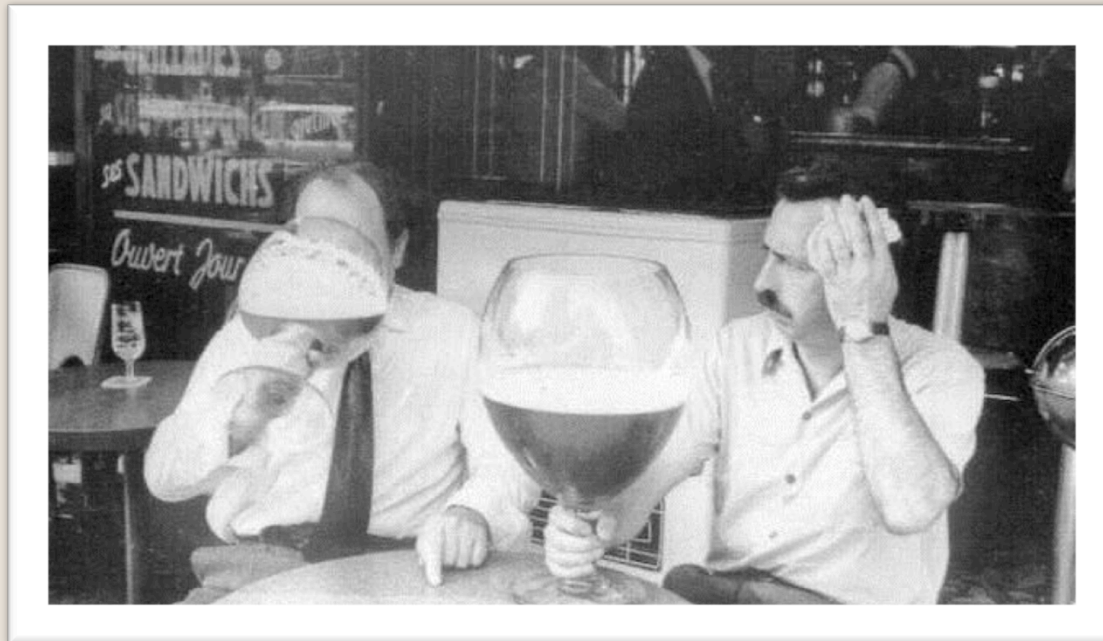
Provide feedback and process response:

“In reviewing your screening results, I noticed that you are drinking (or using drugs) at a level that may be harmful to your health.

How do you feel about your alcohol (or drug) use?”

Note: Providing the information and then eliciting the persons own views, allows you to collaborate and to gauge person’s motivation level.

When screening or during brief interventions, it's useful to clarify what one drink is!



How Much Is “One Drink”?

5-oz glass of wine
(5 glasses in one bottle)



12-oz glass of beer (one can)



1.5-oz spirits
80-proof
1 jigger



Equivalent to 14 grams pure alcohol

WHAT IS BINGE DRINKING?

A pattern of drinking that brings blood alcohol concentration levels to 0.08 grams per deciliter.

FOR WOMEN:



four drinks
in two hours

FOR MEN:



five drinks
in two hours

Recommended Limits for Alcohol Consumption

Men = 2 per day/14 per week

Women/anyone 65+ = 1 per day or 7 drinks per week

> Regular limits = at-risk drinker

Brief Intervention Process Step #3

Explore and enhance motivation to change:

“Would it be alright if I asked you a few more questions about your alcohol (or drug) use?”

On a scale from 0 to 10 how motivated are you to cut down or abstain from alcohol (or drug) use?”

cont.

Brief Intervention Step #3 cont.

If patient responds with a number other than “0”:

“Why that number (their answer) and not a __ (lower number)?”

NOTE: The patients reply should contain reasons for change.

If the patient responds with “0”:

“Thanks for being open to talk about this. If you were to reduce or abstain from substance use, in what ways would your life potentially change and/or improve?”

Brief Intervention Process Step #4

Negotiate a change plan

Scenario 1: Patient is ready to talk further about change:

“What changes would you like to make? And how could you go about making those changes in order to be successful?”

cont.

Brief Intervention Step #4 cont.

Scenario 2: Patient is not ready to talk about change:

“What are some warning signs that you could look out for that would indicate your alcohol (or drug use) has become problematic?”

cont.

Brief Intervention: Things to keep in mind



Referral to Treatment

The practitioner then provides a referral to treatment or provides the person with resources they could utilize in the future.



Referral to Treatment

Scenario 1: The patient is ready to seek treatment:

“Treatment services are available in your area. Would it be ok if I provided you with a referral and helped you schedule an initial consult?”

cont.

Referral to Treatment Resource

SAMHSA Behavioral Health Treatment Finder
Hotline and website:

1-800-662-HELP (4357)

<http://findtreatment.samhsa.gov/>

cont.

Referral to Treatment

Scenario 2: The patient is not ready to seek treatment:

“Would it be ok if I gave you some resources you could utilize if you decide to make a change in the future?”



Referral to Treatment: Things to keep in mind





Part 5: Case Studies



Case Example #1

Gary is 32 year old Army veteran.

- He was recently discharged (honorably) from the Army and most of his social support network is linked to the military.
- He identifies as gay but has not come out to his friends or family for fear of rejection.
- He screens positive for alcohol misuse and upon inquiring further, you discover a long history of tobacco use and binge drinking dating back to adolescence.
 - Gary's binges are also linked with unsafe sex practices including unprotected sex with men he meets at bars.

Case #1: Approach

- Screen
- Acknowledge the military service – allow him to express what the experiences were about for him.
- Ask permission to discuss alcohol or tobacco (likely best to address one)
- Discuss his own stance on his substance use prior to discussing the possibility of change
- Potentially negotiate a change plan
 - Referral for counseling or support related services.

Case Example #2

- Betty is a 25 year old Navy officer who served in combat theaters in Iraq. She identifies her sexual orientation as Lesbian. She served on ships and as part of a health care team for the Marines.
- She reports that she was sexually harassed and assaulted on the ship. She never reported these events for fear of appearing weak and out of concern that her commission would be in danger.

Case Example #2 con't

- Since returning to the US, she has started again and has found it difficult. Simply being intimate with someone will trigger flashbacks to her assault. She is concerned that she will never get better and be able to have a serious long-term relationship.
- She has started using a combination of alcohol and cannabis to address sleep problems and anxiety.
- Smokes 3-4 times per day to control her anxiety.
- She uses alcohol when she is unable to sleep or is having flashbacks.
- She never drinks with other people. She estimates that she drinks 2-3 times per week at about 3-4 drinks per episode.

Case #2: Approach

- Screen
- Listen for somatic and traumatic symptoms
 - Military sexual trauma often involves somato-psychic symptoms
- Ask permission to discuss alcohol or cannabis use
- Try to address the underlying problem and discuss the potential to reduce use (harm reduction)
- Acknowledge the dual role of substance – they help and can hurt
- “what would it take to reduce your cannabis from 3-4 times per day to 2-3 times per day?”

Part 6: Q and A



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