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Addressing the Substance Use Disorder (SUD) Service Needs of Returning Veterans and Their Families:

The Training Needs of State Alcohol and Other Drug Agencies and Providers

Prepared by:
The National Association of State Alcohol and Drug Abuse Directors (NASADAD) and Abt Associates Inc.

With Support from:
The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), under the Partners for Recovery Initiative

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Executive Summary

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted an environmental scan of the training, outreach, and resources offered by the Single State Agencies (SSAs) in charge of drug and alcohol treatment and prevention services to respond to the needs of returning veterans and their families. This scan was conducted to learn how to more effectively serve returning veterans and family members impacted by substance use disorders (SUDs). To accomplish this, NASADAD conducted case studies of nine States that had been identified as having the largest number of initiatives for returning veterans. The data for these case studies were gleaned from 36 interviews with SSA staff and staff from publicly funded SUD treatment facilities. NASADAD staff gathered data on State policies, trainings, and outreach efforts, as well as recommendations for future development of technical assistance and training materials to address the gaps in services.

Specific requests to the States for technical assistance and trainings included:

- Trainings for substance use services providers, as well as primary care providers, to identify and treat post traumatic stress disorder (PTSD) and traumatic brain injury (TBI);
- Trainings on models to treat veteran-specific trauma;
- Trainings on military culture;
- Trainings to help law enforcement officials, the courts, and hospital workers identify veterans' SUDs; and
- Technical assistance to increase telehealth and webinar capabilities to overcome distance/ transportation barriers.

Introduction

Over 1.6 million soldiers have been in theater in Afghanistan or Iraq since 2001. The pace of the deployments in these current conflicts is faster, deployments have been longer, and redeployment is more common than in the past (Tanielian et al., 2008). Repeated and extended deployments have been associated with increased SUDs and other health concerns (Eggleston, Straits-Trotter, and Kudler, 2009). In addition, recent studies (Hoge et al., 2004; Jacobson et al., 2008; Seal et al., 2009) have shown that veterans who experienced combat or other traumatic situations are at significantly elevated risk of SUDs, both pre- and postdischarge from service. Moreover, SUD symptoms can present years after discharge. Though all States (and their providers) have worked with veterans and their families since the 1970s or before, as more is learned about the unique substance use services needs of returning veterans, and as the SSAs and publicly funded SUD treatment and prevention providers are increasingly called on to prepare for and deliver substance use services for Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans,[1] the States and SAMHSA have recognized that it is necessary to develop and identify specific strategies to address the substance use services needs of these veterans and their families.

The Partners for Recovery Initiative (under the Center for Substance Abuse Treatment [CSAT]) is interested in exploring the training needs of State alcohol and other drug agencies and the community-based prevention, treatment, and recovery support providers to ensure that the workforce is prepared to serve veterans. As a first step in this process, NASADAD conducted a preliminary environmental scan of selected States to learn about what specific kinds of trainings and outreach are being offered by the SSAs in charge of drug and alcohol treatment and prevention services in each State, and what trainings and technical assistance the States would like to receive. The results of that scan are presented in this document.

In July 2008, NASADAD queried its members about the SUD services that they provided for OEF/OIF veterans and their families. This brief inquiry asked States whether they had enacted 18 policies, services, and collaborations relationships that States have used to better serve OEF/OIF veterans and their families. NASADAD received responses from 45 States, representing 94 percent of the U.S. population.

[1] These two operations are part of what is referred to as "Overseas Contingency Operation" by the current administration.

NASADAD found there is great variation in the amount of activity that States are involved in when addressing the SUD needs of OEF/OIF returning veterans and their families. Many State agencies have already begun initiatives to address the SUD needs of these veterans, while others are only beginning to develop and implement plans.

Specifically, NASADAD learned that over half of the States have started critical interagency coordination with the U.S. Department of Veterans Affairs (VA), and the National Guard—but only eight have collaborated with the Department of Defense (DoD)/TRICARE. In addition, many States have basic policies in place to respond to the needs of veterans. In 31 States, SUD treatment providers are required to screen for veteran status; in 40 States, providers conduct screening to determine if clients need mental health assessments; and in 23 States, providers are required to screen for TBI. In addition, States have, at relatively low cost, delivered training on the unique needs of OEF/OIF veterans to SUD providers and counselors (13 States), provided information to SUD providers and counselors on services for veterans (22 States), and performed outreach and advertising to reach OEF/OIF veterans (16 States). However, NASADAD's July 2008 inquiry only revealed which types of strategies SSAs have implemented. It could not examine what they are doing in detail, or the effectiveness of any of the strategies that are being used in the States.

Methodology

Based on the results of the 2008 brief inquiry, nine States that reported the greatest activity targeted to veterans were chosen for the case studies. The nine States that participated in this study were Connecticut, New Mexico, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, Utah, and Wyoming. States that have been particularly active in enacting policies and services and in collaborating with veterans' organizations provide rich information about their own and their providers' training needs. To collect the data for the report, NASADAD interviewed between two and six stakeholders who work at the State, local, or provider levels in each identified State. Interviews were conducted over the phone and lasted for approximately 1 hour, with followup questions answered via email.

A discussion guide was developed before interviews were conducted. Discussions were aimed to assess what interviewees perceived to be the most important training needs, *what* initiatives have been implemented or developed (especially training), and *how* these initiatives have been implemented at the policy and provider levels. Specifically, the topics for the interview included perceived need(s) for training, the kinds of initiatives that the interviewees participate in, the impetus for the initiatives, how the initiatives were envisioned and implemented, how the initiative

is funded, any barriers that were encountered and how they were overcome, and how/if the effectiveness of the initiative is measured (i.e., outcomes). The discussion guide was reviewed by the NASADAD Research Committee, which is responsible for providing input on and approving proposed NASADAD inquiries. The guide is included in Appendix B of this document.

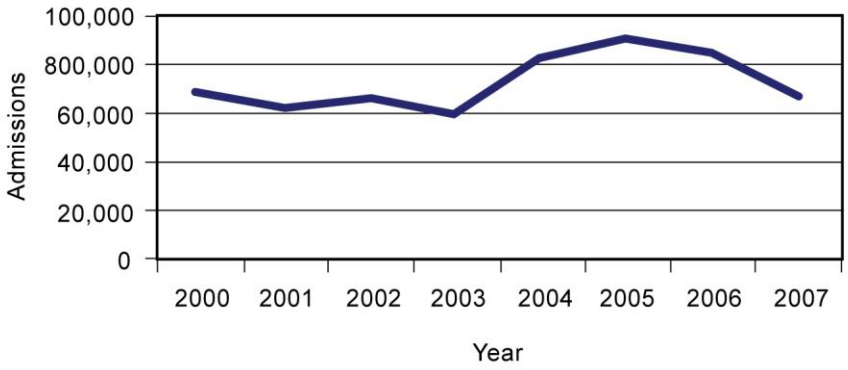
To complement the case studies, NASADAD acquired copies of curricula from trainings and other resources that have already been developed. NASADAD worked with the States to identify other OEF/OIF veteran-specific resources that may be helpful to other States and providers, including specific screening and assessment tools as well as treatment protocols. These documents are included in Appendix C.

Data Trends

To explore trends in the number of veterans who sought admission to the publicly funded treatment systems, NASADAD tabulated data from the Treatment Episode Data Set (TEDS; see Appendix A), which tracks information about admissions to publicly supported addiction treatment facilities. Though the scope of admissions included in TEDS is affected by differences in State reporting practices and varying definitions of treatment admission, TEDS primarily includes facilities that are licensed or certified by the State alcohol and drug agency, facilities that are funded by the SSA, and/or facilities that are required by State legislation to provide TEDS client-level data. Therefore, TEDS does not include all admissions to addiction treatment. A major population missing from TEDS data includes admissions to VA hospitals and facilities. In addition, not all States collect data on veteran status. Between 2000 and 2007, 32 States reported data continuously on veteran status. During this time period, 45 States reported data for at least 1 year. Trends in the data from the 45 States that reported data for at least 1 year are the same as trends in the 32 States that reported data continuously during this time period. Therefore, the following analyses use data from all 45 States that reported data.

The most significant finding was that only an average of 72,326 veterans admissions per year were reported in TEDS from 2000 to 2007 (the most recent year for which data are available). The actual number of admissions has ranged from 59,994 admissions in 2003 to 89,824 admissions in 2005. Figure 1 shows the total number of veterans admissions to substance use (SU) treatment across age groups reported to TEDS.

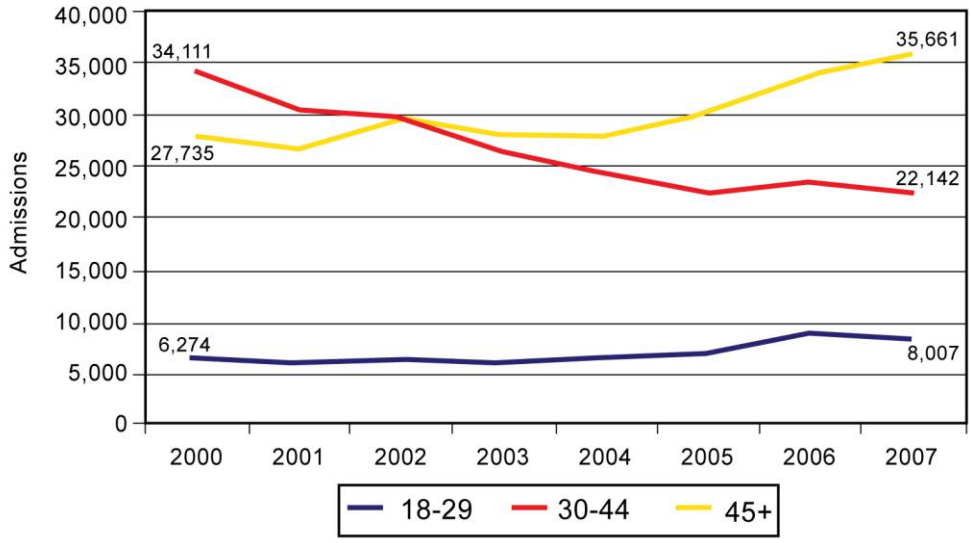
Figure 1: Total Veteran's Admissions to SU Treatment, 2000 – 2007



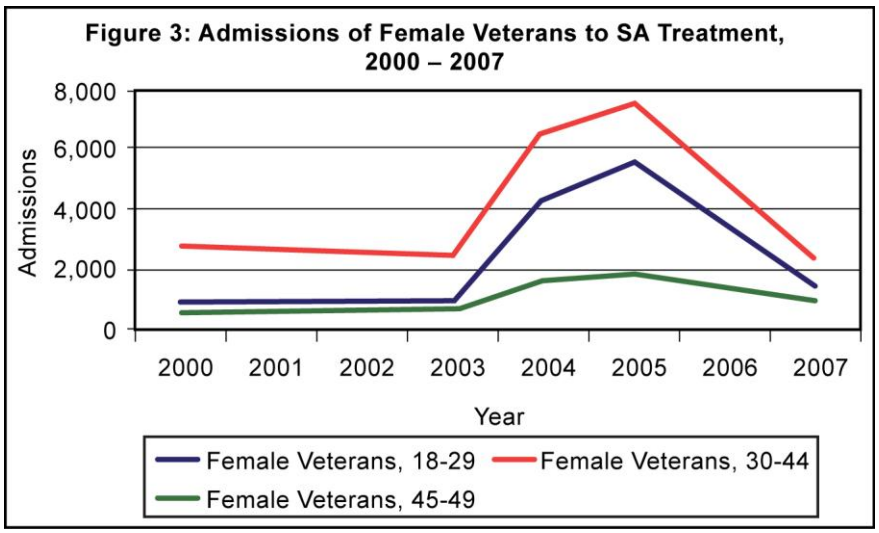
These admissions represent only a small proportion of veterans who are being treated for SUDs. This may be due to a variety of factors, including that veterans are not being treated in the publicly funded treatment system (i.e., they are being treated in VA facilities or privately funded facilities, which are not included in the TEDS universe) or a reluctance on the part of veterans to self-identify as an individual with a substance use disorder.

Despite the relatively small number of veterans reported in the publicly funded systems, it is important to note that the total number of 18- to 29-year-old veterans (the veterans who most likely served in Iraq and Afghanistan during OEF/OIF), increased by 120 percent between 2000 and 2006. The number of 18- to 29- year-old veterans fell sharply in 2007, but remained 30 percent higher than the number of admissions for this group in 2000. This trend warrants further exploration. Figure 2 shows the number of veterans admissions to SU treatment reported to TEDS by age groups.

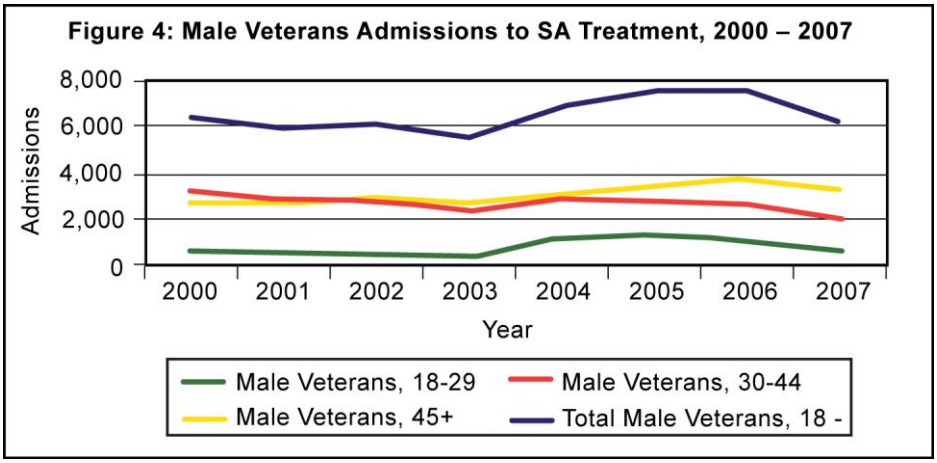
Figure 2: Veterans Admissions to SA Treatment by Age Group, 2000 – 2007



Generally, women represent only about 10 percent of all veterans admissions captured in TEDS between 2000 and 2007. Nationally, the number of woman veterans admitted to the publicly funded substance use treatment system rose drastically in 2004 and 2005, and subsequently dropped equally as drastically in 2006 and 2007, particularly among woman veterans ages 18–44. During these dramatic increases, female veterans admissions rose to nearly 18 percent of all veterans admissions. This trend calls for additional research. Figure 3 shows the rise and fall of the numbers of women's admissions to treatment from 2000 through 2007.



A similar trend can be noted among male veterans admissions during the same time period, but the rise and fall of admissions is not nearly as drastic, as can be seen in Figure 4.



The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH) asks respondents: "Are you currently on active duty in the armed forces, in a reserves component, or now separated or retired from either reserves or active duty?" Combined data from the 2004–2006 NSDUH showed that one-quarter of veterans age 25 and under had suffered from SUDs in the preceding year, though it is impossible to discern from the NSDUH data whether these veterans had been deployed to combat zones. Unfortunately, the numbers of NSDUH respondents who self-identified as veterans in any given year (e.g., in 2007, 168 respondents reported being on active duty in the armed forces or in a reserves component, and 2,168 reported being separated or retired from either reserves or active duty) are too low to discern meaningful

longitudinal trends. Finally, NSDUH cannot identify veterans who might have sought or did seek treatment.

To better understand the data trends from TEDS, and to ascertain how the States are assisting their providers to better serve the SUD needs of returning veterans and their families, NASADAD staff conducted qualitative case studies of nine States. The nine States chosen for the case studies were those that had reported engaging in the largest number of initiatives focused on serving the SUD needs of veterans and their families. By documenting these efforts, other States can benefit from the lessons learned and resources that have been developed from other States.

Case Studies

These nine case studies provide a qualitative picture of the perceived training needs of SUD providers to address the unique needs of returning veterans and their families. To complete these case studies, NASADAD staff interviewed between two and six key stakeholders from each State, including the SSA; the National Treatment Network (NTN) representative; training or continuing education units (CEUs) staff; the staff responsible for veterans services in the SSA's office (if so designated); and providers identified by the SSA's office who participated in initiatives serving returning veterans and/or their families. Topics discussed included policy initiatives, trainings for providers, outreach initiatives, funding streams, and data collection.

Connecticut

The Connecticut Department of Mental Health and Addiction Services (DMHAS) is a combined mental health and addiction services agency. The Director of Veterans Services within DMHAS, Jim Tackett, oversees DMHAS's many veterans' initiatives.

DMHAS contracts with an administrative services agency, Advanced Behavioral Health, to assist in recruiting, training, credentialing, and managing a statewide panel of licensed clinicians (private practitioners) interested in working with military personnel and their family members. To date, there are 235 licensed clinicians in the panel, which is accessed through a 24/7 call center. After a quick triage, the caller is provided the names of three clinicians in his or her neighborhood, and community case managers follow up on these calls to make sure that every caller is connected to services.

DMHAS staff believed that the overall barrier for veterans was access to care, so DMHAS recently enacted a new policy which mandates that veterans get the "next available bed" in their two residential substance use rehabilitation programs. Connecticut has found that automatically referring veterans to the VA without engaging them is often ineffective. They are addressing this issue by training providers on veterans issues and on the services that are available throughout the different systems. In addition, clinicians are encouraged to work with their VA counterparts to conduct discharge planning to assist veterans with their transition back to the community. Finally, regional DMHAS staff can evaluate whether veterans are eligible for VA care and if they meet DMHSAS eligibility requirements (unemployed, homeless). If veterans are eligible for both VA and DMHSAS services, they are given a choice.

The State of Connecticut is one of six States selected by SAMHSA to participate in a $2 million, 5-year Jail Diversion Program for veterans which involves a comprehensive strategic planning process and a pilot project in the Norwich/New London area. Four workgroups have been created: Benefits and Advocacy; Traumatic Brain Injury; Psycho-Social Supports; and Trauma-Integrated Care. A State advisory panel will resolve policy issues and also address sustainability issues. A local panel will provide aggressive outreach and training.

In 2004, the General Assembly appropriated $900,000 for the Military Support Program (MSP). The MSP became operational in March 2007; it instructed the State to provide outpatient behavioral health services to National Guard soldiers and their family members. The CT General Assembly has considered expanding the MSP beyond the reserves and their family members.

DMHAS collects data on all clients admitted to programs that receive State funding (including the MSP). Veteran status is established at intake, and DMHAS serves approximately 5,500 veterans a year. They are unaware, however, of how many OEF/OIF veterans are actually admitted into the system; DMHAS staff hopes to address this issue in the future.

In April 2008, DMHAS began to offer the Veterans Resource Representative Program—a 2-day training directed at DMHAS clinicians (see Appendix C for training handbook). In this program, key clinicians from the VA are brought in to talk about their programs covering such topics as eligibility criteria, enrollment processes, referral protocols, disability compensation, pension, home loan guarantee, and education benefits for veterans. A clinician from the PTSD anxiety clinic provides an overview of the clinical presentation of the newest generation coming home. Another expert on TBI discusses the difficulty in teasing out the differences between symptoms of PTSD and TBI. Clinicians receive 12 CEUs for attending the training. Seventy-five clinicians have been trained so far, but because of monetary restrictions DMHAS is unable to do the trainings more frequently than twice a year. The training is advertised in the DMHAS course catalog, and DMHAS did targeted outreach to encourage participation. Three of these trainings were conducted in 2008 and the first half of 2009; another is planned for October 2009.

The addiction treatment providers interviewed who had received the trainings rated them very highly, both clinically and in terms of education about systems, and expressed interest in attending other trainings. One provider suggested that, in lieu of receiving additional trainings, follow-up regional, quarterly meetings or calls to discuss lessons learned would be very useful. Another provider agreed, but thought

that DMHAS specific trainings focusing only on addressing veterans issues within treatment centers would be helpful.

In addition, DMHAS organized two 2-day trainings conducted by the National Guard for their clinicians in the MSP in 2007; each clinician received 2 days of training and 6 CEUs per training day (12 CEUs in all). The panel members went through "Military 101" training (military organizational structure, policies, and procedures), and a clinician from the VA, Dr. Steven Southwick, provided training on new clinical thinking regarding PTSD. Topics of discussion included State VA benefits, TBI, and treatment modalities for PTSD (including Cognitive Processing Therapy), and DMHAS provided a detailed overview of the MSP. About 20 clinicians have joined the panel since then, and they have been trained individually.

To conduct outreach, Jim Tackett and his VA counterpart have given about 40 presentations across the State—to employers and teachers—to alert them to predictable symptoms of returning veterans and to encourage them to develop local programs. A summary report of the MSP, called "Findings on the Aftereffects of Service in Operations Enduring Freedom and Iraqi Freedom and The First 18 Months Performance of the Military Support Program," has also been completed (see Appendix C) and is being publicized (the 2004 legislation that authorized the MSP earmarked $500,000 for research). The local panel of the Jail Diversion Program will be providing educational activities in the pilot area for veterans who are at risk for arrest as well as for police officers during roll call and during a week-long crisis intervention training.

Beginning in April 2009, DMHAS received funding from the MSP to train and embed clinicians with Guard units that have been deployed or are soon to be deployed. Twenty-four Behavioral Health Advocates have been assigned to Guard units (14 are already embedded); they will participate in drill weekends with the unit (reimbursed for 4 hours)—either doing individual counseling or running workshops, depending on the psycho-education needs of the unit. The assigned clinician will act as the primary point of contact for National Guard members. When the unit deploys, the clinician will shift focus to the family members, and then will work with the unit when it returns. The clinician will provide the necessary services, but if the National Guard or family member needs services in another geographic area or another specialty, the clinician will refer to another MSP clinician. The clinicians will assist with the Yellow Ribbon Reintegration Program, a 30-day and 60-day prevention program aimed at reservists and their family members (a National Guard requirement introduced in March 2008 in a Defense Reauthorization Act). Jim Tackett has also provided outreach to the State

Troopers Offering Peer Support (STOPS), as the State troopers have realized that many in their ranks are in the National Guard.

To complete this summary NASADAD staff talked to Jim Tackett, Director of Veterans Services; Marla Ackerley, Connecticut Valley Hospital–Merritt Hall; and Celeste Cremin-Endes, Director of Rehabilitation Services for Connecticut's Southwest Region.

New Mexico

The New Mexico Behavioral Health Collaborative oversees systems of care, data management, and performance and outcome indicators; monitors training; and funds both substance use and mental health services in the State of New Mexico. The Collaborative is unique in that it is a cabinet-level office representing 15 State agencies and the Governor's office.

In October 2007, the Collaborative began a pilot program in Sandoval County called Veteran and Family Support Services (VFSS). The VFSS initiative is a legislatively funded program focusing on providing triage, case management, and behavioral health services to veterans, service members, and their families, as needed. This initiative has targeted all veterans and their families, including veterans who are eligible for VA benefits, regardless of their ability to pay or their insurance status in the county. In addition to the pilot study, the collaborative maintains and staffs a dedicated telehealth connection room within the National Guard headquarters. This allows VFSS staff to provide brief interventions, triage services, and referrals to National Guard members who are not able to physically go to the VA facility. A VFSS program description and pamphlet are included in Appendix C. Collaborative staff have also agreed to begin a pilot program that will use Access to Recovery (ATR) vouchers to provide wraparound services for National Guard members. The ATR project is funded through a SAMHSA grant.

The VFSS project was funded by the New Mexico Legislature in 2006. In 2008, as a result of a request from Governor Richardson, the legislature provided VFSS with an additional $1.5 million to expand the VFSS project, specifically with regard to PTSD screenings and treatment.

In implementing the VFSS system, Collaborative staff emphasized the importance of family-centered treatment. An evaluation of the project showed that working with families led to positive outcomes. Veterans systems currently do not provide treatment to the families of veterans. In addition, transportation is a major barrier for veterans and their families in need of services. New Mexico has a large

population of homeless veterans who are unable to get transportation to care centers, but even veterans who are not homeless can be hesitant to travel to receive services. The current telehealth services that the Collaborative offers are not sufficient to provide comprehensive services to all of New Mexico's veterans. The Collaborative is also working to diminish the stigma associated with having a mental health or substance use diagnosis, and to allow veterans and their families to maintain anonymity if desired, because it recognizes that there can be negative consequences to such diagnoses. Collaborative staff are working to create policies and practices that will allow veterans and their families to get help without being disempowered; they encourage policymakers to be supportive without labeling.

Minimal information is tracked on veterans and their families. Treatment providers collect veteran status at admission for the TEDS database, and VFSS staff have been working to develop strategies for more consistent data collection. They track direct services that are provided to returning veterans and their families, as well as individuals who were enrolled in direct service. Through the ATR pilot program, the collaborative will be able to track exactly what services veterans and their families are accessing.

All of the Collaborative's initiatives for returning veterans and their families are evaluated on an ongoing basis by staff at the University of New Mexico, Deborah Altshul and Brian Isakson. Their evaluation of the VFSS initiative is included in Appendix C. Specifically the evaluators track the numbers of services provided, individual outcomes, and consumer satisfaction.

The Collaborative has just begun working to identify trainings on addressing the substance use needs of returning veterans and their families. At the December 2008 Behavioral Health Collaborative Conference, a speaker from the VA gave an overview about how to build DoD, VA, and community partnerships to support returning veterans and their families. The Collaborative has not determined if providers have all the skills necessary to serve the needs of returning veterans and their families. They hope to identify training needs through the ATR pilot study.

As part of its VFSS initiative, Collaborative staff have conducted extensive outreach to returning veterans and their families, military and veterans' advocacy groups, the courts and other social service providers to encourage these groups to refer their members and clients to VFSS services. VFSS has also participated in New Mexico's Yellow Ribbon weekends, making presentations to National Guard members and their families. Two additional counties not involved in the VFSS project, which have high proportions of veterans, have given out flashlights and other gadgets with a substance use hotline number (1-877-929-9797) on them to encourage veterans

and their families to utilize this resource as a starting point for receiving SUD services.

To complete this summary NASADAD staff talked to Linda Roebuck, CEO, New Mexico Behavioral Health Collaborative/SSA; Harrison Kinney, New Mexico Behavioral Health Collaborative/NTN; Deborah Altshul, Primary Evaluator, University of New Mexico; and Chris Burmeister, VFSS.

New York

The Office of Alcoholism and Substance Abuse Services (OASAS) plans, develops, and regulates the public prevention and treatment system in New York State (NYS). OASAS staff conduct trainings for providers; license, fund, and supervise providers; and monitor substance use and use trends in the State. Though OASAS funds and supervises Samaritan Village, which has had specific programs to address the substance use treatment needs of returning veterans since 1996, their involvement with returning veterans and their families has escalated in the past 2 years, beginning with their participation in SAMHSA's National Behavioral Health Conference and Policy Academy on Returning Veterans and their Families in August 2008. Since this meeting, the NYS agencies that participated in the Policy Academy continue to work together and meet monthly. OASAS also participates in the NYS Council on Returning Veterans and Their Families, a gubernatorial initiative, with several other State agencies and consumer representatives; the council meets quarterly. Both the Policy Academy Team and the council are targeting all veterans (regardless of discharge status), National Guard members, and family members of veterans. OASAS staff emphasize the importance of working with family members of veterans, a population that they believe is gravely underserved.

New York has several initiatives specifically to address the substance use treatment and prevention needs of returning veterans and their families. In 2008, four providers (including Samaritan Village) were selected for capital project awards to create 100 new residential beds specifically for returning veterans using one-time funding from legislative general funds. The State also allocated $280,000 for prevention counseling in schools near the Fort Drum base. OASAS has also identified two staff members as the designated leads to coordinate regional outreach and services specifically for returning veterans and their families in the upstate and downstate field offices. OASAS also conducts direct outreach at reunification weekends for returning National Guard members and their families, recruits veterans to work in the NYS substance use service system, and is in the process of planning three 90-minute trainings on returning veterans for their providers.

OASAS staff have identified two major barriers to creating initiatives for, and providing services to, returning veterans. Funding is the most significant barrier to addressing the needs of returning veterans and their families. State budgets are stretched thin and there are very few funds to start new programs or provide new trainings. Although OASAS had developed an "Action Plan" (see Appendix C) after participating in SAMHSA's Policy Academy on Returning Veterans and their Families, no funding was provided to finance the plan. In addition, OASAS staff believe that TRICARE is a barrier to access to substance use services for returning veterans and their families. TRICARE pays medical staff other than physicians (individual practitioners and organized providers) a very low rate for services and does not cover substance use services to the family members of returning veterans. Roy Kearse, Vice President of Samaritan Village, pointed out that most of the veterans that are treated by his agency have never been eligible for TRICARE benefits, either because they received a dishonorable discharge (possibly for using illicit drugs or alcohol), or because they are National Guard members.

Based on data from the NYS OASAS Data Warehouse, OASAS estimates that veterans represented 5 percent of all admissions in NYS from October 1, 2006 to September 30, 2007. During that year, there were 13,950 veteran admissions. More information on these admissions is included in the "Veteran Fast Facts" document in Appendix C. However, OASAS staff believe that this number is a significant undercount of the accurate numbers of veterans served. Beginning in 2009, all of the partner agencies involved in the NYS Council on Returning Veterans and Their Families identify veterans in the same way, by asking "have you served in the military?" This is important because people with less than honorable discharges and active-duty military are more likely to identify themselves this way. OASAS staff believe that even using this more global question, they will still be undercounting the number of veterans in the New York public substance use treatment system. In 2009, OASAS and its partner agencies are trying to identify and implement a similar question to be used across agencies to identify the family members of those who have served.

New York has two training mechanisms for its providers: OASAS conducts its own trainings and also certifies individuals and organizations to provide CEUs to providers in New York. OASAS delivers trainings via its online Addiction Medicine Free Educational Series, which are workbooks about specific topics; individuals receive 1 CEU for each completed course in this series. To date, New York has only done one session of its Addiction Medicine series on identifying and working with clients who have TBI (see Appendix C). OASAS also presents biweekly, 90-minute webinars designed to enhance the skills and knowledge of the addiction profession in their Learning Thursdays initiative. Currently, Learning Thursdays

trainings reach 400 substance use providers. These trainings are funded as part of OASAS's annual budget. OASAS training staff are currently developing the following webinars for the Learning Thursdays series: TBI Strategies (how to treat the substance use disorders of clients with TBI); Military 101 (an introduction to military culture); and TBI and Substance Abuse (the causal links between TBI and substance use). These topics were identified by the OASAS Training Division in March 2009, and the trainings were developed in May 2009. OASAS staff noted that online trainings are particularly effective for their providers because they can be accessed remotely and do not require providers to travel to a site-based training.

In addition to OASAS's trainings, several national and State-based training providers have been certified by OASAS to conduct trainings on the needs of returning veterans for providers in NYS (see "Learning and Development Initiatives for Addiction Providers Working With Veterans" in Appendix C for examples of these trainings). In addition, the Institute for Professional Development in the Addictions, which serves as the New York Office of the Northeast Addiction Technology Transfer Center, has offered a series of free workshops on the needs of returning veterans, as well as quarterly returning veterans roundtables (see Appendix C for Veterans Roundtable agenda and presentations).

OASAS is confident that its providers are able to meet the SUD needs of OEF/OIF veterans. However, OASAS staff believe that providers need training on recognizing, treating, and referring patients with TBI and PTSD. Roy Kearse and Carol Davidson of Samaritan Village reemphasized the importance of cultural competency when working with returning veterans (they believe that most providers who are not returning veterans themselves have very little knowledge about the culture of the military), as well as the importance of helping veterans learn to secure safe housing. Lack of funding has prevented OASAS from conducting additional trainings.

The NYS Council on Returning Veterans and Their Families has adopted a "no wrong door" approach, and in support of that approach, each of the member agencies has been making presentations and providing updates to the other agencies to make them aware of what each agency is doing for returning veterans and their families. OASAS has also done outreach to providers in neighborhood health centers to teach them to make referrals to substance use providers. Finally, OASAS presents information about its initiatives for veterans and their families to substance use treatment and prevention providers during OASAS regional provider meetings.

OASAS conducts outreach with veterans and their families directly during reintegration weekends for National Guard members who are being released from active duty. OASAS is also committed to recruiting veterans from all wars to work in substance use services facilities. In support of this initiative, a $200 waiver is provided to returning veterans to take New York's Credentialed Alcoholism and Substance Abuse Counselor licensure test. OASAS staff are also conducting an inquiry of publicly funded outpatient providers in NYS to determine the number of veterans currently working in the system. Lack of funding has prevented OASAS from conducting additional outreach.

To complete this summary NASADAD staff talked to Reba Architzel, Director, Bureau of Special Programs Financing, OASAS; Tom Nightingale, Associate Commissioner, Division of Treatment and Practice Innovation, OASAS; Paul Noonan, Training Coordinator, OASAS; Roy Kearse, Vice President of Samaritan House; and Carol Davidson, Program Director of Samaritan Village's Veterans Program.

North Carolina

North Carolina has the fourth largest active-duty military population in the United States, distributed among eight military bases and 14 Coast Guard facilities. There are 110,000 active-duty soldiers and 25,000 reserve and National Guard soldiers employed in North Carolina. More than 792,000 veterans reside within the State, the 10th highest number in the country. There are over 3,000 reservists currently mobilized, and 35 percent of North Carolina's population is considered military, veteran, spouse, parent, or dependent.

The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (Division of MH/DD/SAS) leads the Governor's Focus on Returning Combat Veterans and Their Families task force, an initiative mandated by the governor to "promote best practices in the service of veterans who served in the Global War on Terrorism and their families." The task force maintains a website, www.veteransfocus.org, which provides information about the prevalence of SUDs, mental health disorders, and TBI among veterans; a list of mental health, substance use, and TBI resources; resources for homeless veterans; and a toll-free information and referral telephone service for veterans called CARE-LINE, with trained staff answering calls 24 hours a day to answer questions, provide information, and make referrals. This website also provides a summary of, and the materials from, the 2006 Governor's Summit on Returning Combat Veterans and Their Families which endeavored to increase collaborations between Federal and State government, service providers, and programs to ensure the maximum level of care possible for

OEF/OIF veterans (see Appendix C for more on the Governor's Summit). North Carolina also maintains the NCcareLINK website (www.nccarelink.gov), which lists information concerning programs and resources across the State and includes information specifically for military veterans. Veterans can access the site to locate the nearest center that provides services for their individual needs. In addition, upon return from deployment, informational packets and a letter from the Governor with a list of resources are also distributed to North Carolina veterans.

Data have been collected on veterans in North Carolina through the NC-Treatment Outcomes and Program Performance System (NC-TOPPS) as well as TEDS. The Governor's Focus on Returning Combat Veterans and Their Families website has minimal statistics available on veterans being served in the health care system. Currently, 12,000 North Carolina OEF/OIF veterans are enrolled with the Veterans Health Administration (VHA).

The Division of MH/DD/SAS has contracted with the North Carolina Area Health Education Centers (NC AHEC) Program to conduct training for service providers on the treatment needs of returning veterans and their families. "Painting a Moving Train," a presentation on PTSD and TBI, has educated 900 primary care providers and 350 substance use treatment professionals (see Appendix C for more information). NC AHEC hosts a podcast for the Citizen Soldier Support Program (CSSP) to present information on the mental health service needs of OEF/OIF veterans (see Appendix C for examples of podcasts). In addition, the Governor's Focus on Returning Combat Veterans and Their Families task force posts training opportunities on its website—including those from the University of North Carolina at Chapel Hill and NC AHEC (see Appendix C for examples of past trainings).

The Division of MH/DD/SAS staff noted that there are many barriers to conducting trainings for SUD providers. One potential obstacle centers on the ability to deliver the trainings that are available. It can be difficult for providers to travel to a central location for a workshop, and it can be costly to bring the workshop to the provider. Another need is for proper training in screening for specialty care, so that individuals who are not screened by their primary care physician do not go without needed services. There is also a desire to implement telehealth care in rural areas.

The Human Ecology Department at East Carolina University directs outreach services for veterans within the State. East Carolina University conducts one-on-one outreach to providers at no cost to the provider. The SSA also works in collaboration with the National Guard Drug Prevention Program, providers, and licensed treatment practitioners to provide assessments and referrals for service members identified with potential substance use disorders.

To complete this summary NASADAD staff talked to Flo Stein, SSA, North Carolina Division of MH/DD/SAS; Spencer Clark, NTN, North Carolina Division of MH/DD/SAS; John Harris, Veterans Mental Health Program Manager, North Carolina Division of MH/DD/SAS; and Barbara Davis, Director of Mental Health Education, Area L AHEC.

Oregon

In Oregon, the SSA is in a combined mental health/substance use department called the Addictions and Mental Health Division (AMH). Beginning in 2008, AMH has focused progressively more on the substance use and mental health services needs of returning veterans and their families. The Governor of Oregon, who is a veteran himself, established the Governor's Task Force on Veterans' Services, and asked one of his advisors to focus specifically on veterans affairs in March 2008.

Although Oregon is not home to any military bases, it has the second largest number of deployed soldiers per capita in the nation. More than 7,000 National Guard men and women from Oregon have been deployed for active duty to Iraq and Afghanistan since September 11, 2001. The State will deploy another 3,000 National Guard members in May 2009. Services in Oregon continue to primarily target National Guard members and their families. The Governor's Task Force on Veterans' Services specifically examined the need for gender-specific services and focused on the special needs of woman veterans.

As Oregon continues to improve its services to returning veterans and their families, the task force is looking across the nation to identify best practices to better serve that population. They are specifically interested in learning about jail diversion programs, including veterans courts, and trainings for law enforcement officers about how to recognize and address veterans issues. In December 2008, the task force released a report (see Appendix C) detailing their findings and recommendations for improvements in a variety of areas, including mental health and addiction service delivery that affect the lives of veterans and their families. Although AMH currently is not systematically collecting any data, they have contracted with a consultant to do a stakeholder analysis. This analysis is being financed through AMH funding.

A policy action package, titled "Addiction Services for Uninsured Workers and Returning Veterans," was proposed by AMH for 2009–11 (see Appendix C for the full document). If AMH receives the $5,710,000 necessary for its implementation, the package will support "outreach, brief intervention services and outpatient

addiction treatment to 3,000 workers and returning veterans who have substance use and/or co-occurring substance use and mental health disorders and are uninsured or have exhausted their healthcare benefits" (Department of Human Services, Policy Option Package 2009-2011).

Oregon's rural areas specifically face numerous challenges exacerbated by geography. For veterans and their families who live in rural areas, traveling to and from distantly located VA facilities becomes a major inconvenience as well as a financial burden that can ultimately prevent them from obtaining necessary addiction services. In addition, according to findings from the task force, existing access for addiction services in remote/rural areas of the State is insufficient for the current and projected needs of veterans and families. Finally, no residential or inpatient program exists in the VA system that allows children to accompany their mother into treatment, which is often a deterrent for women who might otherwise seek care.

AMH has recognized the need to create training programs for their providers on the needs of returning veterans and their families. Currently, they hold biannual meetings that provide training and presentations on the latest research for mental health/substance use providers, and they believe that this would be a good venue to provide such trainings (see "Working With Trauma Survivors in Appendix C for an example training). AMH staff are currently trying to identify trainings and trainers that would be appropriate for this conference.

The Governor's Task Force on Veterans' Services identified trauma as a major issue for returning veterans and their families, particularly military sexual trauma, which disproportionately affects women. There are no gender-specific VA treatment facilities in Oregon; this is a barrier for women, who are more comfortable and have better outcomes when they receive such treatment (e.g. child care and prenatal care). In addition, substance use providers' lack of knowledge about PTSD/TBI in working with returning veterans and their families is a major barrier found in Oregon's addiction treatment system. Identifying PTSD, TBI, and SUD continues to be a problem in Oregon, and AMH staff are working to identify appropriate screening and assessment tools.

AMH staff, in conjunction with other entities (including the Oregon National Guard), regularly conduct pre- and postdeployment outreach on substance use and mental health services to returning veterans and their families. This outreach includes a series of discussions, along with the appropriate referral information and resources for veterans and their families, by the Oregon National Guard Reintegration Team. AMH compiles a yearly State directory of providers that is

shown to returning veterans and their families in a PowerPoint presentation. In addition, AMH uses the Reintegration Team's monthly newsletter as a publicity tool for its alcohol and drug use hotline.

The task force found that despite this outreach, veterans and their families still were unaware of many of the services that were available to them. To address this problem, they recommended the creation of a one-stop web-based "Bulletin Board"–type resource to provide a clearinghouse of information for service members and their families.

To complete this summary NASADAD staff talked to Karen Wheeler, NTN/Addictions Policy Manager, and Diane Lia, Women's Services Network (WSN), from the Addictions and Mental Health Division and Elan Lambert, Director of National Alliance on Mental Illness (NAMI) Oregon, to learn about the ways Oregon has responded to the needs of OEF/OIF veterans.

Pennsylvania

The Pennsylvania Bureau of Drug and Alcohol Programs (BDAP) is charged with developing and implementing a comprehensive health, education, and rehabilitation program for the prevention, intervention, treatment, and case management of drug and alcohol use and dependence. This program is implemented through grant agreements with the 49 Single County Authorities (SCAs) who, in turn, contract with private service providers. Each of the SCAs operates independently and handles its own administrative oversight, funding, and program initiatives while BDAP provides for central planning, management, and monitoring. Programs are funded with State and Substance Abuse Prevention and Treatment Block Grant funds. The State only collects data on returning veterans through the TEDS systems.

Since 2005, BDAP has participated in the PA Returning Military Task Force, or PA CARES (www.pacares.org). This group meets monthly to address the various needs of Pennsylvania service members returning from Afghanistan and Iraq. The group was developed by Jane Bishop and Captain James Joppy and includes about 20 partners from various State departments, military veterans, advocacy associations, and others. BDAP ensures that a representative takes part in the monthly meetings.

In September 2007, the Pennsylvania Regional Drug and Alcohol Training Institute (developed by BDAP and implemented through the Institute for Research, Education and Training in Addictions [IRETA]) hosted a 3-day training titled "Serving Those Who Serve: Veterans and Their Families" (see Appendix C for the training agenda). The

training was offered to the SCAs as well as to providers within the State. State dollars from BDAP's budget supported the training through the Department of Health. Topics included Treatment for Veterans with PTSD, Secondary Stress, and Addiction Issues; Issues That Impact Women in the Military; Addressing and Treating the Stressors on Families of the Veterans; Traumatic Brain Injury; and Veterans and Homelessness. See Appendix C for Summary of Guidelines for Field Management of Combat-Related Head Trauma.

The State of Pennsylvania partners with IRETA, as well as with the Northeast Addiction Technologies Transfer Center (NeATTC) to provide trainings on various facets of SUD treatment and prevention, including serving returning veterans. As a complement to these trainings, IRETA hosts online newsletters developed by NeATTC to provide education and training for providers. CEUs are offered to those who read the newsletters. In 2002, a newsletter titled "Trauma, Terrorism, and Substance Abuse" focused on substance use and PTSD (see Appendix C).

Several training barriers persist within the State. Of prime importance are the financial barriers and the ability to bring providers to the trainings that are offered. Webinars are being utilized to conduct trainings for medical professionals, but they are not yet readily available for addiction issues. It was noted through the interview process that there is great expertise within the substance use system, but the system is underfunded and collaboration between the substance use field and the State Department of Veterans Affairs is lacking. Training for providers also needs to be ongoing. Providers must be aware of the latest research, treatment protocols, and needs of veterans.

Outreach activities are conducted by individual SCAs, independently of BDAP. One example provided of such activities within the State is an outreach van in Scranton that disseminates information to returning combat veterans. Pennsylvania also relies on its Vet Centers (free services provided to all combat veterans through the VA) and veteran advocacy organizations to conduct outreach services. Outreach services were, however, identified as a greater need throughout the interviews conducted.

To complete this summary NASADAD staff spoke with Jeffrey Geibel, Drug and Alcohol Program Supervisor, BDAP; William Noonan, Program Analyst, BDAP; Michael Flaherty, Executive Director, IRETA; and Jim Aiello, Director, NeATTC.

Rhode Island

The Rhode Island Department of Mental Health, Retardation, and Hospitals is responsible for providing access and support for those with substance use and mental health issues, as well as developmental disabilities. The Division of Behavioral Healthcare Services (DBH) within the department was very active in the Veterans Task Force from 2005 to 2008. Due to budgetary restrictions, DBH employees have not participated in the task force over the last year, but they are hoping to reengage with this group in the future.

In 2005, the New England ATTC, which is based in Rhode Island, collaborated with DBH and various branches of the military and community organizations to create *The Rhode Island Blueprint* (see Appendix C), a document outlining strategic steps to create a system of care for returning veterans; this blueprint has been used as a model by the Department of Defense. More information about the Veterans Task Force, including the Blueprint, a draft handbook, and agendas of task force meetings, is available on their website, http://states.ng.mil/sites/RI/Resources/vettaskforce/default.aspx. This initiative resulted in the identification of a military liaison within the Rhode Island Family Court system, evening programs in both the primary health care clinic and the Addictions Treatment program at the VA Medical Center, and the development of a workforce training project with the Rhode Island Council of Community Mental Health Organizations.

Activities for veterans have, in the past, been paid for out of the DBH budget. Currently, DBH is using a SAMHSA grant to increase supportive housing for veterans and is applying for a SAMHSA Jail Diversion grant (5-year grant for close to $400,000 each year), to divert veterans and others with mental illness, such as trauma-related disorders, from the criminal justice system to community-based trauma-integrated services. DBH is considering using ATR money to provide vouchers to allow veterans to access assessments and case management.

At least two of Rhode Island's substance use providers have a contract with DoD/TRICARE to provide services for veterans. One of these providers offers clinical services that are provided by the VA, while substance use staff members arrange for transportation and the delivery of services. Despite these provider community based organizations and VA collaborations, DBH staff noted that most veterans served by their system do not have TRICARE health insurance and most mental health/substance use providers in Rhode Island are not part of the TRICARE network.

Currently, DBH collects information on veteran status on mental health patients only; addiction providers can report their clients' veteran status in TEDS at this time, but when the mental health and substance use systems merge this year, reporting veteran status will be required for substance use clients as well.

DBH has not provided recent trainings regarding the substance use service needs of returning veterans and their families. They, however, provide scholarships for the New England School of Addiction Studies, where training is offered on PTSD and substance use.

Veterans Task Force committees have undertaken the bulk of the outreach activities for returning veterans in Rhode Island. They have set up a website for women veterans and have provided training for employers to better respond to needs of veterans (see Appendix C). They have also developed and broadcast public service announcements (PSAs) and television announcements. Finally, the task force conducts peer-to-peer training, which trains eight National Guard members and eight civilians to provide assistance to guardsmen. The eight National Guard members that are trained in this program are then embedded in units to help soldiers. If the veteran does not wish to go through the military channels for service, that person is referred to the civilian counterpart to provide referrals.

To complete this summary NASADAD staff interviewed Rebecca Boss, NTN, Corinna Roy, Behavioral Health Planner, and Lori Dorsey, WSN and Public Health Promotion Specialist from DBH; Kathy Rathbun, Director, NRI Community Services; Judy Bolzani, Director of Residential and Substance Abuse and Supported Housing Services at Wilson House; and Dr. Susan Storti, New England School of Addiction Studies.

Utah

There are a total of 16,000 veterans in Utah, and it is estimated that 13,000 Utah service members have been deployed during OEF/OIF. The Utah Division of Substance Abuse and Mental Health (DSAMH) is a combined substance use and mental health agency, working with counties that are authorized as 13 local authorities (10 of those local authorities are combined substance use and mental health). In its veterans initiatives to date, DSAMH has focused primarily on expanding mental health services. DSAMH has participated in monthly meetings of the Veterans and Families Counseling Committee (VFCC), which was convened by the Utah Legislature beginning in 2006, along with representatives of the National Guard, the Utah Veterans Administration, the Brain Injury Association of Utah, DoD, and veterans and family members, to address the needs of returning veterans

and their families. Utah's efforts have been targeted at the families of veterans, because they believe that this is the best way to engage the veterans. They have also targeted active Utah National Guard members.

The Utah legislature passed the Counseling for Families of Veterans bill in 2006, which provided $210,000 for fiscal year (FY) 2007; $210,000 for FY 2008; $100,000 for FY 2009, and $50,000 for FY 2010 to address veterans' issues. Currently the Mental Health Services Division of DSAMH administers the VFCC's funds, but that responsibility will shift to the State Department of Veterans Affairs in July 2009. In addition to funding the VFCC, this expenditure has funded two surveys. The first survey queried providers about existing services for veterans and their families. From this survey, the VFCC concluded that Utah has sufficient capacity to serve veterans and their families with SUDs, but that veterans and their families were not utilizing the services that were available. The second survey was distributed to veterans and tried to identify the reason that they were not utilizing services. From this survey, VFCC members concluded that the reasons were (1) a lack of awareness of existing resources and (2) the stigma attached to using substance use and mental health services.

Utah's NTN representative, Dave Felt, reported that, anecdotally, Utah has seen no increase in utilization of addiction treatment services by veterans or increases in crisis calls. Bart Davis, the Transition Assistance Advisor for the Utah National Guard and Reserves, who helps National Guard members and reservists navigate DoD and VA services, has been able to link every veteran that has contacted him with appropriate services. DSAMH employees believe that most new veterans are utilizing benefits from the VA or private insurance rather than entering the publicly funded addiction system.

Since 2006, over 400 people have attended free trainings conducted by various branches of the military. The trainings focused on OEF/OIF readjustment issues and on recognizing and treating PTSD. One 2-hour session was aimed at mental health and addiction treatment professional counselors, church leaders, and city and county leaders; the session described clinical symptoms of PTSD and other signs to look for that might prompt referrals to services. The second 2-hour session was designed for veterans and their families and discussed, in more general terms, readjustment issues and symptoms of PTSD as well as information on how to obtain help, general veterans benefits, VA hospital and veterans center resources, and other topics. SUDs were mentioned briefly in these trainings but were not discussed in detail.

On April 1–2, 2009, DSAMH held its Generations Conference, an annual 2-day conference targeted at mental health providers (DSAMH's conference for addiction providers takes place in the fall); both public and private providers were invited, and about 500 people attended. A number of sessions were devoted to veterans' issues. The sessions included information on PTSD and TBI clinical considerations in treating veterans. The keynote speaker was Eric Newhouse (a specialist in PTSD and TBI). Eighty-five veterans and family members were invited to the conference for free.

In the future, DSAMH staff would like to develop a DVD to train law enforcement officers on effectively addressing in-home violence and diffusing hostage situations with returning veterans.

The state of Utah developed a DVD, "Benefits for all Utah Veterans," that encourages veterans and their family members to seek the wide range of services that are available to them, including services related to physical or emotional health issues, vocational services, and so on. The DVD was sent to all known family members of veterans (12,000) in all the different branches of the military. The DVD presents the Governor and the four commanders of the different branches of the Utah National Guard encouraging veterans to seek any services they might need. Rather than outlining all the services (telephone numbers and a link to their website, www.utvethelp.com are provided), the DVD attempts to dispel the mindset that the VA's services are only for those who are severely wounded and to encourage people to consider seeking help for their family member. A segment also addresses the myth that a PTSD diagnosis will automatically affect a security clearance, when in fact there has to be a defect in sound judgment and there is a low risk of a PTSD diagnosis affecting a security clearance.

DSAMH staff have learned that the timing of when to conduct outreach with returning veterans is important. Rather than overwhelming the returning veterans with prevention education materials immediately upon their return, it is more effective to give them a brief orientation upon their return and then wait 3–6 months to present the bulk of the material, when symptoms might be starting to appear and veterans and their families would be more receptive to the outreach. In the most recent VFCC meeting, it was noted that symptoms are appearing in about a year, and that this might be a good time to provide interventions and materials.

To complete this summary NASADAD staff interviewed David Felt, NTN, and Ron Stamberg, Director of Mental Health Services, DSAMH.

Wyoming

Although providers in Wyoming have been treating veterans for many years, the combined mental health/substance use department, the Mental Health and Substance Abuse Services Division (MHSASD) has undertaken various initiatives to systematically address the substance use and mental health services needs of returning veterans and their families since 2007. In 2007, MHSASD, in conjunction with the Wyoming Veterans Commission, formed a task force to assess and address the needs of returning veterans and their families. The group conducted a gaps analysis to identify several short-term and long-term needs that the Federal government is not currently addressing. The analysis also identified the resources and services necessary to fill these gaps (see The Wyoming Department of Health's "Executive Report on Veterans' Mental Health Needs" in Appendix C for more details).

During the gaps analysis, the task force found that providers' lack of knowledge regarding veteran resources/benefits and PTSD/TBI are the major barriers within the health care system. MHSASD hopes to obtain funding for housing and financial planning to help stabilize returning veterans and their families with mental health/substance use problems; this stability is necessary to allow returning veterans and their families to confront the source of their problems.

In addition to conducting trainings for providers and outreach to returning veterans and their families, MHSASD gives families a telephone number for MHSASD that they can call for help with almost anything—ranging from a broken refrigerator to an emergency contact for the brigade. Since the beginning of 2008, MHSASD has been transporting counselors, physicians, and psychiatrists to rural communities without VA medical facilities in order to provide OEF/OIF veterans and their families with needed care. MHSASD also reimburses OEF/OIF veterans and their families for mileage to travel to a VA facility from a rural community. MHSASD also provides reimbursement for veterans and their families to travel to a MHSASD funded services when they are not eligible for VA benefits.

The Wyoming State Legislature appropriated $848,000 in 2008 to address gaps in service identified by the task force. The funding allows for the contracted services of two Veterans Advocates whose duties include assisting soldiers and their families who may be in need of mental health or addiction treatment services. The appropriation also included $68,000 for reimbursement of physicians to provide assessments; $250,000 to reimburse soldiers and their families for such items as childcare, transportation, and mileage to access mental health or addiction treatment services; $40,000 to provide training to physicians and other health care

providers on war-related injuries and illnesses; and $50,000 to provide reintegration training for community leaders and employers.

MHSASD informally tracks treatment services, including assessments, of OEF/OIF veterans visiting publicly funded providers only. In the opinion of Ronda Brauburger, the Veterans Advocate, OEF/OIF returning veterans are unique because society is now aware of and can look for the symptoms of PTSD and other mental health/substance use conditions when they return from combat. She believes that TBI is more prevalent within OEF/OIF veterans because of their increased exposure to explosions.

MHSASD uses the legislative appropriation to host a number of training programs with the objective of improving services for returning veterans and their families. Annually, they organize a statewide 2½-day training called "The Wounded Warrior Wellness Workshop: Preparing Professionals to Meet the Needs of Veterans" to prepare the community for the return of veterans. MHSASD uses this workshop as a mechanism to target the entire community, including primary care physicians, nurses, mental health/addictions providers, police officers, and families, regarding TBI, PTSD, and available resources from MHSASD and the Wyoming Department of Veterans Affairs. Although the workshop targets the community at large, it does have several tracks specific to mental health and addictions providers. They are planning on videotaping the Wounded Warrior Workshops and translating them into a series of three webinars for non-attendees to view. Attendees will receive CEUs for attending the workshop or participating in the webinar.

In November 2007 the Wyoming Department of Health, including MHSASD, partnered with the Wyoming Military Department to host an educational training conference at Camp Guernsey for Wyoming health providers and military leaders. The conference was designed to give attendees a more detailed background regarding war-related illnesses and injuries. The Wyoming Life Resource Center in Lander also offers assessment services and TBI training for providers working with veterans and their families.

A barrier identified by the State is that many primary care physicians do not attend these specialty trainings, for reasons such as a lack of awareness, funds, or desire, and they lack the training for assessing PTSD, TBI, and other SUDs. It is important for physicians to have a good understanding of the resources available to this population, but the vast distances between providers make it difficult for MHSASD to conduct statewide trainings. The integration of telehealth technology will be useful in overcoming this barrier.

MHSASD staff have conducted outreach to returning veterans and their families, as well as providers. The department participates in and provides resources to be handed out at the National Guard's Yellow Ribbon Program in Wyoming. MHSASD runs another program, similar to the Yellow Ribbon Program, called the Family Readiness Fair. This event, which is held prior to deployment, focuses on the soldiers and their families, offering trainings in various problem areas (e.g., maintaining relationships while apart), resources for connecting with providers and other relevant assistance, and educational materials about maintaining healthy lives and looking for warning signs of conditions such as PTSD and TBI. Staff have also embarked on an advertising campaign to increase community awareness of the needs of returning veterans and their families. As part of this campaign, staff have spoken on radio shows, distributed written material throughout the State, and created informative websites.

Conducting outreach to primary care physicians to help them identify and refer patients with SUDs has been a priority for MHSASD. In 2007, MHSAD sent a letter, screening instrument, and referral information to primary care physicians throughout Wyoming. The task force also prompted Governor Freudenthal to mail a letter to the Wyoming Medical Society encouraging Wyoming primary health providers to become TRICARE providers.

MHSASD staff understand that support is necessary for providers to successfully conduct outreach efforts on behalf of veterans. They also believe that without outreach State initiatives will have a minimal impact.

To complete this summary NASADAD spoke with Rodger McDaniel, Deputy Director, Laura Griffith, Program Manager, Regina Dodson, Veterans Specialist and Ronda Brauburger, Veterans Advocate, of MHSASD to learn about the ways Wyoming has responded to the needs of OEF/OIF returning veterans.

Findings

Below is a chart that summarizes target populations among service members and their families, a brief list of State-sponsored trainings for service providers, initiatives to assist veterans and their families, and outreach initiatives that have been undertaken by the SSA in each of the nine case study States. The chart also summarizes barriers identified by the SSA in each of the nine States.

	Target Population	Trainings for Providers	Initiatives for Veterans and Their Families	Outreach Initiatives	Barriers Identified
Connecticut	National Guard soldiers and their family members (Military Support Program [MSP]) Veterans at risk for arrest (Jail Diversion Program)	Veterans Resources Representative Training Program Trainings for MSP clinicians	"Next available bed" policy MSP Jail Diversion Program Embedded Behavioral Health Advocates	Conducted outreach to: State Troopers Offering Peer Support (STOPS) Employers and teachers Veterans and their families	Transportation Lack of data on the number of veterans/family members admitted into the system Access to care (not enough beds) Referrals without engagement Need for better coordination between the SSA and the VA
New Mexico	National Guard members All veterans and their families	General session on "Building Department of Defense, VA and Community Partnerships: Working to Support Veterans of Iraq and Afghanistan and their Families"	Veteran and Family Support Services (VFSS) Access to Recovery	Conducted outreach to returning veterans and their families, military and veterans' advocacy groups, the courts and other social services providers (VFSS) Handed out flashlights with the substance use hotline number in non-VFSS areas	Transportation Funding
New York	All veterans regardless of discharge status National Guard members Families of veterans	Web-based Trainings: TBI Strategies, TBI and Substance Abuse, Military 101 Partners with the Northeast Addiction Technology Transfer Center (NeATTC) to provide additional trainings	"No wrong door" approach Prevention counseling in schools	Conducted outreach during reunification weekends with National Guard members and their families Conducted outreach to the other agencies participating in the NY State Council on Returning Veterans and their Families to make them more aware of resources	Transportation Funding TRICARE

	Target Population	Training for Providers	Initiatives for Veterans and Their Families	Outreach Initiatives	Barriers Identified
North Carolina	Veterans who served in the Global War on Terrorism and their families	Regional and web-based trainings through the Area Health Education Centers (NC AHEC) Program	Web-based resource lists	Outreach conducted to individual providers on the needs of returning veterans and their families by East Carolina University	Transportation Funding
Oregon	National Guard members and their families Female veterans	Currently trying to identify trainings and trainers that would be appropriate	Proposed creation of a one-stop web-based information clearinghouse	Conducts outreach with the National Guard to National Guard members and their families Publicizes a list of providers and a substance use hotline number	Transportation Substance use providers' lack of knowledge about PTSD/TBI Identifying appropriate screening and assessment tools Lack of VA facilities that allow children to accompany their parents into SUD treatment Despite outreach, veterans and their families still unaware of many available services
Pennsylvania	Identified by the Single County Authorities (SCAs)	Partnered with IRETA to host "Serving Those Who Serve: Veterans and Their Families" and publish web-based newsletters Department of Health trainings: Treatment for Veterans With PTSD, Secondary Stress and Addiction Issues; Issues That Impact Women in the Military; Addressing and Treating the Stressors on Families of the Veterans; Traumatic Brain Injury; Veterans and Homelessness	Conducted by the SCAs	Conducted by the SCAs Vet Centers and advocacy organizations PA cares website	Transportation Funding Need better collaboration between PA Bureau of Drug and Alcohol Programs (BDAP) and VA

	Target Populations	Training for Providers	Initiatives for Veterans and Their Families	Outreach Initiatives	Barriers Identified
Rhode Island	All veterans and their families National Guard members Female veterans and National Guard members	Work with New England School of Addition Studies to provide trainings Peer-to-peer training	Supportive housing initiative Workforce training project with the Rhode Island Council of Community Mental Health Organizations Created a military liaison within the Family Court system	RI Veterans Task Force has: Created public service announcements Conducted outreach to employers Created a website for woman veterans	Transportation Funding/staffing
Utah	Families of veterans National Guard members	Generations Conference sessions on veterans issues	"Benefits for all Utah Veterans" DVD sent to all families	Outreach conducted when National Guard members return from combat and 3–6 months post return Distributes the DVD "Benefits for all Utah Veterans"	Transportation Lack of awareness of existing resources Stigma
Wyoming	National Guard members	"The Wounded Warrior Wellness Workshop: Preparing Professionals to Meet the Needs of Veterans" Wyoming Life Resource Center offers TBI training	Veterans Advocates Wyoming State Training School offers assessment services Provide transportation	Outreach to primary care physicians Participates in and provides resources to be handed out at the National Guard's Yellow Ribbon Program Family Readiness Fair Advertising campaign	Lack of knowledge regarding veteran resources/benefits and PTSD/TBI Funding for housing and financial planning Transportation/ distance between providers and clients

Note: IRETA = Institute for Research, Education, and Training in Addictions; PTSD = posttraumatic stress disorder; TBI = traumatic brain injury; VA = U.S. Department of Veteran Affairs

Themes

Though each State case study is unique, several themes became apparent upon analysis. These themes can be grouped in several topic areas: lack of data; targeted populations; need for training resources and evidence-based practices; common barriers and key issues. A summary and more extensive discussion of the themes are provided below. The themes provide valuable information for planning future services for veterans and their families.

Lack of Data

- Most States capture limited data on veterans and their family members.
- Data are often considered to be an underestimate of the numbers of veterans served in the substance use systems.
- Data are not captured consistently from State to State.
- Service data are not routinely tracked on veterans and family members between the substance use system and the VA system.

Targeted Populations

- All States provide services to veterans in combat and noncombat situations, dating back to World War II.
- Most States identified National Guard members as a priority population.
- Family members of veterans were identified by several States as target populations.

Need for Training Resources and Evidence-Based Practices

- States noted the need for information on evidence-based practices for returning veterans and their families, particularly for OEI/OIF veterans.
- States seek resources, such as screening and assessment tools.
- States require training and training materials, particularly on PTSD, TBI, and military culture.

Common Barriers

- Funding, particularly to expand services and to provide training
- Transportation
- Collaboration with and knowledge of the VA

Key Issues

- Strong leadership from the Governor, State funding, and cross-systems collaboration were key elements to the success of these State efforts targeted to addressing the substance use issues of returning veterans and their families.
- Three States emphasized the "no wrong door approach," which provides individuals easy access to services wherever they enter the system.
- Five States mentioned the importance of coordination, communication, and linkages between the SSA and the VA.
- Lastly, several States noted the importance of providing holistic services to veterans and their family members.

Lack of Data

The lack of accurate data on the number of veterans was frequently identified as an issue in States. Seven of the nine case study States can provide an estimate of the numbers of veterans in their systems. However, most believe that these numbers are significantly lower than the actual numbers of veterans served. Several States emphasized that the way questions are asked regarding veteran status led to undercounting. For example, many people who have served in the National Guard, or who have been less than honorably discharged, are not considered "veterans." Additionally, many veterans are hesitant to reveal their status because of stigma associated with addictions. Active military members may experience fear of negative repercussions, including effects on security clearances and promotions and the ability to redeploy.

In addition, because little is understood about the unique needs of OEF/OIF veterans and their families, or what trainings need to be provided to help substance use providers address these needs, it is important to track actual services that veterans are receiving. Connecticut found that many referrals to VA treatment were not leading to engagement. New Mexico has begun to use electronic health records to track the referrals. Rhode Island is considering using the Access to Recovery voucher system to track services; New Mexico has already begun that process. No States are currently tracking access to SUD services by the families of veterans.

Targeted Populations

Each of the nine case study States provides addiction treatment services to veterans who served in a variety of combat and noncombat situations, including veterans who served during World War II, as well as active members of the military and

their families. All of the States have targeted what they perceive as underserved populations of veterans and their families. In seven of the nine States (Connecticut, New Mexico, New York, Oregon, Rhode Island, Utah, and Wyoming), the SSA has identified National Guard members as a priority population. Their rationale for this is that National Guard members have access to fewer benefits and services, and often received less preparation prior to deployment. Seven of the nine States (Connecticut, New Mexico, New York, North Carolina, Oregon, Rhode Island, and Utah) have also identified the families of veterans as another targeted population. These States explained that they believe that families of veterans are underserved, and often are the first to ask for help when a veteran experiences the symptoms of PTSD, TBI, or an SUD. Through its SAMHSA-funded Jail Diversion Program, Connecticut has been able to target veterans at risk of arrest. Because of the large numbers of recently discharged veterans in North Carolina, the SSA in that State has focused specifically on serving veterans who served in the war on terrorism and their families. In Oregon, female veterans are another targeted population because of perceived additional barriers to treatment, including the lack of VA facilities that allow children to accompany their parents into SUD treatment, and because of the prevalence of military sexual trauma, which often leads to SUDs and disproportionately affects women.

Need for Training Resources and Evidence-Based Practices

From these case studies, NASADAD learned that initiatives directed at addressing the substance use needs of returning veterans and their families are new and varied. Many States noted difficulty in identifying evidence-based practices for serving returning veterans and their families with SUDs, particularly for OEI/OIF veterans. States seek resources such as screening and assessment tools and training, particularly on PTSD, TBI, and the military culture.

New York, Connecticut, and New Mexico believe that providers are capable of addressing the substance use treatment needs of this population, but are concerned that providers need to be trained on how to recognize and/or address associated issues like PTSD and TBI. Specifically, States have been looking, unsuccessfully, for screening and assessment tools for PTSD and TBI, and corresponding trainings to teach their providers to use such tools. In addition, the responsibility for conducting trainings for primary care physicians on how to identify PTSD and TBI and make appropriate referrals often falls on the substance use/mental health division in a State. A major initiative in nearly all of the States is the cross-training of providers (e.g., primary care providers and SUD providers) focused on how to identify and assess PTSD and TBI.

Connecticut, North Carolina, and Oregon identified trauma training, which addresses methods to treat co-occurring SUD and PTSD, as an important component of helping providers and partner agencies address the SUD needs of returning veterans and their families. All of these States currently train providers who work with veterans on the Seeking Safety model (Najavits, 2002), but they believe that something specific to veterans' trauma would be more useful.

Another common training that States are working to develop is "Military 101" training. Currently Connecticut and New York offer trainings on military culture to providers. The States that have implemented this training believe that providers will be better equipped to understand the experiences of their clients, less likely to inadvertently retraumatize clients, and better able to communicate with clients after participating in these trainings. A related training that States are providing more informally is about understanding TRICARE, the VA systems, and VA benefits.

The SSAs in Connecticut, New York, Oregon, and Utah are working across systems as part of jail diversion programs. SSA staff in each of these States has provided, or is planning to provide, outreach and trainings to law enforcement officials, the courts, emergency medical technicians, and hospital workers about the specific needs of veterans and their families. Often, domestic violence workers are included in these initiatives. However, trainings on recognizing SUDs, PTSD, and TBI for these groups have not yet been developed in most States.

No States are providing trainings to providers specifically on conducting prevention among returning veterans and their families. Both New York and North Carolina provide school-based outreach and prevention to the children of OEF/OIF veterans, and several States participate in predeployment prevention for National Guard members with their States' National Guard units and their National Guard members' families.

Common Barriers

There are many barriers to SUD treatment for returning veterans and their families. The most common barriers cited by the case study States were funding, transportation, and collaboration with and knowledge of VA.

Due to the current budget situation, many SSAs are facing level or reduced budgets. Limited funding is a major barrier to providing additional trainings to substance use providers, primary care physicians, and others. Some States have been able to leverage dollars within their region to create regional trainings through the ATTCs. Other ATTCs have used their Federal funding to create such trainings.

Materials from these trainings, and agendas from conferences held by ATTCs, are included in Appendix C.

Transportation was cited as a major barrier in every State (including even the small State of Rhode Island). This problem is exacerbated in large rural States like Wyoming, Utah, Oregon, and New Mexico. New Mexico Behavioral Health Collaborative staff noted that OEF/OIF veterans spent a great deal of their combat time in a vehicle, and many experienced traumatic events in a vehicle. For these veterans, specifically, there is a danger that they will be retraumatized or suffer a flashback while being transported for services. In addition, for many of the veterans served by the publicly funded addiction treatment system, a long commute to treatment is a major financial burden. This is particularly a problem for veterans who are eligible for or enrolled in TRICARE. TRICARE's network is limited, and in most States, veterans with TRICARE eligibility are not eligible for services in the publicly funded treatment system, and are therefore unable to receive community-based services. In Connecticut, New Mexico and Oregon, lack of nearby VA facilities (and transportation to such facilities) have been recognized as a major barrier to treatment, and veterans are eligible to receive publicly funded services, even if they have TRICARE or other health insurance benefits. These policies are financial drains on the publicly funded system, which is not reimbursed by the VA for providing services to veterans.

To alleviate this problem, five States are using or are hoping to invest in telehealth services, which will allow returning veterans to receive SUD services remotely. Connecticut currently uses a call center to provide referrals to community-based services, and New Mexico's Behavioral Health Collective has a designated telehealth unit housed within a VA facility and using VA psychiatrists. In addition to easing transportation problems, telehealth allows for anonymity for veterans who are receiving substance use services.

Transportation is a barrier, not only to getting services for veterans and their families, but also to conducting trainings to providers. Like their clients, SUD treatment and prevention providers find traveling across the State to be a major burden. To address this problem, States are increasingly turning to web-based trainings through podcasts, webinars, and webcasts. North Carolina has begun to offer training podcasts to reduce costs. New York has found that providing a combination of online workbooks and webinars has been effective in training providers on a variety of subjects, including the substance use needs of returning veterans and their families. They are hoping to develop webcasts, which will allow them to increase participation in webinars from 400 participants to an infinite number of participants, and will allow providers to access the webcasts at times

that are convenient for them. Pennsylvania is also utilizing web technology to provide trainings and updates to their providers.

Other barriers cited by the case study States included the need for better collaboration between the SSA and the VA (Connecticut and Pennsylvania) and a lack of knowledge regarding resources and benefits for veterans and their families, both among veterans and among community-based SUD providers (Oregon, Utah, and Wyoming).

Key Issues

In each of these nine States, the SSA noted strong leadership from their Governor and State funding for programming that addresses the needs of returning veterans and their families, ranging from about $500,000 in Wyoming to S1.5 million in New Mexico. Each of these States initiated such projects by working with a Governor's task force and with other State agencies that serve this population. Informants noted the importance of cross-systems collaborations. Specifically, States noted that their partnerships with the VA are particularly effective in addressing the substance use service needs of returning veterans. States that work collaboratively believe that they have improved engagement rates.

Connecticut, New York, and Rhode Island emphasized their "no wrong door approach," which means that regardless of what system the veteran or his or her family presents to, they will be assessed and steered toward a menu of appropriate services, including SUD services. In this approach, the importance of coordination with and linkages to other systems and agencies to let them know what services are available is paramount. With this information, these agencies can make referrals and conduct outreach on behalf of the SSA to their clients.

Specific mention was made by Connecticut, New York, Pennsylvania, Rhode Island, and Wyoming about the importance of coordination, communication, and linkages between the SSA and the VA. After working with its VA counterparts, Connecticut found that SSA staff/providers were able to help returning veterans engage in SUD services provided by the VA, rather than only making referrals. In addition, community-based clinicians in Connecticut have successfully worked with their VA counterparts to conduct discharge planning to assist veterans' transition back into the community.

States also noted that, often, veterans are unaware of the benefits that are available to them, both within the VA system and in the community-based system. North Carolina has a web-based resource center to provide information about all services

available in their States to returning veterans and their families, and Oregon is considering creating a true one-stop referral bulletin board on the internet to better educate returning veterans and their families about the mental health, SUD, TBI, and PTSD services available to them.

Wyoming emphasized the importance of helping returning veterans and their families find safe, permanent housing and providing financial counseling to allow them to create stability in their lives while addressing SUDs. In addition, New Mexico, New York, and Oregon noted the importance of addressing the holistic needs of veterans and their families.

Lessons Learned

During the course of the case studies, several lessons were learned. Specifically, NASADAD learned that initiatives for returning veterans are relatively new and varied; there is a large need to analyze the specific needs of OEF/OIF returning veterans and their families and to evaluate the specific initiatives for veterans. States are increasingly looking to the internet to provide and improve SUD treatment to returning veterans and their families.

Though States have treated veterans within their systems for decades, these States did not begin their current dedicated initiative to address the needs of returning veterans and their families before 2005. Pennsylvania and Rhode Island both began their initiatives in that year; Connecticut, New Mexico, Utah, and Wyoming began working on their initiatives in 2007; and New York and Oregon began their current programs in 2008. Because very limited data are available on the numbers of individuals served, types of services delivered, and client outcomes, additional evaluation of State efforts is required in the future.

In addition, there are few nationally recognized trainings, or manualized, evidence-based practices that States have been able to adapt for their own systems. As publicly funded, community-based SUD providers treat increasing numbers of returning veterans and their families, it is important to identify cost-effective, evidence-based practices to serve this population most efficiently. The only State that is conducting a rigorous evaluation of its dedicated programming is New Mexico.

Finally, as trainings are developed, it is important to consider that States are increasingly using web-based systems to provide treatment to returning veterans and trainings to providers. States believe that telehealth services are cost-effective and minimize transportation and distance barriers. In addition, SUD services provided via telehealth systems minimize stigma by increasing anonymity, which is very attractive to many returning veterans and their families.

States are also using web-based technology to conduct trainings for substance use providers. Like returning veterans and their families, it is expensive for SUD providers to travel to trainings. Additionally, they lose much-needed revenue because of their unavailability to provide services to their clients. States have been able to provide web-based trainings to providers that reduce this barrier. Currently, most States are using webinar technology, but webcast technology would allow providers to complete online trainings at times that are most convenient to them.

Conclusion

As more veterans and active duty military return from combat, the publicly funded substance use prevention, treatment, and recovery system and the office of the SSA will be increasingly called upon to provide services to this population and their families. In anticipation of this, Partners for Recovery (funded by SAMHSA) is working to ensure that the substance use service workforce is prepared to serve veterans that access the community-based system. As a first step in this process, NASADAD conducted a brief environmental scan of selected States to learn about specific trainings and outreach initiatives being offered by the SSA to substance use treatment and prevention providers to help them better serve returning veterans. To accomplish this, NASADAD conducted case studies of nine States that had been identified as having the largest number of initiatives for returning veterans. The data for these case studies were gleaned from interviews with SSA staff and staff from publicly funded SUD treatment facilities, during which NASADAD staff gathered data on State policies, trainings, and outreach efforts, as well as recommendations for future development of technical assistance and training materials to address the gaps in services.

Upon review of these case studies, several training needs have become apparent. Most importantly, States requested trainings for substance use services providers, as well as primary care providers, to identify and treat PTSD and TBI as well as veteran-specific trauma (military sexual trauma). States are working to identify appropriate screening and assessment tools for PTSD and TBI. Once these tools are identified, States will need to train their providers in how to use them. Many States are also responsible for training primary care physicians, law enforcement agents, and others to recognize and assess mental health disorders, SUDs, TBI, and PTSD.

The case study States emphasized the importance of treating returning veterans and their families holistically. For returning veterans and their families, this means that clinicians must have an understanding of military culture. Clinicians should also be prepared to provide or refer to a variety of community services including childcare services, financial planning services, primary care services, and safe housing. The provision of these services often requires outreach and collaboration with multiple systems.

Each of the case study States noted transportation as a major barrier to training providers and treating the SUDs of returning veterans and their families. To address this barrier in a cost-effective way, all of the States requested technical assistance to

increase telehealth and webinar capabilities. Such capabilities will also allow veterans and their families to increase their anonymity.

Finally, because best practices on addressing the SUD service needs of OEF/OIF veterans and their families are limited and difficult to acquire, States are unsure what skills providers need to successfully work with this population. Even when States are able to identify training needs, it is costly for them to develop and deliver their own trainings. This remains the largest barrier to addressing the specific needs of returning veterans and their families.

The nine States chosen for the case studies are leading the Nation in the efforts to address the unique substance use services needs of returning veterans and their families. Many other States are beginning to address this critical issue as well. Included in the nine case studies are large States and small States, representing rural and urban areas. They are geographically and politically diverse. Some have major military bases located within the State, others do not. Their diversity provides a range of rich information on State initiatives directed to serving returning veterans and their family members affected by SUDs. Further, the information gleaned from the case studies begins to identify areas where States require additional training for the workforce and related disciplines, including primary care and law enforcement, to adequately serve veterans and their families.

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Appendix A: Admissions Data from the Treatment Episode Data Set (TEDS)

Veterans by Age Group

	Veterans, 18-20	Veterans, 21-24	Veterans, 25-29	Veterans, 30-34	Veterans, 35-39	Veterans, 40-44	Veterans, 45-49	Veterans, 50-54	Veterans, 55 AND OVER	All Veterans, 18+
2000	624	1,761	3,889	7,008	12,542	14,561	11,577	8,354	7,804	68,120
2001	606	1,897	3,282	6,384	10,647	13,369	10,994	8,103	7,436	62,718
2002	654	2,047	3,238	5,945	9,926	13,608	12,251	8,959	8,186	64,814
2003	629	2,080	2,982	5,272	8,461	12,607	11,456	8,097	8,410	59,994
2004	3,184	5,458	6,656	7,898	11,110	15,716	13,774	9,308	9,761	82,865
2005	3,514	6,400	7,942	8,183	11,170	15,872	15,487	10,248	11,008	89,824
2006	2,204	4,871	6,756	6,469	9,654	14,393	16,157	11,684	12,276	84,464
2007	748	2,713	4,546	4,370	6,938	10,834	13,379	10,487	11,795	65,810
Total	12,163	27,227	39,291	51,529	80,448	110,960	105,075	75,240	76,676	578,609

Veterans Admitted to the Public Substance Use Disorder Treatment System in the Case Study States (no TEDS data for Oregon, Rhode Island, and Utah)

Connecticut

	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	215	165	175	229	261	318	245	264
Veterans, Age 30-44	1584	1295	1136	1025	935	822	761	605
Veterans, Age 45+	1333	1163	1178	1013	881	990	925	895
% of all admissions who were veterans	7.0%	5.9%	5.8%	5.5%	5.4%	5.5%	5.0%	4.7%

New Mexico

	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	50	32	27	37	20	25	26	47
Veterans, Age 30-44	142	191	159	134	65	96	136	133
Veterans, Age 45+	115	173	173	124	80	136	255	248
% of all admissions who were veterans	6.5%	6.0%	6.2%	6.0%	5.0%	4.8%	5.5%	5.7%

New York

	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	979	902	959	822	803	924	1310	1192
Veterans, Age 30-44	6888	6420	6000	5309	4307	4196	5201	4559
Veterans, Age 45+	5279	5503	5651	5431	5141	5338	7870	7605
% of all admissions who were veterans	6.6%	6.4%	6.0%	5.5%	5.3%	4.7%	4.7%	4.5%

North Carolina

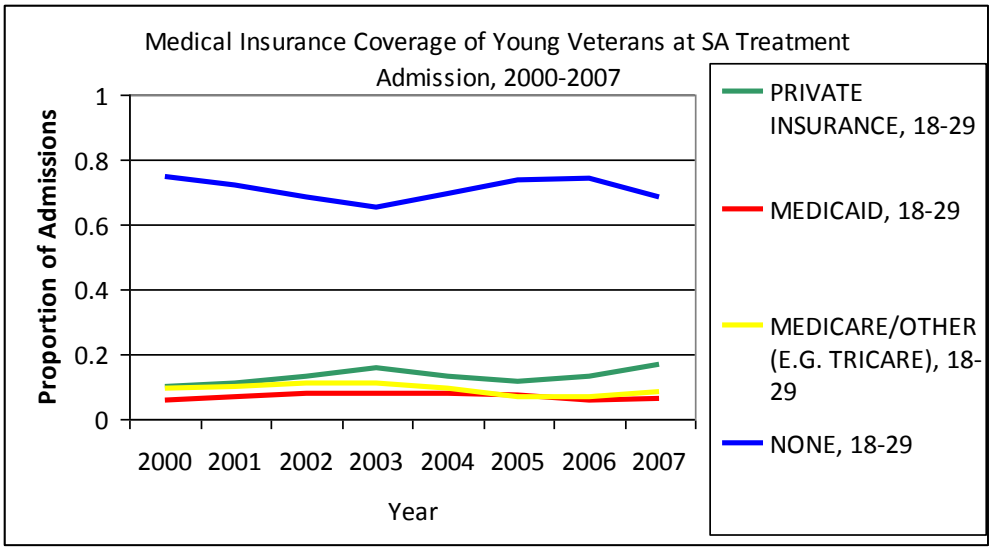
	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	150	159	123	72	92	81	66	81
Veterans, Age 30-44	863	802	687	581	498	409	297	333
Veterans, Age 45+	709	702	656	626	609	576	415	479
% of all admissions who were veterans	7.0%	6.3%	5.8%	5.4%	5.2%	4.8%	4.6%	4.4%

Pennsylvania

	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	296	259	207	193	318	228	259	267
Veterans, Age 30-44	1705	1431	1156	975	1128	794	728	711
Veterans, Age 45+	1347	1156	1029	988	1178	1047	976	858
% of all admissions who were veterans	5.3%	4.7%	3.9%	3.3%	3.0%	2.7%	2.7%	2.7%

Wyoming

	2000	2001	2002	2003	2004	2005	2006	2007
Veterans, Age 18-29	51	63	48	80	60	64	36	37
Veterans, Age 30-44	138	162	163	1745	1575	1593	1311	1179
Veterans, Age 45+	181	171	180	176	156	182	104	93
% of all admissions who were veterans	8.8%	6.9%	7.7%	6.8%	6.2%	6.3%	4.5%	4.6%



Appendix B: Discussion Guide

Addressing the Substance Use Disorder (SUD) Service Needs of Returning Veterans and Their Families:

The Training Needs of State Substance Abuse Agencies
(Single State Agencies, or SSAs) and Their Providers

NASADAD staff will interview key stakeholders from nine States to understand the State's current initiatives for OEF/OIF Veterans. In each of the nine States, NASADAD staff will interview: the SSA; the NTN; the person responsible for trainings or CEUs; the person in charge of services for veterans in the SSA's office (if such a person exists in any of the chosen States); and possibly a provider who would be identified by the SSA's office who has participated in the States' initiatives and serves returning veterans and/or their families. Topics discussed will include:

- Policy initiatives;
- Initiatives to assist providers;
- Trainings for providers;
- Outreach assistance;
- Other initiatives;
- Funding streams; and
- Data collection.

Interviews will be structured around the interview guide and will be conducted over the phone and will be targeted to last 30 minutes, with possible follow-up and clarifying questions via email. The States chosen will be the nine States (RI, NM, CT, NC, WY, UT, PA, OR and NY) that reported having undertaken the greatest number of initiatives for this population in NASADAD's July/August 2008 brief inquiry on returning veterans and their families.

1. We would like to talk to you about policy initiatives in your States that serve the substance use treatment and prevention needs of OEF/OIF Veterans and their families. In response to our inquiry in July/August 2008, we learned that your State has several such initiatives including _____.

   1a. Please describe the initiative.

   1b. Please describe the goals of the initiative.

   1c. Please describe your agency's role in each initiative.

   1d. How were the initiatives funded? Which agencies contributed? Was it funded with new or redistributed funds?

1e. What were the practical implications of these policy initiatives? For example, did communication with the National Guard lead to the SSA providing materials or trainings to Guardmembers and their families?

1f. What barriers did you encounter while trying to implement these initiatives? How were they overcome?

1.g. Beyond the initiatives that I just mentioned, has your State implemented any other policy initiatives to better serve the substance use treatment needs of OEF/OIF Veterans? The family members of OEF/OIF Veterans?

2. We learned from our 2008 inquiry that your State has implemented several initiatives to help providers in your States respond to the substance use treatment and prevention needs of OEF/OIF Veterans and their families. You wrote that your State has _____.

2a. Please describe your role in each initiative.

2b. Was this initiative funded by the SSA, or another agency? Which other agency? Was it funded with new or redistributed funds?

2c. What barriers did you encounter while trying to implement these initiatives? How were they overcome?

2d. Did you work with the VA or DOD?

2e. Were particular OEF/OIF populations targeted (branches, etc.)?

2f. How is the effectiveness of these initiatives evaluated?

2g. Beyond the initiatives that I just mentioned, has your State implemented any other initiatives to help treatment providers better serve the substance use treatment needs of OEF/OIF Veterans? Prevention providers? Family members of OEF/OIF Veterans?

3. Some States have assisted their providers by conducting trainings for providers to specifically help them to better serve the unique substance use treatment and prevention needs of OEF/OIF Veterans and their families. In response to our inquiry in July/August 2008, your State responded that it (had/had not) done this.

3a. Please describe any SSA-sponsored trainings for substance use disorder *treatment* providers to treat OEF/OIF Veterans? What topics were addressed in each training?

3b. Who was trained (# of people and their roles)? Who was the trainer and what were their capabilities? Can you please email us the training manual and agenda?

3c. Please describe your role in each training.

3d. Please describe the goals of the trainings.

3e. Were the trainings funded with new or redistributed funds?

3f. Did participants fill out evaluations of these trainings? Was the effectiveness of the training measured in any other ways?

3g. What barriers were encountered? How were they overcome?

3h. Please describe any SSA-sponsored trainings for substance use disorder ***prevention*** providers to treat OEF/OIF Veterans.

3i. Please describe any SSA-sponsored trainings for substance use disorder treatment or prevention providers to treat the ***family members*** of OEF/OIF Veterans.

3j. What other entities have provided trainings on this topic to providers in your State? Examples might include the National Guard, the ATTCs and others.

3k. What are the unmet training needs of providers in your State with regards to serving OEF/OIF Returning Veterans and their families? What barriers exist that prevent States from receiving this training?

3l. How did you determine who to train?

3m. How did you market the events (listerv, etc.)?

4. We are interested in learning about the ways that your State has **helped providers to conduct outreach** for OEF/OIF Veterans and their families who might be in danger of developing, or have already developed a substance use disorder. In response to our inquiry in July/August 2008, we learned that your State has assisted providers to conduct outreach in these ways:_____.

4a. Did the State fund the outreach, and/or play a more active role?

4b. If the State played a more active role, please describe the role of the State.

4c. If the State funded the outreach, was the outreach funded with new or redistributed funds?

4d. Is outreach targeted to veterans who do not have access to services (e.g., not eligible for VA or DOD services)? Please describe.

4e. If known, please describe the outreach methods used by providers in your State.

4f. How is the effectiveness of these outreach efforts evaluated?

4g. What barriers were encountered? How were they overcome?

4h. Beyond the initiatives that I just mentioned, has your State assisted providers to conduct outreach on available substance use disorder treatment services to OEF/OIF Veterans? Substance use disorder *prevention* services?

4i. Please describe any additional assistance that your State has provided to help providers conduct outreach to the families of OEF/OIF Veterans.

5. In response to our inquiry in July/August 2008, we learned that your State has several **other initiatives** to improve substance use disorder treatment and prevention services, and access to such services for OEF/OIF Returning Veterans and their families, including _____.

5a. Has your State participated in any other initiatives to improve services and access to services for OEF/OIF Returning Veterans? If so, please describe them.

5b. Were particular veterans targeted?

5c. Please describe your role in each initiative (including the ones noted in the 2008 survey).
What were the goals of the initiatives?

5d. If funding was provided, were they funded with new or redistributed funds?

5e. Did you work with or receive funding from the VA or DoD?

5f. How was the effectiveness of each initiative measured?

5g. What barriers were encountered? How were they overcome?

5h. Has your State participated in any other initiatives to improve services and access to services for *the family members of* OEF/OIF Returning Veterans? If so, please describe them.

6. What data do you collect on veterans?

   6a. Do you specifically identify OEF/OIF Veterans as well as veterans from other wars?

   6b. Do you collect data on what branch of the military they are or were in?

   6c. Do you ask whether they are active or inactive?

   6d. Are there any other data elements that you collect on OEF/OIF veterans?

Appendix C – List of Resources by State

Connecticut

Findings on the Aftereffects of Service in Operations Enduring Freedom and Iraqi Freedom and the First 18 Months Performance of the Military Support Program

PowerPoint on Veterans' Jail Diversion Program

Veterans Resource Representative Training Handbook

New Mexico

VFSS Annual Evaluation Report, 2008

New York

Action Plan for Returning Veterans and Their Families (New York State) Developed During SAMHSA's Policy Institute on Returning Veterans

Veterans Fast Facts from the New York State Office of Alcoholism and Substance Abuse Services Data Warehouse

Learning and Development Initiatives for Addiction Providers Working With Veterans – New York State Office of Alcoholism and Substance Abuse Services

Addiction Medicine Educational Series Workbook: Traumatic Brain Injury and Chemical Dependency Connection – New York State Office of Alcoholism and Substance Abuse Services

Brain Injury in the Community: Wounded Warriors in Transition (Brain Injury Association of New York State)

Institute for Professional Development in the Addictions – Veterans Roundtable at Fort
- Drum Commons Presentations
- Letter from the organizers
- Agenda
- Access to Veterans Affairs Health Care for OIF OEF Service Members – Veterans Affairs New York Harbor Healthcare System

New York Department of Veterans Affairs
Using TRICARE at the Veterans Affairs Medical Center – Veterans Affairs New York Harbor Healthcare System

What Every Clinician Should Know About Posttraumatic Stress Disorder

Buffalo City Court Veterans Project – Western New York Veterans

Homelessness and Returning Veterans – Veterans Outreach Center

Traumatic Brain Injury in the War Zone

Veterans Affairs Healthcare for Returning Combat Veterans

Why We Serve

North Carolina

Painting a Moving Train Training Workshop Agenda and PowerPoint presentation

Interview/Registration Form: Standardized Consumer Screening-Triage-Referral

Integrated Payment and Reporting System Target Population Details – FY 2008-09: Adult Mental Health and Child Mental Health Veteran and Family Target Populations

The Governor's Focus on Returning Combat Veterans and their Families: Information Brief for Substance Abuse Professionals

Added: Citizen Soldier Demonstration Project outline

What Primary Care Providers Need to Know

Treating the Invisible Wounds of War (online tutorial)

Invisible Wounds of War/Traumatic Brain Injury Training Program

Working Miracles in People's Lives: Connecting the Faith Community and Behavioral

Health Professionals to Help Service Members and Their Families

4th Annual RAH Symposium: Operation Reentry: Rehabilitation Strategies Facing Military Personnel, Veterans, and Their Dependents

The Governor's Summit on Providing Mental Health and Substance Abuse Services to Returning Combat Veterans and their Families: Summary Report

North Carolina Web Resources

North Carolina Area Health Education Centers Program
http://www.ncahec.net/

Area Health Education Center Course: Treating the Invisible Wounds of War
http://www.aheconnect.com/citizensoldier/cdetail.asp?courseid=citizensoldier

Area Health Education Center Course: ICARE: What Primary Care Providers Need to Know About Mental Health Issues Facing Returning Service Members and Their Families
http://www.aheconnect.com/ahec/cdetail.asp?courseid=icare7

North Carolina CareLINK
https://www.nccarelink.gov/
Painting a Moving Train
http://bluenc.com/painting-moving-train

Governor's Institute on Alcohol and Substance Abuse
http://www.governorsinstitute.org/

Citizen-Soldier Support Program (CSSP)
http://www.aheconnect.com/citizensoldier/

Carolinas Rehabilitation - TRICARE Network Provider as a Direct Result of Citizen Soldier Support Program Traumatic Brain Injury Training
http://www.carolinasrehabilitation.org/body.cfm?id=27&action=detail&ref=37

Citizen Soldier Support Program Podcast, Part 1. 2. 3
http://www.arealahec.org/index.php?option=com_content&task=category&sectionid=4&id=42&Itemid=100

Oregon

Governor's Task Force on Veterans' Services: Final Report (December 2008)

VHA- Oregon Medical Services PowerPoint

Portland VAMC PowerPoint

Table of Geographic Distribution of FY07 VA Expenditures in Oregon

Housing, Homelessness, and Community Services PowerPoint

Central City Concern PowerPoint

Worksource Oregon- Oregon Employment Department Veterans' Programs

Hire Oregon Veterans Project (HOV)

Working With Trauma Survivors PowerPoint

Oregon Department of Human Services 2009-11 Policy Option Package: Addiction Services for Uninsured Workers and Returning Veterans

Oregon Web Resource

Oregon National Guard Reintegration Team
http://www.orng-vet.org/

Pennsylvania

Serving Those Who Serve: Veterans and Their Families Brochure – Pennsylvania Regional Drug and Alcohol Training Institute (RTI)

Trauma, Terrorism, and Substance Abuse NeATTC Newsletter

Traumatic Brain Injury – Institute for Research, Education, and Training in Addictions (IRETA)

Veterans and Homelessness Training Session Information – IRETA

Treatment for Veterans with PTSD, Secondary Stress and Addiction Issues – IRETA

Pennsylvania Web Resources

PACARES
http://www.pacares.org/

Pennsylvania Department of Military and Veterans Affairs
http://www.milvet.state.pa.us/DMVA/index.htm

IRETA
http://www.ireta.org/

Rhode Island

The Rhode Island Blueprint: Addressing the Needs of Returning Soldiers and Their Families

Rhode Island Web Resource

Virtual Bulletin Board for Information for Female Veterans in Rhode Island
http://www.dhs.ri.gov/Veterans/Resources/tabid/783/Default.aspx

Utah

Returning Veterans and their Families Strategic Planning Conference and Policy Academy – State of Utah Team Application

Utah Web Resource

http://www.utvethelp.com/

Wyoming

The Wyoming Department of Health Plan to the Select Committee on Mental Health and Substance Abuse: Executive Report on Veteran's Mental Health Needs

Wounded Warrior Wellness Workshop Agenda

Wyoming Web Resource

Wyoming Family Readiness Program
https://www.wy.ngb.army.mil//

Other State Resources

New Hampshire

"Coming Together: Coming Together to Better Serve Our Veterans" Agenda
Article From the *Union Leader* About "Coming Together" Training

Ohio

Ohiocares Webshot/Brochure

South Dakota

South Dakota National Guard Joint Substance Abuse Prevention Program Brochure

Virginia

Virginia Is for Heroes Conference Report and PowerPoint presentations
Conference Report

What Can We Learn From Col Jenny Holbert's Story

Outreach Initiatives

DoD, VA, State and Community Partnership in Service to OEF/OIF Service Members, Veterans and Their Families

Wisconsin

Returning Veterans: Combat Stress and Substance Abuse in the Wake of War

Resources List

Additional Web Resources

Brown University's Center for Alcohol and Addiction Studies
Understanding the Language of Warriors: Substance Abuse Treatment for Iraq and Afghanistan Veterans
http://www.browndlp.org/dlpannouncement.php?course=94

Great Lakes ATTC
Finding Balance After a War Zone Brochure
http://www.attcnetwork.org/learn/topics/veterans/docs/FindingBalanceBrochure.Pdf
Finding Balance After a War Zone Quick Guide for Veterans and Service Members
http://www.attcnetwork.org/learn/topics/veterans/docs/FindingBalancePocket.pdf
Finding Balance After a War Zone - Clinicians Guide (Draft)
http://www.attcnetwork.org/learn/topics/veterans/docs/FindingBalance.pdf

MidAmerica ATTC
Pocket Resource for Policy Makers
http://www.attcnetwork.org/learn/topics/veterans/docs/PocketResouce.pdf

National Center for PTSD (www.ptsd.va.gov/index.asp)
Returning from the War Zone: A Guide for Families of Military Members
http://www.ptsd.va.gov/public/reintegration/guide-pdf/FamilyGuide.pdf
Returning from the War Zone: A Guide for Military Personnel
http://www.ptsd.va.gov/public/reintegration/guide-pdf/SMGuide.pdf

Iraq War Clinician Guide: Substance Abuse in the Deployment Environment
http://www.ptsd.va.gov/professional/manuals/manual-pdf/iwcg/iraq_clinician_guide_v2.pdf

Northeast ATTC
Resource Links, Vol. 6, Issue 1, Fall 2007: Issues Facing Returning Veterans
http://www.attcnetwork.org/learn/topics/veterans/docs/VetsNwsltr2007.pdf
Resource Links, Vol. 3, Issue 1, Summer 2004: Substance Use Disorders and the Veterans Population
http://www.attcnetwork.org/learn/topics/veterans/docs/vetnwsltr2004.pdf

Resource Links, Vol. 1, Issue 1, April 2002: Trauma, Terrorism and Substance Abuse
http://www.ireta.org/attc/resources/newsletters/rl_1-1_trauma.pdf

Northwest Frontier ATTC
Addiction Messenger: Returning Veterans Journey, Part 1, Awareness
http://www.attcnetwork.org/learn/topics/veterans/docs/Vol%2011Issue7.pdf

Addiction Messenger: Returning Veterans Journey, Part 2, Trauma and Substance Abuse
http://www.attcnetwork.org/learn/topics/veterans/docs/Vol%2011Issue8.pdf

Addiction Messenger: Returning Veterans Journey, Part 3, Families
http://www.attcnetwork.org/learn/topics/veterans/docs/Vol11Issue9.pdf

SAMHSA
Resources for Returning Veterans and Their Families
http://www.samhsa.gov/Vets/