U.S. Department of Veterans Affairs

Substance Use Disorder (SUD) Care in the VA

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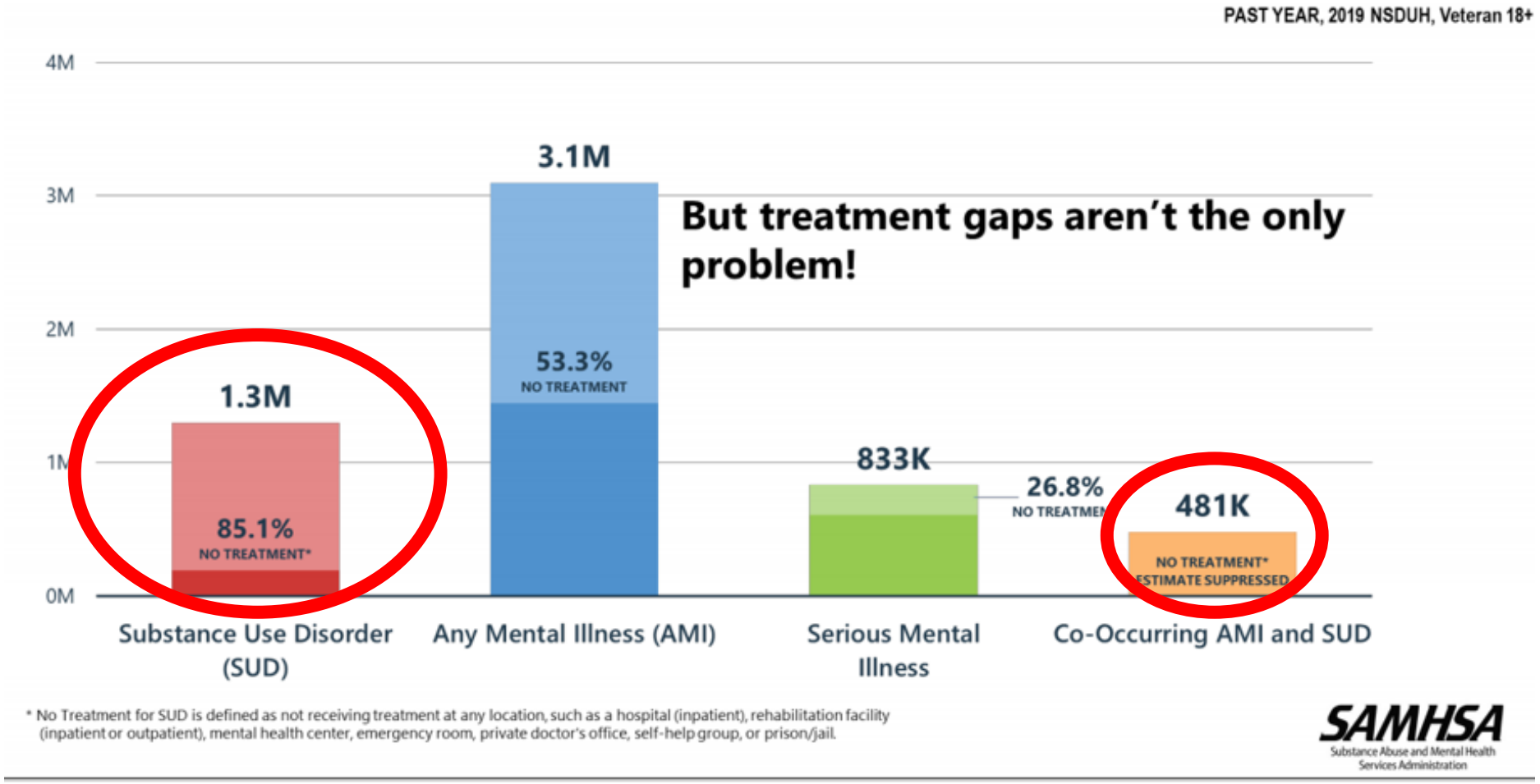
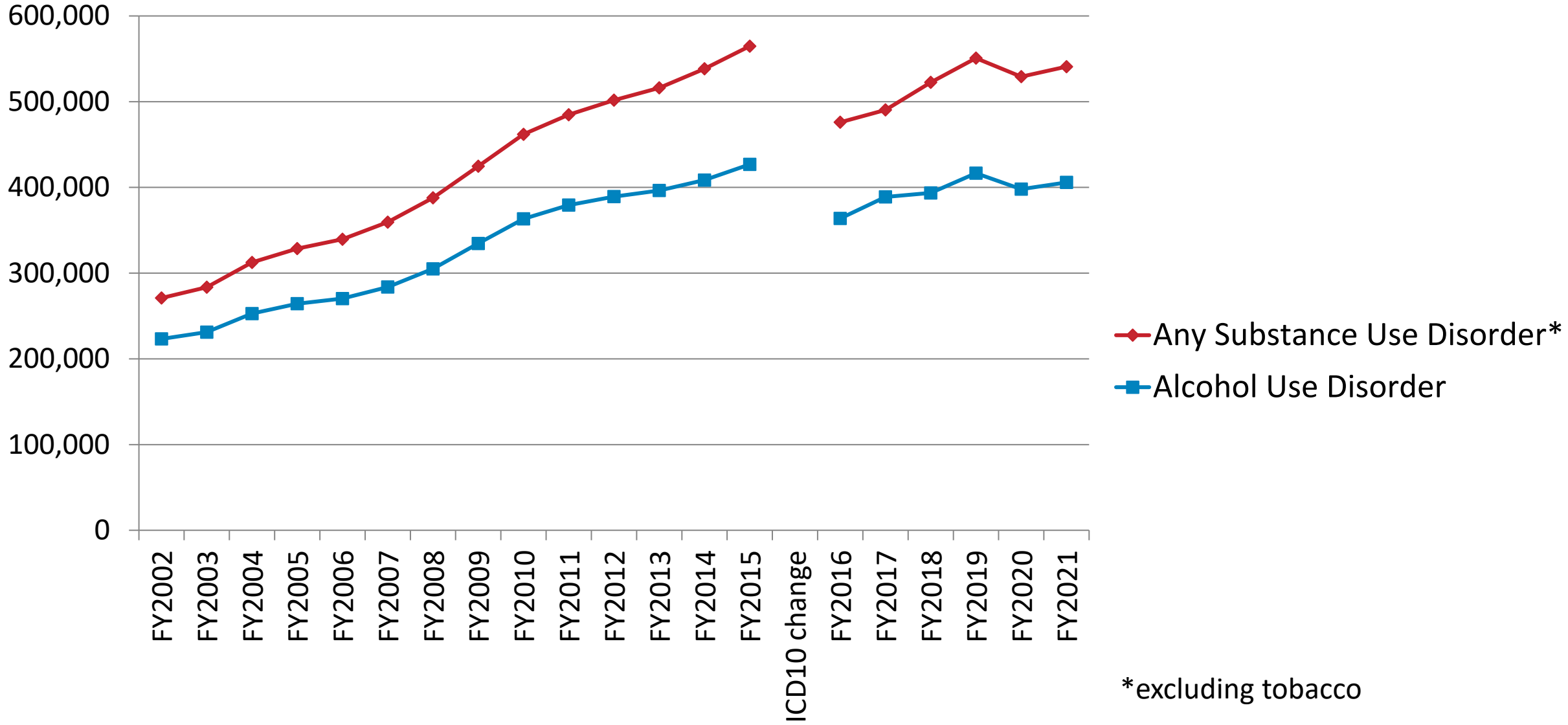
Mental and Substance Use Disorders Among Veterans: High Prevalence/Huge Treatment Gaps



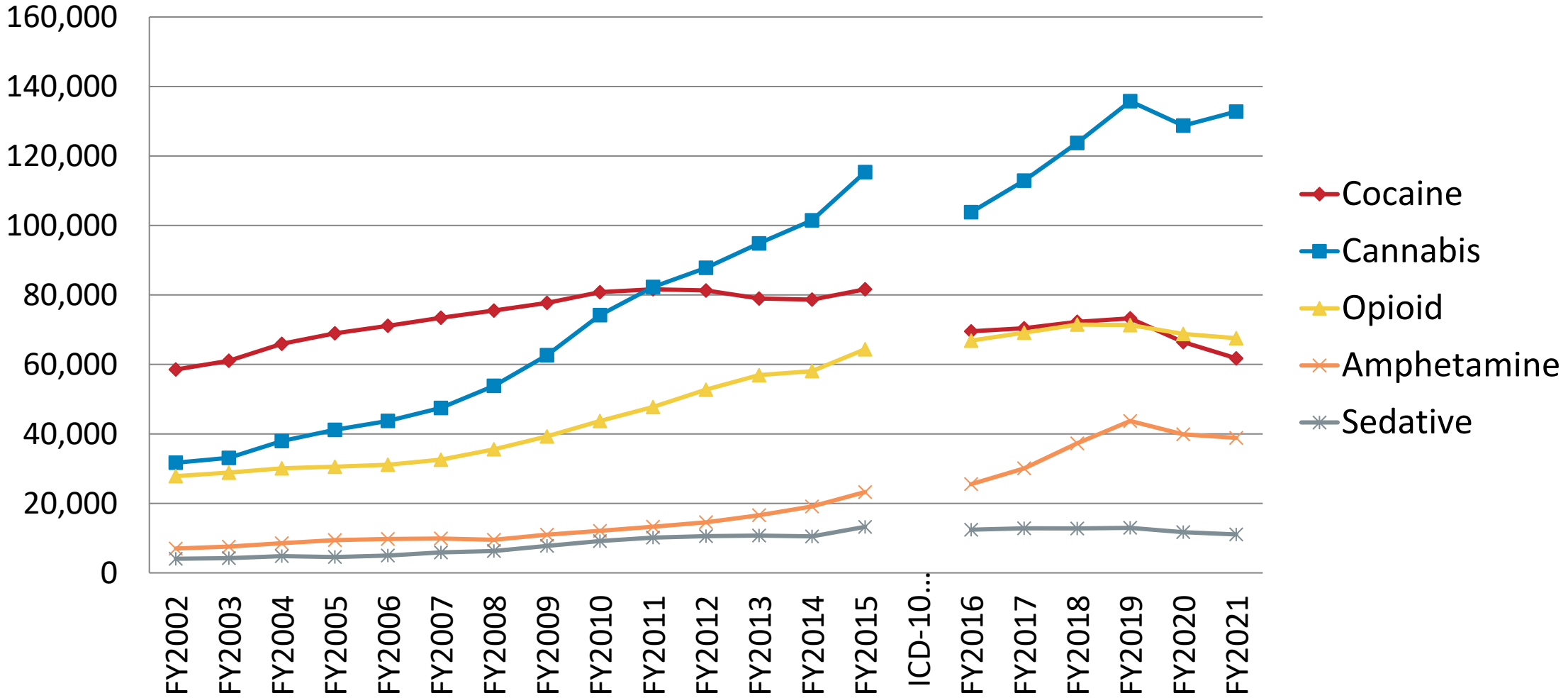
VA Diagnostic and Specialty Care Treatment Trends

VA Trends in Alcohol & Substance Use Disorders

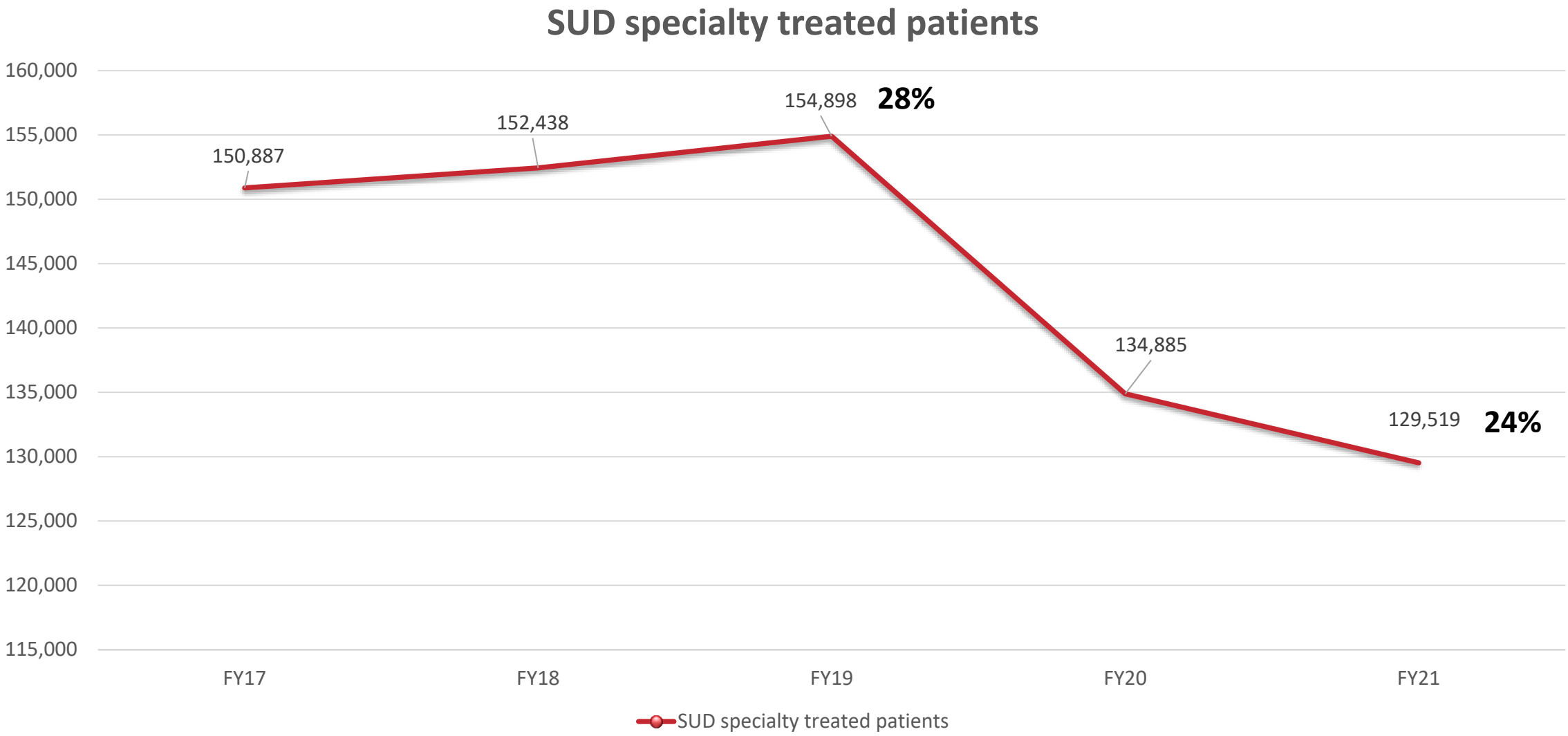


*excluding tobacco

VA Trends in Drug Use Disorders



Patients treated in SUD specialty clinics per year



Overdose Epidemic

DRUG-INVOLVED OVERDOSE DEATHS HAVE INCREASED SUBSTANTIALLY OVER THE PANDEMIC*

	ALL DRUGS	HEROIN	NAT & SEMI – SYNTHETIC	METHADONE	SYNTHETIC OPIOIDS	COCAINE	OTHER PSYCHO-STIMULANTS (mainly meth)
3/2020*	75,702	14,136	12,342	2,828	**40,708**	17,530	**18,004**
9/2020*	90,009	14,292	13,566	3,484	**54,122**	20,009	**22,837**
3/2021*	99,472	12,723	14,041	3,888	**63,327**	20,743	**27,354**
9/2021*	104,288	10,048	13,734	3,624	**68,110**	22,691	**30,992**
Percent Change 3/20-9/21	**37.8%**	**28.9%**	**11.3%**	**28.1%**	**67.3%**	**29.4%**	**72.1%**

*NCHS Provisional drug-involved overdose death counts are PREDICTED VALUES

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Veteran drug overdose mortality, 2010–2019*

Age-adjusted rate of drug overdose mortality among Veterans increased by:

- 53% overall
- **93% for opioid overdoses**
- **333% for stimulant overdoses**
  - 219% for cocaine
  - 669% for psychostimulants

Table 1
Veteran Overdose Mortality Rates,[a] 2010–2019, Overall and by Drug Type[b].

	All drug overdose			Opioid overdose			Stimulant overdose		
	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019	2010 Rate	2019 Rate	Change from 2010 to 2019
All Veterans	19.8	30.3	53.2%*	11.1	21.5	93.4%*	3.0	12.9	333.4%*
Sex									
Female	17.9	18.0	0.4%	8.9	11.3	26.3%*	1.9	5.2	168.0%*
Male	20.3	32.8	61.2%*	11.7	23.6	102.5%*	3.1	14.3	361.1%*
Age group (years at death)									
18–24	16.8	16.0	-4.7%	12.1	12.2	1.0%	–[c]	5.7	–
25–34	22.3	38.7	73.4%*	13.8	31.4	127.9%*	2.7	13.7	402.4%*
35–44	21.3	41.8	96.2%*	11.7	29.9	156.6%*	3.2	17.9	454.0%*
45–54	32.2	31.1	-3.4%	17.0	21.0	23.3%*	5.9	14.6	148.8%*
55–64	20.9	41.0	96.7%*	10.2	25.3	147.8%*	4.3	20.5	374.4%*
65+	3.5	9.3	167.2%*	1.1	5.0	337.8%*	0.2	3.9	1490.2%*
Geographic region[d]									
Midwest	20.0	33.6	67.8%*	10.7	24.3	125.6%*	2.9	12.5	334.8%*
Northeast	22.4	52.8	136.1%*	11.9	43.9	267.9%*	3.6	20.8	483.5%*
South	17.7	24.9	40.6%*	10.1	17.7	74.9%*	2.5	10.8	336.3%*
West	22.5	27.3	21.5%*	13.0	15.4	17.7%	3.8	13.5	255.2%*
Race[e]									
American Indian, Alaskan Native	23.3	22.7	-2.6%	11.7	10.4	-10.5%	–	11.0	–
Asian, Hawaiian, or Pacific Islander	15.6	17.4	11.4%	7.8	9.6	22.7%	4.6	8.1	77.2%
Black	16.5	34.5	109.4%*	6.6	22.1	236.3%*	7.8	20.6	164.7%*
Multiple Races	17.2	69.5	304.1%*	7.9	48.0	510.1%*	–	34.6	–
White	15.6	21.5	37.4%*	8.3	14.2	70.2%*	1.9	8.7	358.2%*
Ethnicity[f]									
Hispanic	17.4	20.5	18.1%	10.0	13.1	31.2%*	3.6	9.4	165.3%*
Not Hispanic	15.4	24.0	55.4%*	7.9	15.7	99.6%*	2.5	10.8	322.3%*
Recent Use of VHA Services[g]									
Yes	37.0	41.7	12.8%*	21.0	29.7	41.2%*	5.3	18.0	242.3%*
No	15.6	25.7	65.1%*	8.7	18.3	108.9%*	2.4	10.7	356.0%*

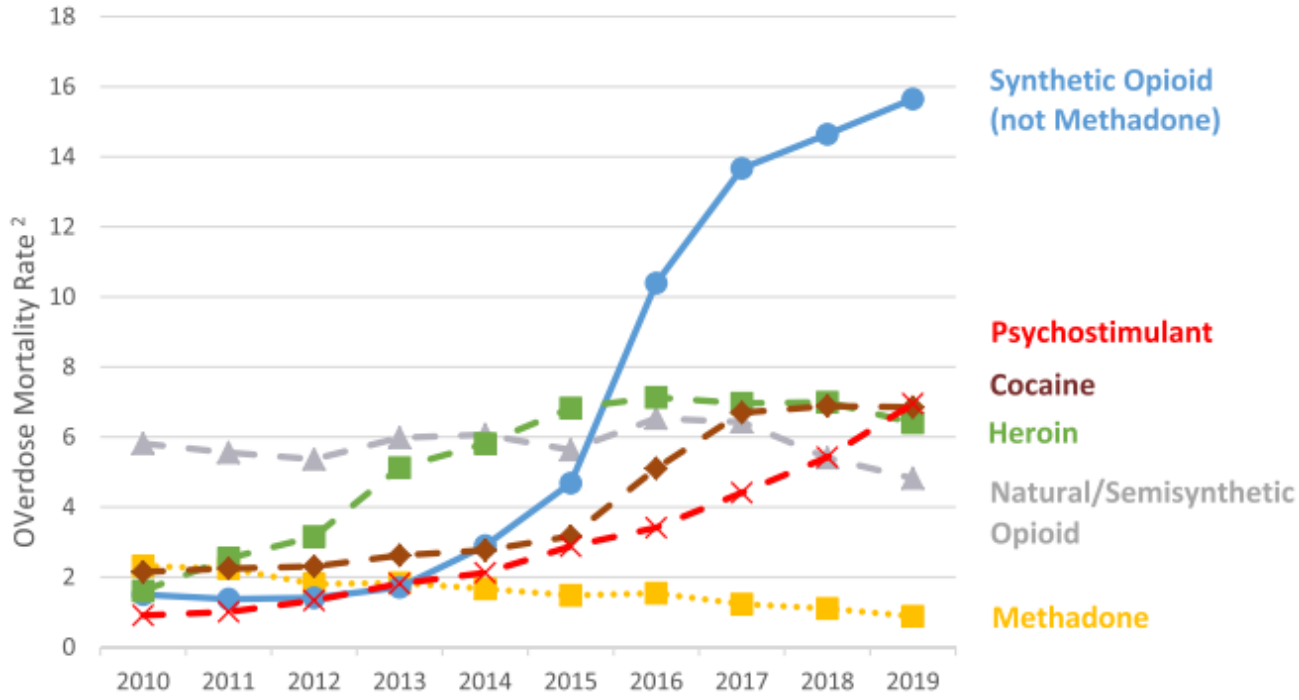
* https://linkinghub.elsevier.com/retrieve/pii/S0376-8716(22)00033-3

Veteran drug overdose mortality, 2010–2019* (Begley et al., 2022)

Table 2
Veteran Overdose Deaths, Crude and Adjusted Rates by Drug.

Year of death	Drug	Deaths	Veteran population estimate	Crude rate per 100,000	Age adjusted rate per 100,000
2010	All Overdose	3669	22,752,000	16.1	19.8
2011	All Overdose	3737	22,521,000	16.6	21.0
2012	All Overdose	3624	22,193,000	16.3	20.8
2013	All Overdose	3866	22,000,000	17.6	23.2
2014	All Overdose	4010	21,666,000	18.5	24.0
2015	All Overdose	4130	21,241,000	19.4	25.0
2016	All Overdose	4820	20,863,000	23.1	30.8
2017	All Overdose	5119	20,480,000	25.0	32.6
2018	All Overdose	4787	20,166,000	23.7	30.4
2019	All Overdose	4865	19,797,000	24.6	30.3
2010	All Opioids	1891	22,752,000	8.3	11.1
2011	All Opioids	1894	22,521,000	8.4	11.6
2012	All Opioids	1854	22,193,000	8.4	11.4
2013	All Opioids	2084	22,000,000	9.5	13.6
2014	All Opioids	2314	21,666,000	10.7	15.0
2015	All Opioids	2441	21,241,000	11.5	16.0
2016	All Opioids	3010	20,863,000	14.4	20.7
2017	All Opioids	3236	20,480,000	15.8	22.4
2018	All Opioids	3080	20,166,000	15.3	21.3
2019	All Opioids	3197	19,797,000	16.1	21.5
2010	All Stimulants	612	22,752,000	2.7	3.0
2011	All Stimulants	605	22,521,000	2.7	3.2
2012	All Stimulants	660	22,193,000	3.0	3.5
2013	All Stimulants	771	22,000,000	3.5	4.3
2014	All Stimulants	861	21,666,000	4.0	4.7
2015	All Stimulants	1031	21,241,000	4.9	5.8
2016	All Stimulants	1395	20,863,000	6.7	8.2
2017	All Stimulants	1719	20,480,000	8.4	10.4
2018	All Stimulants	1955	20,166,000	9.7	11.7
2019	All Stimulants	2172	19,797,000	11.0	12.9

- Age-adjusted rates of Veteran drug overdose deaths increased 65% from 2010 to 2017, decreased 7% from 2017 to 2018, and were not significantly different between 2018 and 2019
- **Veteran overdose deaths** involving opioids increased from 51% to 66% and involving stimulants increased from 17% to 45%
  - In 2019, one quarter of Veteran overdose deaths involving opioids also involved a stimulant



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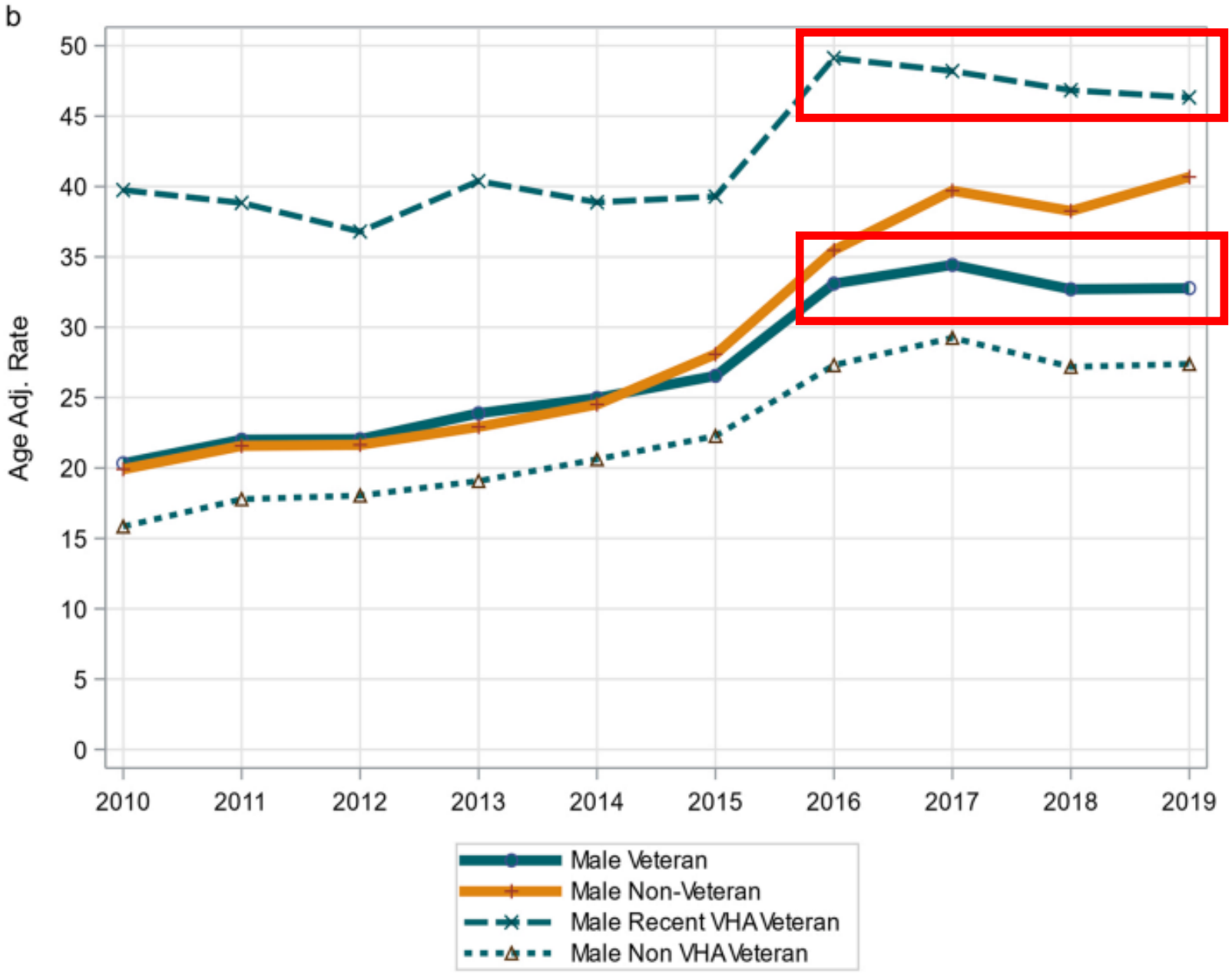
* https://linkinghub.elsevier.com/retrieve/pii/S0376-8716(22)00033-3

Veteran drug overdose mortality, 2010–2019 (Begley et al., 2022)

- Veteran men experienced lower age-adjusted overdose rates than non-Veteran men
- While there was an overall increase in age-adjusted overdose mortality among both male Veterans and male non-Veterans, overdose rates among male Veterans decreased relative to male non-Veterans after 2014
  - Average annual percent change (AAPC) was significantly lower for male Veterans (AAPC=6.4) than male non-Veterans (AAPC=9.6)
- While overdose rates across all years were higher among male Veterans with recent VHA use than those without recent use, the rate of increase did not significantly differ according to recent VHA use



Patient characteristics and treatment utilization in fatal stimulant-involved overdoses in the United States Veterans Health Administration (Coughlin et al., 2021)

- **48% of stimulant-related overdose deaths involved opioids**
- **1 out of every 2 cocaine-related deaths involved opioids***
- **1 out of every 3 methamphetamine-related deaths involved opioids***
- 46% involved synthetic opioids (e.g., fentanyl); 45% involved heroin; 26% involved prescription opioids
- 31% of stimulant+opioid overdose deaths involved ANOTHER substance
  - 18% of all stimulant+opioid overdose deaths involved alcohol

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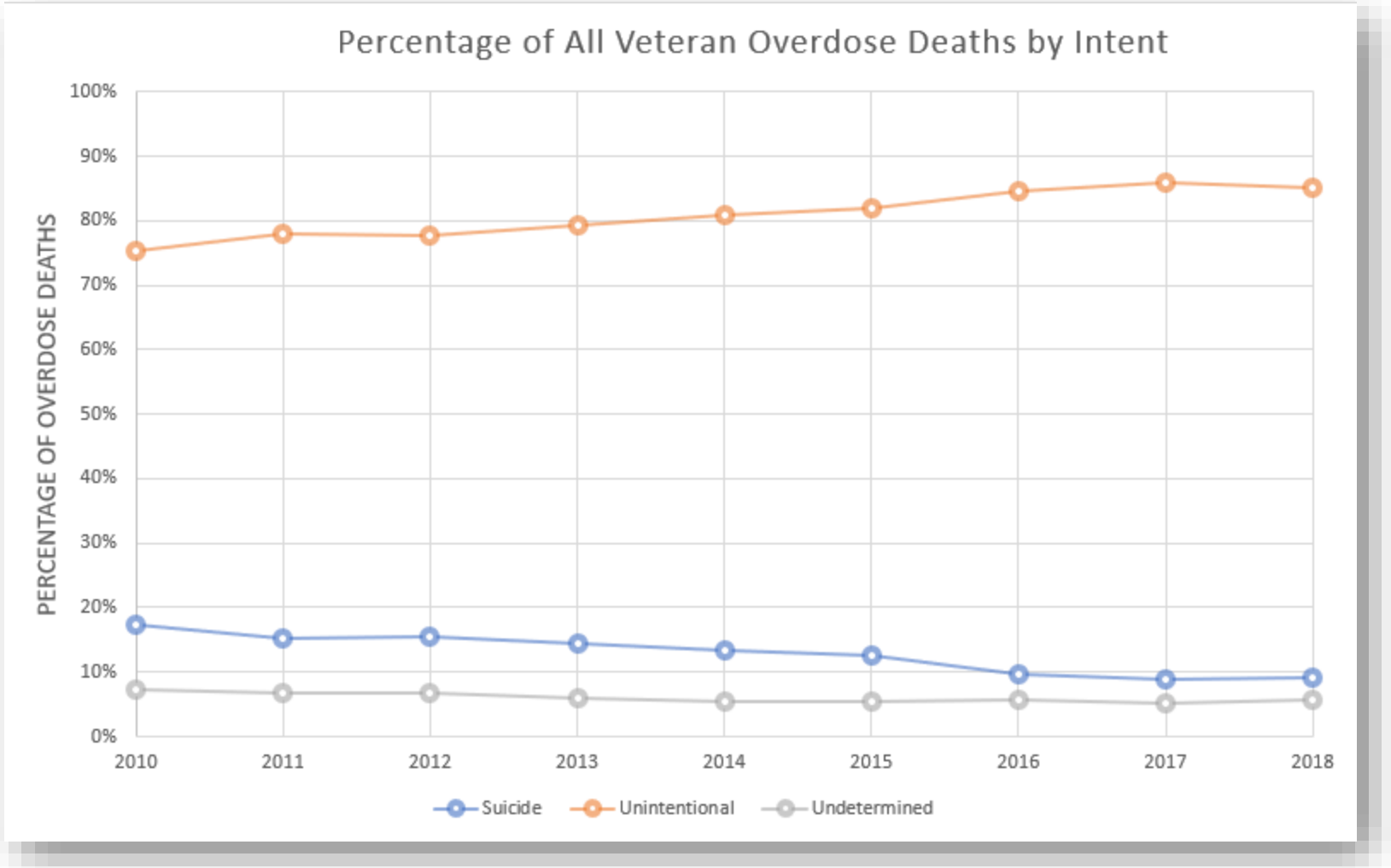
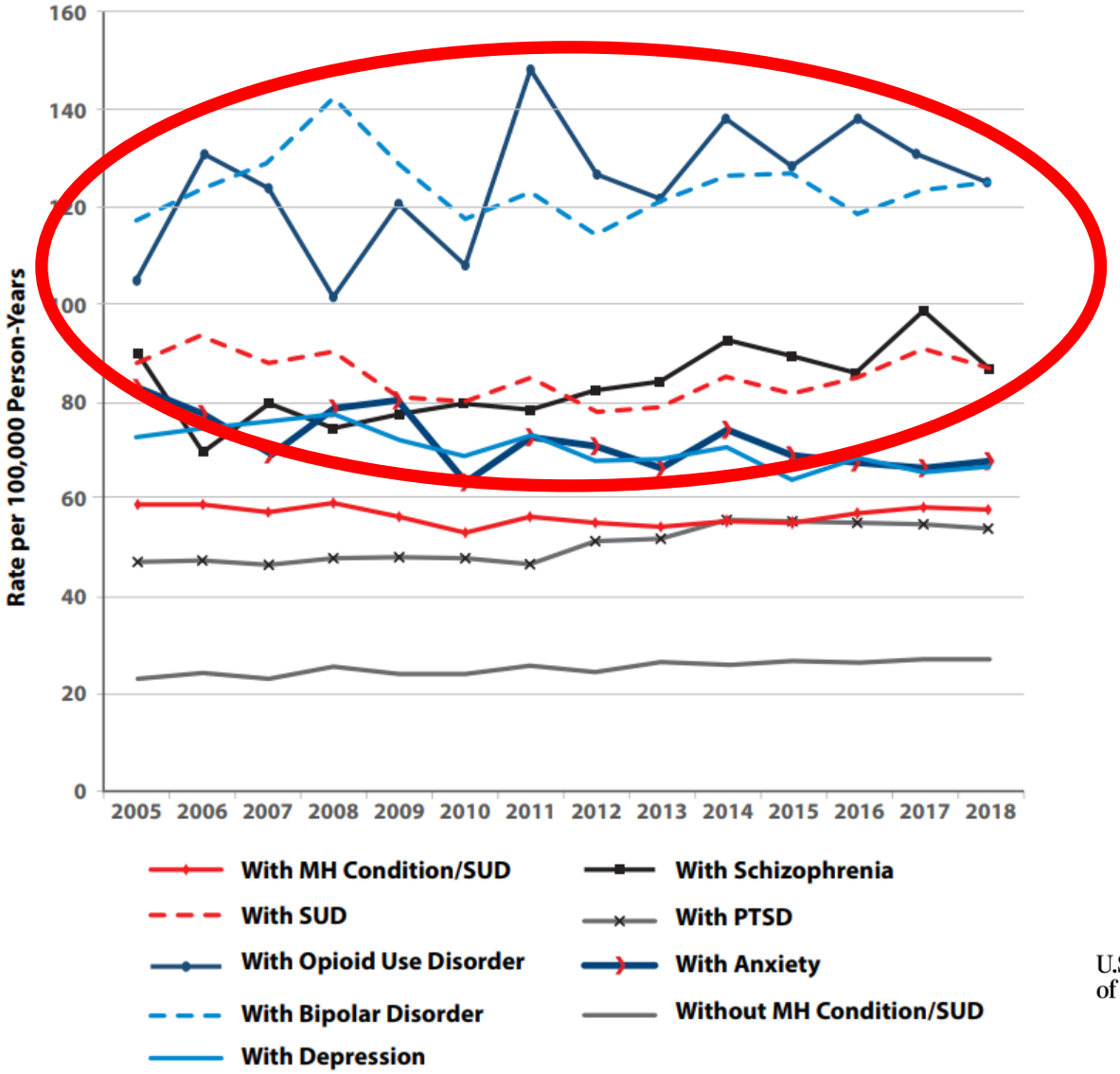
*11.10.21 personal communication with Dr. Lin; 90 deaths involved cocaine+methamphetamine+opioids→55% of cocaine-related deaths involved opioids (n=1325) and 37% of methamphetamine-related deaths involved opioids (n=508)

Suicide and Substance Use Disorder


Percentage of All Veteran Overdose Deaths by Intent
PERCENTAGE OF OVERDOSE DEATHS
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2010
2011
2012
2013
2014
2015
2016
2017
2018
Suicide
Unintentional
Undetermined

2020 National Veteran Suicide Prevention Annual Report

- Substance Use Disorders (SUD) diagnoses as a whole have higher rates of suicide when compared with depression
- Opioid Use Disorder (OUD) consistently among the highest rates of suicide



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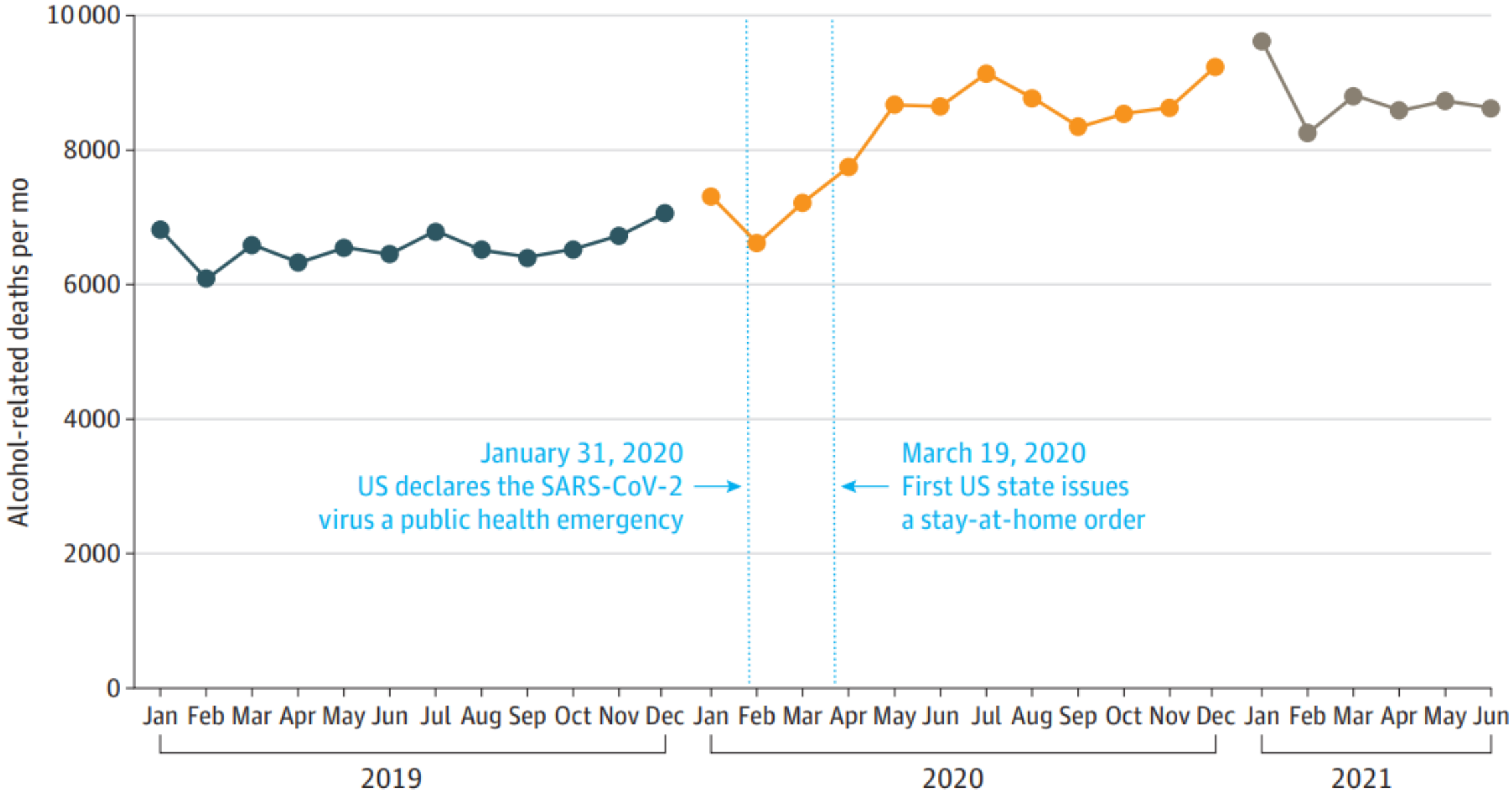
Alcohol-Related Deaths During the Pandemic

Alcohol-Related Deaths During the COVID-19 Pandemic

Figure. Monthly Alcohol-Related Deaths Among People 16 Years and Older



Biden-Harris Drug Policy Priorities

Biden-Harris Administration's Statement of Drug Policy Priorities

- Expanding access to evidence-based treatment
- Advancing racial equity in our approach to drug policy
- Enhancing evidence-based harm reduction efforts
- Supporting evidence-based prevention efforts to reduce youth substance use
- Reducing the supply of illicit substances
- Advancing recovery-ready workplaces and expanding the addiction workforce
- Expanding access to recovery support services

BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf (whitehouse.gov)

National Drug Control Strategy

https://www.whitehouse.gov/ondcp/national-drug-control-strategy/

Harm Reduction

- **Principle 1: Integrating Harm Reduction into the U.S. Substance Use Disorder System of Care Is Necessary to Save Lives and Increase Access to Treatment**
  - Enhance federal harm reduction efforts to support state and local partners
  - Ensure that harm reduction organizations have a plentiful supply of naloxone
  - Consider allowing coverage for harm reduction services
  - Comprehensively assess current evidence base on harm reduction strategies, and develop a plan for additional translational research
  - Conduct a national harm reduction needs assessment
  - Support harm reduction training and education for the treatment workforce
  - Facilitate low barrier buprenorphine induction through harm reduction organizations
- **Principle 2: Collaboration on Harm Reduction with Public Safety Agencies**
  - Reduce fatal overdoses through data-driven efforts to get naloxone to where it is most urgently needed
- **Principle 3: Foster Changes in State Laws and Policies to Support Harm Reduction**
  - Promote access to services and supports addressing social determinants of health for those receiving harm reduction services
- **Principle 4: Support Partnerships on Harm Reduction**
  - Consult with experts on harm reduction

Substance Use Disorder Treatment

- **Principle 1: Improve Treatment Engagement by Meeting People Where They Are**
  - **Implement a national case-finding initiative**
  - **Scale up primary care screening technology and computerized brief interventions to promote treatment entry**
  - **Support engagement through "low-threshold" or "low barrier to entry" settings**
- **Principle 2: Improving Treatment Quality Including Payment Reform**
  - **Explore reimbursement for evidence-based motivational incentives such as contingency management, and explore emerging evidence for digital screening, assessment, and treatment (digital therapeutics)**
  - **Make methadone more accessible for patients in federal health care systems**
  - **Review and update withdrawal management programs and policies to be followed by treatment programs and services**
- **Principle 3: Supporting At-Risk Populations**
  - **Expand mobile units for MOUD including to prisons and jails**
  - **Arrange for treatment for people leaving incarceration**

Building a Recovery-Ready Nation

- **Principle 1: Expand the Science of Recovery**
  - **Establish a federal recovery research agenda to support the development of science-based policy**

- **Principle 2: Make Recovery Possible for More Americans**
  - **Expand Peer Recovery Support Service (PRSS) capacity and foster the adoption of more consistent standards for the peer workforce, Recovery Community Centers, Recovery Community Organizations, and similar peer-led organizations**
  - **Expand and sustain funding for recovery support services and recovery housing**
    - ***Financing for PRSS and Peer-led Organizations***
    - ***Financing for Recovery Housing***

- **Principle 3: Eliminate Barriers and Increase Opportunities**
  - **Ensure the adoption of consistent, neutral, science-based language regarding substance use and related topics across the Federal supply and demand control functions.**
  - **Expand, enhance, and improve the coordination of federal anti-stigma efforts related to SU/SUD**
  - **Expand employment opportunities and promote Recovery-Ready Workplace policies**
  - **Reduce legal, regulatory, policy, and practice barriers to recovery**

Building a Recovery-Ready Nation

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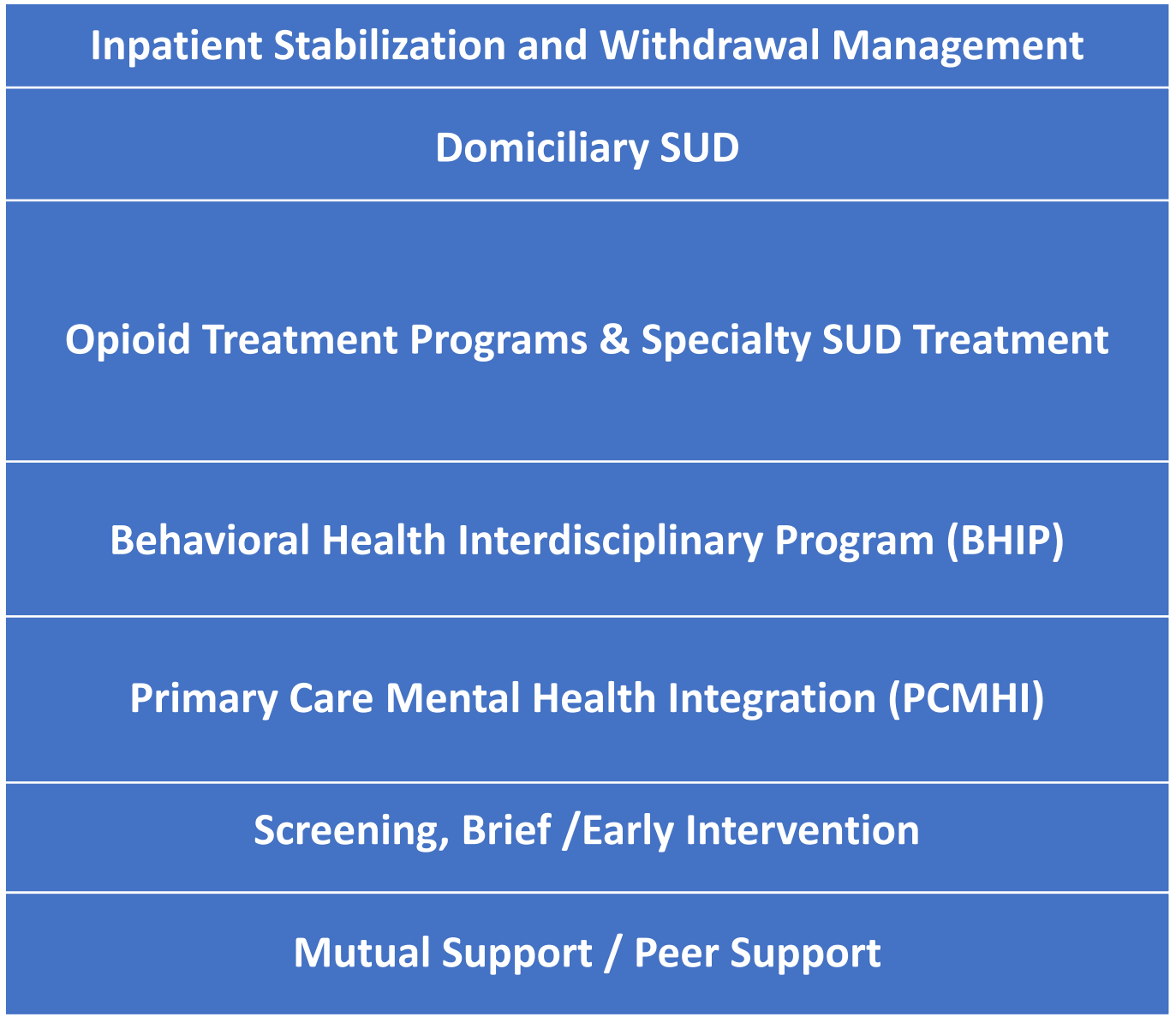
VA Substance Use Disorder Treatment

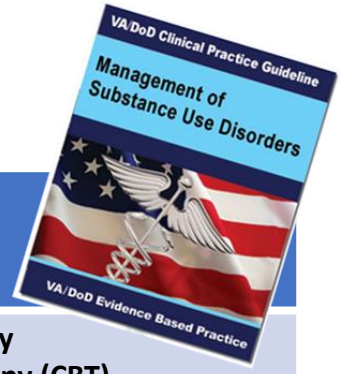


SUD treatment provided across settings of care and outside of SUD specialty care.
Medications provided in general mental health, primary care, pain management, and ED settings

Core Characteristics of Substance Use Disorder (SUD) Services

- Timely – Same day triage with engagement within 48 hours
- No Wrong Door
  - ✓ Provision of SUD treatment in general mental health, primary care, and pain management settings
  - ✓ Initiation of treatment in emergency department and inpatient settings particularly medications
- Concurrent treatment for co-occurring needs
- Veteran-centered and individualized based on needs and preferences of the Veteran
  - ✓ Consideration for prior treatment experience
  - ✓ Patient centric vs. Program centric
  - ✓ Variable Length of Stay (LOS)
  - ✓ Culturally sensitive
- Use of non-stigmatizing language
- Emphasis on engagement with barriers minimized
- Responsive to local trends
- SUD treatment is not automatically discontinued or limited based on use of a substance
- Treatment for SUD is normalized - Focus on retention in treatment
- Treatment is informed by use of standardized patient reported outcomes

- Screening and Brief Alcohol Intervention
- Treatment (Pharmacotherapy and Psychosocial Interventions) for all SUDs with a focus on:
  - Alcohol use disorder
  - Opioid use disorder
  - Cannabis use disorder
  - Stimulant use disorder
- Promoting Group Mutual Help Involvement (e.g. AA, NA, Smart Recovery)
- **Address Co-occurring Mental Health Conditions and Psychosocial Problems**
- Continuing Care Guided by Ongoing Assessment
- Stabilization and Withdrawal
- **Principles of care: Shared Decision Making and Motivational Principles**

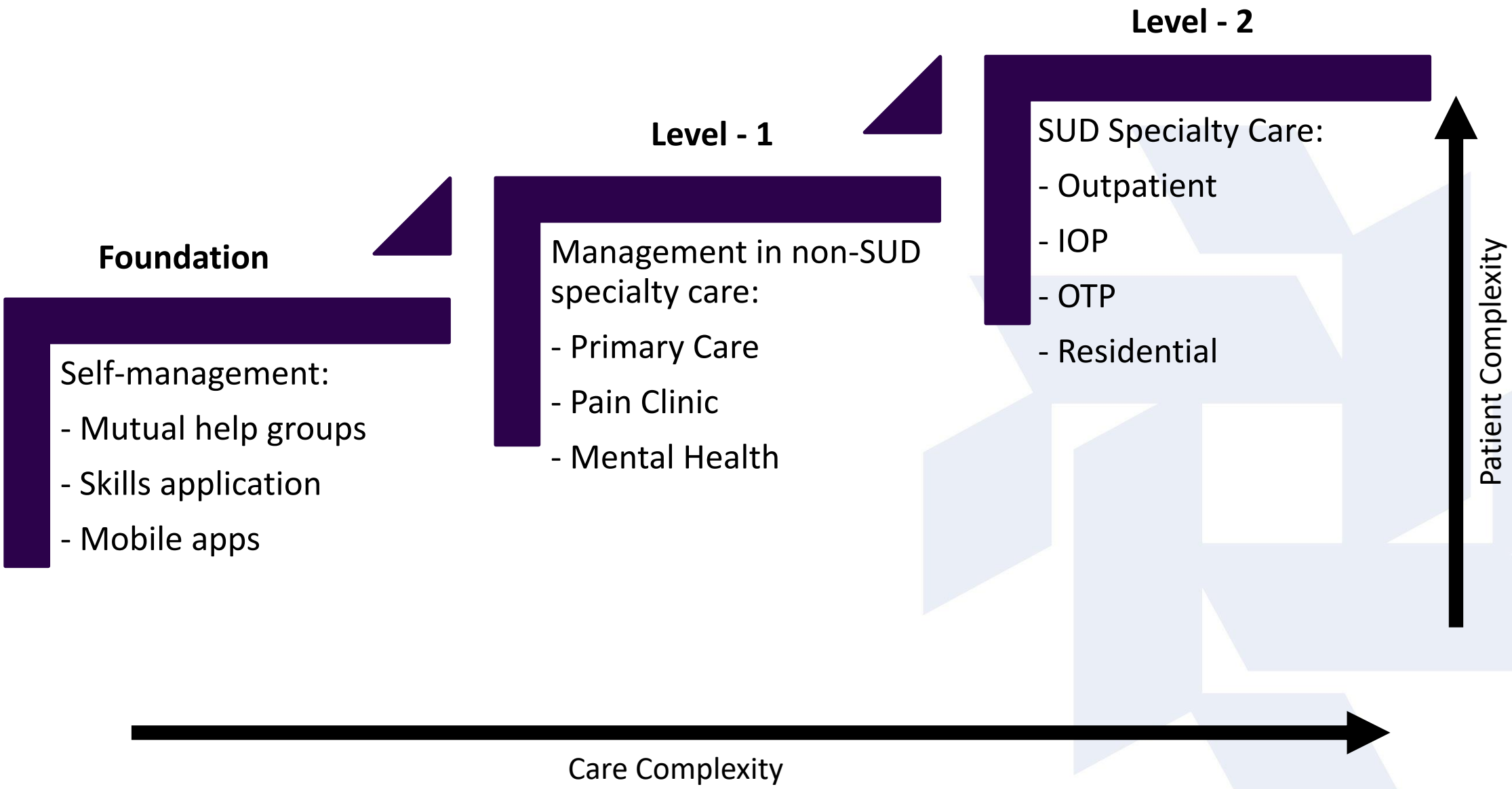


SUD	Medications	Psychosocial Interventions
Alcohol	"Strong for" Naltrexone Topiramate "Weak for" Acamprosate Disulfiram "Weak for" (2nd Line) Gabapentin	Behavioral Couples Therapy Cognitive Behavioral Therapy (CBT) Community Reinforcement Approach (CRA) Motivation Enhancement Therapy (MET) Twelve-Step Facilitation (TSF)
Opioid	"Strong for" Buprenorphine/naloxone Methadone "Weak for" ER-Injectable Naltrexone	
Cannabis		CBT/MET/Combined CBT/MET
Stimulants		Cocaine - CBT/Recovery Focused Behavioral therapy +/- Contingency Management (CM) Amphetamine/Methamphetamine – Contingency Management + treatment

http://www.healthquality.va.gov/guidelines/MH/sud/

Opioid Use Disorder

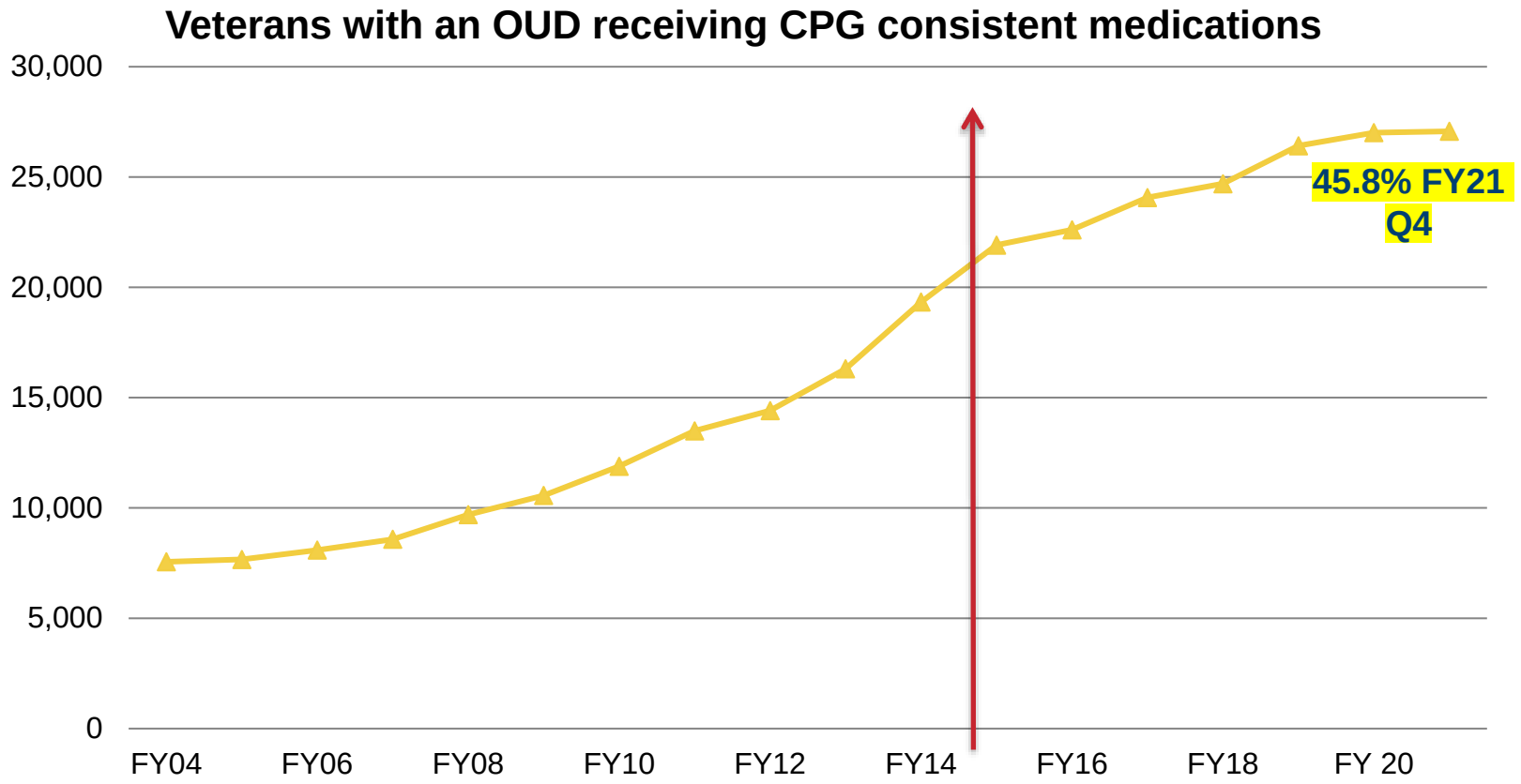
Stepped Care for Opioid Use Disorder Treatment



Medication Treatment For Veterans Treated in VHA with an OUD

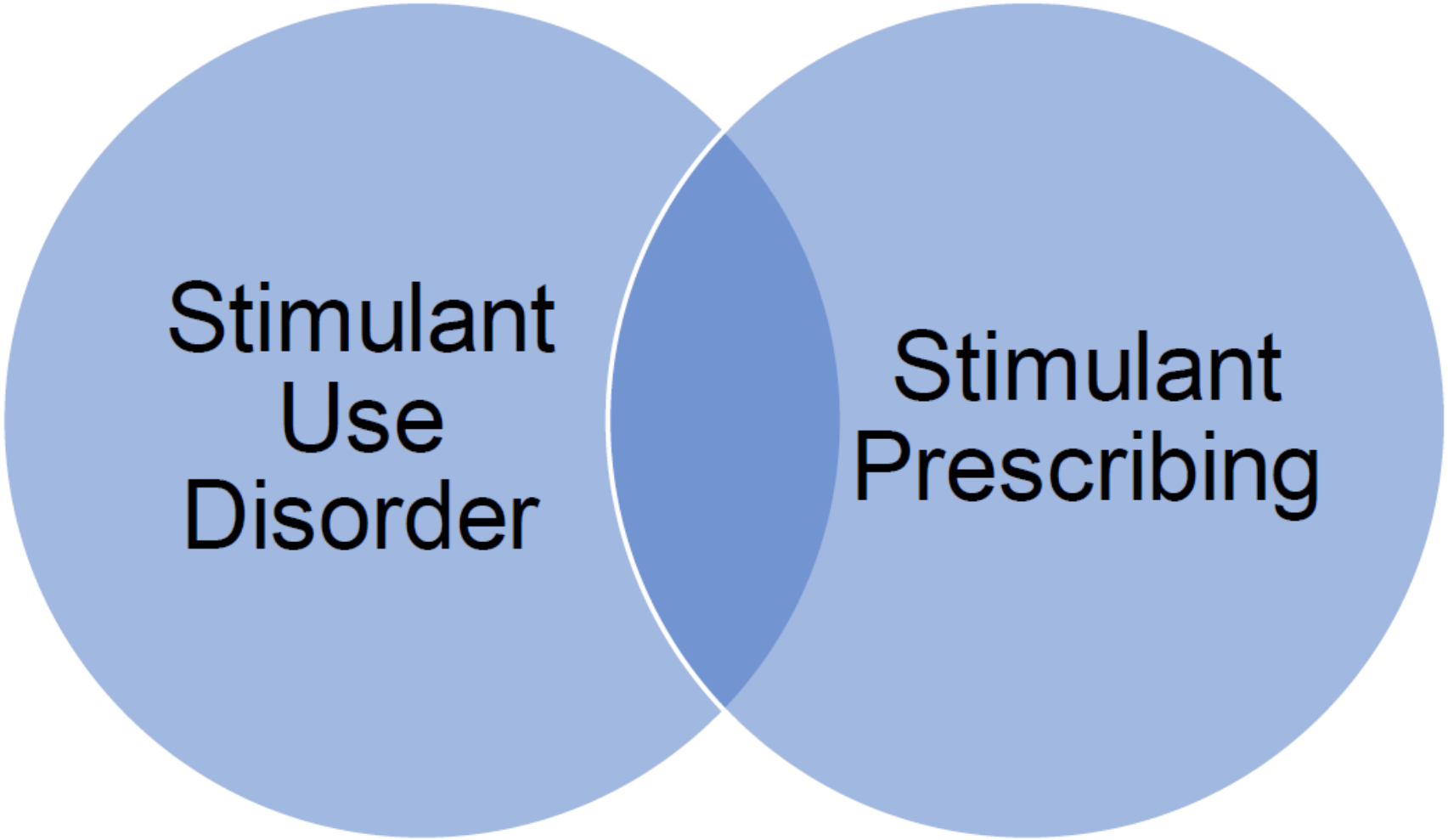
Starting in FY14, Extended-Release Naltrexone was counted as a medication assisted treatment for OUD

- **SUD16:** Percentage of VHA-treated Veterans with clinically diagnosed OUD who received indicated medications (i.e., OTP-administered methadone, buprenorphine, or injectable naltrexone)
- Most of this medication provided in SUD specialty care settings.



Stimulant Use Disorder

A Two-Pronged Approach



Metrics: STEP 1, Objective 1

Choose 1 !

CM_Program: Facilities meeting VA requirements to engage in Contingency Management (Displayed as + or -)

1. Provider Trained in Contingency Management
2. Ability to return a urine toxicology sample in 30 min or less
3. VA funds for patient rewards distributed to the facility

CBT-SUD_Provider: Proportion of all Mental health providers at the facility, who have completed training requirements to competently deliver CBT-SUD

- Numerator derived from databases maintained by the OMHSP Psychotherapy Program Office

Contact **Dom DePhilippis**
Dominick.DePhilippis@va.gov

Contact **Maryann Gnys**
Maryann.Gnys@va.gov

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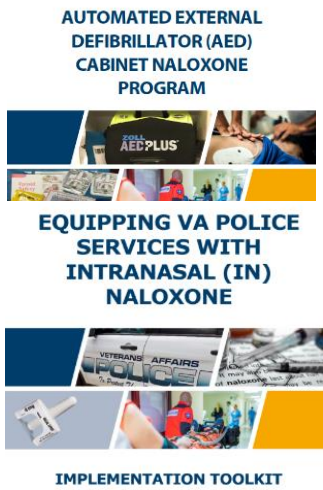
Harm Reduction

Overdose Education and Naloxone Distribution (OEND)

- Risk mitigation initiative to prevent opioid-related overdose deaths
  - Provides opportunity to discuss risk of opioids—**A few minutes of training could save a life!**
  - No cost to at-risk VHA patients (eliminated copays for naloxone and training)
- Opioid Overdose Education (OE)
  - Provide patient education on how to *prevent, recognize, and respond* to an opioid overdose
- Naloxone Distribution (ND)
  - Provide patient with *naloxone*; train patient and potential bystanders on administration
- Target patient populations
  - Patients with opioid use disorder and patients prescribed opioids
  - **Patients with stimulant use disorder and patients who recently discontinued opioids**
- VHA Rapid Naloxone Initiative: OEND, VA Police Naloxone, Select Automated External Defibrillator (AED) Cabinet Naloxone
  - 2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award
    - OEND (July 2022): More than 374,100 Veterans dispensed naloxone prescribed by over 42,100 prescribers with over 3,000 reported overdose reversals
    - VA Press Release: 3,552 VA police officers with naloxone (136 opioid overdose reversals); 1,095 AED Cabinets with naloxone (10 opioid overdose reversals) [April 2021]

https://www.youtube.com/watch?v=0w-us7fQE3s



VA Academic Detailing Service OEND site; Oliva et al. (2017; 2021); Bounthavong et al. (2017, 2020); QUERI Roadmap; NPR feature; Eisenberg—The Joint Commission (TJC) Journal on Quality and Patient Safety Paper, Podcast, Blog; VA Press Release

U.S. Department of Veterans Affairs

Patient Guide

Opioid Overdose Prevention and Reversing an Overdose with Naloxone

PATIENT GUIDE

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Services

Opioid Overdose Prevention and Reversing an Overdose with Naloxone

What are opioids?

Opioids are a type of medicine used to treat pain, cough, and addiction. Opioids can also be non-prescribed substances like heroin.

Common opioid medicines:

- codeine (Tylenol #3®)
- fentanyl (Actiq®)
- hydrocodone (Vicodin®)
- hydromorphone (Dilaudid®)
- methadone (Methadose®)
- morphine (MS Contin®)
- oxycodone (Percocet®)

SAFER USE OF OPIOIDS

ANY OPIOID

- There is no safe dose of opioids.
- Naturally found opioids have the same risks as those made in a lab.
- Go slow! If you have not used opioids in a few days, your usual dose may cause an overdose.
- Wait! If you use an opioid, wait long enough to feel the effects before taking more.
- Many who overdose do so when using opioids alone. Tell someone so they can check on you.
- **Mixing opioids with alcohol and other substances can cause an overdose.**
- **Naloxone is a medicine that can reverse the effects of an opioid overdose.**

PRESCRIBED OPIOIDS

- Know the name of the opioid, strength, and amount taken each day.
- Take prescribed medicines exactly as instructed by your healthcare provider. Do not stop opioids abruptly since this can cause withdrawal.
- Review the booklet ***Safe and Responsible Use of Opioids*** with your healthcare provider. Download using the QR code at the right.

NON-PRESCRIBED OPIOIDS

- If you choose to use, go slow!
- Even a few days off opioids could make you more sensitive to them.
- Reduce your dose to half or less after any period of not using (even a couple of days).

WATCH OUT!

Some opioids, like fentanyl and carfentanil, are very powerful. **Even a very small amount can be deadly.** Opioid tablets purchased online or from non-healthcare sources are commonly mixed with fentanyl. Cocaine and methamphetamine can also contain deadly amounts of fentanyl or carfentanil.

Download a handout on fentanyl and carfentanil using this QR code.

Lethal opioid doses

Opioid	Strength compared to morphine	Lethal dose
morphine	1x	1 pea
heroin	2x	1 sunflower seed
fentanyl	100x	1 sesame seed
carfentanil	10,000x	< ½ grain of salt

Source: https://www.clearvuehealth.com/sufentanil

Opioid overdose:

- Opioid overdose occurs when a person takes more opioids than the body can handle. The person may pass out and have difficulty breathing or slow breathing. In some cases the person may die.
- **Do not use opioids alone.** Tell your family, friends, and others how to recognize an overdose.
- Do not share your opioids with another person. The amount you take may be too much for a person who is not regularly taking opioids.

Things that put you at higher risk for an accidental overdose:

- **Loss of tolerance:** If you stop taking opioids, even for a few days (like during a hospital stay), you may lose your tolerance. This means that the dose you took before could be too much and lead to an overdose.
- **Medical conditions:**
  - Sleep apnea
  - Reduced liver or kidney function
  - Advanced AIDS
  - Smoking cigarettes and cannabis
  - Chronic obstructive pulmonary disease (COPD) or other lung problems
- **Older age:** As a person gets older, they do not process medicines as well and many need lower doses.

Mixing opioids with other substances puts you at higher risk for an accidental overdose. Avoid mixing opioids with:

- Alcohol
- Benzodiazepines like alprazolam (Xanax®), clonazepam (Klonopin®), or lorazepam (Ativan®). Only take if directed by your healthcare provider.
- Sleep medicines such as zolpidem (Ambien®), muscle relaxants like cyclobenzaprine (Flexeril®), some antidepressants, and nerve pain medicines like gabapentin and pregabalin (Lyrica®).
- Ask your healthcare provider or pharmacist if you have questions.

Ask a VA clinician if naloxone is right for you

Naloxone is a medicine that can temporarily reverse an opioid overdose.

- Opioid overdose can happen quickly. Make sure your family and friends know how and when to use naloxone and where you store it.
- Naloxone is not a substitute for safe use of opioids.
- Naloxone is available as an easy to use nasal spray. There is an intramuscular injection available if you are unable to use the nasal spray.
- Check the expiration date of your naloxone every year. Ask for a renewal before it expires.

Dispose of opioids to keep others safe

Prescribed medicine disposal:

- If you have prescribed opioids left over, ask your pharmacy for safe disposal instructions.
- Contact the VA Pharmacy to request medical disposal envelopes or to find the nearest location where you can bring your medicines for disposal.

Patient Guide

Opioid Overdose Prevention and Reversing an Overdose with Naloxone

Non-prescribed medicine/illicit substance disposal:

- Sharps containers may be available from the VA Pharmacy to safely dispose of syringes.
- Substances, cookers, spoons, and pipes can be placed in a coffee can, laundry detergent jug, or other heavy plastic container.
  - — Crush and dissolve solid substances in a liquid. Add to the container.
  - — Place sharp objects like broken glass or syringes in the container.
  - — Add kitty litter, sawdust, dirt, or coffee grounds to the container. Seal container.
  - — Destroy any information that may contain your name. Dispose in trash.

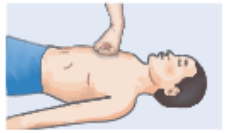
Responding to an overdose

Safety check: Look for signs of an overdose

Check	Listen	Look	Touch
• sleepy • heavy nodding • deep sleep • hard to wake • vomiting	• slow or shallow breathing (1 breath every 5 seconds) • snoring • raspy, gurgling, or choking sounds	bluish or grayish: • lips • fingernails • skin	• clammy sweaty skin

STOP If the person responds to the initial safety check, continue to monitor them. Some opioids can take longer to take effect. Stay with the person until help arrives. If they do not respond then follow the steps below:

1 Check for a response



- Give the person a light shake. Yell their name. Firmly rub their sternum (bone in center of chest where ribs connect) with knuckles and your hand in a fist.
- If no response, continue to Step 2.

2 Shout for help, call 911, and get naloxone

- Shout for nearby help.
- Call 911 or if someone else is around, have them call 911.
- Give your address and location. Say the person is not responding.
- Get naloxone.
- If available, get an automatic external defibrillator (AED).

3 Check for breathing

Look at the chest to see if it rises and falls. Check mouth to make sure airway is clear. **The person is not breathing normally if:**

- the chest does not rise or fall.
- you see slow or shallow breathing. This means about 1 breath every 5 seconds or longer.
- you hear snoring, raspy, gurgling, or choking sounds.

If the person is NOT breathing normally, start life saving treatment:

Give naloxone and use an AED if available:

- If you have **naloxone nasal spray**, DO NOT PRIME OR TEST the spray device. Gently insert tip of nozzle into one nostril and press the plunger firmly to give the dose.
- If you have **intramuscular naloxone**, insert syringe through rubber plug with vial upside down and pull back on plunger to 1ml. Inject 1 ml at a 90-degree angle into a large muscle (upper arm, upper leg, or buttocks).


Naloxone nasal spray


Intramuscular naloxone

Start chest compressions:

- Place heel of one hand over center of the person's chest (between nipples).
- Place one hand on top of your other hand, keep elbows straight, shoulders directly above hands.
- Use body weight to push down, at least 2 inches, at a rate of 100 to 120 per minute.
- Continue until EMS arrives.

Start rescue breathing *(If trained in CPR):*

- After 30 chest compressions, open airway using the head-tilt, chin lift maneuver.
- Put your palm on the person's forehead and gently tilt the head back. Then gently lift the chin forward with the other hand. Give 2 rescue breaths.
- Continue chest compressions and rescue breaths at a rate of 2 breaths for every 30 compressions.

If the person is breathing normally, prevent worsening:

- Tap and shout.
- Reposition into the recovery position.
- If person stops responding, give naloxone.
- Continue to observe until EMS arrives.

4 Consider a second dose of naloxone if:

1. The person does not start breathing in 2 to 3 minutes after the first dose of naloxone.
2. Naloxone may wear off in 30 to 90 minutes. A second dose may be needed if the person stops breathing again. **Stay** with the person until EMS takes over or for at least 90 minutes to make sure the person does not stop breathing again.

5 Place in recovery position

If the person is breathing but unresponsive, put the person on their side to prevent choking if they vomit.

Resources:

VA Substance Use Disorder Program Locator: www.va.gov/directory/guide/SUD.asp
Substance Use Disorder Treatment Locator for Non-Veterans: https://findtreatment.samhsa.gov
Prescribe to Prevent: www.prescribetoprevent.org
Syringe Service Programs: www.hiv.va.gov/patient/ssp.asp

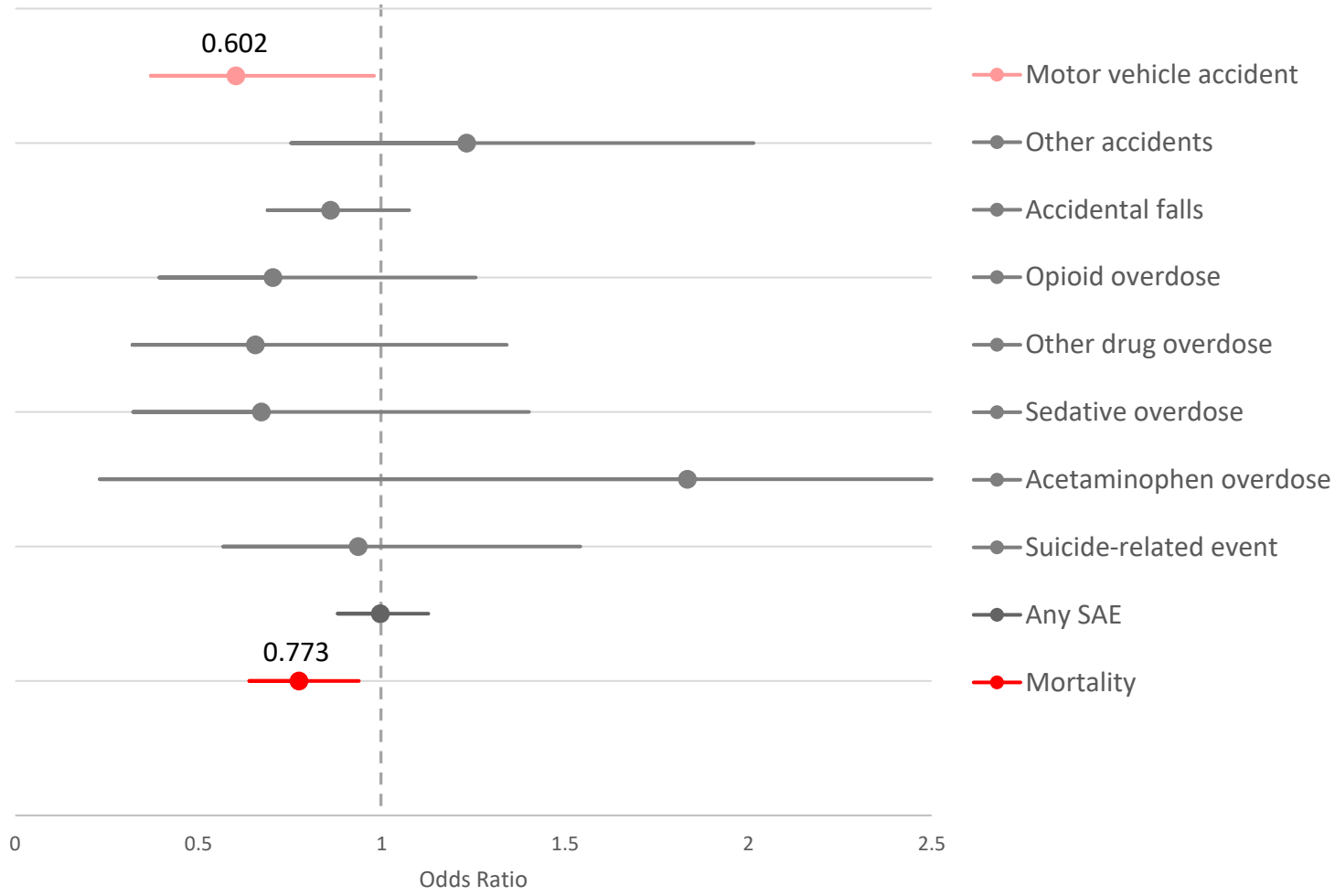
Help is available anytime — **Local Emergency Services: 911 • National Poison Hotline: 1-800-222-1222**
Veterans Crisis Line: 1-800-273-TALK (8255), or text–838255

U.S. Department of Veterans Affairs

What is STORM?

- Uses demographic, diagnostic, pharmacy, and health care utilization data from the VHA's Corporate Data Warehouse
- Predicts risk of overdose or suicide-related health care events or death in the next year and generates patient-specific risk score
- Parameters from model are applied to Veteran health care data and updated nightly to create individual estimates of risk in STORM
- Detailed background and data on the STORM risk model:
  - Oliva EM, Bowe T, Tavakoli S, Martins S, Lewis ET, Paik M, Wiechers I, Henderson P, Harvey M, Avoundjian T, Medhanie A, Trafton JA. Development and applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to improve opioid safety and prevent overdose and suicide. Psychol Serv. 2017 Feb;14(1):34-49.

Impact of STORM Dashboard Inclusion on the Risk of Serious Adverse Events and Mortality



PEPReC
Partnered Evidence-based Policy Resource Center
A VA QUERI Program

*These findings are not yet peer-reviewed

STORM dashboard patients had **23%** lower odds of all-cause mortality relative to control patients.

Improving Access to Syringe Service Programs (SSPs) for People Who Inject Drugs (PWID)

- Distribution of syringes/disposal/exchange
- Provision of preventive/ risk mitigation strategies
- Linkage to SUD care including buprenorphine induction
- Reduction in infectious disease transmission

Operational status of SSPs in VHA

- At least six VAMCs currently operate Syringe Service Programs (SSPs)
- At least twenty-four SSPs are in development
- Publication of an AUSH-CS Directive has been drafted that will require VA Medical Centers to establish SSPs where allowable by law

Evidence-based harm reduction

☑ SSPs do:

- SSPs are associated with an estimated 50% reduction in HIV and HCV incidence
- When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds
- SSPs serve as a bridge to other health services, including HCV/HIV testing and treatment and MAT for opioid use disorder
- SSPs prevent overdose deaths by teaching PWID how to prevent overdose and how to recognize, respond to, and reverse a drug overdose

☒ SSPs do not:

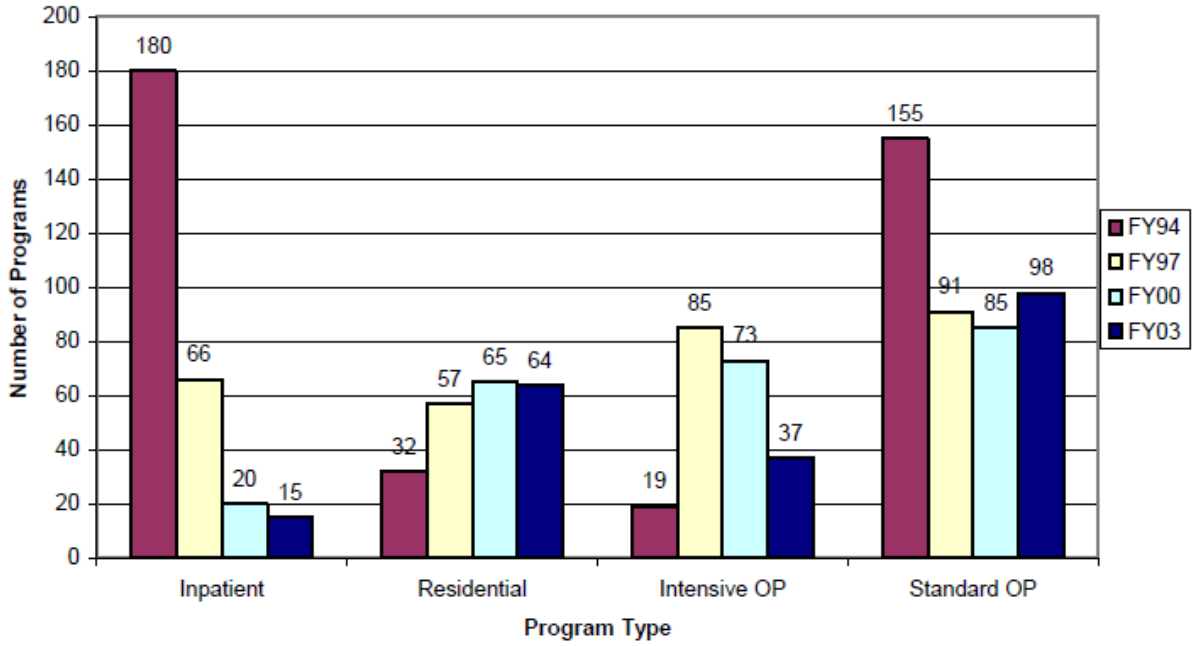
- Increase substance use. New users of SSPs are 5x more likely to enter drug treatment and 3x more likely to stop using drugs than those who don't use the programs.
- Increase syringe litter. SSPs protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.
- Increase crime. Studies in Baltimore and New York City have also found no difference in crime rates between areas with and areas without SSPs.

https://www.cdc.gov/ssp/syringe-services-programs-factsheet.html

Residential Program Data

SUD Treatment in VA – Understanding Changes Over Time

Figure 1: Number of VA Substance Abuse Treatment Programs, FY94 - FY03



*Results from the 2003 Drug and Alcohol Program Survey

Today

- Inpatient SUD Programs:
  - 4 Facilities
- SUD Residential Programs:
  - 68 Programs (1,865 Beds)
- Opioid Treatment Programs
  - 33 Locations (29 VAMC/HCS)
- 124 Facilities with IOPs (FY 2019)
- Approx. 1,480 SUD FTEE (Approx. 155,000 Veterans Treated)

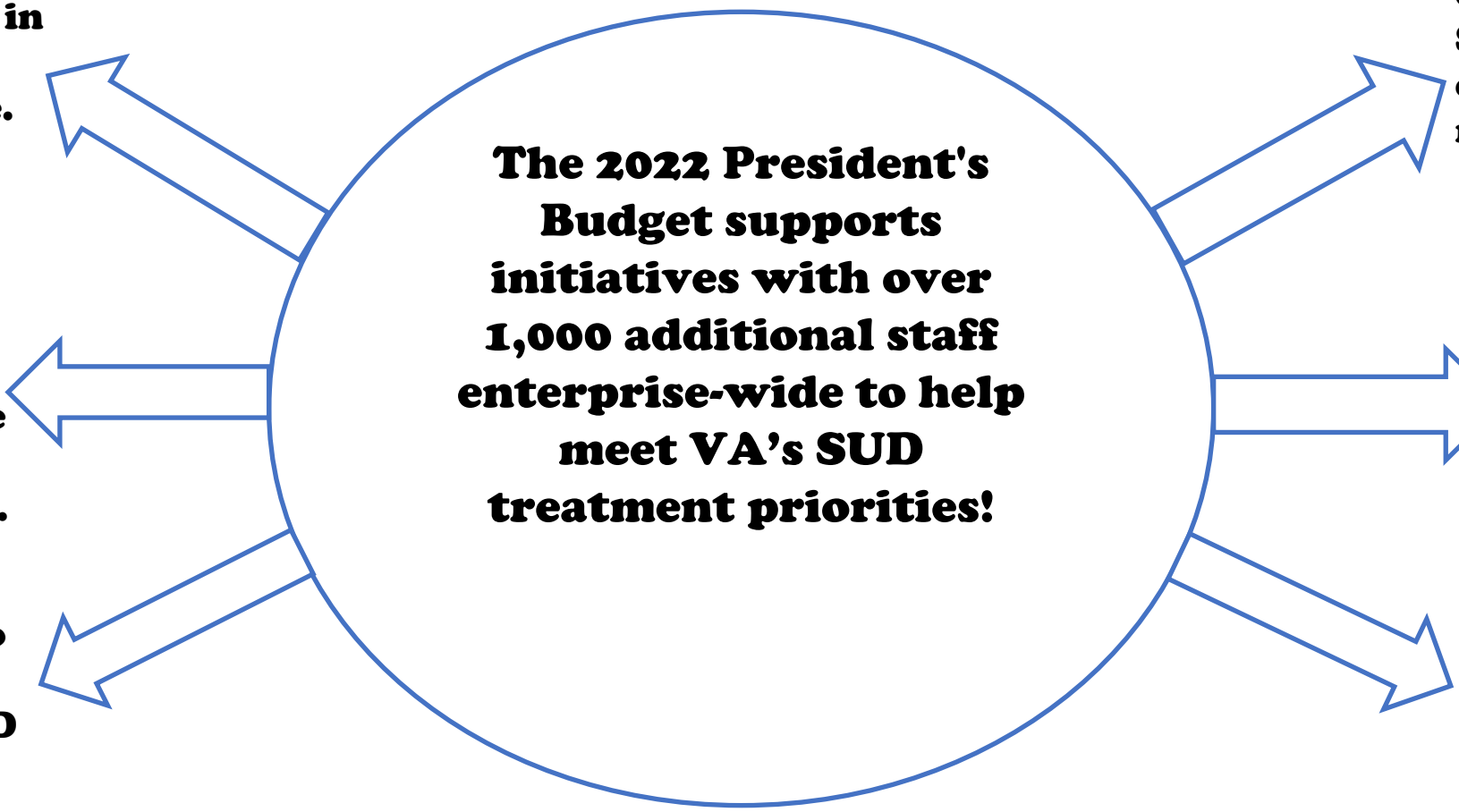
SUD FY22 Special Purpose Funding

2022 President's Budget Expands Access to Treatment for Substance Use Disorders (SUD)

Stepped Care: To expand access to evidence-based treatment for SUD in settings outside specialty SUD Care.

SUD Residential Treatment: To reduce wait times and improve the quality of SUD care with expansion of staff and programs.

SUD Telehealth: To expand access to evidence-based SUD treatment via telehealth.



Homeless Program SUD Treatment Coordinators: To engage Veterans with SUD into VA SUD outpatient and residential services.

Supported Employment Specialists: To expand access to employment opportunities for Veterans in recovery.

SUD Peer Specialists: To increase engagement and retention in evidence-based SUD treatment.

SELECTED SUD PROGRAM OFFICE PRIORITIES

- **Expanding access to evidence-based treatment**
  - Increasing MOUD among patients with OUD (including Pain clinics, General Mental Health, Primary Care, inpatient/ED/Rural settings)
  - Increasing Evidence-Based Treatment of Stimulant Use Disorder
  - Increasing Pharmacotherapy for Alcohol Use Disorder
  - Improving Withdrawal Management
  - Increasing access to residential SUD treatment
  - ? Implementing drug use disorder screen

- **Enhancing evidence-based harm reduction efforts**
  - Increasing Overdose Education and Naloxone Distribution (OEND) to Veterans with OUD or Stimulant Use Disorder
  - Promoting Post Overdose Assessment/ Care
  - Improving Access to Syringe Service Programs (SSPs) for People Who Inject Drugs (PWID)
    - Provision of preventive/risk mitigation strategies, Linkage to SUD care, Reduction in infectious disease transmission
  - Increasing Utilization of the STORM database and other Risk Mitigation Strategies (Fentanyl test Strips)

- **Advancing racial equity in our approach to drug policy**
  - Addressing SUD healthcare disparities with newly formed task group

- **Advancing recovery-ready workplaces and expanding the addiction workforce / Expanding access to recovery support services**
  - Increasing DOM SUD expansion
  - Enhancing coordination of care for Homeless Veterans
  - Enhancing employment opportunities for Veterans in recovery
  - Increasing Peer Support Services in the SUD Lane