SMVF Opioid Addiction: Increasing Access to Prevention, Treatment, and Recovery

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Webinar

May 29, 2019

SAMHSA

Substance Abuse and Mental Health Services Administration

SAMHSA Welcome

Cicely K. Burrows-McElwain, L.C.S.W.-C.

Military and Veteran Liaison

National Policy Liaison Branch,

Division of Regional and National Policy/Office of Policy, Planning, and Innovation, SAMHSA

SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

SAMHSA Background

Since 2008, SAMHSA has partnered with states and territories to strengthen behavioral health systems serving **service members, veterans, and their families** (SMVF) providing Technical Assistance (TA) through its SMVF TA Center.

SAMHSA leads efforts to ensure substance use and mental health issues among all Americans, including SMVF, are well understood.

SAMHSA's SMVF TA Center

- Strengthening ongoing collaboration among military and civilian stakeholders
- Providing a centralized mechanism for cities, states, and territories to learn, connect, and share
- Increasing awareness of and access to resources and programs that strengthen behavioral health care systems for service members, veterans, and their families (SMVF)
- Supporting coordinated responses to the behavioral health needs of SMVF
- Encouraging cities, states, and territories to implement promising, best, and evidence-based practices

SAMHSA
Substance Abuse and Mental Health Services Administration

Technical Assistance Methods

The SMVF TA Center provides training and technical assistance through activities such as:

- Policy Academies
- Implementation Academies
- Webinars
- Learning communities
- Onsite and virtual expert consultation
- Resource dissemination

Webinar Objectives

- Describe how VA addresses the national epidemic of opioid use disorders through its prevention, treatment, and recovery supports

- Recognize how community systems of care are imperative to SMVF long-term recovery

- Describe how we can build the Illustrate mental health comorbidities with increased risk of opioid use

Webinar Objectives (cont'd)

- Describe opioid risk mitigation and overdose prevention strategies for long-term opioid therapy

- Explain the components of a *Recovery-based Integrated Model of Care for SMVF*

- Demonstrate the importance of a paradigm shift in pain management, especially among serve members and Veterans, toward multimodal and integrated team-based pain care (biopsychosocial interdisciplinary care)

Why this Webinar is Important

- Addressing best practice methods to preventing opioid use, treating those experiencing addiction, and supporting service member and Veterans in recovery

- Community services should form a person-centered network to provide measurably improved health, wellness, and quality of life for SMVF

Today's Presenters

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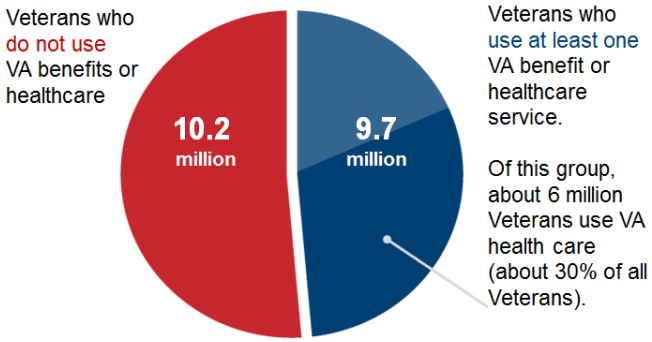
SAMHSA
Substance Abuse and Mental Health Services Administration

VHA Strategies to Address the National Epidemic of Opioid Overuse, Diversion, and Opioid Use Disorders



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Office of Mental Health & Suicide Prevention, VACO

No relevant financial relationships or conflicts of interest. No discussion of off-label use of drugs or devices.

The presentation is the personal opinion of the presenter and does not reflect the official views of the Department of Veterans Affairs or any other Federal Agency.

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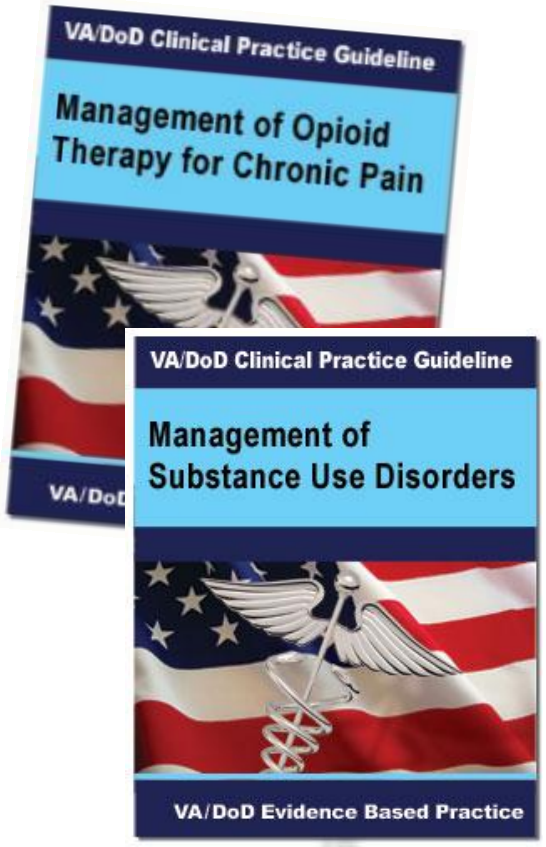
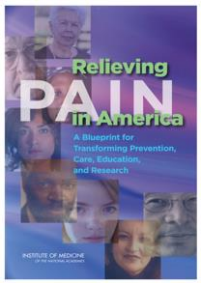
Overview

- How did we get here?
  - Health Impact of Pain, Overdose and Opioid Use Disorder (OUD)
  - Risk Factors for Overdose, Suicide, and OUD
- VA Opioid Safety Initiatives
  - Clinical Practice Guidelines
  - Opioid risk mitigation strategies for long-term opioid therapy
  - Increasing access to safe, effective Pain Management, Opioid tapering & OUD treatment
- What can you do?
  - Recommendations to mitigate suicide risk related to Pain, Opioids, and OUD
  - Connect Veterans & Clinicians with VHA resources



Chronic Pain as a Major Public Health Problem

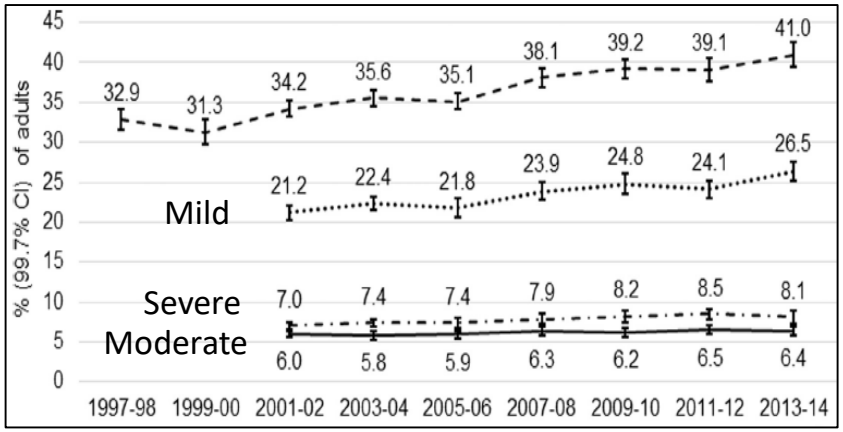


Institute of Medicine Report 2011

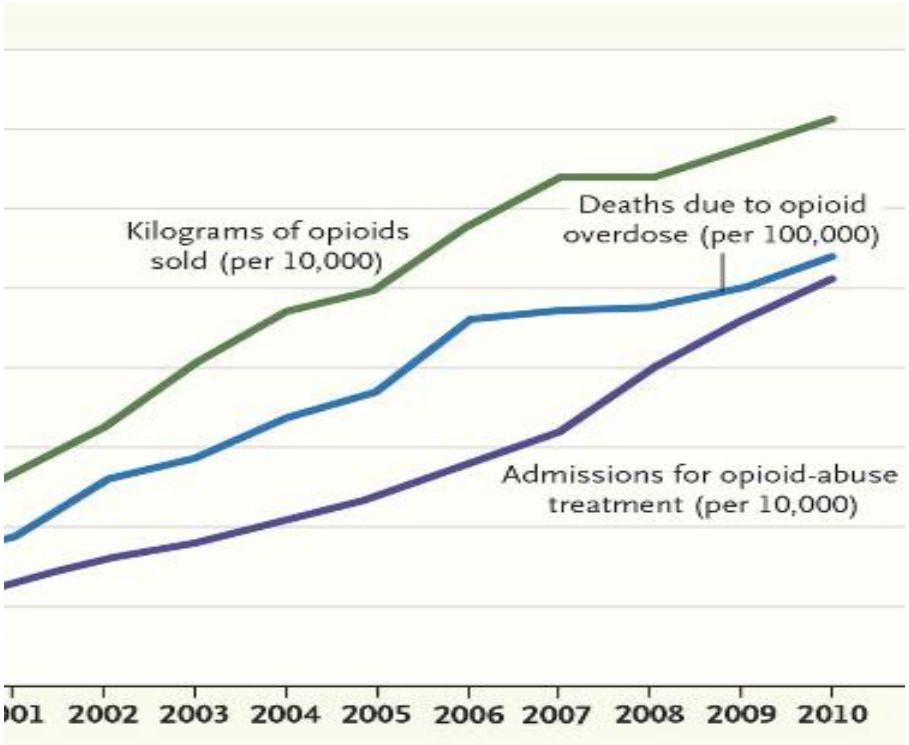
(now National Academy of Medicine)
Relieving Pain in America

- **> 100 Mil in US with chronic pain (30 percent of adults)**
- **Cost greater than cancer and heart disease combined**

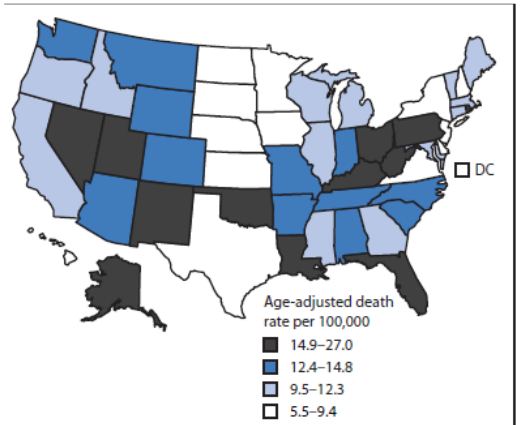
Prevalence Noncancer Pain
United States
1997 to 2014



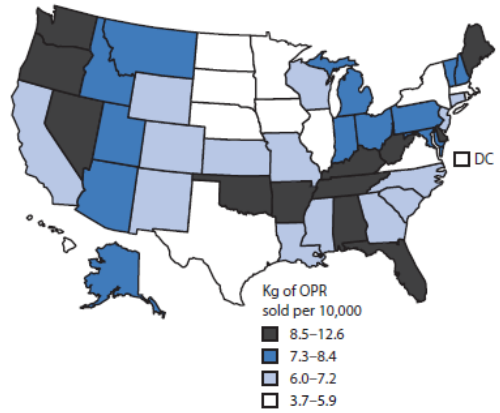
U.S. Opioid Prescribing, Overdose Deaths, and Opioid Use Disorder



Age-adjusted death rate per 100,000



Kg of Opioid Pain Reliever sold per 10,000



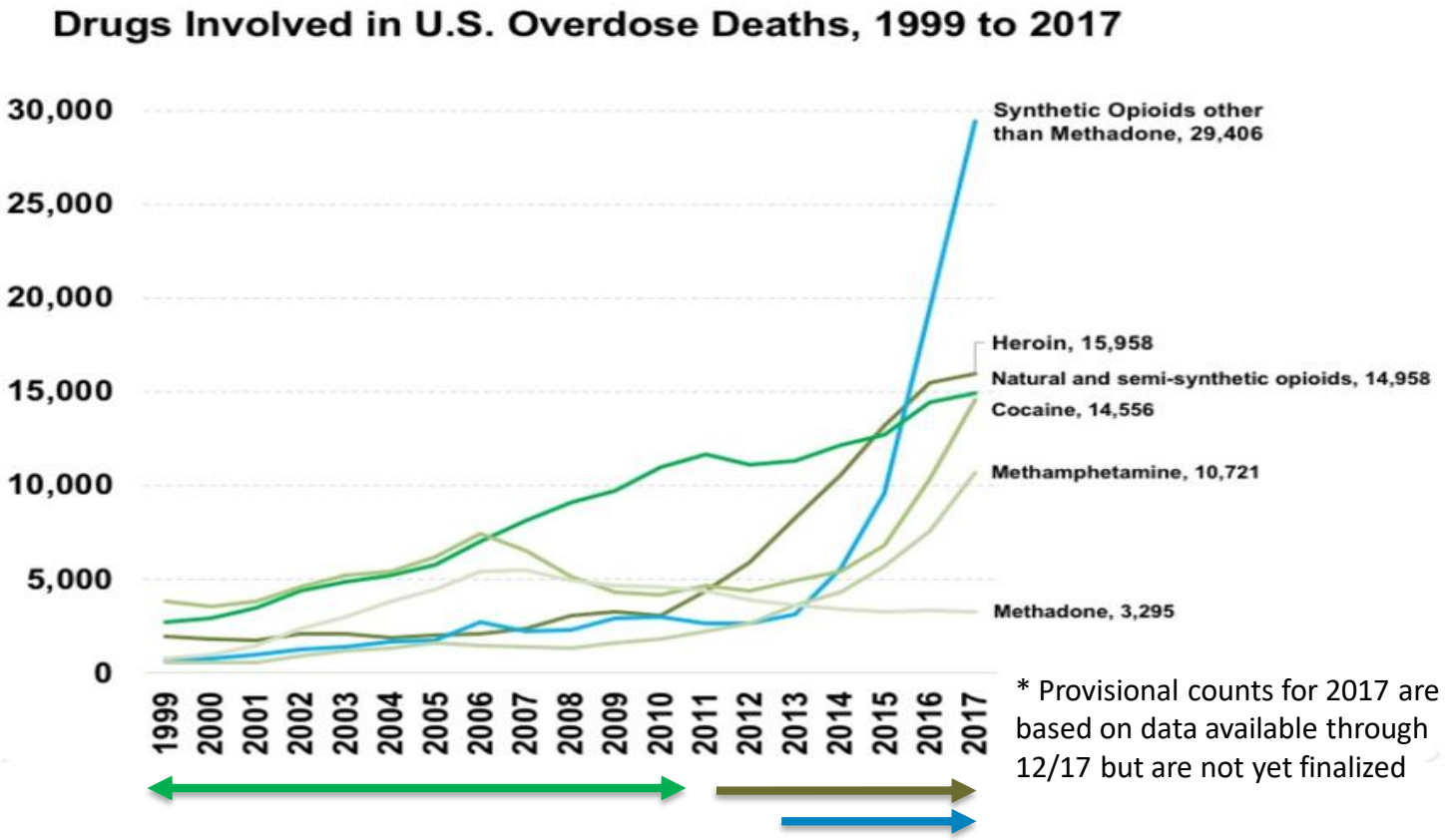
CDC MMWR- Nov 4, 2011
https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm

May 10, 2017

Drexler-OUD Treatment for AAAS-Dana Foundation

Overdose Deaths Involving Opioids: 3 Waves

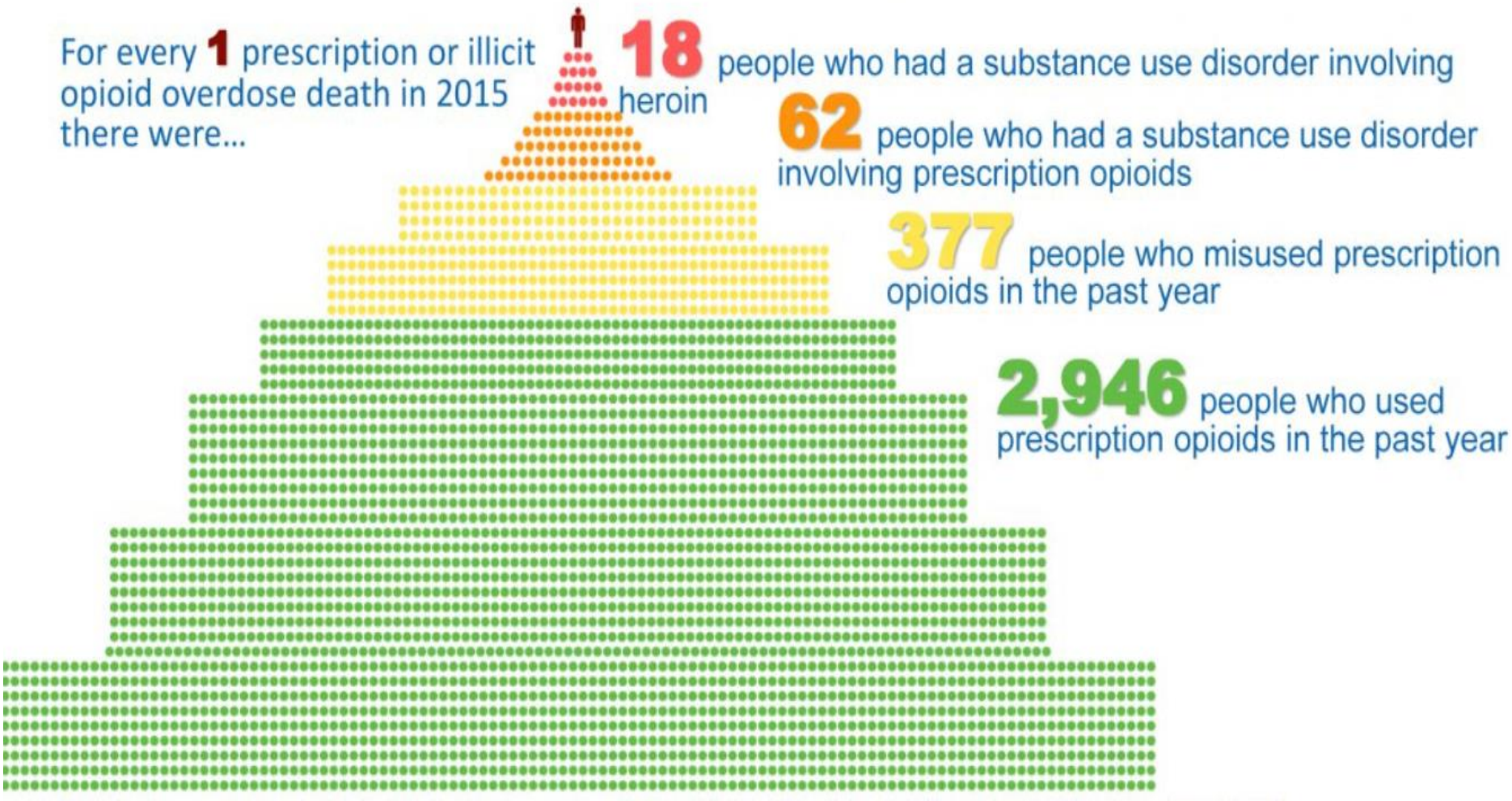
1) **Natural and semi-synthetic opioid deaths increased 4-fold from 1999 to 2011;** Methadone rate increased 6-fold from 1999 to 2007
2) **Heroin death rate increased over 5-fold since 2011**
3) **Synthetic opioid (excluding methadone) death rate increased more than 6-fold from 2013 to 2016**



* Provisional counts for 2017 are based on data available through 12/17 but are not yet finalized

https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

Opioid Overdoses as the Tip of the Iceberg



Results from the 2015 National Survey of Drug Use and Health, as reported by
https://www.cdc.gov/media/releases/2017/a1203-hargan-fitzgerald-infographic-508.html

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- 54 year-old Licensed Practical Nurse
- Referred for substance use disorder (SUD) care after overdose
- Injured back at age 24 treated with opioid pain medicine
- Exacerbations treated with opioids and muscle relaxants
- Multiple providers, then illicit use & overdose

Drexler-OUD Treatment for AAAS-Dana Foundation

May 10, 2017

DSM-5 Prescription Opioid Use Disorder

DSM-5 Criteria (2 or more)	Example signs and symptoms
Craving or strong desire to use opioids	Constantly thinking about next dose
Recurrent use in hazardous situations	Driving repeatedly when impaired
Using larger amounts of opioids or over a longer period than intended	Requests for early refills, needing to supplement with illicit opioids
Persisting desire or inability to cut down or control opioid use	Difficulty tapering from high risk pain medicine regimen
Spending a lot of time to obtain, use, or recover from opioid effects	Driving to different doctor's offices to obtain opioids from multiple providers
Continued use despite knowing that opioids are causing medical or psychological problems	Request for more opioids after overdose, bowel obstruction, etc.
Continued use despite knowing that opioids are causing social or interpersonal problems	Continued use despite poor work performance or family requests to quit
Failure to fulfill obligations at home or work	Neglecting tasks- cleaning, gardening
Activities given up or reduced because of opioid use	No longer playing softball, bridge

*Tolerance and opioid withdrawal are not considered in patients taking opioids as prescribed

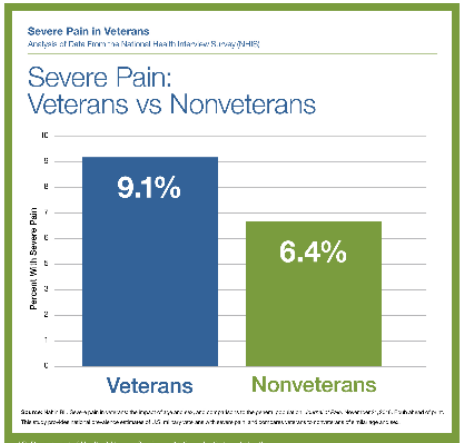
Prevalence of Pain in Veterans (US population)

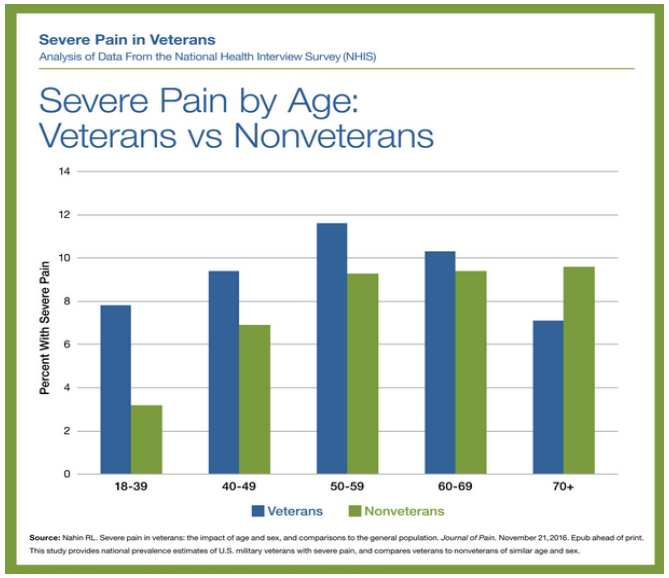
Chronic pain is more common in Veterans than in non-veterans and more often severe.

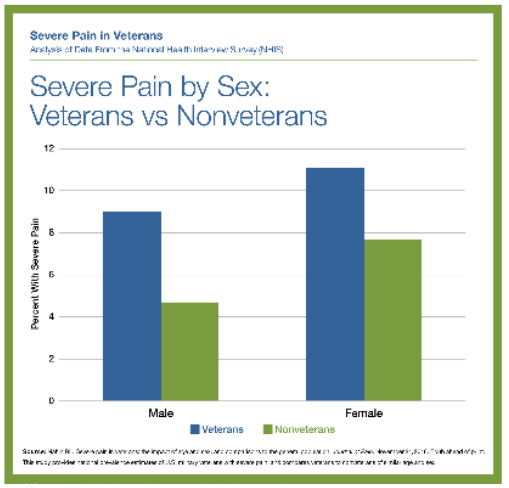
- 66 percent of Veterans versus 56 percent of non-veterans with pain in prior 3 month
- Severe pain in Veterans is 40 percent more common than in non-Veterans
- Most common pain conditions: musculoskeletal pain (joint 44 percent, back 33 percent, neck 1 percent)

Severe Pain

Pain which occurs "most days" or "every day" and bothers the individual "a lot,"







National Health Interview Survey
Nahin RL, Journal of Pain 2017;
nccih.nih.gov/veterans pain

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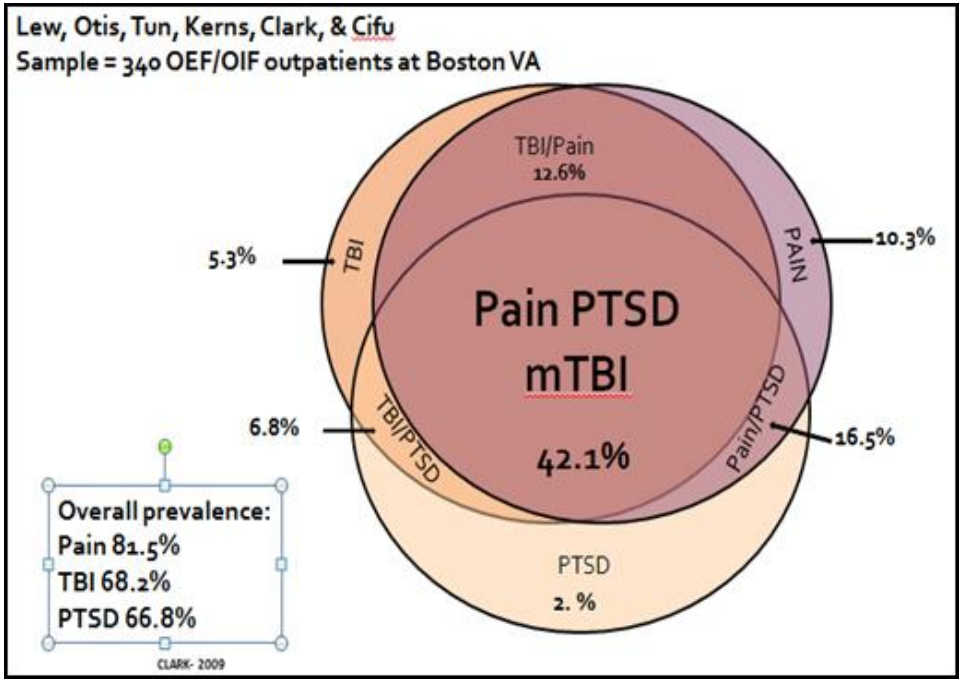
The Pain Challenge in VHA

Chronic pain in Veterans receiving care in VHA is often severe and in the context of mental health comorbidities.

- 60 percent of Veterans from Middle East conflicts with chronic pain, up to 75 percent in women Veterans
- More than 2 million Veterans with chronic pain diagnosis (In 2012, 1/3 on opioids)



- **MH and Pain conditions increased in prevalence from 2008 to 2015**
- Increase in pain scores/pain severity

Pain in Veterans (in VHA):
1 in 3 with chronic pain diagnosis
1 in 5 with persistent pain
1 in 10 with severe persistent pain

Risk Factors for Overdose and OUD

Risk factors are related to:

- Opioid prescribing
- Interaction with other medication/drugs

} Prescribing

- Medical comorbidities
- Mental health comorbidities

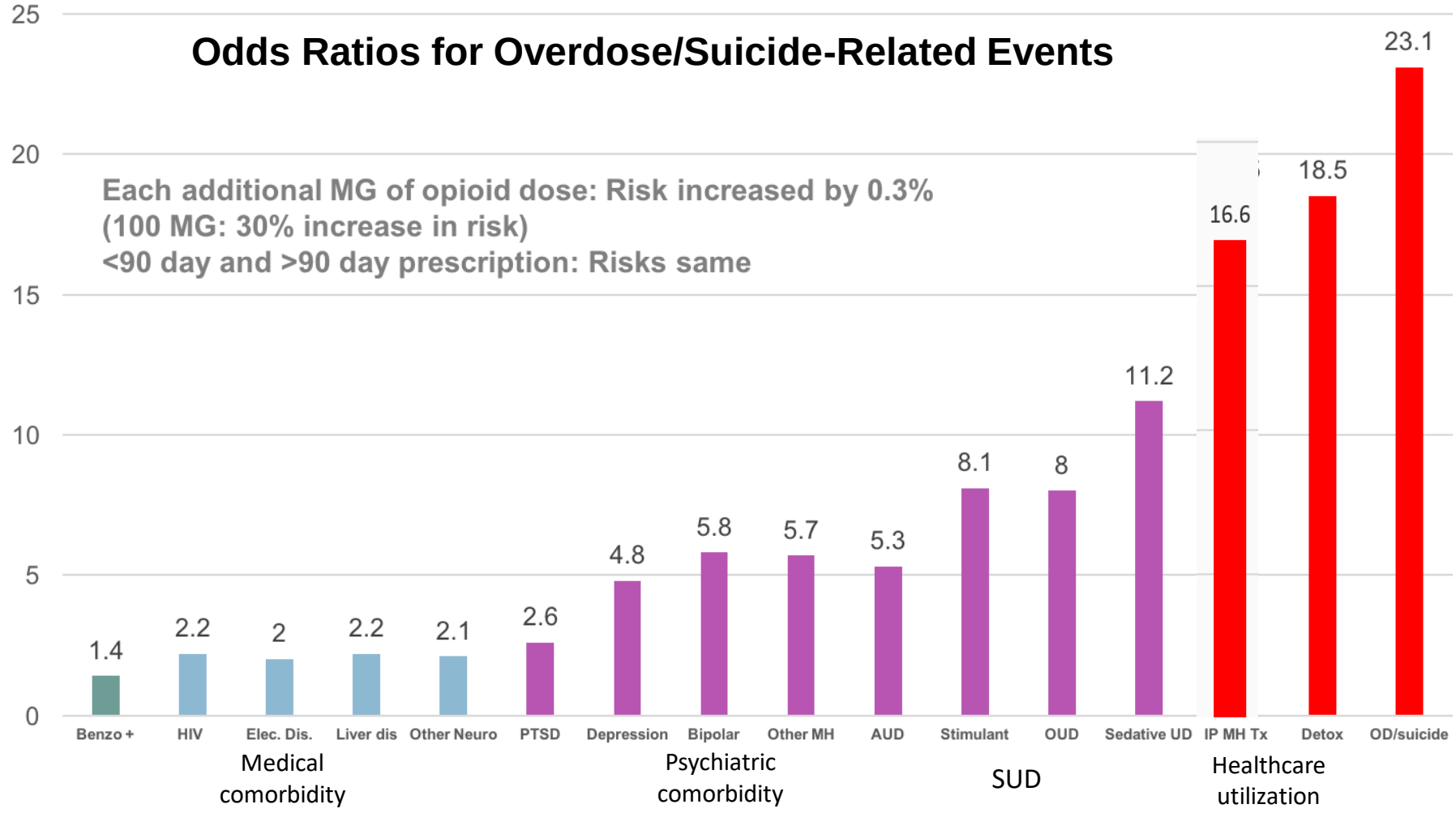
} Patient factors

"**Opioid dosage** was the factor most consistently analyzed and also associated with increased risk of overdose. Other risk factors include **concurrent use of sedative hypnotics**, use of **extended-release/long-acting opioids**, and the presence of **substance use and other mental health disorder comorbidities**."

Park et al. J Addict Med 2016

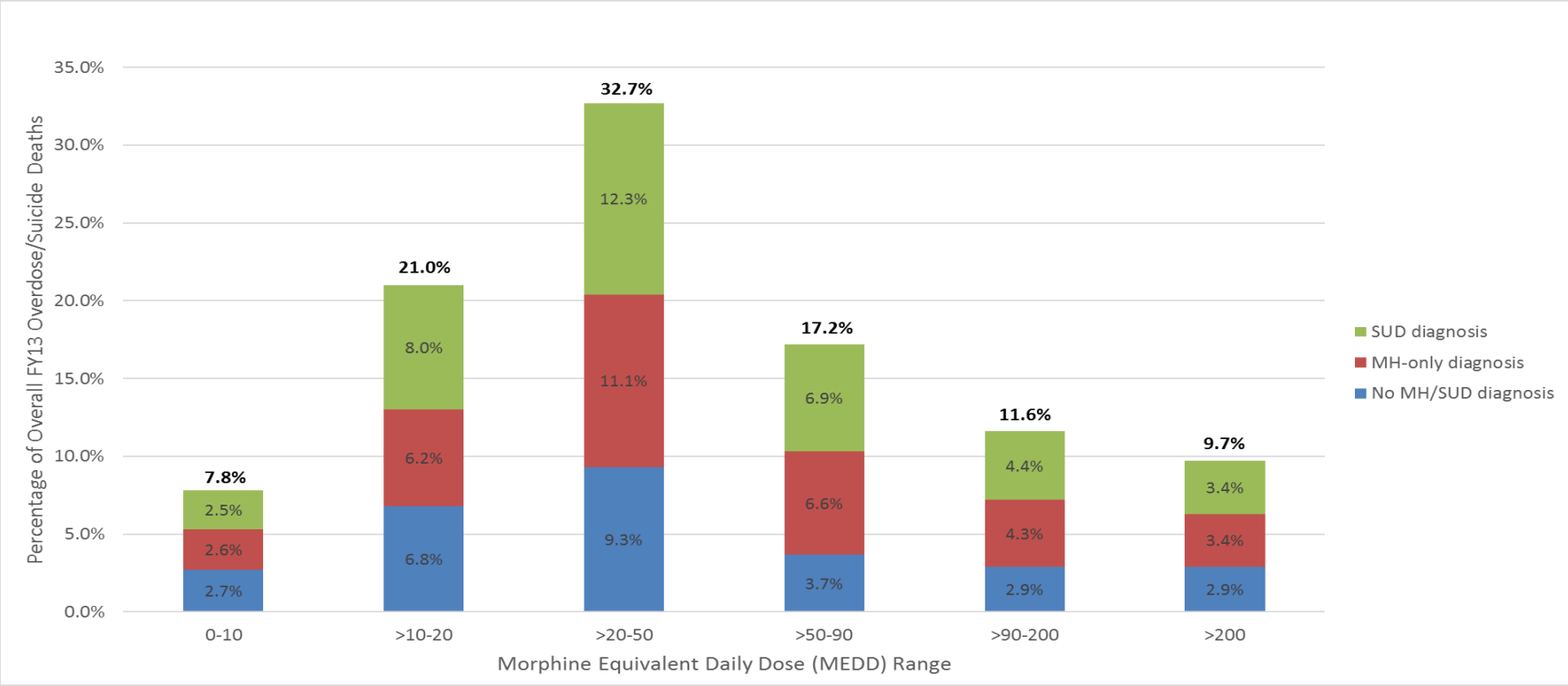
Review of 15 articles published between 2007 and 2015 that examined risk factors for fatal and nonfatal overdose in patients receiving opioid analgesics.

Veterans: Risk Factors for Overdose/Suicide



STORM Analysis: Oliva et. al. Psych. Services 2017

FY2013 Overdose/Suicide Mortality - VHA



- Almost 4 out of every 5 patients who died from overdose/suicide were prescribed doses < 90 MEDD
- Almost 3 out of every 4 overdose/suicide deaths were among patients with MH/SUD diagnoses
- More than 1 out of every 2 deaths were among patients with MH/SUD diagnoses prescribed < 90 MEDD

Public Health Approaches to Mitigate Risk

- Clinical Practice Guidelines:
  - Pain Management
  - Opioid Use Disorder Treatment
- Opioid risk mitigation strategies for long-term opioid therapy
- Increase access to safe, effective:
  - Pain Management
  - Opioid tapering
  - OUD treatment

Paradigm Shift in Pain Care

- ***Paradigm shift away from opioid therapy*** *for non-end-of-life pain management*
  - There is no completely safe opioid dose threshold below which there are no risks for adverse outcomes
  - Even a short-term use of low dose opioids may result in addiction
  - Realization that any initial, short-term functional benefit will likely not be sustained in most patients
  - Prolonged use of opioids, especially in higher doses, may lead to central sensitization and increase in pain over time (*Opioid Induced Hyperalgesia*)
  - Patients on opioids may actually experience a functional decline in the long term, measured by factors like returning to employment

- ***Paradigm shift towards multimodal and integrated team-based pain care (biopsychosocial interdisciplinary care)***

VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)

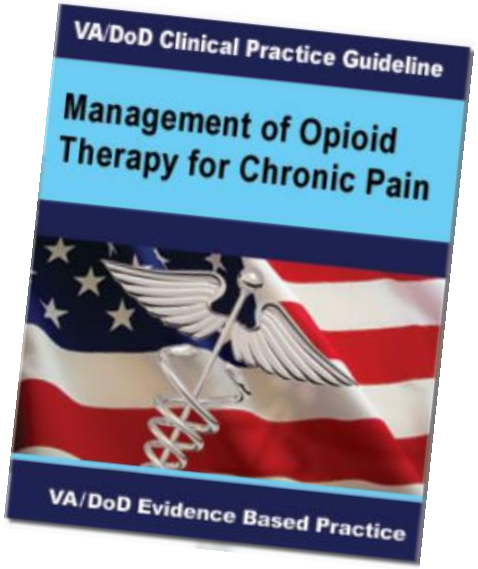
- VA/DoD CPG includes 18 recommendations, organized in 4 topic areas
  - Initiation and Continuation of Opioids

Recommendation 1:

"We recommend against initiation of long-term opioid therapy.

We recommend **alternatives to opioid therapy** such as self-management strategies and other non-pharmacological treatments.

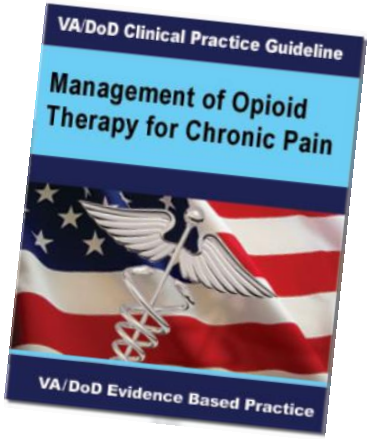
When pharmacologic therapies are used, we **recommend non-opioids over opioids**".



https://www.healthquality.va.gov/guidelines/Pain/cot/

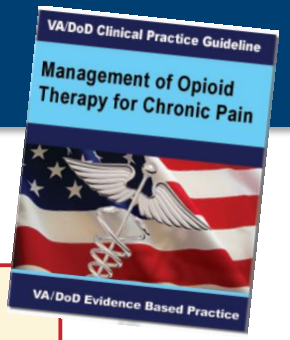
VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)

- Initiation and Continuation of Opioids (cont'd)
  - Recommendation against opioid therapy in patients **< 30 years of age**, in patients with active substance use disorder, and in combination with benzos



- Risk Mitigation
  - Recommendation for risk mitigation strategies, including **Informed Consent, UDT, PDMP, Overdose education and Naloxone prescribing**
  - Assess for **Suicide risk**
  - Evaluate benefits and risks **at least every 3 months**

VA/DoD Clinical Practice Guideline: Opioid Therapy (2017)



- Type, Dose, Follow-up, and Taper of Opioids
  - If prescribing opioids: **short duration and lowest dosage**
  - **No dosage is safe**; Strong rec against of opioids to > 90 MEDD
  - **Avoid long-acting opioids for acute pain, as prn, or upon initiation** of opioid therapy
  - Opioid dosage **reduction should be individualized** to patient

    Avoid sudden reductions; taper slowly if opioid risk > benefit,
  - For **OUD**, offer medication assisted treatment (MAT)

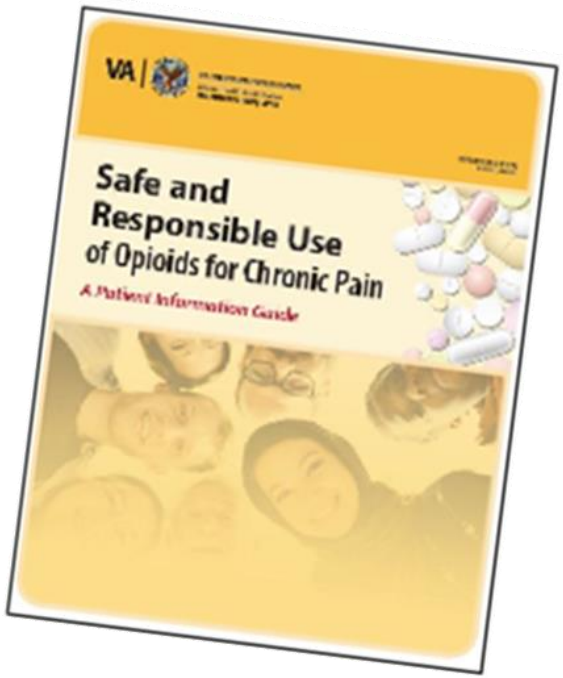
- Opioid Therapy for Acute
  - **Acute pain:** use alternatives to opioids; use multimodal pain care, **if opioids prescribe for ≤ 3-5 days**

https://www.healthquality.va.gov/guidelines/Pain/cot/

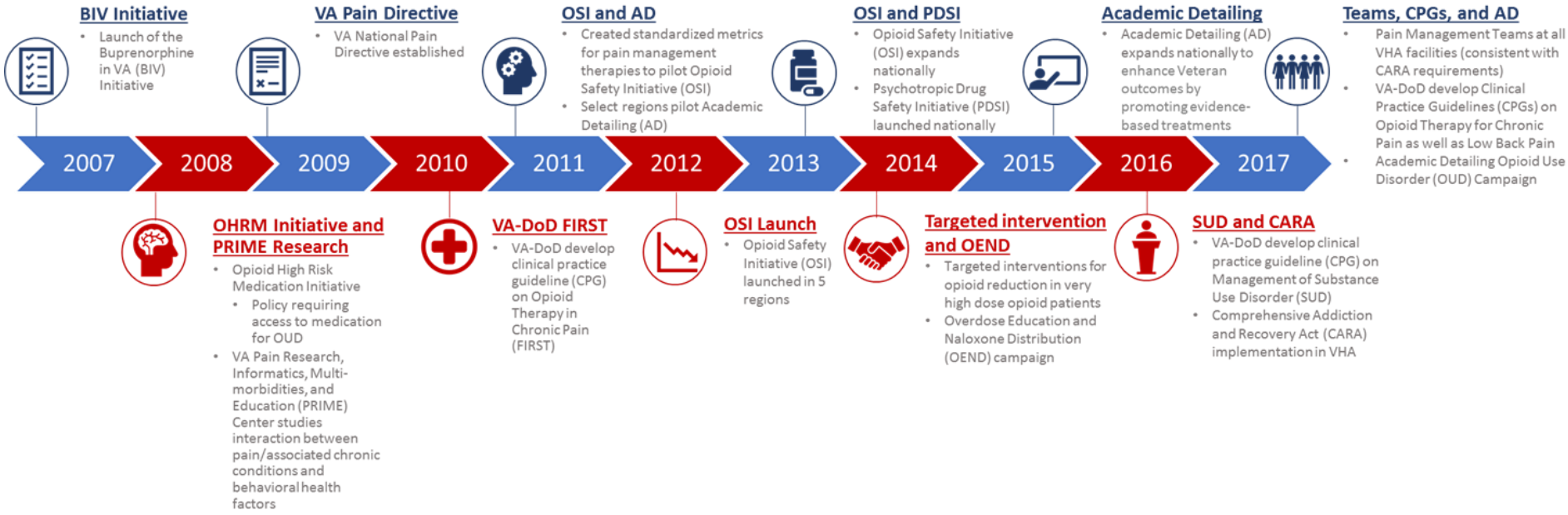
Informed Consent for Long-Term Opioid Therapy

- **VHA Policy: Informed consent (via I-Med) is required for all patients on Long-term Opioid Therapy (LOT)**, defined as > 90 days
- **Excluded are:** patients enrolled in hospice, on opioids for cancer pain → oral consent

- **Opportunity to discuss risks of and alternatives to long-term opioid therapy with the veteran**
- **Supports informed shared decision-making**
- Updated in 2018, expanded are
  - Opioid risks, Opioid dosage reduction/tapering
  - Non-pharmacological strategies for pain care
- After education of patient and family and obtaining the signature informed consent, a copy of the signed document including the brochure "Taking Opioids Responsibly" is given to the patient



VHA Directive 1005, Informed Consent for Long-Term Opioid Therapy for Pain. May 6, 2014



The VA Opioid Safety Initiatives

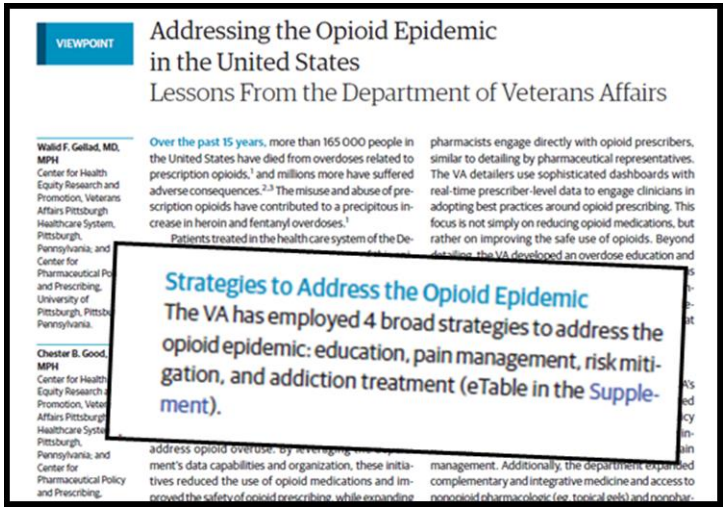
The VA Opioid Safety Initiative (OSI)

Opioid Safety Initiative (OSI) expanded nationally in FY 2013

- **OSI Aims**
  - Reduce over-reliance on opioid analgesics for pain management
  - Safe and effective use of opioid therapy when clinically indicated

- **Comprehensive OSI strategy includes**
  - Provider education; Academic Detailing
  - Access to non-pharmacological modalities including behavioral and CIH modalities

- **OSI Dashboard**
  - Totality of opioid use visible within VA
  - Provides feedback to stakeholders at VA facilities regarding key opioid parameters


VIEWPOINT

Addressing the Opioid Epidemic in the United States
Lessons From the Department of Veterans Affairs

Walid F. Gellad, MD, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing, University of Pittsburgh, Pittsburgh, Pennsylvania.

Chester B. Good, MPH
Center for Health Equity Research and Promotion, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; and Center for Pharmaceutical Policy and Prescribing,

Over the past 15 years, more than 165 000 people in the United States have died from overdoses related to prescription opioids,[1] and millions more have suffered adverse consequences.[2,3] The misuse and abuse of prescription opioids have contributed to a precipitous increase in heroin and fentanyl overdoses.[1]

Patients treated in the health care system of the De-

Strategies to Address the Opioid Epidemic
The VA has employed 4 broad strategies to address the opioid epidemic: education, pain management, risk mitigation, and addiction treatment (eTable in the Supplement).

address opioid overuse. By leveraging
ment's data capabilities and organization, these initiatives reduced the use of opioid medications and improved the safety of opioid prescribing, while expanding

pharmacists engage directly with opioid prescribers, similar to detailing by pharmaceutical representatives. The VA detailers use sophisticated dashboards with real-time prescriber-level data to engage clinicians in adopting best practices around opioid prescribing. This focus is not simply on reducing opioid medications, but rather on improving the safe use of opioids. Beyond
detailing, the VA developed an overdose education and

management. Additionally, the department expanded complementary and integrative medicine and access to nonopioid pharmacologic (eg, topical gels) and nonphar-

Gellad, Good CB, and Shulkin.
JAMA Intern Med. 2017 May 1;177:611-2

Overdose Education and Naloxone Distribution - OEND

- **Overdose Education (OE)**
  - How to *prevent, recognize, and respond* to an opioid overdose
- **Naloxone Distribution (ND)**
  - FDA approved as **naloxone auto injector and nasal spray**
  - *Dispense and train* patient and caregiver/family

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

- **Target patient populations: OUD and prescribed opioids**
- **Naloxone to be offered widely, low threshold for prescribing.**
  - Factors that increase risk for opioid overdose include h/o overdose, h/o SUD, higher opioid dosages (≥50 MMED), or concurrent benzodiazepine use
  - Offer to patients with recent opioid discontinuations or during tapering of opioids

- **More than 255,000 kits dispensed, with 345 overdose reversals** (March 18,2019)
- **No cost to Veterans**
- Rapid Naloxone Initiative: first responders, AED (defibrillator) cabinets

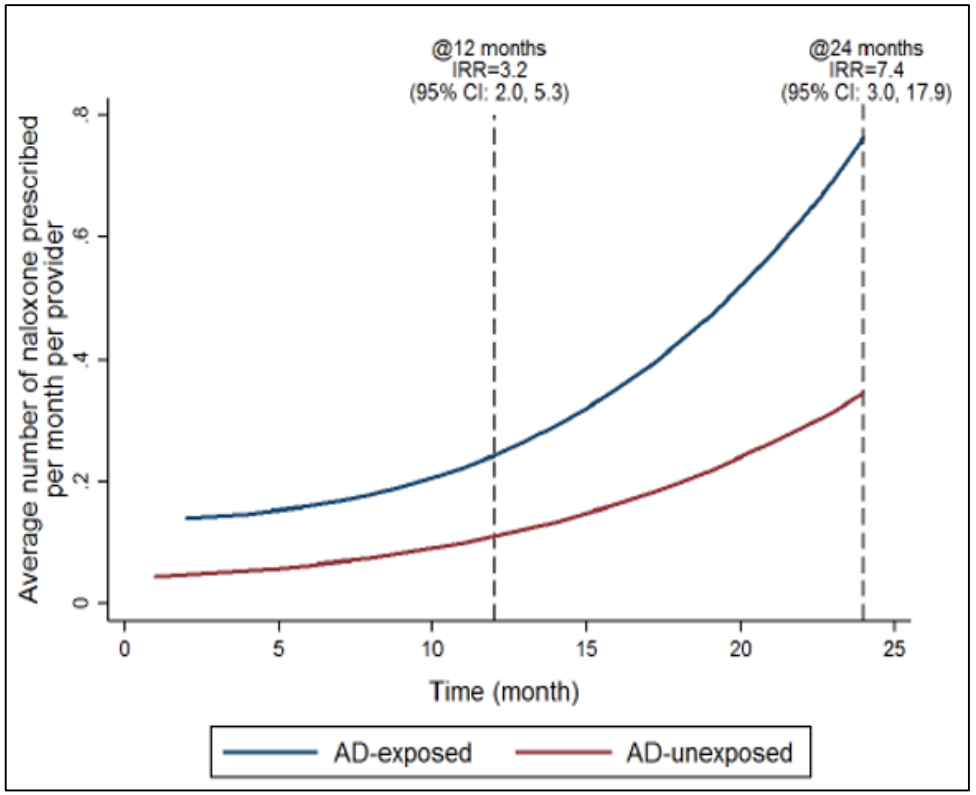
NPR feature

Provider Education: Academic Detailing

VA Academic Detailing Service

- ***In-person*** educational outreach
- Evidence-based information and tools
- Pharmacists skilled in persuasive communication
- Trusted and useful ***relationship*** with providers
- Training/provider tools
- > 28,000 outreach visits (June 30, 2018)
- Multiple campaigns, examples: Pain Management, Opioid Safety Initiative, Opioid Use Disorder (OUD), Insomnia; Psychotropic Drug Safety Initiative (PDSI), incl. benzodiazepines

AD Exposure and Naloxone Prescribing

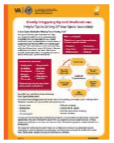


VA Academic Detailing Educational Materials

Pain/Opioid Safety Initiative

Marijuana: Natural = Safe, Right?

Classification: Patient Factsheet
File Name: Marijuana Use: Patient Discussion Tool
IB&P Number: IB 10-927; P96809



Slowly Stopping Opioid Medications
Helpful Tips to Getting Off Your Opioid Successfully

Classification: Patient Factsheet
File Name: Pain – Patient – Slowly Stopping Opioids
IB&P Number: IB 10-1016; P96884

Pain
New Ways to Treat a Common Problem

Classification: Patient Factsheet
File Name: Pain – Patient – Pain Information Guide
IB&P Number: IB 10-1017; P96885

Opioid Use Disorder

Provider Materials

Opioid Use Disorder
A VA Clinician's Guide to Identification and Management of Opioid Use Disorder (2016)

Classification: Provider Educational Guide
File Name: OUD – Provider AD – Educational Guide
IB&P Number: IB 10-933; P96813

Opioid Use Disorder
Identification and Management of Opioid Use Disorder

Classification: Provider Quick Reference Guide
File Name: OUD – Provider AD – Quick Reference Guide
IB&P Number: IB 10-932; P96812

Patient Materials

Opioids: Do You Know the Truth About Opioid Use Disorder?

Classification: Patient Brochure
File Name: OUD – Patient AD – Direct to Consumer Brochure
IB&P Number: IB 10-937; P96829

Opioid Overdose Education and Naloxone Distribution

Provider Materials

VA OEND Program Quick Reference Guide

Classification: Provider Quick Reference Guide
File Name: OEND – Provider – Quick Reference Guide_V2
IB&P Number: IB 10-788; P96790

Provider DVD: VA Overdose Rescue with Naloxone

Classification: DVD
File Name: OEND – Patient – Provider DVD: VA Overdose Rescue with Naloxone
IB&P Number: IB 10-770; P96764

Patient Materials

Naloxone Instructions

Naloxone Nasal Spray 4 mg Instructions – Pocket Card

Classification: Patient Brochure
File Name: OEND – Patient – OEND Patient Brochure – Pocket Card
IB&P Number: IB 10-926; P96808

Opioid Overdose Rescue with Naloxone: Auto-Injector Kit Instructions_v2

Classification: Patient Brochure
File Name: OEND – Patient – Naloxone Kit Instructions – Auto-Injector_V2
IB&P Number: IB 10-780; P96782

Intranet: https://vaww.portal2.va.gov/sites/ad
Internet: VA PBM Academic Detailing Public Internet Site LINK

VA | U.S. Department of Veterans Affairs

Opioid Therapy Risk Report – OTRR

- Tool optimized for PACT: review their panel for all patients on long-term opioids
- Multitude of factors that potentially increase risk incl. MH diagnoses
- Opioid risk mitigation parameters including last PDMP check
- Updated nightly
- Individual report includes Visual display
  - Opioid dosage
  - Pain score (severity)
- LTOT definition: opioid dispensed in the last 90 days *and* total days supply ≥ 90 days in the past 180 days

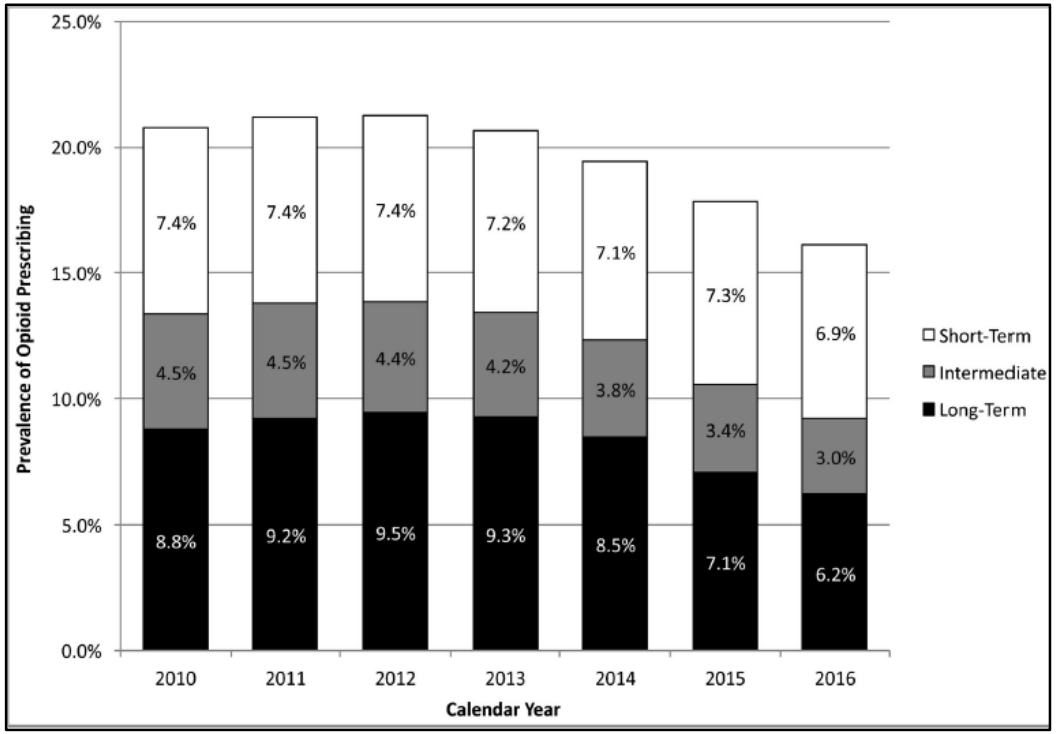
Stratification Tool for Opioid Risk Mitigation – STORM

- Predicts individual risk of overdose or suicide-related health events or death in the next year
- For patients on opioids and when considering opioid therapy
- **Identifies patients at-risk for opioid overdose-/suicide-related adverse events**
- **Provides patient-centered opioid risk mitigation strategies, targeted at risk level**

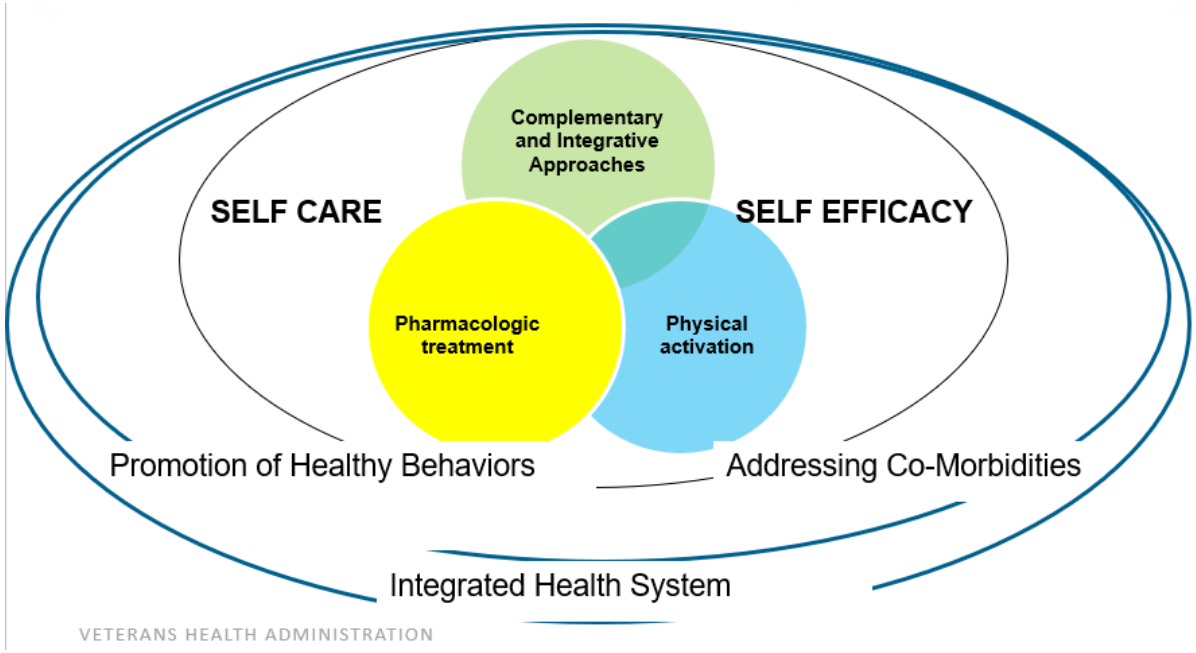
Reduction in Opioid Prescribing in VHA

Decline in Prescription Opioids Attributable to Decreases in Long-Term Use: A Retrospective Study in the Veterans Health Administration 2010–2016

Hadlandsmyth et al, J Gen Intern Med 2018

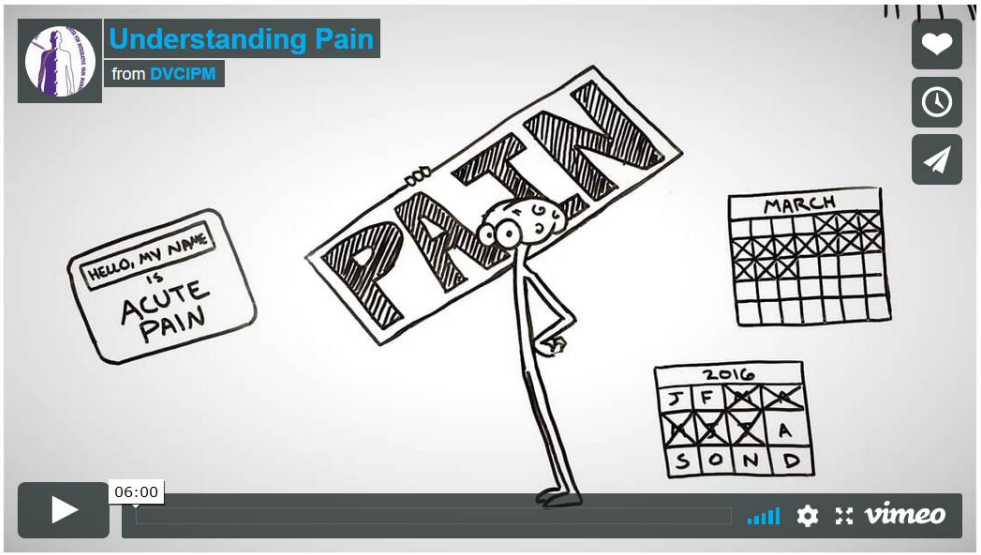


- 83 percent of decline in opioid scripts due to decreases in LOT
- 90 percent of reduction from fewer new LOT prescription fills.
- < 10 percent from increases in cessation of existing LOT users



Pain Management - Beyond Opioids …

Patient Education – Video (JPEP)



Joint Pain Education Program (JPEP) Available at:

https://www.dvcipm.org

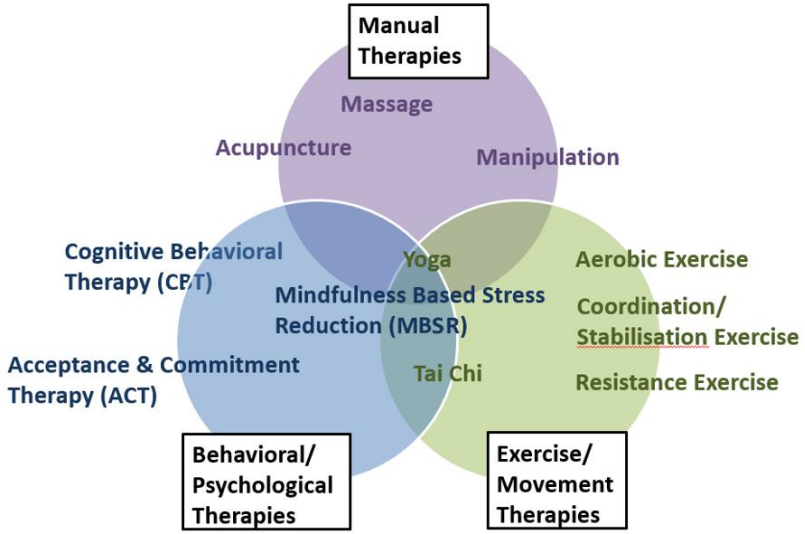
- Standardized pain curriculum for Primary Care providers
- 30 training modules, and provider and patient education videos
- 6 min video: “Understanding Pain”

https://www.dvcipm.org/clinical-resources/joint-pain-education-project-jpep/pain-educational-videos/

Non-Pharmacological Pain Treatments in VHA

VA State of the Art Conference Nov. 2016: Evidence-based non-pharmacological approaches for MSK pain management

- Evidence to support CIH and conventional therapies
- Provision of multi-modal therapies accessible from Primary Care

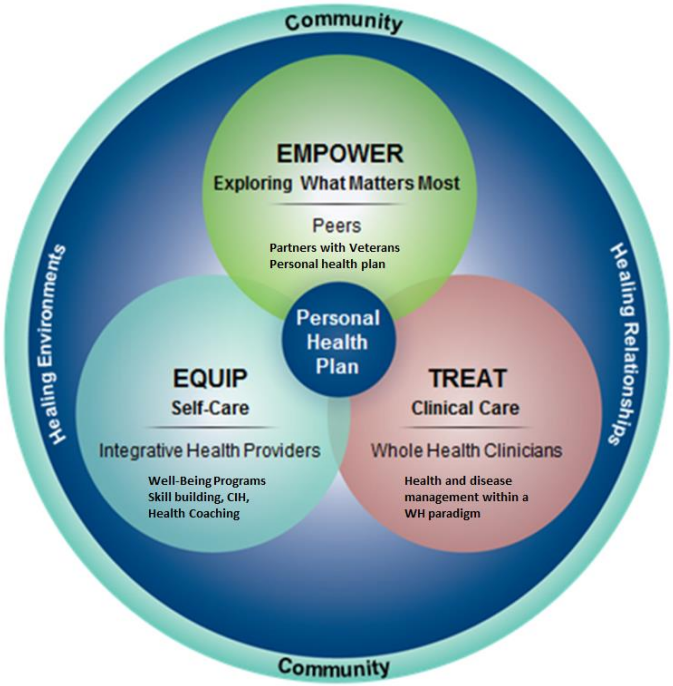


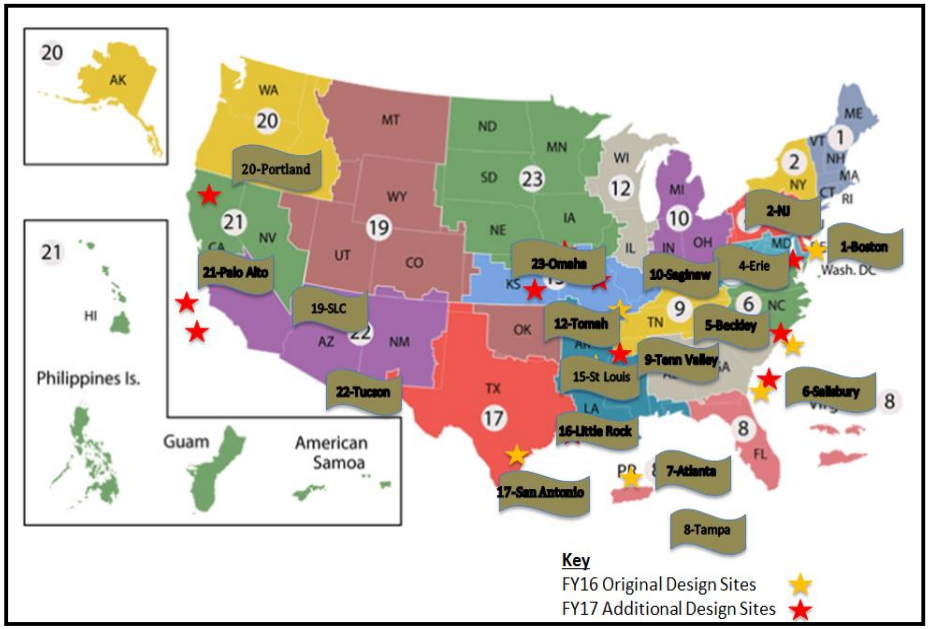
VHA Directive 1137: Advancing Complementary and Integrative Health (May 2017)

- List 1: Approaches with published evidence of promising or potential benefit
  - **Acupuncture**
  - **Massage Therapy**
  - **Tai Chi**
  - **Meditation**
  - **Yoga**
  - **Clinical Hypnosis**
  - **Biofeedback**
  - **Guided Imagery**
- **Chiropractic Care** approved as a covered benefit in VHA in 2004 and is part of VA whole health care
- To be made available across the system, if recommended by the Veteran's health care team

Whole Health and CIH in VHA

The Whole Health approach is a reorientation of the Veteran's relationship with VA. It combines conventional medicine with personalized health planning, CIH, and innovative, self-care approaches





Whole Health/CIH original design sites and additional 18 CIH flagship sites (CARA implementation)

Stepped Care Model for Pain Management (SCM-PM)

Foundational Step: Self-Care/Self-Management

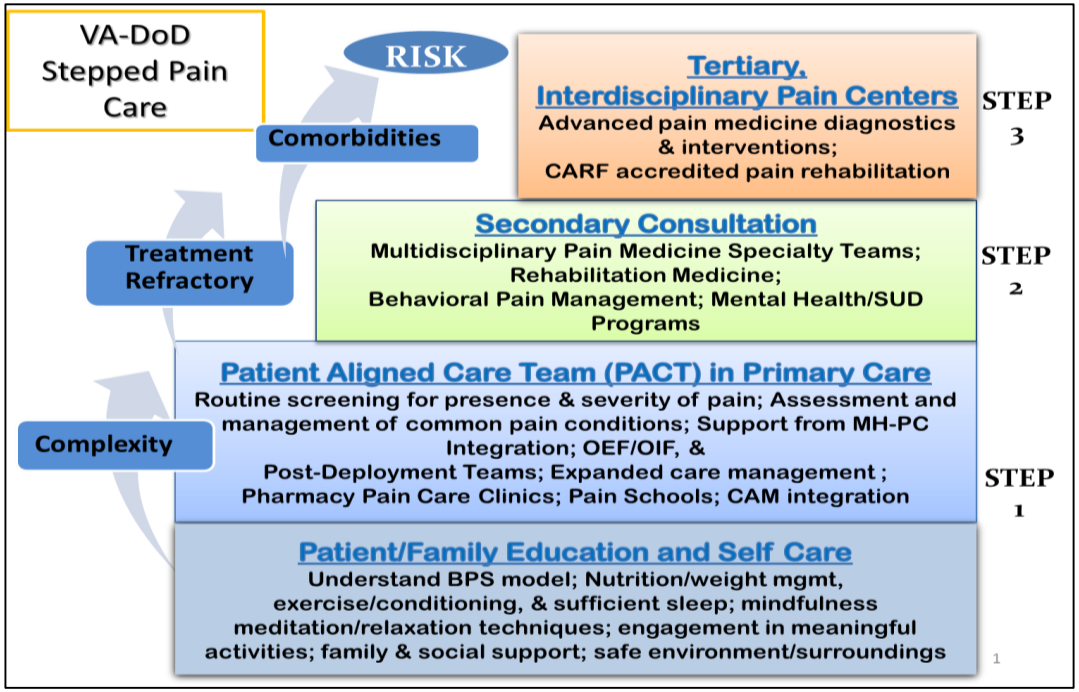
- Broad approach

Primary Care (PACT) = Medical Home

- Coordinated care and a long-term healing relationship, instead of episodic care based on illness
- Primary Care Mental Health Integration (PCMHI) at all facilities

CARA Legislation:

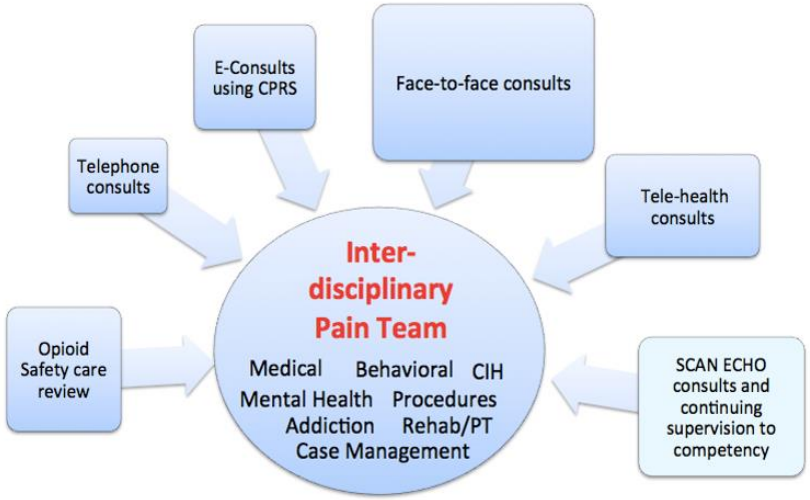
- Full implementation of the SCM-PM
- Pain Management Teams at all facilities



Step 2 – Pain Management Teams/Pain Specialty Care

Function:

- **Evaluation of patients with complex pain conditions**
- Provide **follow-up care** as clinically indicated
- **Medication management and actual prescribing** of pain meds, as needed



- **At a minimum, the composition of the PMT must include:**
  - **Medical Provider with Pain Expertise**
  - **Addiction Medicine expertise** to provide evaluation for Opioid Use Disorder (OUD) and access to Medication-Assisted Treatment (MAT)
  - **Behavioral Medicine** with availability of at least one evidence-based behavioral therapy
  - **Rehabilitation Medicine** discipline

Optional team components: interventional pain provider, nursing, case management, pharmacist, and others

Opioid Use Disorder

SAMHSA Treatment Improvement Protocol (TIP) 63

Key Messages:

- Opioid use disorder (OUD) is a chronic treatable illness
- General principles of good care for chronic diseases can guide OUD care
- Patient-centered care includes informed, shared decision-making about treatment options
- Patients with OUD should have access to mental health and medical care as needed, in addition to addiction counseling and recovery support
- The words you use are powerful – Adopt recovery-oriented language that will reduce prejudice, negative attitudes or discrimination
- OUD treatment must be tailored to fit each individual's needs & preferences – "One size fits all" is not appropriate
- The science demonstrating the effectiveness of methadone, extended-release injectable naltrexone, and buprenorphine is strong
- Medication for OUD should be integrated with outpatient and residential substance use disorder treatment
- Expanding access to OUD medication is an important public health strategy

NATIONAL ACADEMIES OF SCIENCE, ENGINEERING & MEDICINE

Key Points:

- OUD is a treatable chronic brain disease
  - Due to changes in brain structure & function from repeated use of opioids
- OUD is life-threatening-
  - 20-fold risk of death from overdose, infectious diseases, trauma & suicide
- Medications normalize brain function
  - Alleviating withdrawal, reducing craving & decreasing brain response to future opioid use
- Patients receiving OUD medications
  - Stay in treatment, succeed in recovery
  - Live longer

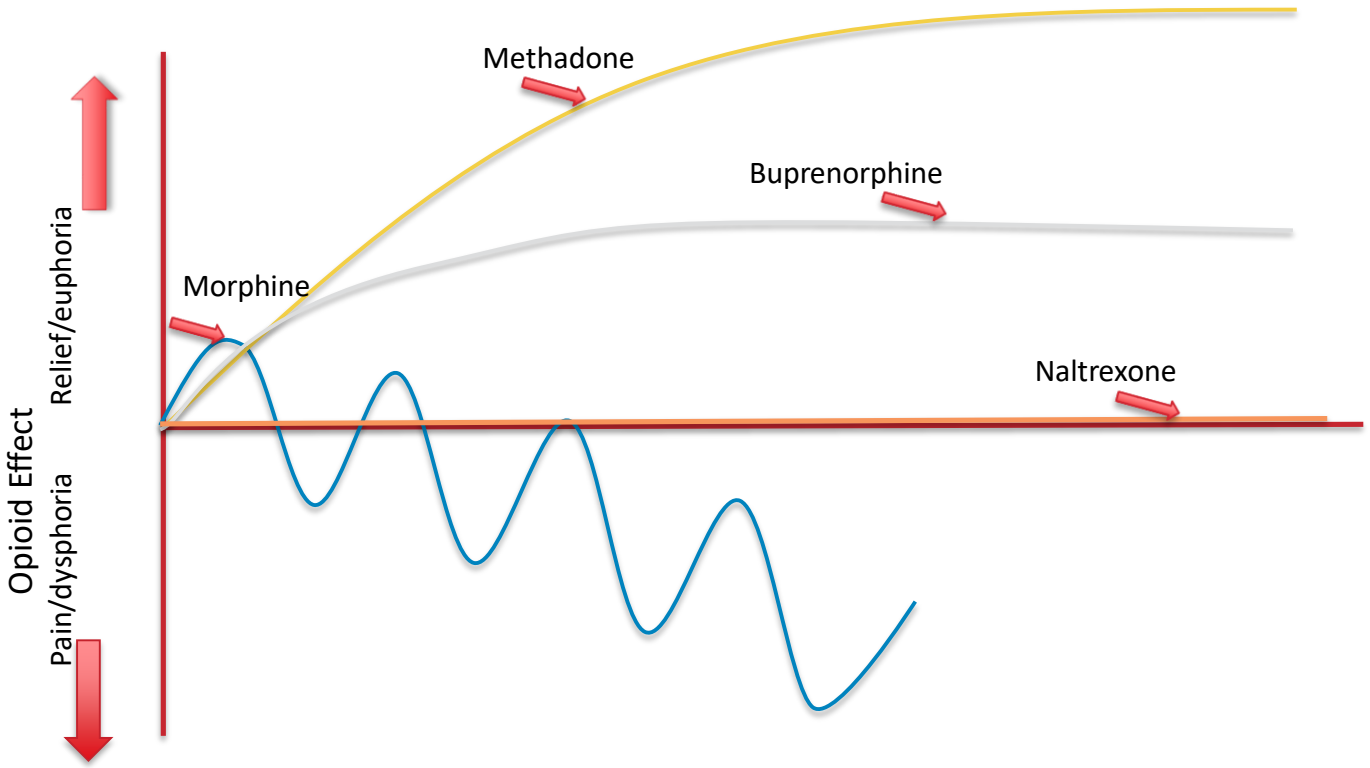
Call to Action

- Confront barriers to treatment
- Broaden access to treatment
- Expand research

http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=25310

- 54 year-old Licensed Practical Nurse
- Starting substance use disorder (SUD) care after overdose
- Discussed risks/benefits of buprenorphine, (ER-naltrexone), or OTP-administered methadone
- Patient selected buprenorphine/naloxone

SIMPLIFIED MECHANISM OF OPIOID ACTION

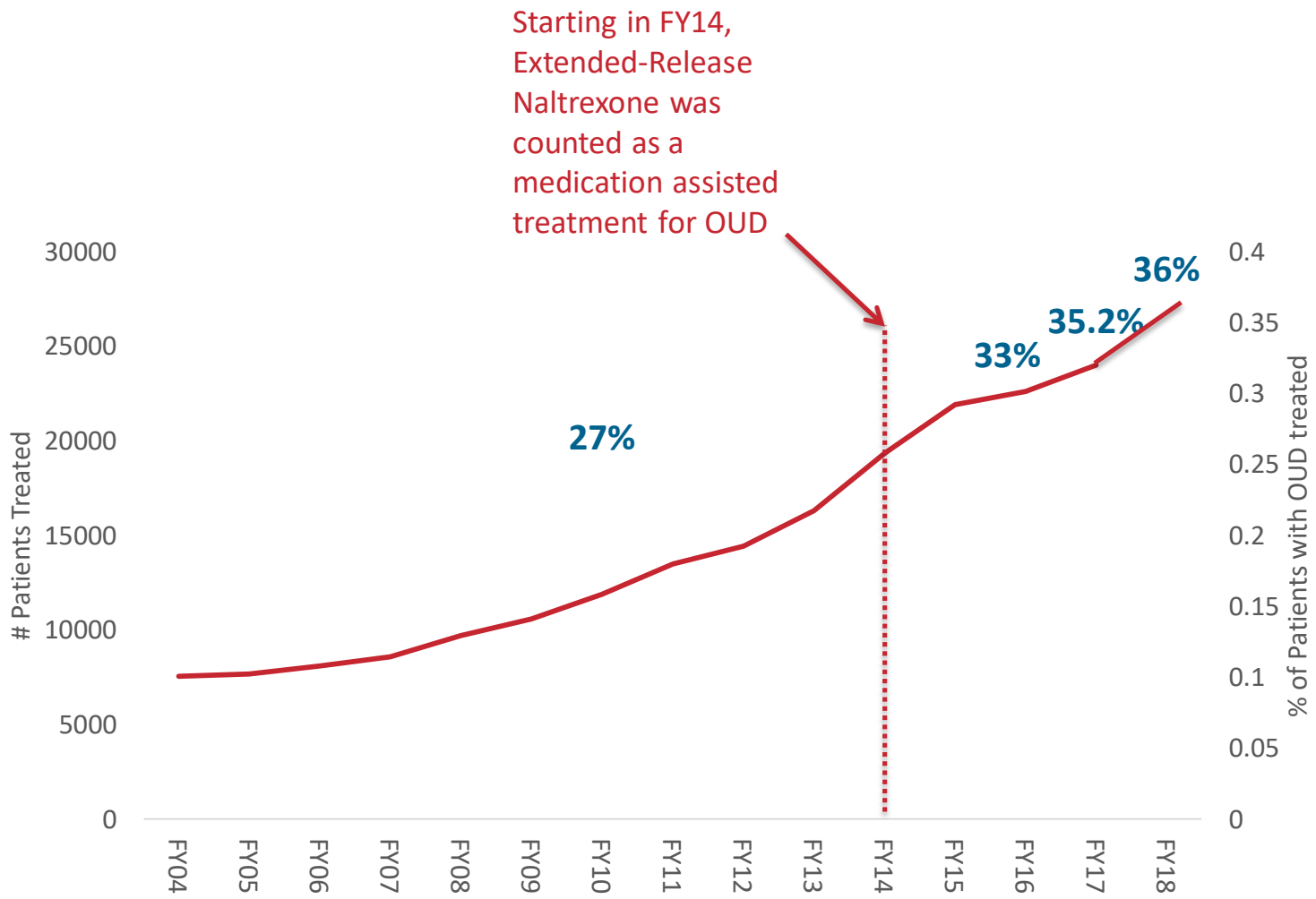


- 54 year-old Licensed Practical Nurse
- Pain managed with buprenorphine twice daily
- Completed in Intensive Outpatient SUD Program
- Began exercise, 12-step recovery groups
- Transferred to continuing care group with call-back program
- Remained in recovery on medication for years

May 10, 2017

Drexler-OUD Treatment for AAAS-Dana Foundation

Opioid Use Disorder (OUD) Medication for VHA Treated Veterans with OUD

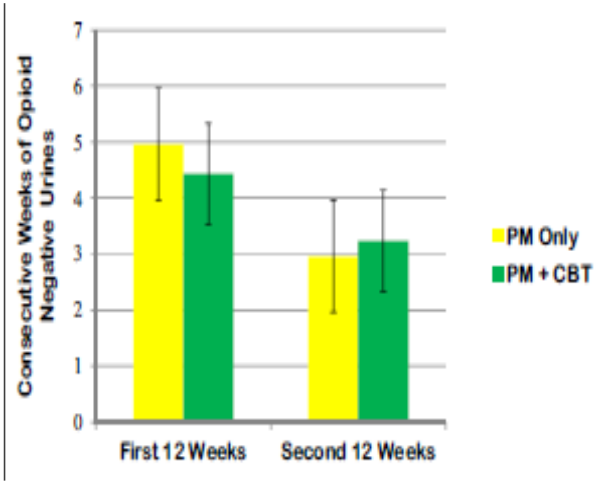


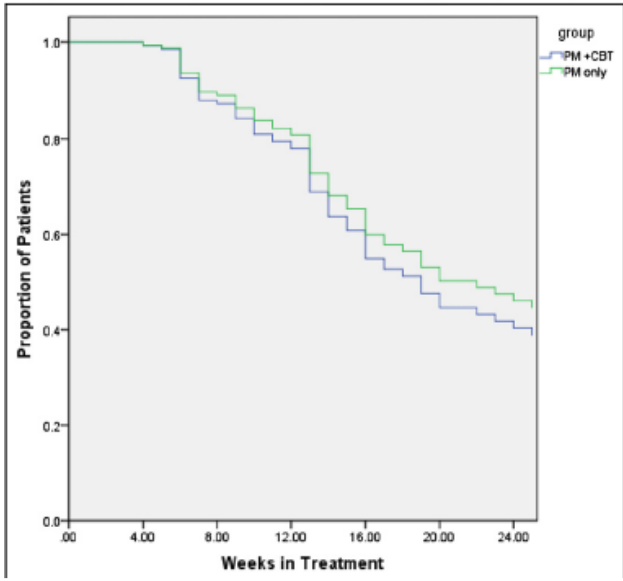
Brief Counseling is Sufficient for Many with OUD

24-wk RCT in Primary Care
(n=141)

- Physician Management (PM) is 15 min structured counseling by MD x 24 wks.
  - Weekly tapering to monthly
- CBT-SUD is weekly individual therapy
- PM +/- CBT-SUD associated @ 12-weeks with:
  - **Almost 80 percent retention**
  - **4-5 weeks of consecutive abstinence**

Average weeks of consecutive abstinence from opioids





2013-Fiellin et al- Am J Medicine

ADDICTION-FOCUSED MEDICAL MANAGEMENT[16]

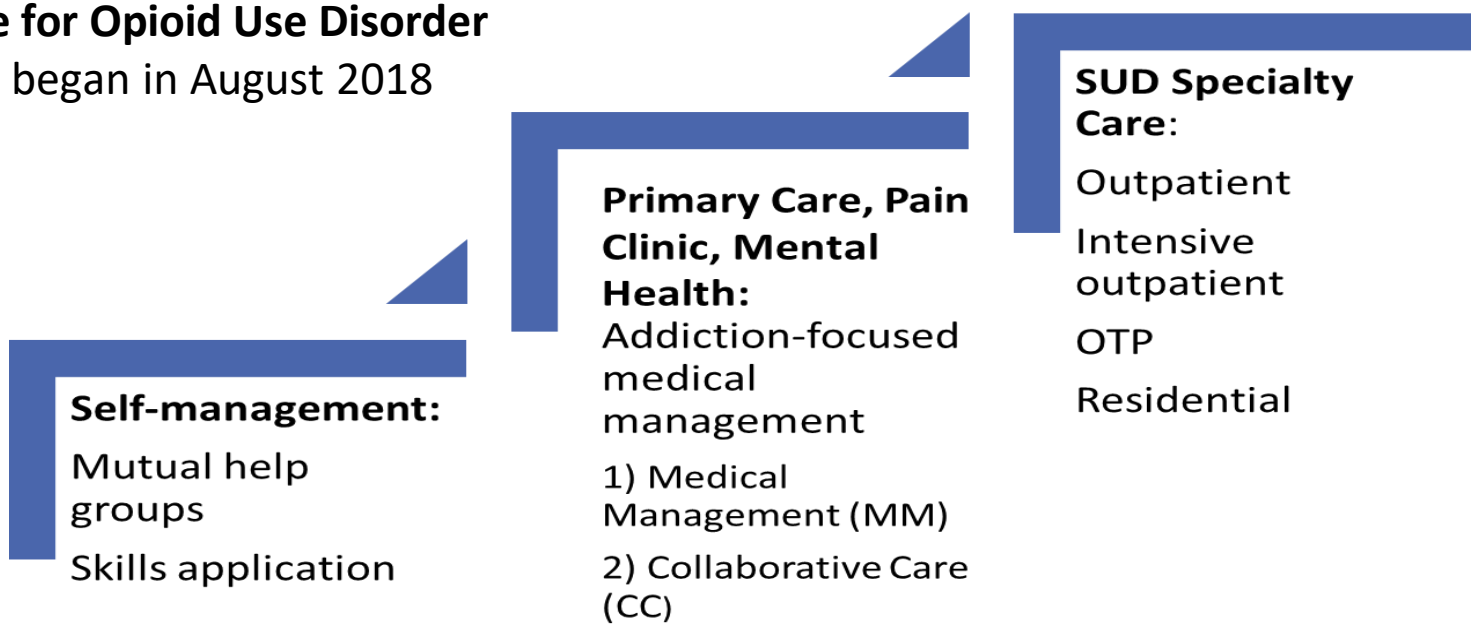
Structured psychosocial intervention designed to be delivered by a medical professional (e.g., physician, nurse, physician assistant) **in a primary care setting.**

Figure 10. Components of addiction-focused medical management*

*Session structure varies according to the patient's substance use status and treatment compliance; BAM = Brief Addiction Monitor

VHA Stepped Care for OUD

- Pain Management Teams must include providers with addiction expertise to allow for integrated access to OUD evaluation and treatment.
- **Medication Assisted Treatment (MAT):**
  - Buprenorphine/naloxone
  - Methadone (through Opioid Treatment Program)
  - Naltrexone (Extended-release injectable only)
- **Stepped Care for Opioid Use Disorder**
  - Training began in August 2018



VA/DoD CPG: Management of Substance Use Disorder (SUD) (2015) : https://www.healthquality.va.gov/guidelines/MH/sud/

If you are a Veteran in crisis — or you're concerned about one — free, confidential support is available 24/7. Call the Veterans Crisis Line at 1-800-273-8255 and Press 1, send a text message to 838255, or chat online.

Opioids and Suicide Risk

https://www.mentalhealth.va.gov/suicide_prevention/

Access to Pain Care, Opioid Tapering, and Suicide Risk

FOX NEWS

HEALTH · **Published** December 10, 2018 · **Last Update** 6 days ago

As doctors taper or end opioid prescriptions, many patients driven to despair, suicide

By **Elizabeth Llorente | Fox News**

"The doctor said: '…So we've decided as a group that we're going to take all of our patients down,'

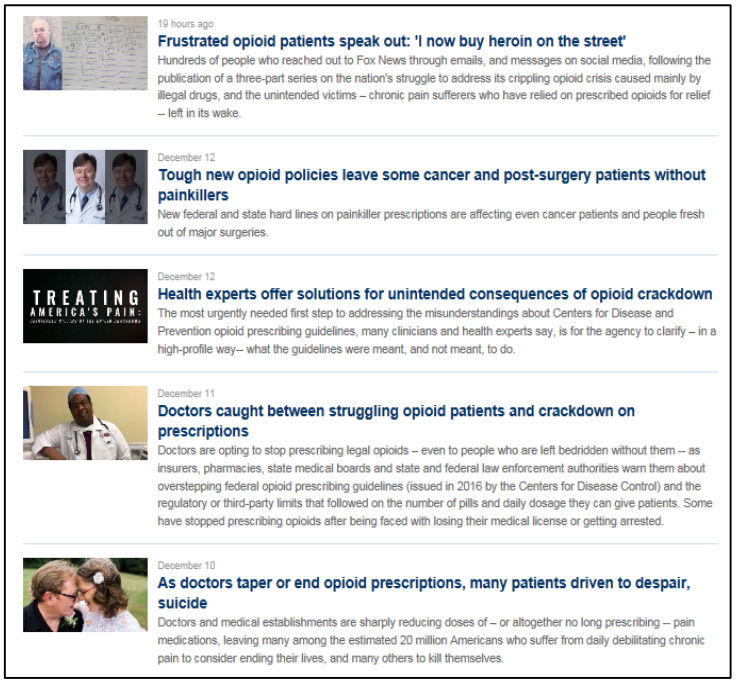
Lawrence's pain returned with a vengeance. He could barely move or sleep. He soiled his pants, unable to make the bathroom in time, Meredith said.

"It feels like every nerve in my body is on fire," he told his wife.

Meredith said she and her husband went to their primary care physician and asked for a referral to another pain clinic. They were told it would take a minimum of six weeks.

That was too much for Lawrence. In March, on the day of his next medical appointment, when his painkiller dosage was to be reduced again, he instead went to a nearby park with his wife. And on the very spot where they renewed their wedding vows just two years earlier, they held hands.

He raised a gun to his chest and killed himself."



19 hours ago
Frustrated opioid patients speak out: 'I now buy heroin on the street'
Hundreds of people who reached out to Fox News through emails, and messages on social media, following the publication of a three-part series on the nation's struggle to address its crippling opioid crisis caused mainly by illegal drugs, and the unintended victims – chronic pain sufferers who have relied on prescribed opioids for relief – left in its wake.

December 12
Tough new opioid policies leave some cancer and post-surgery patients without painkillers
New federal and state hard lines on painkiller prescriptions are affecting even cancer patients and people fresh out of major surgeries.

December 12
Health experts offer solutions for unintended consequences of opioid crackdown
The most urgently needed first step to addressing the misunderstandings about Centers for Disease and Prevention opioid prescribing guidelines, many clinicians and health experts say, is for the agency to clarify – in a high-profile way– what the guidelines were meant, and not meant, to do.

December 11
Doctors caught between struggling opioid patients and crackdown on prescriptions
Doctors are opting to stop prescribing legal opioids – even to people who are left bedridden without them – as insurers, pharmacies, state medical boards and state and federal law enforcement authorities warn them about overstepping federal opioid prescribing guidelines (issued in 2016 by the Centers for Disease Control) and the regulatory or third-party limits that followed on the number of pills and daily dosage they can give patients. Some have stopped prescribing opioids after being faced with losing their medical license or getting arrested.

December 10
As doctors taper or end opioid prescriptions, many patients driven to despair, suicide
Doctors and medical establishments are sharply reducing doses of – or altogether no long prescribing – pain medications, leaving many among the estimated 20 million Americans who suffer from daily debilitating chronic pain to consider ending their lives, and many others to kill themselves.

https://www.foxnews.com/health/as-opioids-become-taboo-doctors-taper-down-or-abandon-pain-patients-driving-many-to-suicide.amp
https://www.foxnews.com/person/l/elizabeth-llorente Accessed Dec. 20, 2018

Suicide Risk, Pain, and Opioids

- Co-occurring mental illness is associated with increased risk of suicidal thoughts and behaviors in opioid-dependent individuals (Demidenko-2017, Gen Hosp Psychiatry)

- Internal VHA data show that Veterans were at increased risk of unintentional overdose or suicide death (all manner of suicide, not just overdose) within the first six months of starting or stopping prescription opioid pain medicine, similar to starting or stopping medication for OUD (Sordo et al-2017, BMJ)

Suicide Risk, Pain, and Opioids

- Patients with chronic pain are twice as likely as those without chronic pain to die of suicide (Tang & Crane- 2006, Psychol Med)
  - Risk increases with the intensity of pain (Ilgen et al-2010, Suicide & Life)
  - Risk increases with opioid analgesic dose (ilgen-2016, Pain)

- Patients with opioid use disorder are 13 times more likely to die of suicide than the general population (Wilcox et al-2004, Drug Alc Dep)
  - VHA-treated Veterans are ~7 times more likely to be diagnosed with OUD than the commercially insured population (Baser et al-2014, Pain Practice)

Opioid Use and Suicide Risk

REVIEW ARTICLE

Julie R. Ingelfinger, M.D., *Editor*

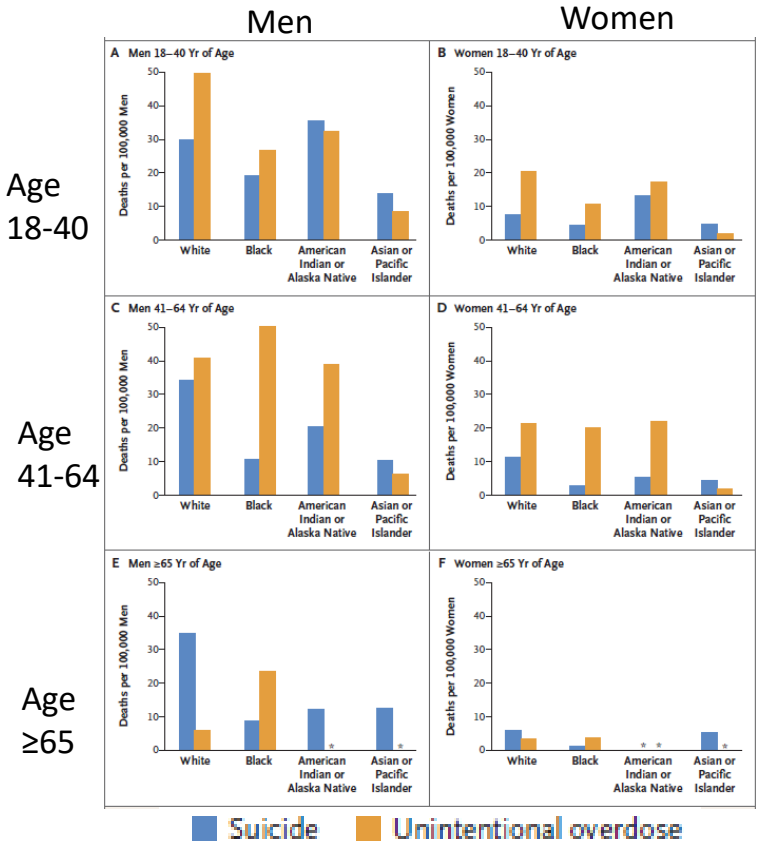
Understanding Links among Opioid Use, Overdose, and Suicide

Amy S.B. Bohnert, Ph.D., and Mark A. Ilgen, Ph.D.

The combined number of deaths among Americans from suicide and unintentional overdose increased from 41,364 in 2000 to 110,749 in 2017 and has exceeded the number of deaths from diabetes since 2010

1) **Demand side hypothesis - "Deaths of Despair"** – opioid use as a way of coping with stress, lack of opportunity
2) **Supply side hypothesis** – increased availability to both prescription and illicit opioids

→ Both pathways are relevant and must be addressed



Bohnert and Ilgen: N Engl J Med 2019:380:71-9
The NEW ENGLAND JOURNAL of MEDICINE

From the Department of Psychiatry, Institute for Healthcare Policy and Innovation, and Injury Prevention Center, University of Michigan, and the Veterans Affairs Center for Clinical Management Research

Interventions to Address Risk of Suicide and Overdose Related to Opioid Use

Goal and Intervention	Low-Risk Opioid Regimen	High-Risk Opioid Regimen or Opioid Misuse	Opioid Use Disorder or Illicit Opioid Use
Identifying who is at risk for suicide and overdose			
Determination of risk score on basis of medical record	+	+	
Assumption that high level of opioid exposure and misuse puts the patient at risk			+
Preventing suicide or overdose among those identified as being at risk			
Treatment for mental health conditions, when present	+	+	+
Cognitive-behavioral therapy for suicide risk and motivational interviewing for overdose risk		+	+
Patient-centered opioid taper		+	
Overdose education and naloxone distribution		+	+
Medication treatment for opioid use disorder			+

2019-Bohnert & Ilgen-NEJM

Ways You Can Help Prevent Suicide in Veterans with Pain, Opioid Use, or Opioid Use Disorder (OUD)

- Assess for suicide risk among all Veterans with opioid use
- Assess for opioid use among Veterans at risk for suicide
- Access the Opioid Safety Initiative Toolkit
- Direct Veterans to the VHA's online opioid safety information:
  - https://www.va.gov/painmanagement/opioid_safety/index.asp
- Provide additional support, treatment, and wrap around services during transition periods on and off opioid therapy for pain and medication for OUD

Ways You Can Help (continued)

- Ensure that Veterans considered for or receiving opioid pain medication are screened for illicit substances and other prescriptions per treatment guidelines

- Address and treat co-occurring psychiatric conditions in Veterans who have attempted suicide or are at risk for suicide

- Encourage medication treatment for opioid use disorder which reduces the risk of suicide
  - Treatment with buprenorphine may benefits those with depression and OUD

- Provide opioid overdose education and naloxone for overdose reversal to Veterans and their family members

Thank You

THANKS TO:

- **VA, VISN and Facility leadership**
- **VISN POCs and all facility POCs for Pain, SUD**
- **OSI POCs and the OSI review committees**
- **VA research community**
- **Pain Medicine Specialty Teams**
- **Pain Psychologists**
- **PACT Pain Champions, Primary Care**
- **PBM/Pharmacy**
- **Academic Detailing**
- **Mental Health**
- **Suicide Prevention**
- **Substance Use Disorder Treatment**
- **Nursing Service**
- **Rehabilitation Medicine**
- **Integrative Health, IHCC and OPCC**
- **EES, Ethics**
- **Connected Care/Telehealth**
- **DoD partners/colleagues**
- **The Veterans and their families**

Supplemental Slides

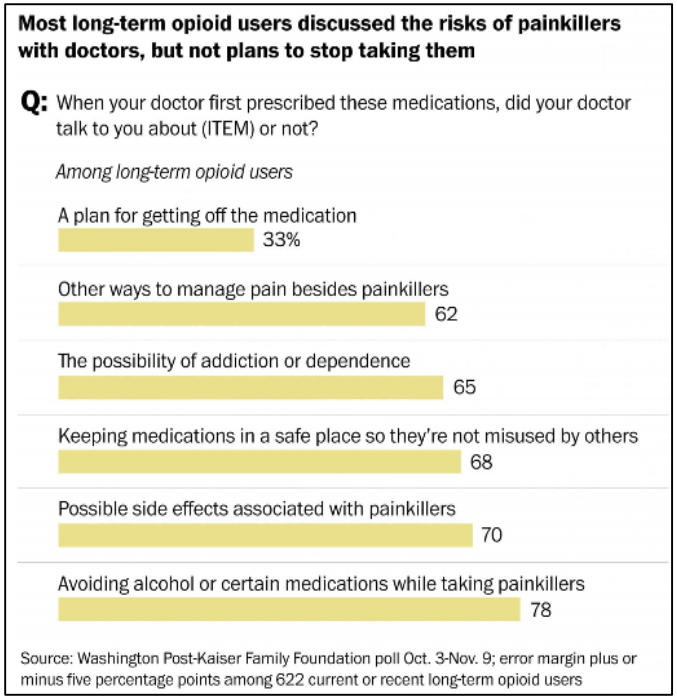
"One-third of long-term users say they're hooked on prescription opioids"

Kaiser Family Foundation and Washington Post

By Scott Clement and Lenny Bernstein, December 9, 2016

Among long-term opioid users:

- 1/3 report they became addicted to, or physically dependent
- **Virtually all were introduced to the drugs by a doctor's prescription**
- 95 percent of long-term users began taking the drugs to relieve pain from surgery, an injury or a chronic condition; Just 3 percent started as recreational users
- **Family members** are far more likely to say the drugs have damaged the users' physical and mental health, finances and personal relationships

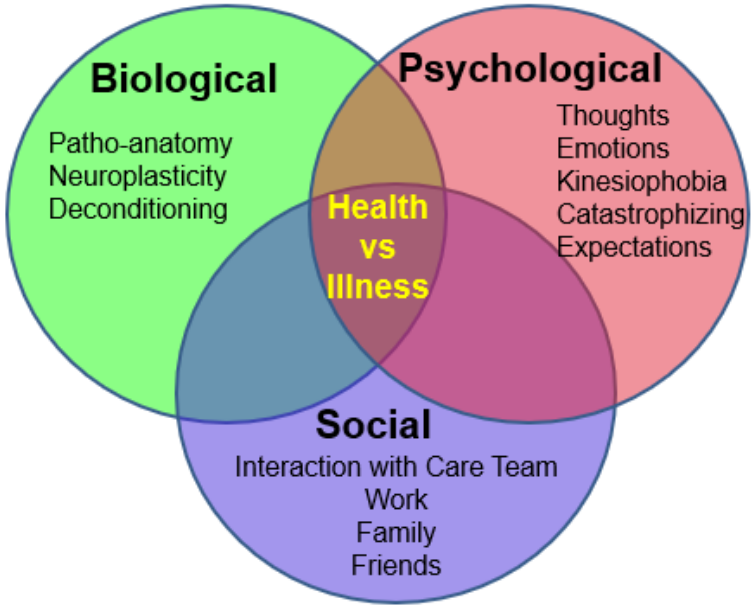


Among uses of prescription opioids

- **34 percent reported taking opioids for fun or to get high**
- **22 percent to deal with everyday stress,**
- **12 percent to relax or relieve tension.**

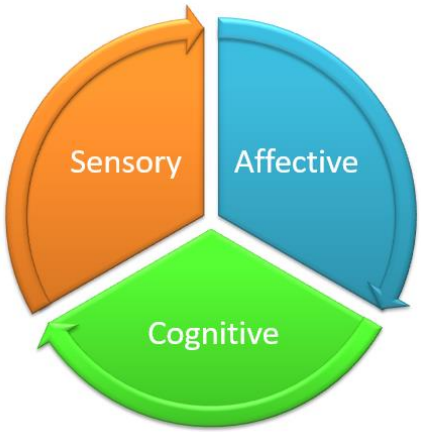
https://www.washingtonpost.com/national/health-science/one-third-of-long-term-users-say-theyre-hooked-on-prescription-opioids/2016/12/09/e048d322-baed-11e6-91ee-1adddfe36cbe_story.html?noredirect=on&utm_term=.8faea0722337

Bio-Psycho-Social Model of Pain: Multiple Components



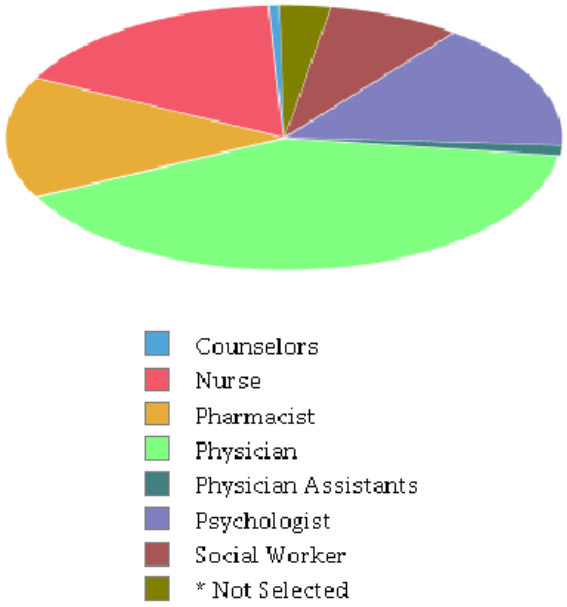
As pain becomes persistent, the pain experiences shift:

- **Brain circuits involved in pain processing** become **sensitized**
- **Emotional and cognitive components become more prominent** than sensory/nociceptive circuits
- **Psychological and Social elements take on a greater role**, serving as a vicious cycle and contribute to the persistence of pain



Stepped Care for Opioid Use Disorder Train-the-Trainer Conference- Evaluation

- 95% Overall Satisfaction
- Appreciated:
  - Breakout sessions with VISN pilot teams
    - Interaction with other clinicians and learning about their views.
    - Allowed team members to start a relationship and to set goals
  - Sharing of the strong practices and networking with colleagues from across the country
  - Explanation of the two models, motivational interviewing and access to the experts
- Areas for improvement:
  - More explanation about medication for OUD - rationale, long-term risks/benefits of buprenorphine, more about naltrexone
  - Including facility leadership in teams



168 Survey Respondents representing seven clinical disciplines

Next Steps

- Facilitation
  - Monthly team consultations
  - Twice monthly webinars
  - Site visits
  - Note templates
- Evaluation
  - Qualitative interviews
  - Metrics
    - % OUD patients receiving medicine
    - # X-waivered prescribers

HHS Pain Management Best Practices Task Force

"The Pain Management Task Force calls for individualized, patient-centered pain management to improve quality of life for individuals who experience acute and chronic pain." (AHRQ)

- Chartered by the Comprehensive Addiction and Recovery Act (CARA)
- To propose updates to best practices and issue recommendations that address gaps or inconsistencies for managing chronic and acute pain. "**GUIDELINE TO THE GUIDELINES**"
- Chairperson: Vanila M. Singh M.D., Chief Medical Officer at the Dept. of Health and Human Services (HHS)
- 29 members, including 8 Federal Representatives
- Draft report released Dec 31, 2018 for 90 day public comment period. **Final report by May 30, 2019**
- Task Force excerpts:

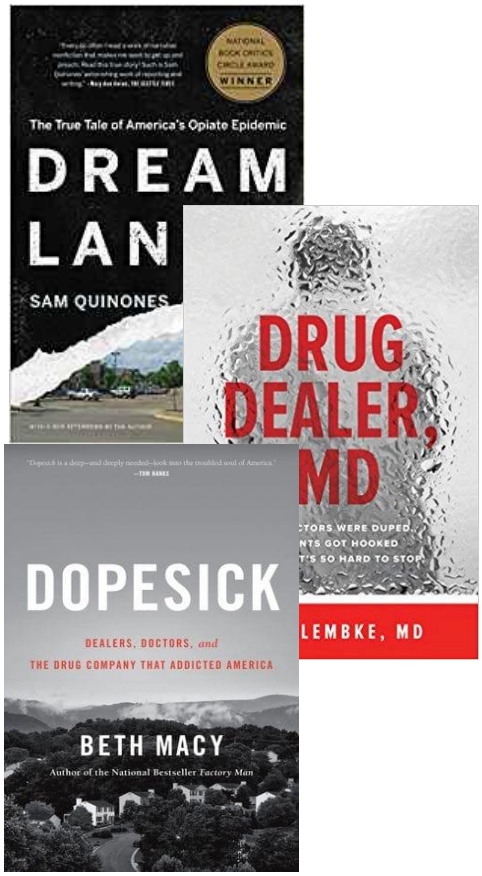
  Gap 1: Current inconsistencies and fragmentation of pain care limit best practices and patient outcomes. A coherent policy for pain management within health systems is needed

  Recommendation 1a: Encourage coordinated and collaborative care that allows for best practices and improved patient outcomes whenever possible. One of many examples is the collaborative stepped model of pain care, as adopted by the VA and DoD health systems

Taskforce: https://www.hhs.gov/ash/advisory-committees/pain/index.html
Draft Report: https://www.hhs.gov/sites/default/files/final-pmtf-draft-report-on-pain-management%20-best-practices-2018-12-12-html-ready-clean.pdf

Summary: Opioid Safety Initiative in VHA

1. Overdoses in the US from **prescription opioids continue to increase, but are being surpassed by illicit drugs**, including fentanyl
2. Risk of prescription opioids is correlated with **dosage and duration**.
3. Opioids in **combination with sedating drugs** are particularly dangerous
4. **Mental health/substance use disorder contribute greatly** to risk
5. The VA/DoD CPG for Opioid Therapy **recommends against *initiation* of *long-term* opioid therapy** for chronic pain
6. **Opioid risk mitigation strategies systemwide including PDMP, UDT, Informed Consent, close follow-up**
7. Overdose education and widespread **naloxone distribution** (OEND)
8. **Opioid dosage reduction (opioid tapering) must be patient-centered** and individualized with the goal to maximize function and safety
9. Many (but not most) patients with long-term opioid therapy fulfill criteria for OUD and must be offered **access to evidence-based OUD therapy**



Approaching Opioid Tapering

- **Integrated approach with patient buy-in and active participation**
  - **Goal is to improve function and long-term outcome** while reducing risk
  - **Slower, more gradual tapers are often better tolerated**, may take months to years
  - **Sudden interruption of opioid prescribing must be avoided** with few safety exceptions
- **Provider approach: empathetic, personalized, building trust**
- **Assess and address patient needs/concerns incl. psychological factors**
- **Close collaboration with MH providers and integrated access to OUD treatment**
  - **Patients are often scared** about opioid dosage reduction
  - Expectations should be clear and **reasonable/achievable**
  - Assess patient preference regarding dosage changes (LA/IR opioid, timing)
  - **Evidence of OUD may manifest during opioid dosage reduction**
- **Patients are often at high risk for overdose after tapering**
  - **Protracted withdrawal and lowered tolerance** increase risk of OD **after** opioid discontinuation
  - Follow-up within 1 to 4 weeks after dosage adjustments and continued follow-up after discontinuations

Caution: Involuntary tapers carry greater risk and interfere with provider/patient relationship.

SMVF Opioid Addiction: Increasing Access to Prevention, Treatment and Recovery

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May 29, 2019

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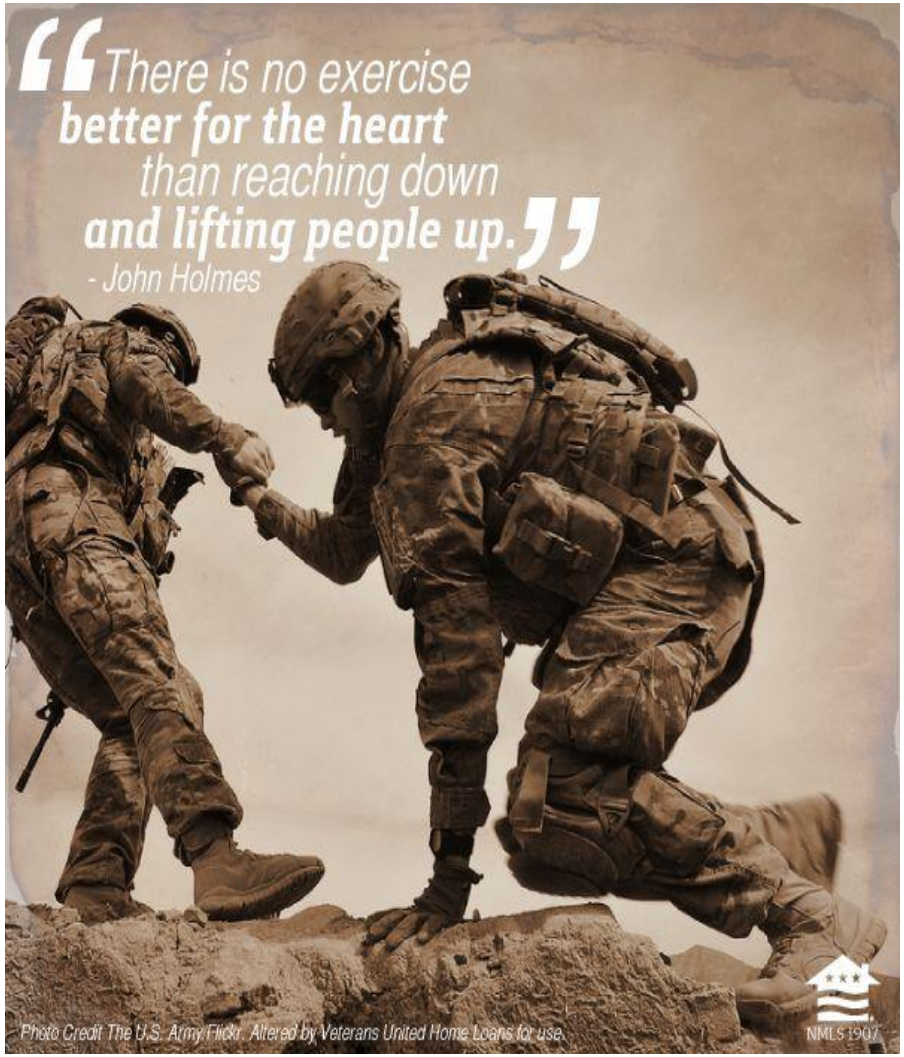
Substance Abuse and Mental Health Services Administration

Lest We Forget Upon Whose Shoulders We Stand

Our Goal Today

What ***you*** can do to create a prevention, treatment, and recovery based opioid use disorder (OUD) healing service for the SMVF population in your community.



"Nothing can be a higher act than to serve those in their hour of need who have served and protected us for so long."

- Michael Flaherty, PhD
CAPTAIN, USNR-Ret

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Today's "SIT REP"

- We are in an epidemic of opioid use and overdose
- We are not alone. It is across America, growing in the West but also surging in Canada, Sweden, Norway and Ireland
- Veterans are almost twice as likely as non-vets to have an OUD and OD
- Particularly vulnerable are Army & combat vets, women, older men, rural vets, vets with secondary battle wounds
- Its causes are **not** just over prescribing or illicit use
- Solutions are complex … but many!

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Meeting the Enemy

- Addressing iatrogenic opioid use – this is not an "addict" but "an ailing warrior."

  (Stigma)

- Providing hope and relief by engaging and retaining the person and family
  - i.e., Improving access to and retention in treatment that offers best science, practice and an *opportunity for recovery in each episode of care.*

    (Do only best science and practice)

- Understand and respect the "military ethos" and culture, working within person and family centered care.

  (Person- and family-based)

Remember each SMVF Carries with them:

- *Military Culture* – both a protective and risk factor!
- The SMVF population exists within a culture that looks askance at seeking help:
  - 65 percent perceive seeking help as a weakness
  - 63 percent fear that leadership might treat them differently
  - 59 percent fear their peer will have less confidence in them
- Their lives are built around discipline, a defined professional hierarchy and a commitment to sustaining "team" or "unit" readiness
- Their Core Values upon which they rely: Loyalty, Duty, Respect, Selfless Service, Honor, Integrity & Personal Sacrifice (courage)

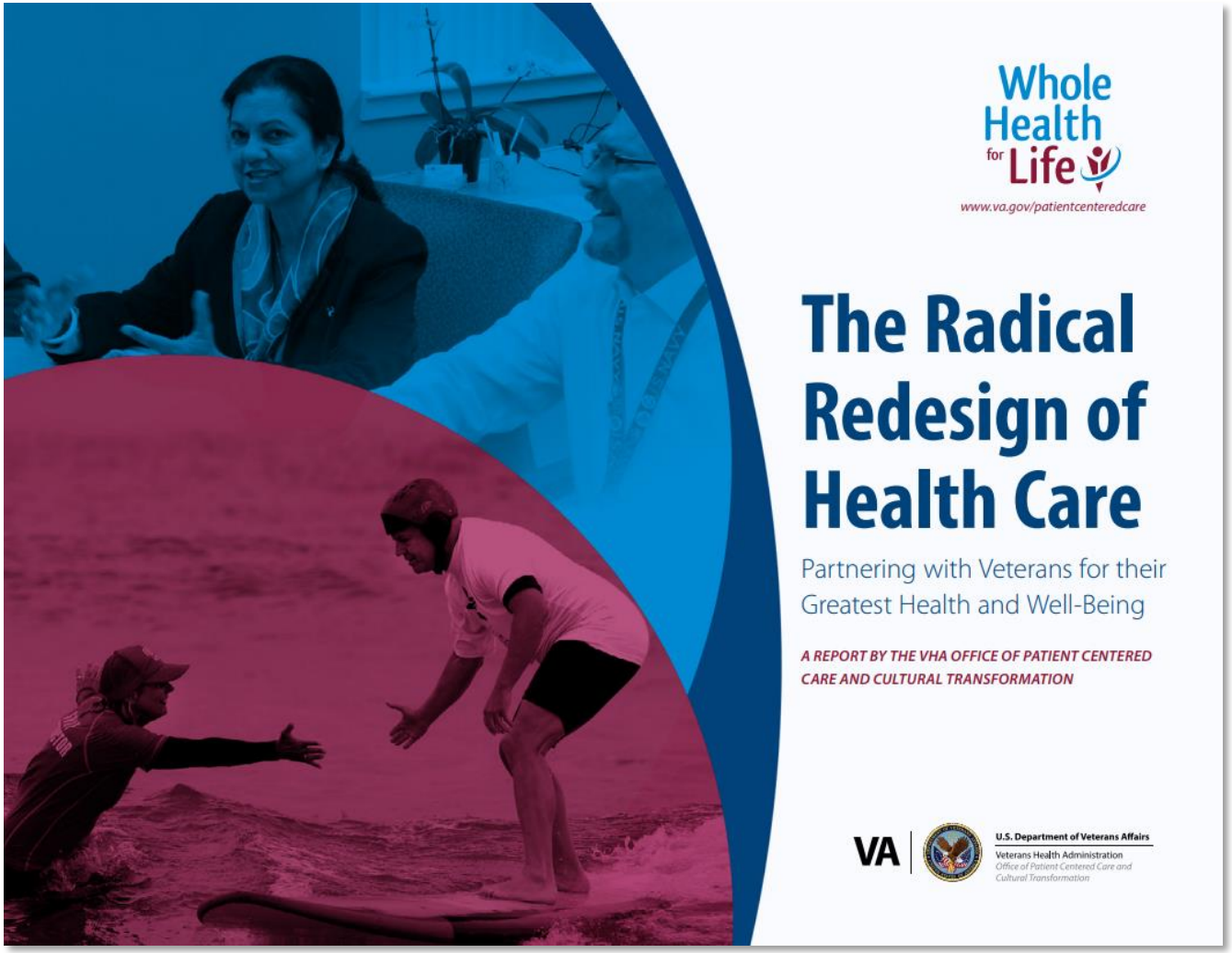
Risk Factors for Co-morbidities

- Stress of deployment – in wartime or peace; multiple deployments
- Zero-tolerance policies
- Stigma
- Confidentiality, Service Record, Readiness evaluations

Risk Factors for comorbidities (cont'd)

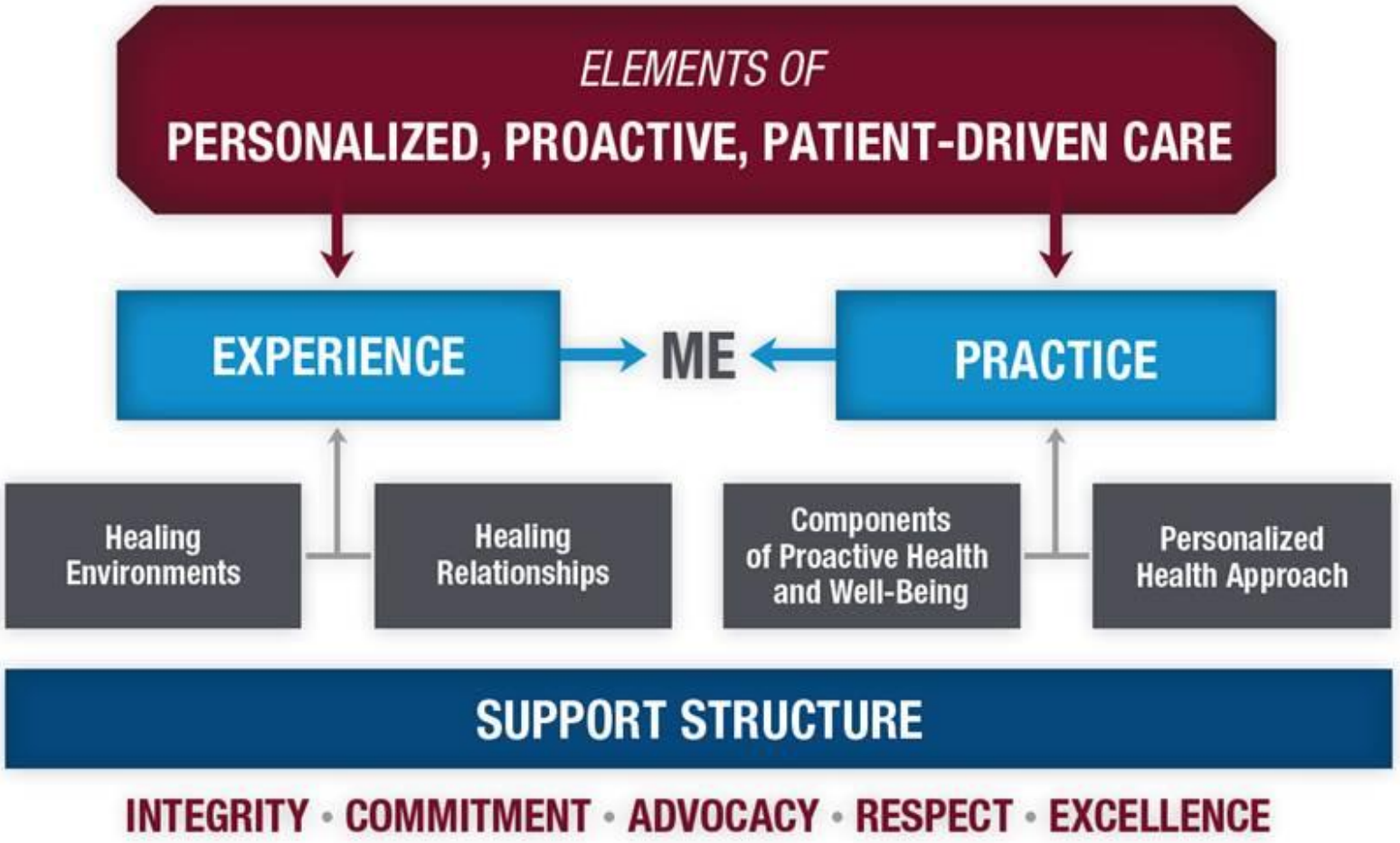
- Pre-existing conditions:
  - Chronic pain
  - Opioid use
  - Suicidal thought
  - PTSD/high states of mental alertness
  - Drug/alcohol or medication misuse
  - Depression, anxiety or other psychological or physical wounds, etc.
- Family or financial difficulty
- Sleep disturbance
- Despair, loneliness, suicidal thought or plan

The VA Vision



https://www.va.gov/PATIENTCENTEREDCARE/docs/2017-AR-Staff-Facing_FNL-W508.pdf

How the VA Addresses a National Epidemic - OUD



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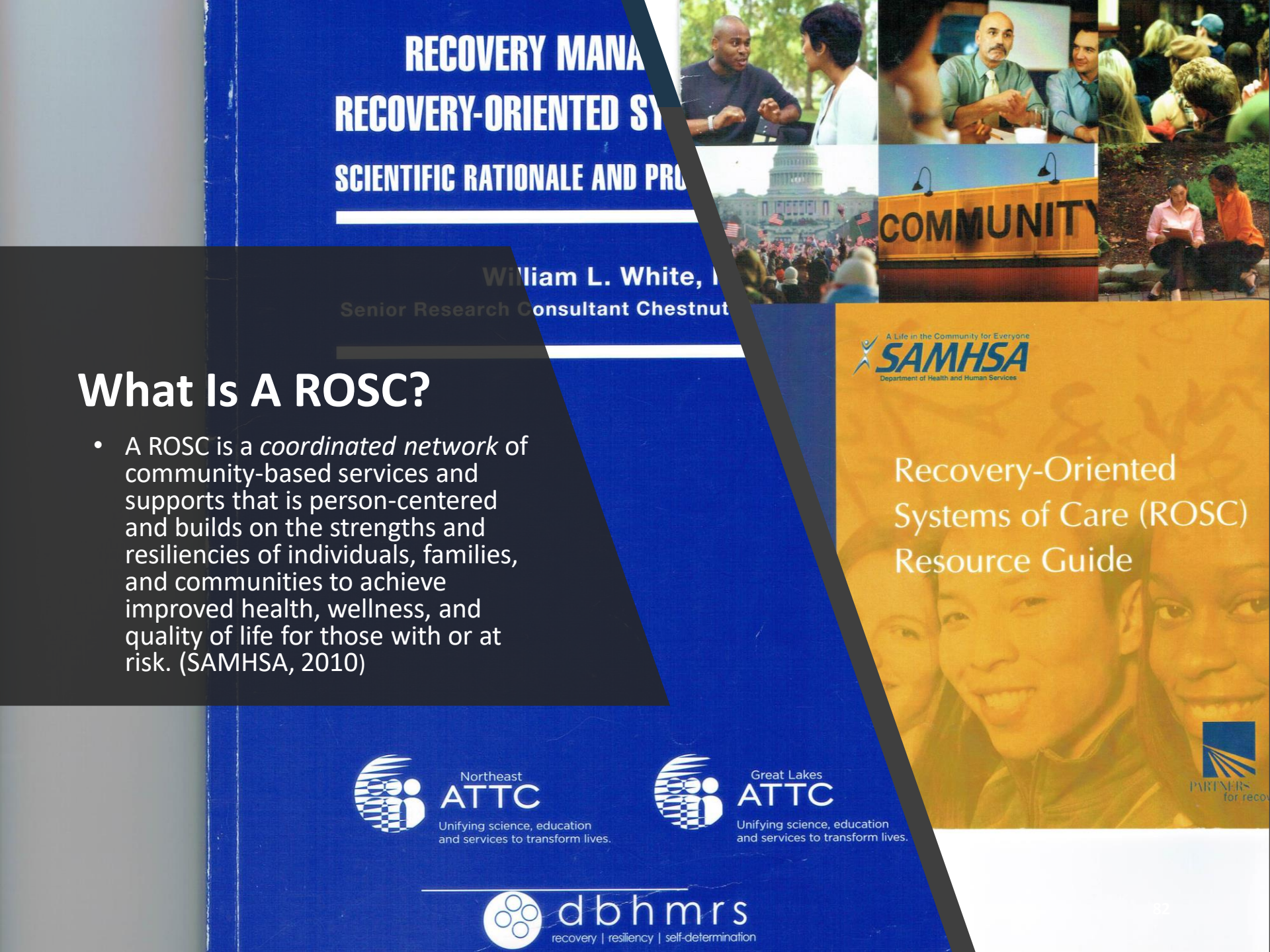
Building an SMVF Plan Tailored to Recovery

Many states, counties and communities are transforming their health care systems into person centered, population based models where building health, wellness and resilience are part of addressing pathology, illness and disease AND improving population health.

Building an SMVF Plan tailored to Recovery (cont'd)

One such model, used today by many states and communities, is a *Recovery Oriented System of Care* where the services within a community form a *network* that is person-centered and builds on the strengths of individuals, families within the community itself to achieve measurable improved health, wellness and quality of life for those both at risk - and in the general population.



What Is A ROSC?

- A ROSC is a *coordinated network* of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve improved health, wellness, and quality of life for those with or at risk. (SAMHSA, 2010)

How To Begin

- Gather all providers in a geographic area, ensure they are military culture informed, so as to complete a continuum of care for SMVF Network
- Define goals and “recovery” amongst this group and vision, objectives, and elements of care designed to attain and sustain recovery
- Establish 24/7 access to care for individuals and families
  - Match each person with best appropriate medical care

How to Begin (cont'd)

- Offer each person a peer support, Battle Buddy, or Vet support to assist 24/7
  - Include family in all treatment
- Seek TA for ongoing SMVF ROSC development
  - Examples:
    - Great Lakes ATTC (greatlakes@attcnetwork.org)
    - National ATTC (https://attcnetowrk.org)

Elements of Community Response to SMVF-R OUD

- Primary prevention
  - Prevention education (OU, Education & NARCAN)
  - Early intervention (SBIRT, other screens)
  - Decrease access to opioids (PDMP, Medical Education & Management)
  - Community support to vulnerable populations (w/Peers)

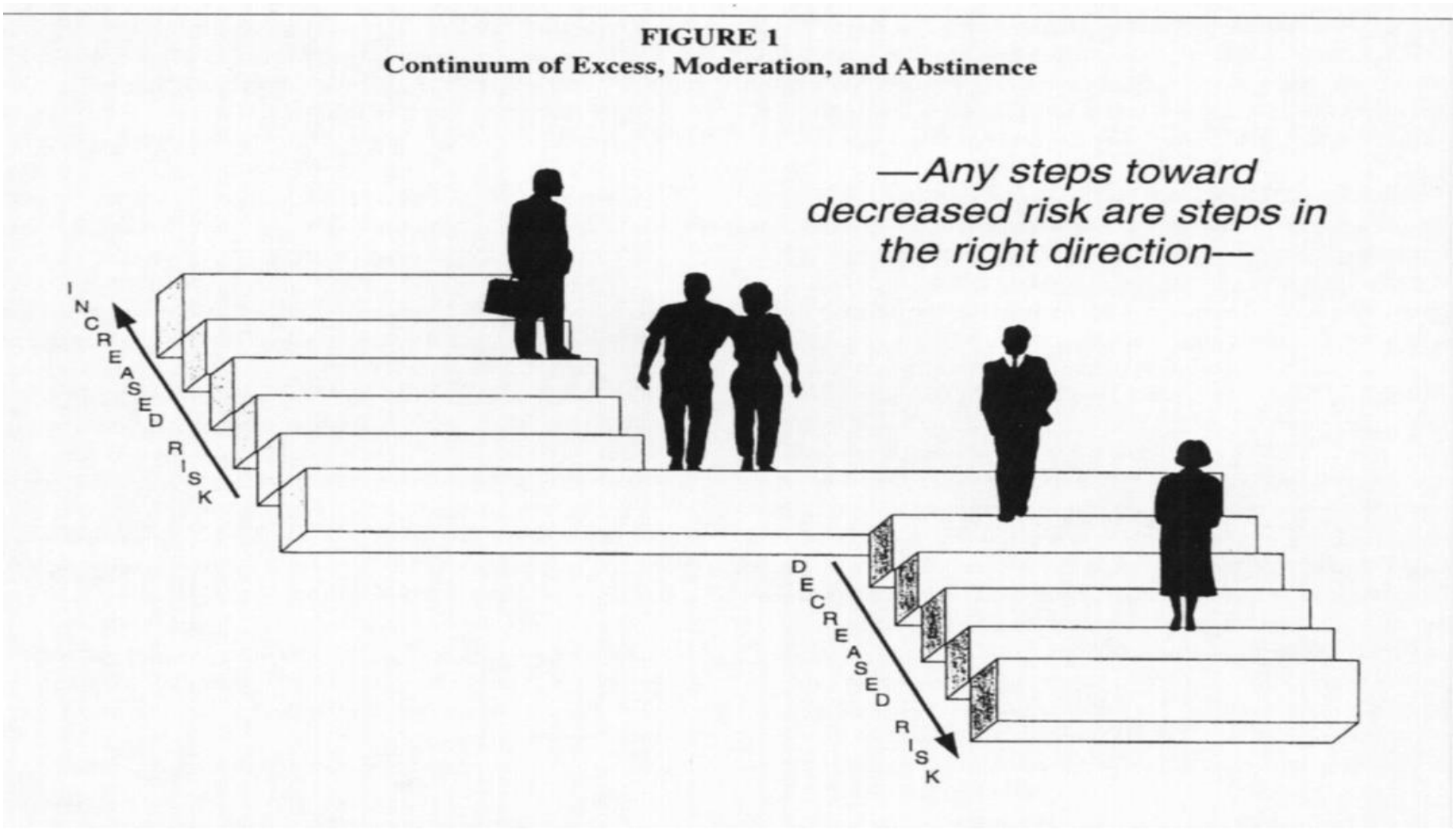
Elements of Community Response to SMVF-R OUD (cont'd)

- Treatment
  - Increased access to medication-assisted treatment (MAT) with medical monitoring
  - Increased access to behavioral treatment, peer support, community support, military career/benefits coordination

Elements of Community Response to SMVF-R OUD (cont'd)

- Secondary Prevention consequences; recovery
  - Integration of medical care with benefits and network
  - Infectious disease, pain, depression, suicide surveillance and sustained wellness and recovery

Floors of Population Intervention



Drawing from Integrating harm reduction therapy and traditional substance abuse treatment: G Alan Marlatt; Arthur W Blume; George A Parks

Journal of Psychoactive Drugs; Jan-Mar 2001; 33, 1; Health & Medical Complete pg. 13

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Aligning Resources for SMVF for OUD ROSC Care

Treatment of OUD is generally aligned to individual along a medical continuum of care (e.g. ASAM, 2013) that includes *MAT* at:

- Military hospital or facility
- VA hospital or VA Treatment Center; Vet Centers, etc.
- Community – TRICARE, Private Insurance, Medicaid, Medicare, public funding (e.g. block grants)
- Physician Expanded Access; community public agencies
- Mission Act of 2018 – expansion June 6, 2019

(see treatment locator for veterans at: www.FindTreatment.samhsa.gov/)

Critical First Steps of an SMVF ROSC:

- Understand military culture as both a risk and a protective factor:
  - Warrior Ethos
  - Structure of military

- Build a local "Vision", "network" and "Op-Plan" that improves access and can achieve health, wellness and recovery via person-centered care

Critical First Steps of an SMVF ROSC (cont'd):

- Address four critical elements of integrated, person centered care for SMVF
  1. Coordinating *care across all systems* for the person and family
  2. Offering a *Continuum of Care* for SMVF that builds *measurable*, resilience, health, and recovery
  3. Addressing "workforce development" for SMVF needs
  4. Establish and monitor SMVF outcomes within the added community services and a continuity of care supported by peers and families

The Continuum of Care for OUD/SUD

OUD require prevention, intervention, treatment and recovery support

- ASAM* Levels of Treatment
  - 0.5 Early Intervention
  - 1.0 Outpatient including MAT
  - 2.0 Intensive outpatient/Partial Hospital
  - 3.0 Residential/Inpatient (3.1,3.3,3.5,3.7)
  - 4.0 Medically managed inpatient
  - Opioid Treatment (MAT)
  - Adult and Adolescent Discharge Criteria
  - Gambling and Tobacco Use

*The ASAM Criteria, American Society on Addiction Medicine, Third Edition, 2013;
** proven effective

The Continuum of Care for OUD/SUD (cont'd)

- Involvement of family/person as unit, peer support, fellowship participation, preventive medication (NARCAN), 24 hour access to treatment, harm reduction strategies when needed, earlier intercept points, co-occurring assessment/treatment, *close* medical management, and support, etc.**

*The ASAM Criteria, American Society on Addiction Medicine, Third Edition, 2013;
** proven effective

Know Co-Occurring with OUD

Post-Iraq-Afghanistan

PTSD	31%
TBI	19.5%
Depression	20%
SUD	25%
Alcohol	20%
Sexual abuse	23%
Homeless	37,000/day
Secondary Service Injury	

Physical Pain*

Back/sciatica pain	34%
Joint pain	16%
Migraine	25%
Neck pain	27%
Jaw pain	37%

* will likely be using opioids

(www.veteransandptsd.com and www.VA.gov)

Set the Course: Monitor Progress Measures

- System: Unified Vision; culturally appropriate; sustainable via systems linkage built on person; improved institutional relationships; augmentation of workforce, shared technological improvements, increased SMVF recognition.

- Service Providers: Integrated health, expanded service team, culturally skilled; earlier outreach, screening, access; improved locus of care; improved retention with assertive linkage to meet needs, improved re-intervention if needed.

- Individual and family: Reductions in AOD use, suicide, depression, OD; improved health care; improved living environment; improved emotional health, improved family relationships; improved service. (W. White, 2008, p.26; Federal block grants)

We Can Do This!

Military Mottos

Army: Defendum Hoc - *This We'll Defend*

National Guard – *Semper Paratus Semper – Always Ready, Always There*

Navy: Semper Fortis - *Always Courageous*

Marine Corps: Semper Fidelis – *Always Faithful*

Air Force – Super Omnia - *Above All*

Coast Guard – Semper Paratus – *Always Ready*

A New Semper – Our "Op" Plan

Semper Covaluisset – ***Always Recovery***

We all know numbers of SMVF suffering from PTSD, chronic pain, opioid/substance use, the number of those who have contemplated and followed through on suicide. Our "Op-Plan" must be fully aware of the pre-cursors our military and their families bring to any sought care, particularly those who have served in combat. As well, our health systems must offer care that is culturally competent, best science and practice, offering in each episode the opportunity for health and wellness and **recovery** to each member and family.

It the least we can do.

We Know What To Do

Contact Info

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Questions?

Contact SAMHSA's SMVF TA Center

SAMHSA ★ SMVF TA CENTER

Service Members, Veterans, and their Families Technical Assistance Center

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Delmar, NY 12054

Phone: (518) 439-7415, ext. 5272

Email: smvftacenter@prainc.com

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Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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