

Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

OPIOID EDUCATION FOUNDATION OF AMERICA

OFFICE OF THE ATTORNEY GENERAL STATE OF NEW JERSEY

OFFICE OF ALTERNATIVE & COMMUNITY RESPONSES

NJCARES.gov
New Jersey Coordinator for Addiction Responses and Enforcement Strategies

Beyond the Opioid Use Diagnosis:
Co-Occurring Conditions & Treatment Considerations for Veterans
November 12, 2026

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- WHERE CAN YOU FIND THE LINK TO APPLY FOR CREDIT?
  - The chat at the end of the program
  - The follow-up email you will receive tomorrow

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Featured Presenter



Timothy Vermillion
DSW, MS, Ed. M, LCSW, BCD

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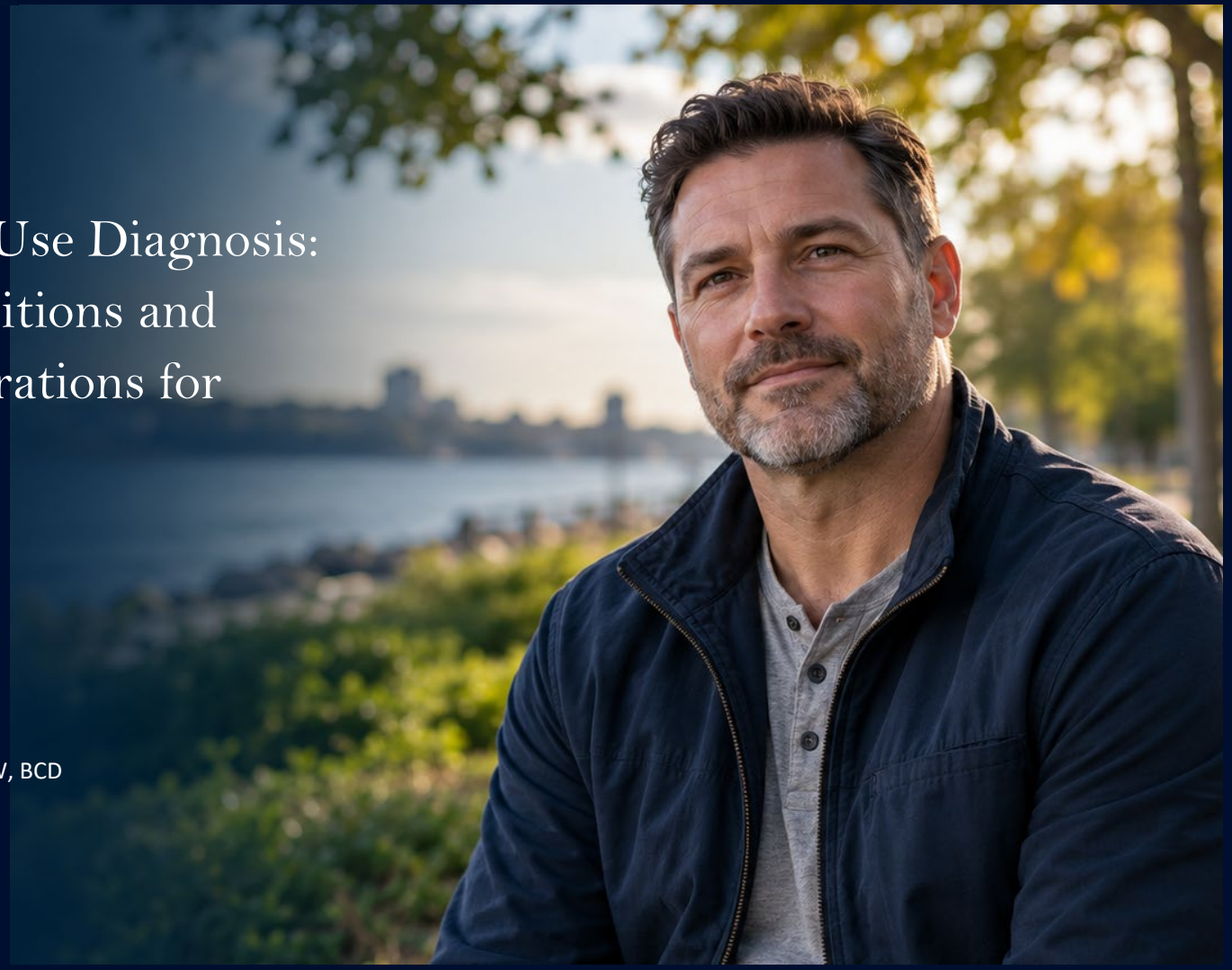
Beyond the Opioid Use Diagnosis: Co-Occurring Conditions and Treatment Considerations for Veterans



Timothy Vermillion, DSW, MS, M.Ed., LCSW, BCD
Paradise Institute

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Objectives

Learning Objectives

1. Identify common trauma-related, mental health, pain, sleep, and substance-use concerns that may co-occur with opioid use among veterans.

2. Analyze how military experiences, service-related injuries, chronic pain, and transitions from military to civilian life may affect opioid use and treatment engagement.

3. Collaboratively apply a harm-reduction-informed approach to assessing opioid-related risk, readiness for change, and barriers to care.

4. Implement practical strategies for coordinating trauma treatment, substance-use services, pain management, and other supportive care without requiring the client to address each concern in isolation.

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Types of Opioid Use

Prescribed use	Taking an opioid medication as directed
Misuse	Using without a prescription or differently from the prescribed directions
Physical dependence	Adaptation that can cause withdrawal; may occur during prescribed treatment
Opioid use disorder	A pattern of use causing significant impairment or distress; assessed by criteria

Tolerance or withdrawal during appropriate medical use does not, by itself, establish opioid use disorder.

Sources: CDC: OUD diagnosis MedlinePlus: opioid misuse

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THE NATIONAL OPIOID USE DISORDER PICTURE

2025 • People age 12 or older

4.0 million

estimated people

with past-year opioid use disorder

1.4%

of people age 12+

U.S. civilian, noninstitutionalized population; includes Veterans.

Sources: SAMHSA: 2025 NSDUH, Figure 45 / Table A.26B FDA: Prescribe with Confidence

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THE NATIONAL VETERAN PICTURE

U.S. Veterans age 18 or older

632,000

estimated adult Veterans reported past-year opioid misuse in 2023

NSDUH includes Veterans who do not use VA care.

Misuse and/or OUD diagnosis.

Civilian pain-reliever misuse and/or heroin use.

Sources: SAMHSA: 2023 NSDUH, slide 18 NASADAD (2025), p. 2

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THE VA PICTURE: PRESCRIBING AND OUD

Opioid prescribing

68%

fewer VA patients receiving opioid prescriptions

Q4 FY2012 → Q4 FY2024

874,897 → 282,346 patients

Recorded OUD diagnoses

0.97%

adjusted prevalence of recorded OUD diagnoses in VHA patients

2022

Not the percentage using opioids

Different measures and years; VA patients, not all Veterans.

Sources: VA (2025), pp. 12–13 Gorfinkel et al. (2024), Table 2

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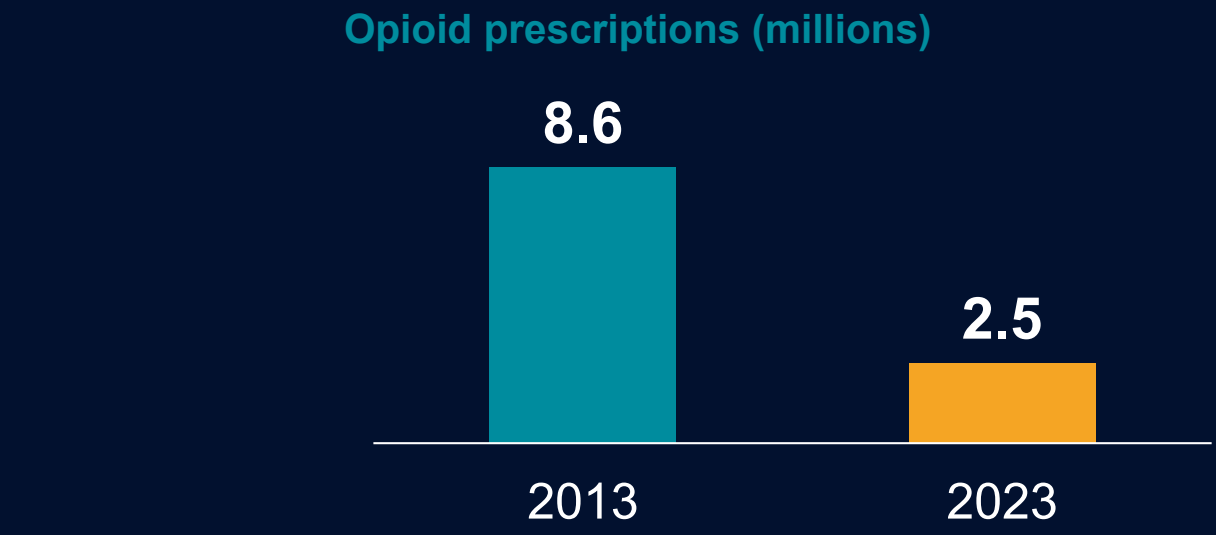
MILITARY HEALTH SYSTEM: OPIOID PRESCRIBING

≈71%

fewer opioid prescriptions

2013 to 2023



Prescription counts, not people or OUD diagnoses.

MHS beneficiaries include more than active-duty members.

Source: DoD: Evaluation of the TRICARE Program, FY2024, p. 111

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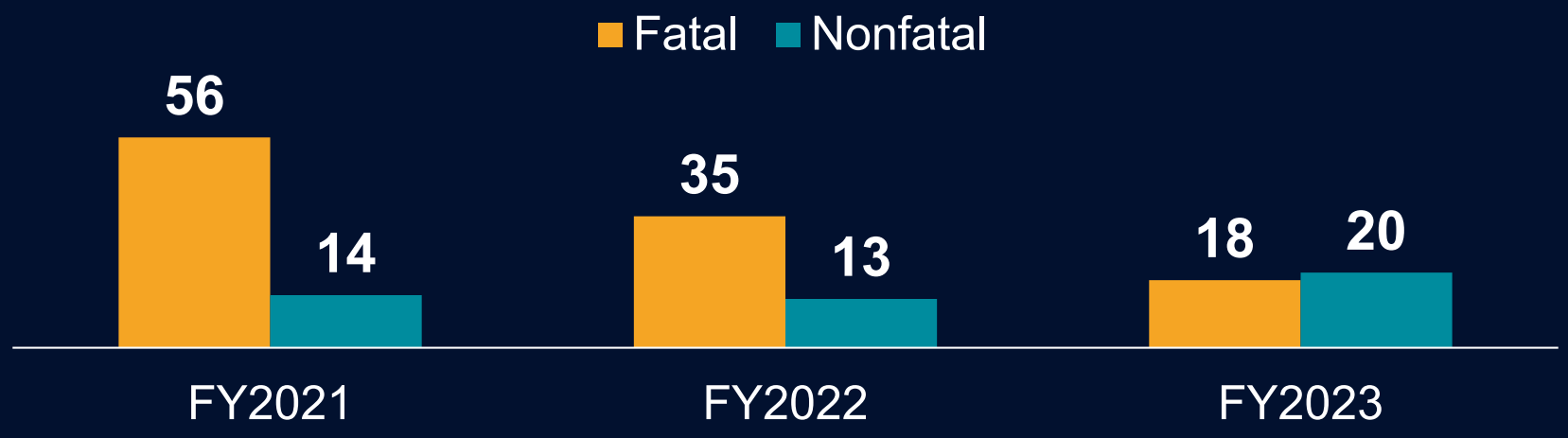
ACTIVE-DUTY FENTANYL OVERDOSES

Reported overdose counts • FY2021–FY2023



Includes fentanyl alone or with other drugs.

Source: DoD IG: DODIG-2026-068, Table 1, p. 16 (March 11, 2026)

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NEW JERSEY

Veteran-identified admissions

1,106

substance use treatment admissions in 2025, across all substances

Admissions may be repeated admissions.

All reported admissions

~32%

24,208 of 75,770 admissions

Heroin or other opiates as the primary substance

Not Veteran-specific

75,770 total admissions had 24,208 admitted for Heroin or other opiates.

Sources: NJ DMHAS: Substance Use Overview 2025, p. 4

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A Bigger Clinical Picture

Trauma / PTSD

Avoidance, hyperarousal, trauma-related symptoms

Mental health

Depression, anxiety, suicide risk assessment

Persistent pain

Interference with function and daily life

Sleep

Insomnia, nightmares, sleep-disordered breathing

Substance use

Alcohol, sedatives, other opioids, and other substances

Sources: VA: pain/PTSD VA: PTSD/SUD Rosen et al. (2019)

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Chronic Pain, PTSD, Insomnia, and Mood Disorders

VA patients with PTSD • 2023

53.2%

of VA patients with PTSD also had chronic pain

Pain, trauma, mood, and sleep can overlap

Ask how symptoms affect functioning and what the person is using to cope.

This is meant to complicate the clinical picture.

Opioids may be used to treat chronic pain and come to help cope with other issues.

Sources: Hadlandsmyth et al. (2024) VA: chronic pain and PTSD

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Jonathan Doe

Veteran is a divorced 50yo Male who currently suffers from chronic pain. He has Post-Traumatic Stress from combat and cares for a disabled school-aged son. The Veteran is trying to find work but finds it difficult to do anything with the amount of pain he experiences. He reports the pain is exhausting. He has been prescribed an opiate by his primary care despite his psychiatrist's concern.

What concerns might you have about this Veteran right now?

COMPOSITE

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WHAT WOULD YOUR NORMAL INTAKE INCLUDE?

Veterans have the same problems as everyone else	Your primary intake should take precedence
Safety is paramount	We want to ensure safety and ask about suicide
Assess for resources	Include friends/family, their knowledge of 911 & 988, and what other emergency services are available.

Also determine- Why now? Why did the Veteran enter into your care at this time.



Exploring the Veteran’s service and injury history.

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MILITARY EXPERIENCE CAN BE A STRENGTH OR A TRIGGER

Ask about service	Include the National Guard and Reserves Substance/opioid use may have led to discharge
Explore its meaning	Ask about roles, experiences, and identity
We can recognize triggers and strengths	Difficulties, pride, skills, and support/mentors

Why did you join? Why that particular service? Where did you excel? We're you a leader? Answers to these questions help find qualities we can use in treatment.

Sources: VA: provider resources APA guidelines (2021)

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INJURY, PAIN, AND THE ROLE OPIOIDS MAY PLAY

Injury history	Training, deployment, or other duties Injury can be a trigger to PTSD memories
Persistent pain	Effects on sleep, work, activity, and identity Pain can lead to intrusive memories/thoughts
Opioid use in context	Pain history, treatment effects, functional goals Using opioids relieves pain and intrusive thoughts

What does taking the opioid help you do, and what difficulties come with it?
What would happen if you did not have opioids to help you?

Sources: VA: chronic pain and PTSD CDC: pain guideline (2022)

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INJURY, PAIN, AND THE ROLE OPIOIDS MAY PLAY

Planning	Support personally chosen goals Consider visualizing meeting their goal
Teamwork and trust	Build on helpful relationships Therapeutic relationship and trust can be hard won
Self-reliance	Support agency; explore comfort accepting help

What is the Veteran's goal?

Sources: APA guidelines (2021), p. 14 VA: provider resources

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CIVILIAN TRANSITIONS CAN CHANGE ACCESS TO CARE

Daily life changes	Roles, routines, identity, and connections
Care can be interrupted	Work, transport, insurance, or provider changes, new providers, less direction, service-connection
Current/available resources	Relationships, goals, and a sense of purpose

What might make following-up with care easier or harder right now?
Note: Reserve transition is different than active duty.

Sources: VA: provider resources APA (2021), p. 14 Ahern et al. (2015)

Harm Reduction Review

Getting Veteran’s into care
Keeping them in care
Meeting them where they are



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STAGES OF CHANGE

Precontemplation	Contemplation	Preparation	Action	Maintenance
Not considering change	Considering, but ambivalent	Planning the next step	Making the chosen change	Sustaining and responding to challenges



Return to use can mean revisiting a stage, not failure.

Change can go both ways.

Sources: SAMHSA: TIP 35, ch. 1 SAMHSA: TIP 35, ch. 7

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Why do we consider Harm Reduction?

Abstinence can still be the goal. We want to meet the Veteran where they are and help them move forward in their treatment.

Offer protective tools	Naloxone, syringe services, and drug checking
Keep care available	Within the VA, continued use alone is not grounds for ending SUD treatment

Sources: VA: harm reduction VHA Directive 1160.04(2), App. A

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MYTHS ABOUT TREATMENT AND RECOVERY

MYTH	REALITY
“Harm reduction gives up on recovery.”	It keeps people connected to care and preserves recovery opportunities.
“Medication just replaces one addiction.”	Methadone and buprenorphine treat OUD. Dependence alone is not addiction.
“Detox is the end of treatment.”	Withdrawal management alone is insufficient treatment for OUD.

Sources: CDC: OUD treatment VA: harm reduction MedlinePlus: OUD treatment

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MYTHS ABOUT SAFETY AND ACCESS

MYTH	REALITY
“Sterile syringes encourage drug use.”	Comprehensive syringe services prevent infection without increasing illegal drug use.
“A negative fentanyl test means the supply is safe.”	A negative result does not establish safety. Keep overdose precautions in place.
“You must stop using before PTSD care.”	SUD alone is not a blanket reason to withhold evidence-based PTSD treatment.

Sources: CDC: syringe services CDC: fentanyl VA: PTSD and SUD

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ASSESS RISK WITH THE VETERAN

Safety and priorities	Immediate danger first; what matters to the Veteran today
Pattern and exposures	Opioid source and use, prior overdose, alcohol or sedatives, tolerance changes

Would it be okay if we looked together at what could make your current use more or less risky?

Sources: CDC: pain guideline (2022) VA: harm reduction

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What led the Veteran to care? How do we keep them in care?

Remember the stages of change.

Ask about both	How important is this? How confident do you feel?
Find the barrier	Practical limits, fears, and prior experiences with care

What feels possible right now?
What could make that difficult?

Sources: SAMHSA: TIP 35 CDC: OUD treatment

Treatment Options



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Care Options for Veterans

Connect the care	Trauma, substance use, pain, and sleep need a coordinated plan
Keep MOUD accessible	Offer or arrange medication for opioid use disorder when indicated
Agree on timing	Consider safety, preferences, and ability to participate

Veterans can walk-in to the VA Hospital in Lyons or Newark to register. They can also call 1-877-222-VETS for legibility information.

Sources: VA: PTSD and SUD CDC: OUD treatment

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MATCH THE THERAPY TO THE TREATMENT TARGET

Substance use patterns	Cognitive Behavioral Therapy (CBT): coping and relapse Prevention. MI: ambivalence and engagement
PTSD	Cognitive Processing Therapy (CPT) • Prolonged Exposure (PE) • Eye Movement Desensitization and Reprocessing (EMDR)
Chronic pain	CBT-Chronic Pain (CBT-CP): function and coping
Insomnia	CBT-Insomnia (CBT-I): sleep behaviors and thoughts

Psychotherapy complements Opioid Use Disorder medication; it is not a prerequisite.

Sources: VA/DoD: SUD VA: PTSD/SUD VA: CBT-CP VA/DoD: insomnia CDC: OUD

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WHERE EVIDENCE-INFORMED ADJUNCTS FIT

Limited protocol-specific evidence

Feeling-State	Learned links between behavior and a desired feeling
DeTUR	Triggers and urges, paired with adaptive goals
Gary Brothers' pain approach	A clinical framework for pain within coordinated medical care

Alongside established care, not a MOUD replacement.

Dr Vermillion's clinical practice perspective

Sources: Feeling-State (2012) DeTUR (2012) CDC: OUD

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IS VA CARE WANTED AND A GOOD FIT?

Ask about preferences	Preferences, past experiences, and current treatment relationships
Clarify what VA adds	Integrated or specialty care, medication, or a residential program
Verify before a transition	Eligibility, clinical fit, availability, and continuity of care

VA care, community care, or a coordinated combination may fit.
Many Veterans do not want VA services.

Sources: VA: residential care VA: substance use care

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WHAT INTENSITY AND SETTING FIT RIGHT NOW?

Outpatient

Visits while living in the community, including intensive outpatient care

Residential

Structured treatment in a live-in setting; not hospital-level inpatient care

Hospital-level inpatient

Medical or psychiatric needs requiring hospital resources and monitoring

Harm reduction and coordinated support across all settings

Sources: ASAM: levels of care ASAM: engagement and retention

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BUILD ONE SHARED PLAN

Veteran goals	Agree on the changes that matter most
Named roles	Assign treatment leads and a coordinator
Communication & review	Agree on consent, updates, and follow-up

Memory-focused work: an adjunct within the plan

Feeling-State • DeTUR • Gary Brothers' pain approach

Evidence is more limited than for standard EMDR for PTSD.

Do not replace indicated medication or medical pain care.

Sources: VA: PTSD/SUD Feeling-State DeTUR HHS: Part 2

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MAKE THE HANDOFF WARM AND SPECIFIC

Introduce the clinician	With the Veteran's permission, Connect and follow-up
Check fit and access	Appointment, clinical fit, cost, transport, and other practical barriers
Name the next step	A contact, an action, and someone responsible

Confirm that the referral was received.

Sources: VA: treatment access HHS: information sharing

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USE NJ AND VA PATHWAYS PURPOSEFULLY

ReachNJ • 24/7	1-844-732-2465 Addiction treatment and support navigation
VA pathway	Use the right entry point; verify program requirements
Community care	Keep medical, behavioral health, and practical supports connected

Keep needed care moving while access is clarified.
Service Connection can also be considered.

Sources: NJ: ReachNJ VA: substance use care VA: residential care

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CLOSE THE LOOP:
DID THE VETERAN RECEIVE CARE?

Confirm the connection	Did the appointment happen? Did treatment or support begin?
Find the barrier	Adjust the plan and name who owns the next action
Review together	Safety, symptoms, function, and the Veteran's preferences

Sources: ASAM: engagement and retention VA: coordinated PTSD/SUD care

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Questions



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UPCOMING WEBINAR

Kratom 101: What You Need to Know

November 19, 2026

Register at KnockOutDay.DrugFreeNJ.org/events

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