



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 10 2023

The Honorable Edward J. Markey
United States Senate
Washington, DC 20510

Dear Senator Markey:

Thank you for your September 28, 2022 letter to the Secretary of Defense regarding drug overdose among our Service member population. We share your concern that drug overdose is a serious problem and must be addressed for the safety of those at Fort Bragg, North Carolina; Fort Bliss, Texas; West Point, New York; and the safety of all who serve. Drug abuse has a substantial impact on the degradation of Total Force readiness, not to mention the irrevocable impact on Service members and their families. Addressing drug abuse and preventing overdose deaths in our force is a high priority for the Department of Defense (DoD).

Fatal and non-fatal drug overdose data and responses to your questions are provided in the enclosure. The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. We also recognize that fentanyl-related drug overdose deaths remain a national and Department concern despite State, whole of Federal Government, and DoD-specific efforts to alert and educate the public on this dangerous drug. Every drug overdose is a preventable loss of life and we must work to do better.

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.

We are committed to ensuring the health and safety of all who serve, and I thank you for your continued strong support for our Service members. I am sending similar responses to the other signatories of your letter

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", is located below the "Sincerely," text.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 10 2023

The Honorable John Cornyn
United States Senate
Washington, DC 20510

Dear Senator Cornyn:

Thank you for your September 28, 2022 letter to the Secretary of Defense regarding drug overdose among our Service member population. We share your concern that drug overdose is a serious problem and must be addressed for the safety of those at Fort Bragg, North Carolina; Fort Bliss, Texas; West Point, New York; and the safety of all who serve. Drug abuse has a substantial impact on the degradation of Total Force readiness, not to mention the irrevocable impact on Service members and their families. Addressing drug abuse and preventing overdose deaths in our force is a high priority for the Department of Defense (DoD).

Fatal and non-fatal drug overdose data and responses to your questions are provided in the enclosure. The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. We also recognize that fentanyl-related drug overdose deaths remain a national and Department concern despite State, whole of Federal Government, and DoD-specific efforts to alert and educate the public on this dangerous drug. Every drug overdose is a preventable loss of life and we must work to do better.

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.

We are committed to ensuring the health and safety of all who serve, and I thank you for your continued strong support for our Service members. I am sending similar responses to the other signatories of your letter

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", is located below the "Sincerely," text.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 10 2023

The Honorable Elizabeth Warren
United States Senate
Washington, DC 20510

Dear Senator Warren:

Thank you for your September 28, 2022 letter to the Secretary of Defense regarding drug overdose among our Service member population. We share your concern that drug overdose is a serious problem and must be addressed for the safety of those at Fort Bragg, North Carolina; Fort Bliss, Texas; West Point, New York; and the safety of all who serve. Drug abuse has a substantial impact on the degradation of Total Force readiness, not to mention the irrevocable impact on Service members and their families. Addressing drug abuse and preventing overdose deaths in our force is a high priority for the Department of Defense (DoD).

Fatal and non-fatal drug overdose data and responses to your questions are provided in the enclosure. The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. We also recognize that fentanyl-related drug overdose deaths remain a national and Department concern despite State, whole of Federal Government, and DoD-specific efforts to alert and educate the public on this dangerous drug. Every drug overdose is a preventable loss of life and we must work to do better.

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.

We are committed to ensuring the health and safety of all who serve, and I thank you for your continued strong support for our Service members. I am sending similar responses to the other signatories of your letter

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", is located below the "Sincerely," text.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 10 2023

The Honorable Lisa Murkowski
United States Senate
Washington, DC 20510

Dear Senator Murkowski:

Thank you for your September 28, 2022 letter to the Secretary of Defense regarding drug overdose among our Service member population. We share your concern that drug overdose is a serious problem and must be addressed for the safety of those at Fort Bragg, North Carolina; Fort Bliss, Texas; West Point, New York; and the safety of all who serve. Drug abuse has a substantial impact on the degradation of Total Force readiness, not to mention the irrevocable impact on Service members and their families. Addressing drug abuse and preventing overdose deaths in our force is a high priority for the Department of Defense (DoD).

Fatal and non-fatal drug overdose data and responses to your questions are provided in the enclosure. The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. We also recognize that fentanyl-related drug overdose deaths remain a national and Department concern despite State, whole of Federal Government, and DoD-specific efforts to alert and educate the public on this dangerous drug. Every drug overdose is a preventable loss of life and we must work to do better.

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.

We are committed to ensuring the health and safety of all who serve, and I thank you for your continued strong support for our Service members. I am sending similar responses to the other signatories of your letter

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", is located below the "Sincerely," text.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

FEB 10 2023

The Honorable Martin Heinrich
United States Senate
Washington, DC 20510

Dear Senator Heinrich:

Thank you for your September 28, 2022 letter to the Secretary of Defense regarding drug overdose among our Service member population. We share your concern that drug overdose is a serious problem and must be addressed for the safety of those at Fort Bragg, North Carolina; Fort Bliss, Texas; West Point, New York; and the safety of all who serve. Drug abuse has a substantial impact on the degradation of Total Force readiness, not to mention the irrevocable impact on Service members and their families. Addressing drug abuse and preventing overdose deaths in our force is a high priority for the Department of Defense (DoD).

Fatal and non-fatal drug overdose data and responses to your questions are provided in the enclosure. The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. We also recognize that fentanyl-related drug overdose deaths remain a national and Department concern despite State, whole of Federal Government, and DoD-specific efforts to alert and educate the public on this dangerous drug. Every drug overdose is a preventable loss of life and we must work to do better.

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.

We are committed to ensuring the health and safety of all who serve, and I thank you for your continued strong support for our Service members. I am sending similar responses to the other signatories of your letter

Sincerely,

A handwritten signature in dark ink, appearing to read "Gilbert R. Cisneros, Jr.", is written over a horizontal line.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

Rate Calculations

The data have been adjusted into a reference scale, as the total number of Service members for a data subset per 100,000 total Service members (i.e., rate per 100,000 Service members). The data are normalized in this manner due to military population fluctuations.

Responses to your questions are below:

1. How many active military service members overdosed from January 1, 2017 to present?

A total of 15,293 active duty Army, Air Force, Navy, and Marine Corps (USMC) Service members overdosed from 2017 to present. This includes Reservists and National Guard members on active duty. There were 332 fatal drug overdoses (OD) from 2017-2021 and 14,961 non-fatal OD from Fiscal Year (FY) 2017-2022.^{1,2,3,4}

i. Of those, how many overdoses are fatal?

There were 332 fatal drug overdoses from January 1, 2017 through December 31, 2021. Fatal data are only available through 2021. Drug overdose deaths represented 6.9 percent of all active duty deaths over the 5-year period. While the rate of DoD overdose deaths in 2020 (5.0 per 100,000 Service members) was lower than the most recent national rate reported by the Centers for Disease Control and Prevention (28.3 per 100,000 in 2020⁵), we recognize that any preventable loss of life is unacceptable, and we must work to do better.

ii. Of fatal overdoses, how many were ruled a suicide? Accidental?

From 2017-2021, the manner of death for fatal drug OD was classified as follows: 'accidental' (279 cases, 84.0 percent), 'suicide' (42 cases, 12.7 percent), and 'undetermined' (11 cases, 3.3 percent).⁶

¹ Fatal drug overdose data were obtained from the Defense Casualty Information Processing System and independently verified by the Armed Forces Medical Examiner System and are reported on a Calendar Year basis.

² Non-fatal drug overdose data were compiled by Defense Health Agency (DHA) Healthcare Operations (HCO), J-5 Analytics and Evaluation Division using the *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes (T36-T50, F1112, F1122, F1192) from medical records in the Military Health System (MHS) Data Repository (DR) and are reported on a Fiscal Year basis. These cases do not include non-fatal alcohol cases and may also include fatal overdose cases.

³ Tyndall Snow LM, Hall KE, Custis C, et al. Descriptive exploration of overdose codes in hospital and emergency department discharge data to inform development of drug overdose morbidity surveillance indicator definitions in ICD-10-CM. *Inj Prev* 2021;27:i27-134

⁴ CDEC's Drug Overdose Surveillance and Epidemiology (DOSE) System. Last reviewed Oct 6, 2021. <https://www.cdc.gov/drugoverdose/nonfatal/case.html>.

⁵ CDC, Drug Overdose Deaths, June 2 2022, <https://www.cdc.gov/drugoverdose/deaths/index.html>

⁶ All jurisdictions do not follow National Association of Medical Examiners recommendations for reporting overdose manner of death determinations resulting in some regions using 'accidental' and others using 'undetermined' when no specific sign of suicide is present.

iii. *What substances were involved in both fatal and non-fatal overdoses?*

Fatal drug OD from 2017-2021 were grouped into the following four categories:

- a. Category 1 – Fentanyl/fentanyl analogs⁷ alone or in combination with other drugs: (174 cases, 52.4 percent).
 - 1) Fentanyl/fentanyl analogs were the only drugs reported in 73 cases.
 - 2) There were 101 cases with fentanyl/fentanyl analogs and another drug(s) reported. The following drug classes were found most often in combination with fentanyl (order of prevalence): opioids⁸ (includes prescription opioids, heroin, mitragynine⁹), alcohol, cocaine, benzodiazepines¹⁰, amphetamines (includes methamphetamine, MDMA and MDA), and ‘mixed drug’.¹¹
- b. Category 2 – Drugs unspecified and/or non-opioid drugs: (84 cases, 25.4 percent).
 - 1) Most cases were cited as ‘mixed drug’ (36 cases), ‘mixed drug’ with alcohol (8), or ‘mixed drug’ with one drug named (5).¹¹
 - 2) Of the remaining 25 non-opioid drug cases, the following drugs were present (order of prevalence): diphenhydramine¹² (alone or combined with other drugs), alcohol with over-the-counter, prescription, or illicit drugs, and cocaine (alone or combined with other drugs).
- c. Category 3 – Opioid drugs alone or in combination with other drugs: (45 cases, 13.6 percent).
 - 1) Most cases contained heroin alone or combined with other drugs or a prescription opioid combined with one or more drugs.
- d. Category 4 – Alcohol alone with no other drugs: (29 cases, 8.7 percent).

Non-Fatal OD from 2017-2021

Non-fatal OD data were compiled using *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) diagnosis codes. These are the standard medical record codes used by local, State, and Federal agencies conducting drug overdose surveillance; however, it should be noted that these codes also include

⁷ Fentanyl analogs have a similar chemical structure and pharmacological effects to fentanyl.

⁸ Opioids are naturally derived, synthetic and semisynthetic substances that activate peripheral or central opioid receptors; for the purposes of these classifications the term opioid does not include fentanyl or fentanyl analogs.

⁹ Mitragynine is an opioid with euphoric effects found in Kratom leaves. The drug is not Food and Drug Administration (FDA) approved and often sold as a ‘legal high’ (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6490129/>).

¹⁰ Benzodiazepines are a class of FDA-approved drugs used to treat a range of conditions including anxiety, insomnia, and seizures. These drugs are frequently abused alone or in combination with other drugs.

¹¹ Select jurisdictions report the cause of death as ‘multi drug intoxication’, ‘acute combined drug intoxication’ and do not list the offending agents.

¹² Diphenhydramine is an over-the-counter antihistamine used for symptoms of allergy, hay fever and the common cold.

underdosing of drugs and adverse effects from drugs.^{3,4,13} Standard surveillance programs typically monitor ‘accidental’ and ‘undetermined’ intent categories; however, DoD also monitors ‘intentional’ and ‘assault’. This broad approach includes more than 700 intoxication and poisoning diagnostic codes. Medical Affairs (MA) and DHA HCO also utilize a smaller subset of ICD-10-CM codes to monitor prescription and illicit drug intoxication¹⁴. Within the focused subset of 303 codes, there were 10,845 non-fatal drug OD cases from FY 2017-2022. Data from the focused subset are provided here within for comparing fatal and non-fatal OD trends. The DoD monitors non-fatal OD trends in the following two categories:¹⁵

- a. Category 1 – Drugs/Drug Class ICD-10-CM codes that parallel the current DoD drug testing panel¹⁶: (2,803 cases).
 - 1) There were 22 cases involving fentanyl/fentanyl analogs; however, the fentanyl specific diagnostic code has only been active since October 2020. In previous years, these cases were likely captured under one of 12 opioid-related codes (988 cases).¹⁷ While the Centers for Disease Control and Prevention (CDC) reported nonfatal opioid-involved overdoses were increasing nationally an average of 4 percent quarterly during January 2018-March 2022, the same trend was not observed in the active duty population.¹⁸ From FY2017 to FY2021, the number of opioid-involved OD decreased more than 30 percent from 223 in FY17 to 147 in FY21.
 - 2) Cases involving other drug classes included (in order of prevalence): benzodiazepines, amphetamines, other unspecified narcotics, cocaine, LSD, and cannabis.
- b. Category 2 – Other Substances of Interest¹⁹: (13,284 cases).
 - 1) There were more than 5,000 cases in the general category of poisoning by diuretics and unspecified drugs, medicaments, and biologicals; and 90 percent of those cases involved agents or drugs that were unspecified.
 - 2) Antidepressants were cited in 2,638 cases.

¹³ Underdosing is the effect of using less drug than prescribed while adverse effects are pharmacological effects from medications correctly prescribed and properly administered.

¹⁴ Non-fatal drug overdose data were compiled by Defense Health Agency (DHA) Healthcare Operations (HCO), J-5 Analytics and Evaluation Division using ICD-10-CM diagnosis codes (F11.12x, F11.22x, F11.92x, T40, T42, T43, T48, T49, T50) from medical records in the MHS DR. These cases do not include non-fatal alcohol cases.

¹⁵ Numbers based on the overdose code in the most primary position on the medical record. Results may be underestimated for any one particular overdose code if it was secondary to other overdose diagnosis codes on the record. Service members may fall into multiple Substance Type categories if they had multiple overdoses or multiple records for one overdose and the overdose code varied.

¹⁶ Delta-9-THC, delta-8-THC, amphetamine, methamphetamine, MDMA, MDA, lorazepam, nordiazepam, oxazepam, temazepam, alprazolam, cocaine, morphine, codeine, oxycodone, oxymorphone, hydrocodone, hydromorphone, heroin, fentanyl, LSD, and eight synthetic cannabinoids

¹⁷ Vivolo-Kanor, A. Pasalic, E., Liu, S., et al. Defining indicators for drug overdose emergency department visits and hospitalizations in ICD-10-CM coded discharge data. *Inj Prev* 2021;27:i56-i61.

¹⁸ CDC Morbidity and Mortality Weekly Report August 26, 2022, 71(34); 1073-1080
<https://www.cdc.gov/mmwr/volumes/71/wr/mm7134a1.htm>

¹⁹ The category includes a broad range of over-the-counter, prescription and illicit drugs including vaccines.

- 3) Other substances of interest included (in order of prevalence): antitussives (cough suppressants) and other respiratory system muscle drugs, antiepileptic and sedative-hypnotic drugs, and antipsychotics and neuroleptics.

iv. *What were the demographic trends among those who overdosed?*

Fatal OD demographic trends were as follows:

- a. Active duty OD deaths were relatively unchanged from 2017 (61 deaths) to 2019 (60 deaths) but increased in 2020 and 2021 with 75 and 77 deaths, respectively. The trend held when normalized to the average annual end strengths (4.2 OD deaths per 100,000 Service members in 2017 to 5.1 OD deaths per 100,000 Service members in 2021). A national increase was also observed over the same period with CDC issuing advisories of substantial OD death increases beginning in 2019 and reaching historic highs in 2021.^{20,21}
 - 1) The Army had the highest number of fatal OD deaths compared to the other Services from 2017-2021, 171 total (51 percent of all OD deaths) and an average of 34 per year.
 - i. The Army annual rate of fatal OD deaths remained relatively unchanged from 6.5 per 100,000 Service members (36 deaths) in 2017 to 6.1 per 100,000 Service members (35 deaths) in 2021.
 - 2) Total drug OD deaths from 2017-2021 for the Air Force, USMC, and Navy was 45, 36, and 80, respectively
 - i. Air Force OD deaths have increased slightly over time from 9 deaths in 2017 to 11 in 2021. During the same period, USMC, and Navy OD deaths have doubled from 5 and 11 deaths, respectively in 2017 to 10 (USMC) and 21 (Navy) in 2021. A comparison of OD death rates for each Service showed similar trends. Rates per 100,000 Service members in 2017 were Air Force (2.5), USMC (2.6), and Navy (3.2). Respective rates per 100,000 Service members in 2021 were 2.9, 5.2 and 5.7.
 - 3) The number of OD deaths involving fentanyl has more than doubled over the past 5 years reaching a high of 54 cases in 2021 (88 percent of OD cases) compared to 22 in 2017 (36 percent of OD cases). Fentanyl-related drug overdose deaths remain a national and DoD concern despite State, Federal, and DoD efforts to alert and educate the public on this dangerous drug. National fentanyl-related drug overdose deaths continued to increase from 2020 to 2021 with most cases involving illicitly made fentanyl mixed with other illicit drugs or added to counterfeit prescription pills.^{22,23}

²⁰ CDC SUDORS Data Brief, A qualitative assessment of circumstances surrounding drug overdose deaths during early stages of the COVID-19 pandemic. August 2022, Number 2.

<https://www.cdc.gov/drugoverdose/databriefs/sudors-2.html>.

²¹ CDC National Center for Health Statistics <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

²² CDC, Fentanyl Encounters Data, August 9 2021, <https://www.cdc.gov/drugoverdose/deaths/fentanyl-encounters/index.html>.

²³ CDC, National Center for Health Statistics, May 11 2022. "U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 – But are Still Up 15%" https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

- i. The Service breakdown of fentanyl OD deaths for 2021 included Army (14), Navy (4), Air Force (2), and USMC (2) compared to 2017 with Army (27), Navy (13), Air Force (8), and USMC (6).
- b. The majority of fatal drug OD from 2017-2021 were enlisted (320, 96 percent) compared to officers (9, 2.7 percent).
- c. The majority of fatal drug OD from 2017-2021 were males (307, 92.5 percent) compared to females (25, 7.5 percent).
- d. The average age of fatal drug OD from 2017-2021 was 28.7 with an age range of 18-56. More than 80 percent of the deaths were Service members 18-33 years of age.
- e. The majority of fatal drug OD were white (255, 77 percent) followed by Black or African American (40, 16 percent) and unknown race (12, 3.6 percent).
- f. The majority of fatal drug OD were non-Hispanic (259, 78 percent) followed by Hispanic (46, 13.8 percent) and unknown ethnicity (26, 8 percent).
- g. From 2017-2021, approximately 59 percent of continental United States OD fatalities occurred in the ten states with the largest military populations.^{24,25} The number of fatalities, relative rate of fatal overdoses per 100,000 Service members and significant installation trends are provided:
 - 1) California: 28 overdoses, rate 17.2 (13 overdoses at San Diego, 7 at Camp Pendleton).
 - 2) Virginia: 18 overdoses, rate 14.3 (8 overdoses in the Hampton Roads area²⁶).
 - 3) Texas: 33 overdoses, rate 28.6 (13 overdoses at Fort Bliss and 16 at Fort Hood).
 - 4) North Carolina: 36 overdoses, rate 36.0 (31 overdoses at Fort Bragg).
 - 5) Georgia: 13 overdoses, rate 19.0 (4 overdoses at Fort Stewart).
 - 6) Florida: 12 overdoses, rate 19.1 (4 overdoses Jacksonville and 3 overdoses Pensacola).
 - 7) Washington: 17 overdoses, rate 29.5 (11 overdoses Joint Base Lewis-McChord).
 - 8) Hawaii: 6 overdoses, rate 16.8.
 - 9) South Carolina: 4 overdoses, rate 10.1 (3 overdoses at Fort Jackson).
 - 10) Colorado: 7 overdoses, rate 18.8 (6 overdoses at Fort Carson).

²⁴ Rates based on state populations provided in the DoD 2020 Demographics Profile of the Military Community report <https://www.militaryonesource.mil/data-research-and-statistics/military-community-demographics/2020-demographics-profile/>.

²⁵ Information based on assigned Unit Identification Code (UIC) at the time of death. Location of death on death certificate may differ than location of UIC.

²⁶ Hampton roads includes installations and bases in Chesapeake, Hampton, Newport News, Norfolk, Portsmouth, Suffolk, and Virginia Beach.

- h. Notable trends in states with smaller military populations included: Kentucky (17 overdoses, rate 50.4, majority at Fort Campbell (15)), New York (8 overdoses, rate 42.0, majority at Fort Drum (5)), Illinois (9 overdoses, rate 34.1, majority at Great Lakes (8)), and Alaska (5 overdoses, rate 27.5, majority at Joint Base Elmendorf Richardson (4)).
- i. There were 41 fatal OD outside the continental United States representing a rate per 100,000 Service members of 25.4 this includes AP 21, AE 19, and AA 1 death(s).²⁷

Non-fatal overdose trends were as follows:

- a. Active duty non-fatal OD were relatively unchanged from 2017 (1,886 cases) to 2021²⁸ (1,864 cases). A slight decrease in non-fatal OD were observed when normalized to average annual end strengths (130 non-fatal OD per 100,000 Service members in 2017 compared to 123 non-fatal OD per 100,000 Service members in 2021).
 - 1) The Army had the highest number of non-fatal OD compared to the other Services from 2017-2021, (4,793 total; 50 percent of all non-fatal OD).
 - i. Army non-fatal OD have decreased over time from 1,024 in 2017 (54 percent all non-fatal OD) in 2017 to 910 in 2021 (49 percent).
 - ii. The Army annual rate of OD deaths also decreased from 185 per 100,000 Service members in 2017 to 158 per 100,000 Service members in 2021.
- b. Total non-fatal OD from 2017-2021 for the Navy, Air Force, and USMC were 1,930 (20 percent of all non-fatal OD), 1,577 (17 percent) and 1,183 (12 percent), respectively. The increase over time was also observed when deaths were normalized to average annual end strengths for each Service. Respective rates per 100,000 Service members were as follows: Air Force (2.5), USMC (2.6), and Navy (3.2) in 2017 to 2.9, 5.2 and 5.7, respectively in 2021.
 - 1) Navy non-fatal OD have increased over time from 327 in 2017 to 422 in 2021. The rate of non-fatal OD has also increased during the same period from 95.3 cases per 100,000 Service members in 2017 to 115 in 2021.
 - 2) Air Force non-fatal OD have remained relatively unchanged over the past 5 years (306 in 2017 to 313 in 2021).
 - 3) USMC non-fatal OD have remained relatively unchanged over the past 5 years (222 in 2017 to 217 in 2021).
- c. The majority of non-fatal OD from FY 2017-2022 were 'intentional' (6,345), 'accidental' (4,624), or 'undetermined' (2,021).²⁹

²⁷ Location data pending for 19 cases (6 percent); AE are Armed Forces locations in Europe, Africa, Middle East, and Canada, AP are Armed Forces Pacific locations; fatal overdoses in Virginia, Georgia, and Florida were across multiple locations.

²⁸ FY 2022 data not included because it is subject to data lag that is setting dependent (i.e., direct care, purchased care, inpatient, and outpatient). Data lag may take up to 6 months to resolve.

²⁹ ICD-10-CM intent categories are unintentional, intentional self-harm, assault, and undetermined.

- d. The majority of non-fatal OD from FY 2017-2022 were enlisted (10,219, 94 percent) compared to officers (499, 4.6 percent).
- e. The majority of non-fatal drug OD from FY 2017-2021 were males (7,355, 67 percent) compared to females (3,492, 32 percent).
- f. The average age of fatal drug OD from FY 2017-2021 was 25 with an age range of 15-65.³⁰ More than 80 percent of the deaths were Service members 15-34 years of age.
- v. *More generally, how many active duty service members had traces of misused, prescription medication or illicit drugs in their system at the time of death?*

From 2017-2021 there were 53 deaths that were not caused by a drug overdose but drugs and/or alcohol were listed in the Defense Casualty Information Processing System. The cause of death for most of these cases was 'natural' and alcohol-related (38 cases).

2. *How many active duty service members are testing positive in urinalysis testing?*

The overall active duty drug positive rate was 0.79 percent in FY 2021, which is the last fiscal year that data are currently available.

- i. *What substances appear frequently in urinalysis testing?*
 - a. Marijuana (delta-9-THC) was the most prevalent drug for active duty Service members, accounting for 73.4 percent of all unique³¹ drug positive active duty Service members in FY 2021.
 - b. Delta-8-THC, a synthetically derived tetrahydrocannabinol had the second highest drug positive rate accounting for 42.7 percent of all unique active duty drug positive results in FY 2021.³²
 - c. Cocaine accounted for 14.4 percent of all unique active duty drug positive Service members in FY 2021 and was the third most prevalent drug among active duty Service members.
 - d. Fentanyl and its primary metabolite, norfentanyl, had a combined drug positive rate of 2.5 percent for all unique active duty drug positive Service members in FY 2021.

³⁰ Age information was obtained from the Defense Enrollment Eligibility Reporting System.

³¹The term "unique" denotes that multiple collections on the same Service member are counted only once.

³² Most of the delta-8-THC positives also contain delta-9-THC. This is due to delta-9-THC contamination during the production process of delta-8-THC products.

- e. Over fiscal years, FY 2016-2021, prescription opioid drug positive rates have declined a total of 75 percent for active duty Service members.³³
- ii. *Did any service members have a positive urinalysis test prior to overdose? If so, how many since January 1, 2017?*

Of the 332 fatal overdoses from 2017-2021, 23 Service members (9.9 percent) had a positive drug test prior to overdosing. For six Service members, one or more drugs detected at the time of urinalysis testing were also detected postmortem.³⁴ The average number of days between drug test and fatal overdose was 50, which indicates most of these Service members were repeat users.

- iii. *What steps is DoD taking to respond to positive tests?*
 - a. Service initiatives: Department of Defense Instruction (DoDI) 1010.16, "Technical Procedures for the Military Personnel Drug Abuse Testing Program (MPDATP)," delegates to the Military Departments the proper procedures for the collection, handling, and testing of Service member specimens for drug testing, in addition to tracking trends and adjudicating positive results. All Service members are subjected to random tests throughout the year, providing commanding officers the ability to identify military personnel who are misusing or abusing drugs and to process those individuals for separation, thus ensuring unit integrity and mission readiness. The Drug Demand Reduction Program (DDRP) stresses "SMART" testing, which includes random testing conducted in a manner that it is unpredictable by the testing population. Random frequency (how often the commander tests) and periodicity (when during the month/week/day the commander test) enable early identification of Service members who may be misusing substances, so that they can be evaluated for appropriate services. The medical review process ensures that no adverse disciplinary action will be administered to those who possess a valid medical prescription for the drug for which the Service member tested positive. To assist in the commander's prevention efforts, a Drug Demand Reduction Coordinator (DDRC) is available at each major installation to provide education and awareness on the use and abuse of illicit drugs, synthetic drugs, and misuse and abuse of prescription drugs. The DDRC accomplishes this mission by providing proactive information for the prevention of substance abuse, conducting outreach to the community to increase substance abuse awareness, and other activities designed to reduce the demand for illicit and synthetic drugs and misuse and abuse of prescription drugs. The DDRP monitors trends for new and emerging drug threats and modifies the drug testing panel as needed. For example, fentanyl was added in 2019 to address the opioid prescription crisis, and in 2020 LSD became part of the panel after prevalence testing determined increased numbers of Service member specimens contained LSD.

³³ This includes codeine, morphine, oxycodone, oxymorphone, hydrocodone, and hydromorphone.

³⁴ Two additional Service members had 'mixed drug' as the cause of death with no drugs or drug classes specified; therefore, it is unclear if the same drug(s) found during drug testing were also the cause of the overdose.

- b. In addition to Service-level drug use prevention, outreach and education initiatives, the DoD has the Too Much to Lose Campaign (<https://www.toomuchtolose.org/>), which is an educational campaign, aligned to DHA, for the U.S. military. The mission of the campaign is to inform Service members on the facts and risks related to prescription drug misuse and illicit and prohibited drug use. Additionally, DoD's Operation Supplement Safety (OPSS) mission is to provide the best evidence-based information about dietary supplements to Service members, their families, healthcare providers, and leaders (<https://www.opss.org/>). Service members are prohibited from using the certain substances as ingredients in dietary supplements.³⁵ OPSS has the dual goal of promoting anti-drug messaging while ensuring that Service members do not take supplements containing controlled substances and drugs (prescription, over-the-counter, and unapproved), which are prohibited for use in dietary supplements.

3. *What protocol is in place to identify and respond to an uptick in overdoses either generally or at a specific military installation?*

The Department has comprehensive, evidence-based strategies to address and prevent drug misuse and overdose utilizing a combination of prevention, effective treatment, and harm reduction programs. Highlights of these initiatives include:

- i. Prevention programs: The Services conduct randomized drug testing for more than 30 drugs of abuse, including fentanyl with a "zero tolerance policy" combined with education programs with the dual goal of decreasing use of illicit drugs. Awareness and prevention training is customized to educate the military community about local and national trends, recognizing signs and symptoms of substance misuse, available community resources, and the proper use and disposal of prescription drugs. The Department's integrated prevention strategy identifies addressing substance misuse as an essential element in reducing harmful behaviors such as self or other-directed harm, with a focus on outreach, local policy, early intervention, and implementation of research-based prevention resources.
- ii. Treatment programs: The Military Services offer substance use disorder clinical care programs for the assessment, outpatient education, prevention, and treatment of Service members who experience substance use problems. Service members with substance problems are encouraged to seek treatment without fear of reprisal. Service members are encouraged to refer themselves or be referred for evaluation and treatment services. In general, command notification is not required for Service members who self-refer for substance use disorder (SUD); however, after a positive drug test, it is required that the command refer the Service member for treatment services. Physicians within the DoD are educated on the best treatment for substance use disorders and alternatives to the use of divertible opioid or benzodiazepine medication for the treatment of pain or psychiatric disorders. Medical providers receive annual education on current trends and practices in the identification,

³⁵ DoDI 6130.06, "Use of Dietary Supplements in the DoD," establishes the OPSS program and the DoD prohibited list

assessment, and referral of personnel at risk for substance use related problems, including the interpretation and use of the alcohol screening instrument Alcohol Use Disorders Identification Test, Alcohol Consumption Questions. Prescription and patient monitoring measures are in place to identify at risk patients and high-volume providers.

- iii. Harm reduction programs: Since 2017, over DoD-affiliated 500 physicians completed the required Drug Enforcement Agency certification to prescribe buprenorphine, an FDA-approved medication-assisted treatment for opiate use disorder. The Department provides high-risk patients with naloxone, a non-addictive, life-saving drug that can reverse the effects of an opioid overdose. Additionally, liaison programs with the Department of Veterans Affairs (VA) system support transitioning active duty patients with substance use disorders to qualified VA providers following end of service.

4. *What is DoD doing to improve identification and early treatment of SUD among active military members?*

DoDI 1010.04, "Problematic Substance Use by DoD Personnel," is the overarching instruction for the DoD and establishes policy for substance use education and awareness activities to provide information intended to prevent or reduce problematic substance use. Targeted education and awareness activities are offered to DoD personnel who have been identified as using substances problematically, but who do not meet the criteria for having a SUD, with information intended to reduce problematic substance use. Community Prevention Programs are education and awareness activities, which encourage early identification of personnel engaged in problematic substance use through comprehensive prevention strategies and education. These programs enable personnel who have used substances problematically, but do not meet the diagnostic criteria for having an SUD, to receive education from local medical personnel.

In accordance with DoDI 1010.04, the Military Departments analyze data to permit internal assessment and review of the prevalence and incidence of SUD, number of personnel receiving treatment, and substance use trends. The DoDI delegates to the Military Departments the responsibilities of establishing and enforcing policies by or under the authority of the instruction, and implement and regularly evaluate any programs established under the instruction. For example, the Army's Soldiers to Substance Use Disorder Clinical Care (SUDCC) program offers, assessment, outpatient education, prevention, and treatment for Soldiers who experience substance use problems. Soldiers experiencing occupational, readiness, or safety impairment, with a diagnosis of SUD, and those with a positive drug test are formally enrolled with command involvement, deployment restrictions, and mandatory completion standards formally outlined in a treatment plan. SUDCC programs are collocated with Behavioral Health at each installation. Navy Medicine executes an evidence-based, standardized substance misuse curriculum called "Prime for Life," used for education and prevention, or early and pre-treatment. This reduces stigma through non-judgmental engagement and focuses on reducing controllable risk factors for substance misuse. "Prime for Life" is delivered at both the military medical treatment facility (MTF) and limited

operational settings. Additionally, the Navy relies on its Substance Abuse Rehabilitation Program Centers to provide early intervention to combat substance use disorders. The Air Force's Alcohol and Drug Abuse Treatment (ADAPT) program helps Airmen and their families with substance abuse-related issues. The ADAPT program promotes readiness, health, and wellness through the prevention and treatment of substance misuse and abuse, minimizes the negative consequences of substance misuse and abuse to the individual, family, and organization, and provides comprehensive education and treatment to individuals who experience problems attributed to substance misuse or abuse. After being diagnosed with a substance abuse disorder, Airmen are placed in the appropriate level of care through a multi-disciplinary, team approach.

5. *What research has DoD conducted or will conduct regarding the accessibility of treatment, including Medication Assisted Treatment (MAT), for active duty service members?*

DHA established procedures for administering and monitoring medication assisted therapy (MAT), which are predominantly provided through DHA-Procedural Instruction 6025.04, "Pain Management and Opioid Safety in the Military Health System." DHA provides training for designated health care providers in use MAT that complies with Federal, State, and local laws. Prescribing providers who treat patients with opioid use disorder must be trained, possess the necessary Drug Enforcement Administration waiver, and privileged to prescribe these medications as required by law. The DHA Pharmacy Operations Division enables MAT and opioid antagonist reversal capabilities (e.g., naloxone³⁶) at MTFs, and MTF providers and pharmacies promote the availability of MAT as clinically appropriate.

i. *Is treatment equally accessible at all military installations?*

MAT treatment is available either directly from the MTF, through direct care system referral, or through the private sector care network to all MTF patients with an opioid use disorder. Additionally, naloxone or other FDA and enterprise-approved opioid antagonists are available to outpatients considered at risk for opioid overdose.

ii. *Are all treatment options available to all active duty service members?*

Yes, all installation MTFs make MAT available to patients either directly, through direct care referral, or through referral to the purchased care network.

iii. *What accommodations is DoD providing to service members who are seeking treatment?*

The DoD follows Health Insurance Portability and Accountability Act Privacy Rules regarding the privacy of protected health information of Service members, which includes SUD care and treatment. Commanders receive annual training on the identification, management, and treatment of personnel with a SUD. Treatment services range from inpatient to outpatient. The treatment choice setting is based on a combination of clinical guidelines, the individual's ability to cooperate and

³⁶ Naloxone is an FDA approved drug used when a person's breathing has slowed or stopped because of an opioid overdose.

identifying the least restrictive environment with the goal of restoring physical, social, psychological, familial, and employment health free from the harmful effects of SUD. This supports the larger mission of maintaining force health and readiness within the Military Services. The DoD treats each Service member on a case-by-case basis depending on the circumstances and treatment plan to ensure Service members are properly accommodated.

- iv. *What, if any, actual or perceived stigma exists for service members obtaining treatment for SUD?*

The stigma surrounding treatment for SUD and mental health in general continues to be a challenge for both the military population. The DoD aims to dispel the stigma of seeking services for concerns related to problematic substance use by implementing notification practices that are consistent with DoDI 6490.08, "Command Notification to Dispel Stigma," including the limitations on the amount of information provided to leadership when command notification is appropriate. Further, the DoD promotes embedded mental health and integrated primary care mental health programs, which address stigma associated with mental health treatment by increasing immediate access and improving mental health literacy. These programs place mental health resources near Service members, reducing barriers to accessing care.

- 6. *What is the protocol for informing family in the event of an overdose, including non-fatal overdoses?*

- i. *What supports is DoD providing to families after a fatal overdose?*

Each Military Department has policies and procedures for notification and familial support. In general, each Service has a casualty notification process for the death of any Service member. In the event of serious injury, illness, or death, the primary Next of Kin (NoK) listed on the Service member's DD Form 93 is notified. All notified families will have ready access to information, as it becomes available in the investigation surrounding the death, to include fatal overdoses. If the Primary NoK is in the area, immediately after notification it is the standard practice to have a support element present (chaplain, friends, family) to help the survivors as required. The unit remains engaged to help the family as much and as long as the family needs them. An investigating officer is usually appointed to investigate all Service member deaths following Service-specific guidelines. This is another source of information that may provide some details that can later be shared with the family. There are also Survivor Outreach Services located on military installations prepared to assist in such cases.

- 7. *Please provide any other information that may be relevant or helpful in understanding and addressing this problem.*

The Department continues to evaluate, refine, and improve strategies for overdose prevention to ensure we are making every effort to prevent these tragic deaths. Current efforts are focused on integrating all drug related data, including fatal and non-fatal drug overdoses, to ensure timely data monitoring and improve coordination, messaging, treatment intervention, and promote readiness at the DoD, installation, and command levels.