

Prescription Pain Medication Use: An Army Readiness and Leadership Challenge

by

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Abstract

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The Army has experienced a dramatic increase in opioid use, misuse, and addiction since 2001, with nearly 14% of soldiers prescribed opioid pain medication as of 2010. These levels adversely impact force readiness, Army death rates, and overall soldier health. The Army response has been uncoordinated, with the medical branch framing widespread opioid use as a medical issue, Army leadership deeming it the result of risk taking soldiers and poor leadership, and the legal branch addressing it as a disciplinary issue. Opioid use is a new threat environment created by changing medical views on pain treatment, unique wartime drivers that render soldiers particularly susceptible to opioid abuse, and military culture. The Army must review this issue anew to develop an effective response. Army policies, using Vietnam era drug enforcement methods, are failing to mitigate the problem. Preventative policies such as medical monitoring of soldiers prescribed opioids, opioid risk training, and removing stigma for those seeking opioid abuse help are needed to reverse the problem. Erroneously framing the threat as primarily a disciplinary issue is perpetuating misuse and harming soldiers, force readiness, and civilian communities.

Prescription Pain Medication Use: An Army Readiness and Leadership Challenge

There is always an easy solution to every human problem--neat, plausible, and wrong.

—H. L. Mencken¹

The Opioid Pain Medication Environment

The Army's medical response to soldiers' pain has greatly changed during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF)/Operation New Dawn (OND).² Pain relief prescriptions written by military physicians quadrupled between 2001 and 2009 to almost 3.8 million.³ Army opioid pain prescriptions increased every year from 2001 to 2010.⁴ Prolonged use of opioid medications,⁵ while bringing pain relief, also comes with potential long term consequences to soldier health and welfare⁶ through opioid misuse, dependency, and addiction. During OEF and OIF, the Army has not modernized its personnel, disciplinary, or drug rehabilitation policies to respond to a new health and readiness environment formed by soldiers' widespread exposure to opioids through medical channels. This paper explores the impact on force readiness and soldiers' lives when legacy Army policies, designed to combat recreational drug use, are relied upon as the policy response to a complex and adaptive healthcare, social, and cultural challenge created by the era of opioid pain medication.

It is cliché to state that history repeats itself, and yet soldiers serving in OEF and OIF are reliving a healthcare challenge previously faced by Union soldiers in the American Civil War. Many Union soldiers experienced opiate addiction during and following the War Between the States, begun through opiate medication such as morphine and opium being administered by Army doctors for wartime wounds.⁷ The Civil War was the first conflict where opiate drugs became available as treatment tools

to United States (U.S.) battlefield doctors, before the drugs' long term addictive properties were realized.⁸ Union soldiers were first given opiate medications for physical wounds, and then as the psychological trauma of emerging modern warfare appeared in the form of flashbacks, nightmares, and hypervigilance (or "hysteria" as it was called in the nineteenth century) these same soldiers were dosed again with opiates to calm those conditions.⁹

Recent historical research of Civil War era medical records reveals a connection between Post Traumatic Stress Disorder (PTSD), or "soldier's heart" as it was known then, and opiate consumption.¹⁰ Psychologically traumatized soldiers were hospitalized in asylums and long term soldiers' homes, where opiates were an ongoing treatment to calm their agitated psychological state. Opiate dependency and addiction followed from chronic use, and most soldiers who entered these institutions never left them, nor overcame their dependency and addiction, until they died, in some cases decades later.¹¹

Physicians in the nineteenth century believed that by prescribing opiates over lengthy periods of time, they were helping soldiers with pain and psychological conditions of no known cure. Although well intended, and operating under the best medical knowledge known at the time, physicians were in fact turning soldiers and veterans into lifelong opiate addicts. The prevalence of opiate addiction amongst Civil War veterans was so widespread that after the war it became known as "soldier's disease" by the public.¹²

Opioid pain medications today are the synthetic pharmacological descendants of opiates and are again being widely prescribed by Army medical providers. It is often to

help soldiers deal with the immediate severe pain of wounds and acute injuries.

However, opioids are also being increasingly prescribed for chronic pain for noncombat injuries that are milder in nature.¹³ Chronic pain, in medical parlance, is pain that continues beyond twelve weeks, and may not have a medical cure.¹⁴ Examples of chronic pain are arthritis and certain back injuries, where pain can be managed, but not cured. In contrast, acute pain is typically less than twelve weeks in duration and often has a sudden onset, thereby warning the body of injury that often heals through the body's normal recuperative processes.¹⁵

In the 1990s there was a growing school of thought among many doctors that the treatment of pain was not just for patient comfort, but was a necessary part of injury recovery and overall health.¹⁶ This led to an increasing use of opioid pain medication by the profession, where it had formerly been reserved for cancer patients and those recovering from surgery.¹⁷ Today, Americans constitute 4.6% of the world's population, but consume 80% of the global opioid supply and 99% of the global hydrocodone supply.¹⁸ We have become the world's pain pill consumer. This expanded use of opioid medicines has also led to more opioid-related problems across civilian and military society.

In the early 1980s opioids began to be used in the treatment of nonmalignant chronic pain, not just cancer pain. By the 2000s, increased prescribing, the availability of new opioids, and the failure to teach about chronic pain and addiction, along with a zeal to do good, created a backdrop for the growing problem of prescription drug abuse.¹⁹

Today, research from physicians, psychologists, and social workers is raising questions about the long term negative impact of broadening the application of opioids in pain management. The experiences of OEF/OIF soldiers and their Civil War brethren are distinct in many respects. But in both instances there are uncomfortable parallels of

good intentions that result in bad long term medical and life outcomes for soldiers, with large numbers of veterans returning home dependent or addicted to opioid medications provided to them through the Army medical system. The Army cited figures in 2012 indicating that 25-35% of soldiers prescribed a prescription opioid were determined to meet Diagnostic and Statistical Manual of Mental Disorders, 4th Edition criteria for substance dependence while awaiting medical discharge.²⁰

The Scope of the Opioid Pain Medication Issue

Opioid prescription pain medication presents a new environmental threat to Army readiness. The change in pain treatment philosophy that began in civilian society in the 1980s and 1990s took root in Army medicine leading up to the OEF and OIF deployments. From 2001 to 2010 this reliance on opioids as a primary pain management tool by Army physicians impacted a large percentage of the Army's force pool, with the number of opioid prescriptions increasing annually.

In a recent [2010] briefing, the Army Surgeon General estimated that almost 14% (76,463) of the force were prescribed some form of an opiate drug. Of those, 95% (72,764) were taking oxycodone. In addition, almost 34% (25,761) had two or more active prescriptions. The number of prescriptions per year in the Army has increased. This means, the number of pharmaceutical drugs in the force has gone up (by an unknown amount) because there is no expiration for some prescriptions.²¹ (emphasis added)

As of 2010, this was a problem spiraling out of control for the Army, with nearly one in every seven soldiers prescribed opioids, and one third of those same soldiers issued multiple pain prescriptions. This expanded prescription pattern occurred in a wartime environment, with no mandated medical monitoring by Army physicians of soldiers prescribed opioid pain medication to reduce the risk of dependency and addiction. It occurred in a forward deployed Army with frequent combat rotations where there existed no formal training for commanders and soldiers on the dangers of these

prescription medicines. In short, the risk created by high rates of opioid prescriptions was not counterbalanced by plans of an equal scale to manage and mitigate the risk of misuse, dependency, and addiction.

The Nature of Injuries During OEF/OIF Contributed to Expanded Opioid Use

A major contributing factor to the growth in opioid prescriptions beginning in 2001 was the increase in the nature and severity of injuries to soldiers in combat. Not only were the injuries survived severe in nature, but treating them with pain medication was further complicated by co-occurring psychological trauma. The combination of severe physical and psychological trauma heightened the potential for opioid misuse, dependence or addiction.

The highest risk patients for unsafe behaviors have a “trio diagnosis” of psychiatric disease, substance abuse, and pain. These factors are interrelated and mutually reinforcing. This often describes many of our Soldiers returning from Iraq and Afghanistan. In some studies, the prevalence of comorbid PTSD, TBI [Traumatic Brain Injury] and pain exceeds 40% in the VA (Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, 2010).²²

The pain treatment environment changed during OEF and OIF due to the number of soldiers surviving wounds that would have proven fatal in previous wars. Due to advances in military medicine and rapid evacuation from the battlefield, more soldiers survived catastrophic wounds, such as traumatic amputations and severe burns. The 10% death rate for serious wounds in OIF/OEF is the lowest in U.S. military history, a remarkable achievement for military medicine.²³ However, the secondary consequence of more soldiers surviving these wounds is that more soldiers survived to experience chronic severe pain from their wounds. The challenge for Army physicians was how to reduce the suffering of these patients and opioids provided a readily available answer.

In addition to wounds, during OIF and OEF there has been an increase in muscular-skeletal injuries of an orthopedic nature, resulting in part from the increased equipment load soldiers are bearing on their bodies for lengthy periods.²⁴ Over 52% of soldiers evacuated between 2001 and 2010 from the Iraq and Afghanistan theaters were for musculoskeletal disorders, primarily for back and knee non-battle sprains and fractures.²⁵

A Walter Reed Research Institute study found in surveying a U.S. infantry brigade redeploying from Afghanistan in 2011 that half of the unit's soldiers reported still experiencing chronic pain ninety days after redeployment.²⁶ The Army medical community's movement toward increased use of opioids to manage pain occurred at a juncture in the Army's operational history where both the severity and the frequency of soldier injuries were at their zenith. This was a perfect marriage of maladies and available pain treatment modalities, which combined to create the annual increases in opioid prescription levels from 2001 to 2010.

Opioid Prescription Rates Have Degraded Army Readiness

The level of opioid pain medicine use in the Army is higher than that of civilian society.²⁷ This was also reflected in the same Walter Reed Research Institute survey, which found that 15.1% of the brigade's soldiers in 2011 were taking prescribed opioid pain medications ninety days after redeployment.²⁸ This level of opioid usage was considered high by the medical researchers for two reasons. First, 44% of the soldiers in the study reported pain lasting longer than three months, which is the threshold for "chronic pain."²⁹ Opioids are often not appropriate treatment for chronic pain due to their addictive nature and other possible negative medical complications.³⁰ One such complication can be for soldiers to develop a greater sensitivity to pain. The level of

opioid usage in this brigade was also deemed high because, “[o]f those who said they used opioids in the previous month, 38.5% reported experiencing mild pain and 5.6% said they experienced an average of no pain in the previous month.³¹ The Department of Defense (DoD) and VA [Veterans Administration] guidelines recommend opioids only for moderate to severe pain.”³² Accordingly, opioids were being prescribed to a large percentage of the unit’s soldiers whose conditions did not apparently warrant opioid intervention under accepted military medical guidelines.

This disconnect between the number of opioid prescriptions, as compared to soldiers with qualifying pain levels, raises a fairly fundamental question. Why did 44.1% of the soldiers who were prescribed opioids receive them when they did not have the qualifying moderate to severe pain? This result suggests opioids were not being prescribed and used in the Army in 2011 simply for moderate to severe pain, but were also being issued to troops for chronic, nagging pain of a much less severe nature.

This Walter Reed study should be of concern to Army leaders and planners for four reasons. The 15.1% receiving opioid prescriptions works out to roughly one in every seven soldiers in a combat arms unit being on opioids, with the high secondary risks that come with these medications.

[O]pioids can produce significant side effects, including constipation, nausea, mental clouding, and respiratory depression, which can sometimes lead to death. In addition, long-term opioid use can also result in physical dependence, making it difficult to discontinue use even when the original cause of pain is no longer present. Furthermore, there is mounting evidence that long-term opioid use for pain can actually produce a chronic pain state, whereby patients find themselves in a vicious cycle, where opioids are used to treat pain caused by previous opioid use.³³

This level of opioid medicines being dispensed to soldiers without moderate to severe pain is a red flag for Army leadership concerned with projecting combat power and

making the most of fewer personnel resources in an era of defense fiscal cuts. When fewer spaces for personnel exist, the Army needs the most combat ready forces in those remaining slots, without unnecessary medical, and potentially legal complications. Where medical necessity mandates the use of opioids for treatment, this is a medical judgment issue. Where medical necessity does not mandate the use of opioids but they are dispensed anyway, this is an Army leadership and readiness issue.

Second, the prevalence of these medicines in the barracks for non-serious injuries and pain risks sending an unintended message to a generation of soldiers that the Army is a pain pill culture, where opioid pain medication is little more than ramped-up ibuprofen, rather than highly addictive and dangerous controlled substances. It is human nature that the widespread availability of a substance breeds a sense of familiarity and lowers inhibitions that it may be dangerous. The widely available quantities of these drugs, combined with the lack of a high profile Army information and training campaign regarding opioid medication dangers may be contributing to the unauthorized sharing of opioid medications among soldiers.

Third, the fact that the study indicates so many soldiers received opioid pain medication with less than moderate to severe pain symptoms warrants scrutiny across the force as to how the Army is training soldiers and physicians to think about and respond to pain. Addictive pain medication is not the only path to managing pain. This is an education, training and messaging challenge that is not being adequately addressed, with the consequences resulting in heightened opioid use in the force. Opioids are not the only way to address pain and the Surgeon General's office has adopted a Comprehensive Pain Management Plan to widen the use of alternative pain

management treatments and techniques. Awareness of this plan, however, is very low within the general Army force, while opioid prescription rates remain extremely high.

Fourth, the timing of when so many soldiers were being placed on opioid pain medication is a concern. When a unit redeploys from a lengthy combat rotation it often loses many of its soldiers to transfers and the termination of soldiers' service obligations. As is discussed in more detail below, there are serious healthcare and adverse social consequences to soldiers not being medically monitored while prescribed potentially addictive opioids. By placing large numbers of redeploying soldiers on opioids at the very time when many of them will disperse to the civilian world, or to new duty stations, the risk factors for opioid misuse, dependence, and addiction are heightened. Lack of continuity of care and redeployment stress are two drivers recognized to contribute to opioid misuse.³⁴ Putting soldiers on opioids at the very juncture when many of them will disperse, medical oversight will be minimized, and redeployment stress maximized, is a likely driver to the high rates of opioid misuse being seen in OIF and OEF veterans. This timing issue for opioid prescriptions in terms of impacting adverse outcomes is an area worthy of additional study by military and civilian medical, public health, and social scientists.

The scope and seriousness of the Army's opioid problem can be put in context by comparing it to civilian society, which is often erroneously considered to have a more serious prescription drug problem than the military.³⁵ The Walter Reed Research Institute study noted that the incidence of chronic pain in the civilian population was 26%, as opposed to the infantry brigade's 44%, and that prescription opioid use in the civilian population is 4%, as opposed to 15.1% in the surveyed infantry brigade.³⁶ While

one might be tempted to think that the opioid use rate of this one unit is a short term aberration due to their recent return from a challenging deployment, the Army's Suicide Report for 2010 notes the Army Surgeon General reporting an opioid use rate across the entire Army force of nearly 14%.³⁷ Accordingly, the use rate in this one brigade is generally consistent with opioid use rates across the entire Army.

Former Army Surgeon General, Lieutenant General (LTG) Eric Schoomaker raised concerns in response to the Walter Reed Research Institute study, noting, "It is disturbing that the use of opioids for the management of acute pain, where they may be quite effective, is being continued to such a large degree to manage chronic pain where the evidence for their effectiveness is far less."³⁸ He also noted the potential threat to readiness.

While chronic pain and opioid use have been a long-standing concern of the military leadership, this study is among the first to quantify the impact of recent wars on the prevalence of pain and narcotic use among soldiers. The nation's defense rests on the comprehensive fitness of its service members—mind, body, and spirit. Chronic pain and use of opioids carry the risk of functional impairment of America's fighting force.³⁹

LTG Schoomaker sent an important warning to the Army leadership that its future readiness is at risk, and efforts to date have not been sufficient to reduce this threat. Thirteen years into this opioid crisis it is time to look for innovative solutions to preserve that readiness.

This is not a medical paper, but a discussion of the readiness impact of opioid use to the Army as a warfighting organization, and the adverse societal impact to soldiers. However, to understand why the consumption of opioids by soldiers and recent Army veterans is a matter of strategic importance for the Army, Army leaders need a foundational understanding of how opioid medication and its potential misuse is different

from other drugs, and must understand the language of the discussion, including the terms “opiate,” “opioid” “addiction,” and “dependency.”

Opiates are drugs made from the opium poppy. These include morphine, codeine, opium, and heroin.⁴⁰ *Opioid* is a term for a family of drugs that include opiates, but also includes synthetic pharmaceuticals of similar chemical composition that act upon the body’s central nervous system in the same manner as opiates. Examples of synthetic opioids include Percocet, OxyContin, hydrocodone (Vicodin), methadone, and fentanyl, among others.⁴¹ Opioids attach to receptors in the central nervous system that block pain, and produce feelings of euphoria and well-being instead.⁴²

The body naturally produces its own opioids, called endorphins, which activate the central nervous system’s opioid receptors and create feelings of well-being. Examples of endorphins in action are contentment after a good meal, or sexual satisfaction. Opioids from outside the body mimic the feelings of endorphins but are much more powerful and cause intense euphoria while blocking pain.⁴³ With these performance characteristics, one does not have to be a physician to recognize the potential for prescription misuse by soldiers suffering not only physical wounds of war, but also the psychological distress of PTSD and other wartime mental stress. A pill removes their pain, anxiety, guilt, and hypervigilance to imagined threats, leaving them feeling wonderful instead.

Addiction is not merely a matter of wanting to feel good, however. When opioids are taken over time, physical and chemical changes occur in the brain.⁴⁴ These physical changes become visible to the eye on medical imaging devices.⁴⁵ The brain physically alters itself to accommodate the extra opioids, and if they are not available, intensely

unpleasant withdrawal symptoms occur as the brain's chemistry becomes unbalanced. With daily use of opioids, these changes to brain structure can begin within some people within two weeks, although two to six weeks is normal.⁴⁶

Opioids increase the hormonal neurotransmitter called dopamine, which triggers the pleasure centers in the brain. This response can stimulate pleasure more intensely than consuming food or water, or sexual activity, concerning which dopamine generates physical "rewards" to keep the species alive and reproducing.⁴⁷ Accordingly, addiction is a psychological as well as physical condition. It is an obsession and craving for the drug, combined with a physical longing, to achieve the intense physical reward. Susceptibility to addiction can be influenced by social background, genetics, personality, and the availability of the drug.⁴⁸

Opioids and Soldier Risk Factors

Soldiers have several unique risk factors that make them particularly susceptible to opioid misuse and addiction. First, there is widespread availability of opioid drugs in the Army through medical channels. This widespread availability has not yet been balanced with mandatory medical monitoring to reduce the likelihood of misuse, dependency or addiction. Medical guidelines encouraging monitoring exist, but have challenges in real world application with a forward deployed Army engaged in ongoing combat operations.⁴⁹

Personality plays a role in addiction, with, "More cautious people, who like to avoid danger, hav[ing] a lower risk of addiction."⁵⁰ The fundamental soldier job description as a warrior largely results in that cautious segment of society self-selecting out of the all-volunteer force. One's life experiences can influence the risk of addiction. "People who experience traumatic events are more likely to develop an addiction than

those who have not experienced such events."⁵¹ It can be safely asserted that war is near the top of traumatic events a person may experience in their lifetime. Related to the preceding, those with psychiatric disorders, such as PTSD, have an additionally heightened risk of opioid addiction.⁵² The Veterans Administration estimates 10-18% of returning OEF and OIF veterans have combat related PTSD.⁵³

Finally, youth is a factor, with males under the age of 24 being more susceptible due to ongoing maturation and brain development until that age, which limits their ability to make wise decisions regarding regulating medicine use.⁵⁴ With military service beginning at age 18, and many soldiers completing service between ages 18-24, this is also a heightened risk factor for a majority of the soldier population.

While these are only some of the factors influencing the likelihood of addiction, they are significant in that these are shared traits of most returning OEF and OIF veterans. As such, while one might anecdotally expect that soldiers would be at less risk of addiction due to personal self-discipline, strict military discipline, and a general military culture molding soldiers to follow the rules, many risk factors for opioid addiction are actually heightened amongst this population--particularly when their initial opioid use is not coming from an illicit source, but rather from a trusted authority figure in the person of a military healthcare provider.

The sheer number of opioid prescriptions in the Army is itself a risk driver. Those who have an opioid prescription are three times as likely to engage in opioid misuse as those who do not.⁵⁵ Accordingly, with military opioid pain prescriptions quadrupling between 2001 and 2009, the risk of misuse has likewise multiplied many times over. The ease and frequency of access by soldiers to opioid prescriptions since 2002 has

been recognized by medical researchers as directly contributing to the increased rate of opioid misuse and addiction.⁵⁶

The impact of widespread opioid pain prescriptions on prescription pain medicine misuse is reflected in Army drug abuse statistics, which show that soldiers generally have a lower rate of drug abuse than civilians (2.3% soldier misuse versus 12% civilian misuse) with other drugs.⁵⁷ However, soldiers far exceed civilians in the rate of prescription medicine misuse.⁵⁸ From 2002 to 2008, the number of soldiers misusing their prescription drugs grew from 2% to 11%.⁵⁹ The majority of the prescriptions misused were opioid pain medications.⁶⁰ Civilian misuse of prescription opioid drugs from 2002 to 2009-2010 increased from 2.2% to 3.8% of civilians. Civilian prescription misuse rates less than doubled. Military rates of prescription misuse for the same period grew fivefold. The disproportionate growth in opioid misuse by soldiers while military personnel remained generally compliant with other drugs should signal to senior Army leaders that they are dealing with a different challenge with opioids than they are from recreational drugs.

As opioid pain drugs bring a sense of calm, euphoria, and well-being, they are very attractive and susceptible to self-medication abuse by soldiers who suffer both physical pain and combat related psychological maladies. Studies indicate that those suffering from PTSD may have reduced endorphin production following traumatic events, which causes them to compensate with other pain numbing substances, such as alcohol or drugs.⁶¹ Accordingly, while PTSD does not cause drug abuse in a cause and effect sense, prescribing opioids to soldiers who are suffering PTSD must be closely monitored, because many will find the significant short term pain relief benefits

from opioids difficult to give up. Medical monitoring through urinalysis or other means has not been mandated by the Army to ensure that soldiers issued an opioid pain medicine prescription use it only as directed. Rather, medical monitoring is a guideline that Army physicians may employ or not, depending upon case and situational circumstances.⁶² The Surgeon General's office is currently considering an approach that may mandate medical monitoring of those prescribed opioids in the future.⁶³

The soldiers who have served during OIF and OEF are unique in Army history. They have fought in the nation's longest war, deployed more tours than any prior conflict, and experienced a dwell time with family at home station of less than 2 years for every one served overseas.⁶⁴ The reserve components have also been used at a rate and duration never before seen in the nation's history.⁶⁵ This is not a generation of soldiers who have elected to engage in recreational drug use for personal entertainment or out of a lack of good order and discipline. Many have returned from over thirteen years in combat hobbled by wounds, physical wear, and psychological trauma. As reflected in the Walter Reed Institute of Research study, many soldiers have been introduced to opioids through prescriptions for pain of a relatively low nature.⁶⁶ This is a medically vulnerable population that is being placed into a high risk environment due to the prevalence of opioid pain medication. This is not an undisciplined force.

Opioid Pain Medication and Reserve Readiness

The growing substance use disorder (SUD) trends among veterans who participated in OEF and OIF can be seen in the following Veterans Health Administration data compiled by researchers from the National Academy of Sciences.⁶⁷

Table 1. OEF/OIF/OND Veterans in the VA System Reporting Substance Abuse Issues⁶⁸

Component	2006	2007	2008	2009	2010
Active Duty	4,696	8,272	13,249	19,950	26,440
Guard/Reserve	4,423	6,594	9,576	12,860	16,058
Total	9,119	14,886	22,825	32,810	42,498

*Analysis includes the number of OEF/OIF/OND veterans who accessed the Veterans Health Administration (VHA) for an inpatient stay or outpatient encounter and had a primary or secondary SUD diagnosis. These figures include alcohol abuse and dependency, as well as abuse and dependency to drugs.

This annual growth in substance abuse issues among OEF and OIF veterans demonstrates that across the active and reserve components, the longer the Nation's wars continued, the more OEF and OIF/OND veterans were experiencing substance abuse issues. While the numbers reported are concerning, they do not tell the full story. These numbers omit the most vulnerable veterans--those with substance abuse issues who are so dysfunctional they have not yet reached out for help, and second, those who have sought help, but have been denied access to the VA health treatment system by virtue of receiving an Other than Honorable discharge from the military, which is grounds for disqualification from VA medical and rehabilitation benefits.⁶⁹ While this paper is focused upon the opioid issue, not all substance abuse, these figures are presented to show that the problem of substance abuse among former OEF and OIF personnel is not a static issue. It is a growing and multiplying threat to health that is increasing by the year.

As Table 1 indicates, substance abuse also exists on a large scale among the reserve component personnel who served in OEF, OIF and OND. In a 2006 survey of all reserve soldiers it was shown:

. . . that 6.6 percent of the Selected Reserves had engaged in illicit drug use (including prescription drug misuse) in the past 30 days and 12.0 percent in the last year. The past year estimate did not differ significantly from the past year rate of 10.9 percent for the active duty component from the 2005 HRB Survey.⁷⁰

These figures included, but were not limited to opioids. The data on reserve illicit opioid use has been inadequate to date, as reservists in the past have not been widely tested for opioids on random urinalysis, and as with their active duty brethren, they have not been subject to mandated medical monitoring.⁷¹ Accordingly, while it is known that reservists have opioid misuse issues, this lack of data is a blind spot for Army leaders in assessing Army reserve component readiness.

Army reservists are increasingly appearing as defendants in civilian criminal courts in the United States for misusing opioids that they began receiving while on active duty.⁷² However, this information is anecdotal and the full scope of the reserve opioid problem merits further empirical study by the Army. Researchers note that figures provided by military personnel in response to survey based research, such as the above 2006 reserve component survey should be viewed as conservative, i.e., the reality in terms of use rate may actually be higher, because due to the fear of discovery and prosecution there is an incentive for soldiers to under-report.⁷³

Social science and medical researchers are beginning to recognize that the combination of traumatic experiences during military service, coupled with the stressors of assimilating back into peacetime society can make soldiers and veterans particularly susceptible to opioid misuse.

The potential overdose risks that veterans face as they readjust to civilian life are often rooted in their military experiences and the associated mental health and pain management challenges. Many veterans endure traumatic events and injury resulting from combat and general military training activities. Physical pain due to injury can become chronic and impair all

domains of functioning involved in the civilian readjustment process (e.g., stable work and housing, sleep and mood, social isolation and homelessness, and health care and social service utilization). POs [Prescription Opioids] are often prescribed as primary pain management tools. However, the use of POs carries risks, especially if POs are misused. Such misuse or aberrant practices include unauthorized dose escalation, mixing of medications or use with alcohol, and snorting or injecting substances intended for oral ingestion. Some veterans who use POs and other drugs for pain management can escalate their use as they face general reintegration challenges including finding housing, employment, and connections within their home communities. While some veterans' drug and alcohol use is motivated by boredom, stress, or general recreation purposes, research is suggesting that it may also be rooted in aspects of military lifestyle and culture.⁷⁴

While the quoted researcher is discussing recent veterans, as opposed to active duty personnel, this information is still relevant to Army leaders examining readiness of the Army force. Many of these post-deployment readjustment stressors apply to active duty soldiers trying to return to family and a garrison environment. Second, all of these assimilation stressors apply to every U.S. Army Reserve and National Guard redeployment, whose personnel comprise over half of the Army's manpower pool.⁷⁵ Many U.S. Army Reserves and National Guard soldiers have deployed and redeployed to combat zones multiple times during the course of OEF and OIF, during which time they were medically treated under the same Army opioid prescription practices as their active duty counterparts.⁷⁶

The reserve component aspect to the opioid issue is one that must not be ignored in the discussion of overall Army readiness. The Army Surgeon General's office is considering for the first time implementing monitoring requirements for active duty forces prescribed opioids. The goals are to ensure compliance with prescription parameters, reduce opioid misuse, and promote soldier health.⁷⁷ These are important steps in beginning to rein in the Army's pain medication problem.

However, the Army has no policy for overall force tracking or individual medical monitoring of opioid usage by reserve personnel. It has no tools or procedures to track when they are accessing opioids through civilian practitioners. Many reservists have their own health insurance through civilian employment and use civilian doctors for primary care. Accordingly, the Army has a blind spot on the level of prescribed opioid usage, soldier health impact, and corresponding readiness effect to its reserve force. Due to lack of metrics on this issue, combined with healthcare privacy laws, reserve commanders have no way of evaluating to what extent their units' readiness might be compromised by widespread opioid prescriptions. To develop a comprehensive Army plan to mitigate the detrimental impact of opioids on readiness, it will be necessary to include the entire force structure in the solution, not merely the active component. Otherwise any planned response will be addressing only a portion of the threat, while leaving the potential adverse consequences to 53% of the total Army force pool unknown.

Opioid drugs are highly addictive.⁷⁸ They are also highly effective at controlling pain.⁷⁹ It is for medical professionals and pain management specialists to determine the best pain treatment for individual soldiers with moderate to severe pain.⁸⁰ Unlike at the time of the Civil War, however, there are now many pain relief options beyond opioid pain medications for those with chronic pain, including acupuncture, yoga, exercise, behavior modification, biofeedback, and electrotherapy.⁸¹ The Medical Corps has begun to explore and implement these alternatives, developing specialty pain treatment centers at its major medical centers for those on active duty. These initial plans are encouraging, but there is still a large body of soldiers in the active force and reserve

component who are still being prescribed opioids at a high rate, whose ongoing opioid use must be responsibly managed from a personnel, legal, and rehabilitation policy perspective.⁸²

The Social Impact of Opioid Medication on Soldiers

One environmental factor impacting the susceptibility of soldiers to opioid misuse and addiction is what soldiers call “the military mindset.” A soldier is trained to not admit weakness and to use personal drive and force of will to overcome obstacles. While those attributes are an asset to short term mission accomplishment, those same behavioral characteristics can lead to negative personal consequences when dealing with chronic pain and PTSD. The military mindset may cause a soldier to not admit to themselves that there is a physical problem, to avoid behavioral health medical care out of embarrassment or fear of career consequences, and to turn to self-help medication instead.⁸³ This can take the form of borrowing a pain pill from a battle buddy, or it can be the use of alcohol or other controlled substances to suppress the symptoms of PTSD.

The belief that personal force of will can overcome medical and psychological issues can lead soldiers to social isolation from family and friends, and lead to other unhealthy behaviors.⁸⁴ It is a self-destructive path that can lead a veteran who served his nation with distinction to buy the opioid heroin on a street corner post-discharge, because his physical pain and anxiety issues are overwhelming him after his prescription medication runs out.

Among military personnel returning from Iraq and Afghanistan stigma was the most frequently cited reason for not seeking treatment for combat-related mental health conditions, including substance use . . . Self stigma was particularly poignant; it is difficult for military personnel to identify themselves as being in need.⁸⁵

This downward spiral into illegal street drugs from initial legal opioid prescriptions received in the Army is a familiar and tragic scenario that is playing out every day in the civilian criminal courts across this country for OEF and OIF veterans.⁸⁶

A course of opioid treatment that might not trouble one soldier may quickly lead another to addiction. One size does not fit all, and any Army policy response to manage addiction risk and rehabilitate soldiers in the face of widespread opioid prescription practices must be flexible enough to recognize that addiction is a medical condition that ensnares all types and levels of soldiers. It is not a matter of bad versus good soldiers.

A soldier whose body has chemically adapted to the regular use of opioid medication, needs the drug to feel “normal,” but who lacks the psychological obsession for the opioid is diagnosed as *dependent* on opioids, but not addicted. When that same person also develops an irresistible compulsion and obsession to have the drug, they are diagnosed as addicted.⁸⁷ These distinctions are important to drug treatment professionals, physicians, and policy makers because a dependent person can be gradually weaned off of an opioid pain medication with increasingly smaller doses. A person with an addiction cannot be weaned slowly and must stop abruptly, enduring extremely unpleasant physical symptoms that may include chills, vomiting, anxiety, cramps, and fever, among others.

The addicted soldier cannot be weaned slowly, because any use level at all perpetuates the current psychological obsession, and the attendant bad behaviors that often accompany addiction. The experience of opioid withdrawal has been described as “like having the flu . . . and then being run over by a tank.”⁸⁸ As such, the reluctance of those who are addicted to come forth voluntarily for treatment through withdrawal is

probably one of the few semi-rational acts of self-protection by an addict, even though it is contrary to what the Army desires. As discussed in more detail below, withholding rehabilitation as a reward to a select group under the Army Substance Abuse Program (ASAP), rather than treating rehabilitation as a medical remedy for all soldiers with substance use issues, also leads to a stigmatization within the Army that discourages self-reporting.

This paper references *misuse* of opioids as a term distinct from dependency and addiction. Dependency and addiction are medical conditions. Misuse is a legal construct where a soldier is using his prescription in a manner for which it was not intended by the physician, or allowed under the law, at the time the controlled substance opioid was prescribed. Examples can include taking too much of the prescribed drug, or using a pain pill prescribed for physical pain to calm one's anxiety from the ongoing life disruptions of PTSD. It can include saving leftover opioid medications and then taking them at a later date for different conditions than those for which they were originally prescribed. It can also include loaning pills to a battle buddy, and in the most extreme cases selling pills obtained under prescription for personal profit.

This latter case of illegal drug distribution for profit is an intentional crime and such conduct is appropriately subject to the full weight of prosecution under the Uniform Code of Military Justice. As employed in this paper, the term misuse will be not address this latter situation, as there is little doubt that the proper Army policy response is to prosecute drug dealers to preserve good order and discipline. Misuse as addressed herein will be confined to those situations where soldiers are misapplying opioids to their own injuries through inappropriate self-medication. This can occur before or after a

soldier is dependent or addicted to his/her opioid prescription. The problem of soldiers sharing medication downrange and in the barracks is a serious problem within the force. Overcoming this conduct is a matter of education and communication. Many soldiers likely do not understand that sharing an “extra” Percocet with a battle buddy who injures themselves is the same thing as illegal drug distribution.

Addiction controls a person. The opioid drug and its biological and psychological response can become so powerful for an addicted person that it drowns out otherwise normal thought processes, placing further consumption of the opioid above all else, including acts necessary for survival such as eating and drinking.⁸⁹ So while the Army expects a soldier to be focused upon duty, discipline, and mission accomplishment, once that soldier becomes addicted to an opioid pain medication, his priorities are elsewhere, focused on satisfying his addiction to the exclusion of all else. This is obviously not a satisfactory situation for Army readiness, nor for the soldier, who prior to being exposed to opioids, may have been a good duty performer.

The physically dependent (but not addicted) soldier may also be labelled a poor duty performer in the eyes of his chain of command, not necessarily due to psychological addiction, but because opioids can make him/her sedated, unfocused, and dizzy.⁹⁰ These are not the characteristics a commander wants in a troop standing guard in a combat zone, manning the turret gun, nor performing any other vital task. Yet with one in seven soldiers in recent years prescribed opioid pain medication, this is exactly the readiness challenge facing the Army.

Opioid dependency and addiction is back in soldiers' lives one hundred and fifty years after the Civil War. It is harming their health and destroying their careers. This

rebirth is a complex and nuanced story that defies easy solutions, and requires ongoing coordination among physicians, psychologists, drug rehabilitation experts, judge advocates, commanders, and soldiers to understand the environment, plan a coordinated response, and execute it with all stakeholders oriented in the same direction. It is not merely a disciplinary issue, nor solely a medical issue, although it has elements of both.

Civilian Society and the Pain Pill Culture

The military opioid problem has not occurred in isolation from civilian society. Beginning in the 1990s, OxyContin, a new and addictive opioid pain medication, was being presented to civilian doctors and patients as a non-addictive pain solution, until that manufacturer was indicted and fined by the federal government for misrepresenting the addictive qualities of the medication.⁹¹ Despite that misrepresentation, doctors and patients still flocked to the drug's promise of a pain-free existence. OxyContin continued to be marketed as a new breakthrough in pain management, with its sales by 2002 exceeding \$1 billion.⁹² By 2011 it was a \$3 billion part of an \$11 billion per year U.S. opioid pain industry.⁹³

To put these numbers in consumption terms, as of 2010 "254 million prescriptions for opioids were filled in the U.S. . . . Enough painkillers were prescribed to 'medicate every American adult around the clock for a month'".⁹⁴ While these drugs bring relief from pain, they also bring tragedy and high costs to civilian society. "Some 15,000 Americans died of opioid overdoses in 2008--triple the number for 1999, according to the new CDC findings. That's more than from heroin and cocaine combined. As Dr. Irfan Dhalla, a physician and drug-safety researcher, puts it, 'That's

four 9/11s a year.”⁹⁵ Civilian America is beset by its own opioid pain medication epidemic. It is simply small when compared to the proportionate problem in the Army.⁹⁶

There are significantly different viewpoints within the medical community about how to treat pain, and the appropriate scope of military opioid use. Dr. Wayne B. Jones, conducting pain research under a U.S. Army Medical Research and Materiel Command Award, published a paper in which he described this tension.

Chronic pain is a major problem and takes a terrible toll not only on individuals suffering from chronic pain but also on our healthcare system at large. Addressing it is the responsibility of us all, but we have fallen into a trap. The massive amount of money invested in research, advertising and delivery of drugs (\$30 billion in each activity), especially opioid medications, and other expensive practitioner-dependent interventions for the treatment of pain has overwhelmed our approach to this issue and obscured other less expensive and more sustainable treatments...⁹⁷

Neither the civilian world nor the military has been immune from a changing American culture where pain is viewed as something to be resolved quickly with a bottle of pills. The American attraction toward quick solutions has created a nation that consumes 80% of the planet’s opioids and 99% of its hydrocodone.⁹⁸

Army Institutional Challenges to an Effective Response

Opioid use is a unique and growing threat to readiness, requiring an innovative policy response. It is not just misuse that is undermining readiness, but the scope of legal use as well. General drug enforcement and screening policies have been ineffective to curb the scope of the misuse problem, as evidenced by the growth of prescription misuse among soldiers from 2% to 11% from 2002 to 2008.⁹⁹ This is because misuse is tied directly to the scope of the legal use. One feeds the other. The declining relevance of disciplinary measures in reducing prescription misuse is because the issue has been wrongly framed as a disciplinary issue, rather than as a complex

network of social, medical, organizational, and leadership issues.¹⁰⁰ The overwhelming majority of soldiers are not going down to the local club to buy opioids from a drug dealer--they are getting them at the post clinic from an authority figure with a license to issue them. The Army is in fact fueling its own problem. The growth in opioid misuse while other illicit drug use remains low, suggests that it is not mere “risk taking” behavior, lack of discipline, or poor leadership in garrison leading soldiers to misuse their opioid medication, but a complex combination of:¹⁰¹

- 1) Conflicting Army medical, personnel, and legal policies;
- 2) Operational circumstances, including new physical and psychological wounds resulting from recent historically long conflicts;
- 3) Evolving medical knowledge and prescription policies;
- 4) Heightened risk factors for soldier opioid misuse and addiction;
- 5) Army and soldier cultural resistance/stigmatization to admitting injury or the need for help; and,
- 6) The Army’s restrictive use of medical monitoring and drug rehabilitation for those prescribed opioids.¹⁰²

If the Army hopes to defeat this new challenge to readiness, it is going to have to leave its institutional comfort zone and study these issues anew. It will have to raise its level of analysis and critical thinking to understand a complex and adaptive environment, with co-occurring factors, and not rely upon previously espoused, easily digestible ideas regarding soldier risk-taking and lack of commander leadership.

Army Institutional Challenges to Developing an Innovative Opioid Policy

There are several institutional hurdles preventing the Army from developing a coordinated Army-wide strategy to combat the detrimental readiness impact caused by widespread opioid use. First, to date the Army’s responses have been stove-piped and

compartmentalized. The Medical Corps began OEF and OIF with a treatment philosophy that allowed large scale distributions of opioid pain medications to soldiers. Recently, through the impressive efforts of the Army Surgeon General's Pain Task Force, the medical branch is waking to the realization that a different path is needed--a path that reduces the reliance on opioids for pain management, and provides greater controls, improved monitoring, and rehabilitation opportunities for those receiving opioids.

The Army leadership has framed the opioid/prescription pain medicine issue through a nonmedical lens, as reflected in the Army's 2010 Suicide Prevention Report, concluding that soldier risk-taking behaviors, criminality, and poor leadership are at the core of the issue. The Judge Advocate General's (JAG) Corps has approached the response to opioid misuse as a prosecution and administrative discharge issue, as has been its paradigm for forty years. There is no overarching Army strategy. It is a matter of luck, timing, and duty location whether a soldier is treated as a patient or a felon if he overuses his opioid prescription. If prescription misuse is detected by his doctor, he may get revised medical treatment for the underlying physical and psychological factors that caused him to take too much medication, or to use it when not permitted. If his misuse is detected in a random unit urinalysis he faces prosecution or adverse separation, likely without comprehensive rehabilitation.

Unfortunately, luck, rather than planning, plays a significant role in what occurs to soldiers with opioid pain management as well. The military is a transient society with doctors and patients changing locations frequently. Pain management and addiction treatment are areas where continuity of care is indispensable to successful treatment.

Pain management is still a very new field of medicine, with widely divergent levels of expertise and medical philosophies across the Medical Corps. Soldiers changing station may find that a treatment option they had been receiving in one location is unavailable at their next duty station, or that a new physician does not believe in that particular form of treatment. This can lead to inconsistency in treatment, which heightens the chance for a bad medical and social outcome for the soldier.

To date, the Army has not mandated a system of medical monitoring for soldiers prescribed opioids. Such preventative monitoring can ensure that a soldier who is self-medicating the symptoms of his PTSD with pain medication intended solely for a physical injury is detected by a medical professional and corrective medical action taken so the soldier does not ruin his health and lose his career. Such medical monitoring is not a urinalysis conducted under the ASAP program, where the focus is on after the fact detection and discipline. This would be a preventative medicine for all soldiers issued opioids medicines as part of their course of treatment, designed to protect them from the high risk of dependency and addiction that comes with these medicines. It is a proactive and preventative approach to the issue, rather than a reactive and punitive focus.

Accurately tracking this issue in the Army is a major data gathering challenge. The Walter Reed Research Institute study was especially valuable because it caught the soldiers' treatment information fresh from redeployment. Had the researchers waited six months to do the study, many of the affected soldiers may have changed station or left the service, skewing the accuracy of the numbers. Gaining timely access to data is essential to understand the impact of opioid pain medication on readiness.

Examining long term outcomes of opioids on soldiers is difficult, because those who become debilitated by their dependence or addiction to opioids may leave the service through medical or misconduct discharge channels. When they do so, they disappear from the Army's medical system, and by their absence may create a false picture for the Army regarding the negative impact of opioid dependency and addiction in the ranks. Soldiers discharged with opioid dependency and addiction still have those afflictions--they just disappear from Army statistics.

Obtaining accurate data on opioid use and its impact on reserve soldiers has unique challenges. Many reservists have civilian physicians, who are unknown to the Army. In order to do meaningful analysis on this issue, the Army will have to develop systems and procedures that monitor and track the health of its entire force regarding opioid consumption, not just the active component.

The National Academy of Sciences published a report on Substance Abuse in the Military in 2013. The editors noted organizational hurdles in trying to gather military data.

There is no uniform DoD reporting system for monitoring the number of detected alcohol incidents or drug-positive events, the number of referrals for assessment or treatment, or the number enrolled in direct care treatment programs. In response to queries from the committee, each branch provided data using its own definitions, formats, and level of detail. In its site visits, the committee learned that program directors at installations can query their own systems, but do not have access to system-wide data for judging overall trends or monitoring the transfer of patients from one military installation to another.¹⁰³

This observation goes far to explain why the scope of the opioid problem has not been recognized by the Army leadership until recently, if the information has been compartmentalized at the local level. If the quality of data available to senior Army leaders mirrors the experience of the National Academy of Sciences, then there is need

for improvement in information gathering and accessibility, so that assessment and progress of opioid use on readiness and soldier welfare can be accurately captured in force-wide metrics.

At the end of the preceding quote there is a final observation that should not be overlooked. It notes a systemic problem in monitoring the transfer of patients from one military installation to another in terms of their substance use care. As previously noted, with the Army being an inherently transient society, a system must be developed that ensures soldiers with substance misuse issues are not lost in the medical bureaucracy as they transfer from post to post. Failing in this regard will certainly contribute to more soldiers suffering poor outcomes in their efforts to avoid and overcome substance use.

The Army doctors who have treated America's soldiers during OIF and OEF have accomplished medical miracles for injured soldiers under austere conditions. Discussing how opioid prescriptions contribute to opioid dependency and addiction is not a blame game. The U.S. Army has the greatest medical care of any fighting force in the world. But in making tough treatment decisions tradeoffs must sometimes occur. In trying to treat pain across a forward deployed Army at war for over a decade patterns of prescribing have developed that are having secondary adverse effects on readiness and long term soldier health. Before this problem can be corrected, the Army must soberly recognize that its own procedures and policies have unfortunately contributed to the problem. This has been recognized by medical experts.

The lower rates of drug use (excluding prescription drugs) among military personnel compared with civilians suggest either that military policies and practices deter drug use or that military personnel hold attitudes and values that discourage this behavior. However, the military is facing increasing challenges in managing drug abuse, as indicated by the apparent rise in prescription drug misuse. Given the military's stringent

policy prohibiting drug use and the strong deterrence of the urinalysis testing program, it appears likely that the difference in prevalence of drug use between military personnel and civilians is the result of military policies and practices.¹⁰⁴

To resolve this internal problem, the Army must get its medical, legal, rehabilitation and personnel policies in alignment to attain the desired end of a healthy and combat-ready force. Opioids have been a blessing and a curse. To keep the force strong, alternatives to opioids must be considered, and where opioids are the best choice, their social cost and risk must be recognized and managed by preventative strategies. To keep faith with those soldiers who have already been treated with opioids, solutions beyond merely discharging them as unfit for further service, without the benefits of drug rehabilitation, must also be considered. This is particularly true when the Army created the initial vulnerability to opioid dependency or addiction by issuing opioids to the soldier.

It is the nature of the opioid issue that it does not fit neatly into clean categories of good soldiers versus bad soldiers that allow easy policy choices, such as exist with recreational drug abuse. For every anecdote about a soldier who manipulated the system to get opioid drugs for recreational use, there is another of a hard working soldier who gets wounded and becomes addicted through no fault of his own. The institutional response to soldiers doing recreational drugs is an easy call for the Army. They are separated in most instances to preserve good order and discipline. Soldiers self-medicating, dependent on, or addicted to opioids after being prescribed opioids for bona fide injuries present a more complex issue.

There are also soldiers who are self-medicating contrary to their prescription's instructions that do not neatly fall into the dependent or addicted category. This includes those who save opioids they have remaining from a prior prescription in case they get

hurt again, rather than going back to the clinic. Some soldiers keep their additional opioid pills for deployment in case they are injured downrange, so they can stay in the fight and not leave their comrades. There are soldiers misusing these drugs as a crutch, like alcohol, to take the edge off of the symptoms of PTSD, so that they do not have to recognize in themselves that they may have a behavioral health issue. None of these actions are wise nor permissive uses of these drugs, but neither are they motivated by criminality. They are the symptoms of a force under stress. For policy responses by the Army to be effective in reducing these misuses of opioids, a broad messaging and education plan will be required that is as nuanced and multi-dimensional as the environment in which these misuses are occurring. It will have to provide the opportunity for comprehensive rehabilitation without stigma, and not merely as a short term response as the soldier is administratively separated.

Conflicting Organizational Views Hinder an Effective Army Response.

The adverse impact of opioids is generally recognized by senior Army leaders, but there are widely different views on the source of the problem. On 30 March 2010, the Office of the Surgeon General briefed the Vice Chief of Staff of the Army on the growing use of opioid pain medications within the force, at a time when oxycodone (Percocet) and hydrocodone (Vicodin) were the second and third most prescribed pain management medications in the Army.¹⁰⁵ That same year the Army published a Health Promotion, Risk Reduction, Suicide Prevention Report [hereinafter “Army Suicide Prevention Report”] forwarded by the Vice Chief in which the Army acknowledged a problem with widespread opioid use contributing to soldier fatalities. That report placed responsibility for the problem largely upon soldiers engaging in “risky behaviors” and a “permissive unit environment,” that did not vigorously separate such soldiers.¹⁰⁶ The

report did not reflect in any depth the environmental, medical or rehabilitation nuances of the issue, framing it almost exclusively as a disciplinary matter.

The Medical Corps, the JAG's Corps, active duty and reserve commanders, and drug treatment professionals all have a role when soldiers taking opioids are misusing their medicines, dependent or addicted. But these different leaders have different purposes in the system, many of which are in conflict with each other under current regulations and policies. The system works well when addressing traditional recreational drug abuse. It stutters and is inconsistent when responding to prescription opioid medicine misuse, dependency, and addiction. The health and career outcome for a soldier with a prescription opioid problem may well depend upon who discovers his problem first – his doctor, his commander, or the unit urinalysis. This leads to inconsistent outcomes, with many soldiers being separated for opioid misuse without being given access to comprehensive drug rehabilitation programs. In the realm of opioid use and misuse the old saying rings true--when everyone is in charge, no one is in charge, and divergent views and policy approaches to opioid dependency/addiction have led to an uncoordinated response across the Army.¹⁰⁷

Soldiers exist in a system that is philosophically reactive and punitive in focus when it comes to opioid misuse, as opposed to preventative and rehabilitative. This is contributing to the ongoing high rates of misuse in the Army. During OIF and OEF, the high operational pace and mobility of troops in and between two combat theaters, the current state of the law and technology limiting medical information sharing, and the changing legal and medical status of reservists as they entered and left active duty, all presented significant internal hurdles for the Army to monitor soldiers to reduce the risk

of them becoming dependent or addicted to their medications. The random unit urinalysis, with its direct chute to punitive consequences, was the only cog operating in the system to determine when a soldier was not using his medicine properly. This systemic structure drove resolutions for soldiers misusing their medication toward a disciplinary and discharge outcome, rather than toward a medical and rehabilitative outcome.

Accordingly, since 2001 the occurrence of drug related misconduct or a positive urinalysis is often the first tripwire that alerts the Army that a soldier has a dependency or addiction to opioids. With no medical preventative monitoring system to help the soldier to a softer landing through routine, non-punitive medical monitoring, a self-fulfilling logic results for those who view prescription misuse primarily a discipline issue. By waiting until the soldier's opioid use has spiraled out of control to the point that he engages in addiction related misconduct, or is positive on a urinalysis, it validates the thought process that this is a disciplinary, rather than a medical issue. It is circular logic that is not much more sophisticated than saying soldiers on opioids are getting detected through criminal enforcement mechanisms, so they must be criminals. It does not have to be that way. If preventative medical monitoring is employed then it can be a medical issue, with a medical response, not a criminal disciplinary issue. Discipline remains an option for those who refuse to take advantage of the benefits of a medical response.

In 2012 the Army chose to expand its screening for opioids in random urinalysis.¹⁰⁸ The Army can likewise choose to medically monitor its soldiers who are prescribed opioids, to manage and reduce the risk that they may develop opioid dependency or addiction. Increased medical monitoring and employment of drug

rehabilitation methods before misconduct occurs can save soldiers' lives and careers, while preserving highly trained resources for the Army. It is a matter of prioritizing resources. The Army can spend money on prevention and monitoring, or it can spend money on administrative boards, courts-martial, and recruitment/training to replace the revolving door of soldiers who are discharged with untreated opioid issues. Conducting the fiscal analysis to weigh the institutional cost of these alternative courses of action should be part of the Army's environmental assessment to develop a strategy to counter this threat.

The operational, medical, and social environment in which the Army and its soldiers exist has changed during OEF and OIF. Any commander who proceeds to contact with an adversary without fully understanding his environment is going to fail. Today the environment in which commanders are operating has changed due to the nature and prevalence of prescription opioids. Yet the understanding of this environment lags within the Army, with tradition causing the institution to cling to familiar and comfortable processes.

The Army had a serious drug abuse problem in Vietnam and immediately thereafter that undermined good order and discipline. It overcame that internal threat through a number of means, including developing an effective drug screening and disciplinary program that removed drug abusers from the force.¹⁰⁹ So, it is understandable that the Army might try to apply a similar strategy to another internal drug threat forty years later. The problem is they are two different situations. The fact that both involve controlled substances is the end of the similarity.

“Over 80% of Army soldiers during the Vietnam War used marijuana, and 45% tried narcotics (34% used heroin; 38% used opium).¹¹⁰ This wide use of illegal drugs was recreational, begun with a voluntary choice against military law and discipline.¹¹¹ It did not originate with Army-issued pain prescriptions prescribed to wounded and injured troops trusting the medical judgment of their healthcare providers. Soldiers are actually following direction from authority when they begin taking opioids, not disobeying the law. It is what occurs after they lawfully begin consuming these drugs, due to opioids’ inherently addictive nature, complex co-occurring conditions, and a system not focused upon prevention and rehabilitation, that creates the threat to soldiers and readiness. Soldiers might become undisciplined while taking these medicines, but they do not take the medicines because they are undisciplined.

The tensions within the medical community in identifying and addressing this issue were previously noted. The Army as an institution designed to defend the nation has its own additional internal tensions weighing against developing an effective policy response. The Army has been sorely pressed since the Iraq War began in 2003 to rotate sufficient troops through two different combat zones in adequate numbers to meet its operational needs. Accordingly, keeping its finite supply of soldiers fully engaged is a tension that must be recognized in discussing this issue, and further examined as to the extent to which that pressure created a culture where pain medication was tolerated in the force to keep soldiers in the fight.

A growing Army opioid pain pill culture has been influenced from two complementary organizational sources. First, it is influenced from the medical community to the soldier level when opioids are prescribed. It is secondly influenced by

unit and branch culture, which may indirectly sway soldiers to not seek medical assistance for problems, a phenomenon noted by the DOD in its report to Congress on Medicine Management for Wounded Personnel.¹¹² The DOD report noted a warrior culture that tolerates concealing injuries and delaying medical treatment as contributing to medicine misuse. Where an organizational culture has been created that tacitly encourages or tolerates soldiers concealing their injuries in the name of mission accomplishment, responsibility must be shared at the leadership level when soldiers are self-medicating to keep themselves in the fight.

The Army's 2010 Suicide Prevention Report does not reflect a shared responsibility mindset, focusing instead upon blame though soldiers' failings and lack of garrison leadership as core sources of the problem.¹¹³ Accordingly, it misses addressing the nuanced organizational factors that have contributed to growing prescription drug abuse. The report repeatedly advocates that there are too many soldiers misusing prescription drugs who need to be discharged for the future health of the Army. It labels those addicted to and misusing opioids as "risk takers," and does not discuss the moral and leadership obligation the Army has to soldiers who have become dependent or addicted to medications issued to them by the Army for wounds or injuries suffered in the line of duty. In a 51 page section titled "The Lost Art of Leadership in Garrison" the report's focus is overwhelmingly on identifying and separating those with dependency and addiction issues.¹¹⁴ In fact, the word "rehabilitation" is mentioned only twice in the 350 pages in a positive context as a potential outcome for soldiers, whereas dozens of pages advocate for quicker separations with more severe characterizations of

discharge. This reflects a legacy institutional philosophy, borne from Vietnam era thinking, that the growing opioid issue is a failure of discipline.

There will always be some soldiers who abuse drugs for recreational purposes, and disciplinary processes are an important tool in such instances for the Army to keep the force strong. However, to take a massively complex issue such as prescription opioid use and view it primarily through the lens of discipline is an oversimplification. Such a vantage feels good, because it is familiar, but it places future Army readiness and soldier health at risk by sidestepping the hard questions regarding what reforms the Army must undertake to reduce this corrosive threat now and in future conflicts when pain medication will again be needed. The fact that this is a complex medical and social issue, with a need for nuanced responses is recognized by medical researchers.

Returning combat veterans are presenting to primary care in large numbers and are seeking relief from physical and psychological pain. Extra care should be taken when prescribing opioids to relieve their distress. These patients may benefit from biopsychosocial models of pain care including evidence-based nonpharmacologic therapies and nonopioid analgesics. Integrated treatments that target both mental health disorders and pain simultaneously are effective for both problems and may decrease harms resulting from opioid therapy.¹¹⁵

There are not unlimited fiscal resources in the Army today, which presents a tension to spending on opioid prevention and rehabilitation initiatives. But, there are always competing short and long term costs to inaction in the face of a complex threat. Failing to act decisively on the opioid issue now is akin to not treating the termite problem in one's home, because the budget is tight.

The Stigma of Addiction and Army Policies

For a soldier to receive rehabilitation for opioid addiction or misuse without punishment they must self-identify to an ASAP counselor, prior to being detected

through urine screening or other command enforcement measures.¹¹⁶ If the soldier is detected by urinalysis or other investigatory methods first, then the ASAP program is part of the Army's response mechanisms leading toward potential separation.¹¹⁷

In application this means that if the soldier's opioid misuse is discovered through routine random testing or other enforcement methods, the soldier is not likely to receive the comprehensive rehabilitative services needed to overcome their opioid addiction. They are referred to the ASAP program, where, as is reflected in the ASAP regulation, short term treatment is focused upon stabilizing the soldier's medical condition pending separation.

Soldiers diagnosed as drug dependent should be detoxified and given appropriate medical treatment. These Soldiers generally do not have potential for continued military Service and should not be retained. These Soldiers will be referred to a VA hospital or a civilian program by the ASAP counselor to continue (or to initiate) their rehabilitation.¹¹⁸

The ASAP program typically does not provide comprehensive rehabilitation treatment focused upon the unique nature of opioid addiction issues, particularly those that may be entwined with co-occurring psychological issues. As stated in paragraph Para. 1-7(c)(6) of the ASAP regulation, "Alcohol and other drug abuse will be addressed in a single program. Rehabilitation will generally be short term and conducted in a manner that supports the military environment."¹¹⁹ The focus is on a short term approach of detoxifying the soldier. The ASAP program has not been designed to handle the complexities of rehabilitation that can occur with co-occurring physical and psychological maladies, because the manner in which the Army has traditionally dealt with these issues is to separate such soldiers, not treat them and restore them to duty.

Army policies regarding drug rehabilitation essentially frame access to such treatment as a command directed option that is rationed and provided to only those deemed worthy of continued service:

If a unit commander believes a Soldier does not have potential for future service, the Soldier will be processed for administrative separation in accordance with AR 600–8–24 or AR 635–200, as appropriate. If rehabilitation services are indicated, the Soldier will be provided services until separation.¹²⁰

This rationing of rehabilitative care turns Army medical care and rehabilitation programs into a component of a command reward and sanction system, rather than an independent medical decision. The structure is fine for preserving readiness from poor soldiers who are abusing recreational drugs. But the system’s structure creates unintended secondary consequences adversely impacting the Army’s goal to reduce opioid misuse. Rehabilitation is not treated by commanders or viewed by soldiers as a force-wide soldier health issue, but as a special program for a limited number of soldiers with prior good duty performance, reflecting future potential. It is granted to only deserving soldiers in the command’s judgment, with the regulatory language conveying to all that separation is the usual best course for those with opioid drug dependency or addiction.¹²¹

This system begs the question, “Why is medical care in the form of rehabilitation a reward dependent on prior job performance?” If a soldier tears his knee playing basketball, the Army doctor does not ask for a copy of the soldier’s noncommissioned officer evaluation report before providing medical treatment. This approach to addiction and dependency feeds the “military mindset” problem among soldiers, discussed earlier, that those with drug complications, even from an authorized prescription, are bad soldiers. The subliminal message conveyed by a system that reserves rehabilitation to a

deserving minority is that rehabilitation is not likely to be a successful outcome for the majority. This, in turn, has a chilling effect on opioid troubled soldiers reaching out for help. Such a treatment-as-reward philosophy perpetuates a pain pill culture where there is no outlet for help in the minds of soldiers, so they keep using.

The lack of distinction between unbecoming conduct and a medical problem creates an environment in which engaging in substance use treatment has counterproductive implications. Receiving treatment, even when treatment causes the desired change in behavior, is perceived as resulting in a negative career trajectory. Consequently, active duty service members (ADSMs) are not highly motivated to enter treatment. This can have the unanticipated effect on public safety of having service members continue to perform critical tasks without having had their problems treated.¹²²

The stigmatization caused by withholding rehabilitation as if it were a reward, rather than a medical response to a medical problem, creates an environment where soldiers do not come forward when they have prescription drug dependency or addiction, so that they spiral deeper into medically and personally destructive behavior. Perhaps this is an area where a different policy should be considered for soldiers whose path to dependency and addiction began through Army medical practices.

As discussed earlier, soldiers possess unique characteristics that render them particularly susceptible to opioid addiction and misuse. Yet, the Army places greater hurdles upon their access to rehabilitation programs while in the service than their civilian counterparts. Civilians need not be a “good duty performer” to get access to rehabilitation. There is a policy disconnect occurring when the soldier population that is already most at risk in society for opioid misuse has its risk of a bad outcome heightened by access to rehabilitation programs being constrained. If the Army wishes to get the opioid problem under control it should explore lowering the barriers to rehabilitation, not raising them.

Different soldiers respond to opioid medicines differently. As noted above, some can take opioids for a long period without complications, whereas others can become dependent in as little as two weeks. Addiction is more a matter of personal characteristics than time, but prolonged consumption heightens risk. These individual vulnerabilities are often a matter of individual biology, not moral culpability. However, opioid misuse risk can be heightened by the extent to which the soldier has previously served in combat. As noted in a recent medical study:

Although both psychological injuries and unhealthy substance use are common, it is important to consider that onset of [PTSD] symptoms might be delayed, and that multiple deployments can have a cumulative effect. For instance, service members on their third and fourth deployments report significantly more problems than those on their first or second deployments--more acute stress, psychological and marital problems, and higher rates of using medication for combat stress.¹²³

If multiple deployments indeed have a cumulative, negative impact on soldier mental health and increased medication use, and if the military mindset causes soldiers to not reach out for help with substance issues, a possibility exists that the Army's presumption that soldiers with opioid dependency and addiction "generally do not have potential for continued military service" may be most impacting those soldiers who have, in fact, given the greatest effort in terms of wartime military service.¹²⁴ This is an unknown worthy of further Army study from a readiness perspective--i.e., What are the combat service years and type of experience that are being lost by pursuing an opioid policy presuming discharge, rather than rehabilitation?

Individual Responsibility and Army Responsibility

In discussing the opioid misuse, dependency, and addiction problem, the role of individual soldier responsibility is important. The Army has provided the ASAP program,

that allow soldiers with opioid dependency or addiction issues to self-identify for some level of treatment without prosecution or punitive consequences. Those who fail to do so, or to fail to seek medical help, perpetuate the danger to themselves. Recreational drug abuse also occurs, to which a disciplinary response is necessary and appropriate. There are soldiers every day who place themselves in a position of opioid misuse by making poor choices. Further, once in a rehabilitation program, it is only the soldier who can choose to succeed, or not. No one can do it for them. Rehabilitation is the greatest test of individual responsibility.

The danger, however, of the individual responsibility discussion is it is often used as an intellectual shortcut to foreclose in-depth discussion of the Army's responsibility to manage risk in the high risk environment it has created through widespread prescription practices. There is a risk in focusing on individual soldier responsibility as being the source of the problem that the Army then fails to examine how its own policies have created this environment. The organizational high risk environment is characterized by its prescription practices, lack of medical monitoring, and by stigmatization of those who develop dependency or addiction during their medical treatment. Individual responsibility is indeed part of the conversation, but it is only one piece of the discussion, not the end point. The Army still has the responsibility to manage risk.

By comparison, the Army has developed highly detailed procedures to maximize weapons' use and safety. In garrison, individual weapons are locked in an arms room. They are not lying about the barracks uncontrolled, or issued without training. They may only be signed out for specified purposes, and then are used under tightly supervised training conditions. Even in a deployed environment, soldiers carrying weapons on a

daily basis follow very detailed procedures for carrying and clearing their weapons to avoid accidents. The Army has created these risk management procedures as it recognizes that there is inherent danger in weapons being issued to tens of thousands of young soldiers. The Army does not simply declare that proper use is a matter of individual soldier responsibility and wait for mistakes; it manages risk. It does not rely upon reactive disciplinary mechanisms as a primary tool; it actively manages risk.

The Army's institutional experience recognizes that good leadership manages and minimizes risk. The fact that there are relatively few accidental discharges or weapon's injuries despite hundreds of thousands of soldiers carrying weapons is the result of this systemic risk management. In contrast, the Army has lacked a prevention and mitigation strategy for highly addictive and dangerous opioids since 2001. Soldiers are dying from prescription drug overdoses at a rate much higher than weapon's misuse, and yet there is not an institutional focus on prevention and risk mitigation in the form of training and education, controls, and monitoring. The policy discussion often begins and ends, as reflected in the 2010 Suicide Prevention Report, with individual soldier responsibility, a declaration of the need for a drug free force, and a quick transition to what procedures can be implemented to clear the decks of these risk taking soldiers.

It is in the Army's self-interest to engage in such analysis and reform, because by managing and reducing risk it will promote a healthier and less opioid-dependent fighting force. This type of reform will certainly include the initiatives already underway from the Surgeon General's office, discussed below. But this is also a leadership issue and must include leader and soldier education on the unique threat of opioid drugs,

organizational culture and stigma regarding medical treatment and rehabilitation, and developing innovative policies that balance soldier healthcare privacy with the need for unit commanders to be aware of the extent to which opioids may be degrading unit readiness.

Are the Right Questions Being Asked to Frame the Problem?

The Army is emerging from OEF and OIF with a significant portion of its force taking prescribed opioids. It is important for readiness to manage and reduce this level of consumption. However, it is important to future readiness for Army leaders to understand how this problem grew in the forward deployed environments of OEF and OIF, so that they can develop policies to prevent its recurrence in the next conflict.

In many instances the operational environment for OIF and OEF soldiers who were prescribed opioid pain medications was that of widely dispersed Forward Operating Bases, and other remote locales, without daily access to sophisticated medical care. Recognizing the highly addictive nature of these medications, and their potential interrelationship with wartime stress, Army leadership needs to know how opioid prescriptions were issued and monitored in the forward deployed environments of OEF and OEF. What was done systemically, if anything, to protect soldiers from the risk of dependency and addiction in such a transient and dispersed environment? Once those facts are understood, leadership must ask, what needs to be different next time to prevent a recurrence of the current opioid problem?

Today the Army is seeking to institute new reforms to opioid prescription and monitoring practices in a garrison environment at major medical centers and major bases.¹²⁵ But, this problem began for many soldiers in Iraq or Afghanistan, when they were prescribed opioids and sent back to duty without medical monitoring. Building

responses in garrison or at major medical centers will not preclude a recurrence of the issue in future conflicts deployments unless procedures sustainable for providing non-addictive pain intervention in an operational environment are part of the solution.

To protect future readiness and soldier health, senior Army leaders need to be asking hard questions about how often we medicate our soldiers with opioids, when, where, and under what circumstances. They need to ask how we will protect soldiers from becoming dependent or addicted in the future, rather than just focusing upon how we can ferret out opioid misuser for adverse discharge. The Army constantly seeks to mitigate risk to soldiers when it comes to weapon's safety, vehicle operation, and alcohol use. That same level of attention and resource commitment should be focused on opioid prescription policies. Here is a partial list that policy makers need to study to mitigate the problem:

- 1) How can opioids responsibly be dispensed, and soldiers monitored, in a highly mobile, decentralized operational environment, where many of the OIF and OEF troops received their first opioids, to reduce the risk of dependency and addiction?
- 2) Is the deployed soldier given any training on the signs of dependency or addiction at the time of prescription, as he would be if handling a dangerous weapon for the first time, and further trained what to do if he feels he cannot stop taking the drug? If not, how do we fix this?
- 3) If the soldier is a mobilized reservist, is the fact that he/she is still on an opioid pain medication at the time of discharge communicated to a reserve medical detachment to follow up on his condition? How do we make that hand-off to reserve and civilian medical authorities so that lawful prescription opioid use at the time of discharge does not devolve into a civilian opioid addiction that costs the Army the skills of that reservist and becomes a civilian law enforcement problem? If Health Insurance Portability and Accountability Act privacy laws are a current barrier to this coordination, what military exceptions need to be sought to promote future force readiness?
- 4) Why doesn't the Army track opioid use as a metric of readiness, when it focuses medical metrics on whether a soldier has a dental exam? A tooth can be quickly

filled or pulled, but opioid use can degrade a unit and kill a soldier. Is the Army allocating resources and placing priorities on the right medical issues in tracking readiness considering the scope and seriousness of the opioid threat?

- 5) When the Army knows which soldiers are prescribed opioids in most instances, why is medical monitoring against prescription overuse/misuse not mandatory during the duration of the prescription and for 6-12 months thereafter, with the goal being to mitigate dependency and addiction, and thereby preserve valuable personnel resources?

By addressing the above questions now, the framework of policies to avoid repeating the current explosive growth of opioid misuse during future conflicts can be developed.

The Civil-Military Divide

In addition to the above force readiness concerns, there is an additional strategic concern regarding opioid prevalence in the force. Army policies that allow widespread medical opioid use, but then transfer the negative consequences of opioid dependency and addiction to the civilian world, have an adverse impact on the civil-military divide.

The Army has largely responded to its opioid problem since 2001 by discharging soldiers who are dependent or addicted. This is consistent with past Army policy presuming an Other than Honorable discharge for soldiers with substance abuse issues who are separated for misconduct under chapter 14 of AR 635-200, as well as a presumption of separation for drug dependent and addicted soldiers in the ASAP regulation.¹²⁶

By regulation, all soldiers who are detected for using illegal drugs will be processed for separation, although their ultimate separation or retention is up to their commander and the convening authority.¹²⁷ An opportunity for rehabilitation treatment is not a required step in the separation process--it need only be provided, if at all, until separation is completed. Opioids are highly addictive and those with addiction issues need rehabilitation or their situation will degrade. As the Army has experienced, those

with untreated prescription drug issues are a major contributor to overdose and suicide rates. By discharging soldiers without resolving their addiction issues, the Army transfers its opioid issue onto the hometowns from which these soldiers originated, and the local community health and justice system budgets that may lack the funds or programs to provide the needed care. This is particularly true when dealing with the complex co-occurring relationship between mental health issues such as PTSD and opioid use.

The Other than Honorable (OTH) discharge is the presumed level of disposition for Army drug abuse. A General under Honorable Conditions discharge is often granted in practice, in part because it speeds the process of administrative separation. Yet, the enlisted separation regulation states that the OTH discharge “is normally appropriate for a Soldier discharged under this chapter.”¹²⁸ The Army’s 2010 Suicide Prevention Report, in fact, recommended increasing the severity of discharges for those who fail Army substance abuse rehabilitation programs to include an Other than Honorable Discharge.¹²⁹ If ever adopted this would further increase the number of opioid addicted soldiers potentially ineligible for rehabilitation services under VA policies, leaving local civilian communities to absorb the expense of rehabilitating even more opioid dependent and addicted Army veterans. There is a fundamental misunderstanding of addiction and treatment when the policy advocated for in the Army’s Suicide Prevention Report is to take those who have failed their first attempt at rehabilitation (a not uncommon occurrence due to the severity of opioid addictions) and place greater hurdles to that high risk population receiving a second chance at rehabilitation once they leave the Army by raising the severity of their discharge. An addict is not punished

by being denied rehabilitation--they want to keep consuming the drug that their body and brain craves. It is the civilian society to which the Army returns that addicted soldier that is punished in the form of crime, local absorption of the costs of future medical and rehabilitation treatment, and social costs of unemployment and broken families. These disconnects between regulatory guidance, practice on the ground, and leadership policy recommendations for the future contribute to the lack of coordination within the Army, and strain civil-military relations.

The “discharge the drug abuser” approach has been accepted by civilian society, even where it creates cost for the civilian community, where addiction has been due to a soldier’s own fault through recreational drug use. Whether civilian society will continue to agree that the cost of the Army’s opioid issue, with its strong roots in military prescription practices, should be borne by local civilian communities, is a different issue. Many communities lack sophisticated drug rehabilitation programs or the finances to support them. Requiring these communities to absorb the ongoing cost for a problem not of their making risks eroding the high esteem with which the military is held in the eyes of civilians.

Further, returning soldiers home addicted, or with other adverse opioid issues, rather than caring for their welfare in the Army, can likewise erode that positive organizational image in the eyes of civilian communities, which is so important to recruiting and preserving the all-volunteer force. Military families are an important source of recruitment and preserving a positive relationship with those families by ensuring their sons and daughters are not sent home with untreated substance issues originating from Army prescriptions is in the Army’s future interest.

The Army's opioid issue has already been adversely impacting civilian society for several years. Approximately 177 civilian Veterans Courts have been founded since 2008 to respond to the increase in crime and substance abuse by OEF and OIF veterans, many of whom have prescription drug addictions.¹³⁰

Veterans Courts seek to treat veterans suffering from substance abuse and mental health disorder, while helping ensure public safety. These special courts combine rigorous treatment and personal responsibility with the goal of breaking the cycle of drug use and criminal behavior.¹³¹

A great sense of patriotism and commitment to the nation's soldiers motivates establishment of these treatment court programs. But as the conflicts in OEF and OIF eventually wind down, the inevitable financial question will be asked, "Why are local communities paying the bill for the Army's opioid problem?" The Army can take steps to shape that discussion before it begins by policies to ensure that soldiers who develop opioid complications after receiving opioid prescriptions in the Army get access to rehabilitation treatment before discharge.

Were it not for the complementary policies of the Army and VA combining to preclude opioid misusing soldiers from getting the rehabilitation treatment they need at the VA level, this question might not be as sensitive to civilian communities. But, the two federal organizations' policies combine in effect in many instances to return soldiers to the civilian community with substance abuse problems without access to VA rehabilitation services. While AR 635-200, paragraphs 14-3(a) and 14-12(c)(2) presume an OTH discharge is appropriate for illicit drug abuse, VA adjudicatory guidelines allows for denying VA drug rehabilitation benefits to veterans who receive an OTH discharge.¹³² Illicit opioid drug use can get the soldier discharged and denied drug rehabilitation at the federal level. In a study of 645 offenders referred to civilian Veterans

Treatment Courts, adverse discharge characterizations precluded 200 of them from receiving Veterans Administration Services, including drug rehabilitation.¹³³ This means that either the cost of treatment was borne by the local civilian community, or the veterans were denied any drug rehabilitation services because of their discharge characterization.

There is a community cost to those denied rehabilitation services, as those veterans are more likely to continue opioid abuse, commit crimes, and raise other social costs to the community through overdose, broken families, and incarceration. Recently discharged soldiers with drug issues are extremely unlikely to keep employment or to have access to private insurance, leaving civilian communities to absorb the cost of rehabilitation and/or crime when the federal agency policies take the position that because the soldier did not serve with honor that they are not going to pay for his treatment. The self-fulfilling logic that is side-stepped can be that the soldier failed to complete their tour honorably, in part, because they became an opioid abuser due to prescriptions issued to them by military medical providers.

By continuing to focus upon disciplinary enforcement, rather than prevention and rehabilitation, the Army is assuming that civilian political leaders will be willing to indefinitely absorb the cost of the Army's opioid problem in local civilian communities. If wrong in that assumption, the Army is placing itself at risk of a future solution being imposed on it from Congress, rather than solving the issue internally now by doing what the Army does best--engaging in strategic planning after studying and understanding the environment in which it must operate.

The Path Forward

During the past ten years there has not been coordinated monitoring of soldiers on prescription opioids, with the Army leaving the untrained soldier in charge of monitoring himself for proper use, dependency and addiction. The Army's 2010 Suicide Prevention Report noted the major role that prescription drug abuse plays in Army overdose and suicide deaths.

. . . while prescription drugs accounted for only 18% of all illicit use cases and made up only 3.1% of felony use or possession cases, prescription drugs were involved in almost one third of the active duty suicides. Expanding this view to FY 2006 – FY 2009, 47% of undetermined or accidental Soldier deaths were due to the excessive use of both legal and illegal drugs and/or alcohol. *Of the 188 accidental or undetermined deaths caused by drugs or alcohol during this period, 139 (74%) were caused by prescription drugs (multiple cocktail or individual overdose).*¹³⁴ (emphasis added)

The report got the facts right, but incorrectly framed the issue in disciplinary terms, leaving the organizational response uncoordinated, and systemic weaknesses in place that continue to place soldier's lives at risk.

There are several reasons why the Army has not placed sufficient focus upon the impact of opioid use on readiness until now. Several have been addressed above. In addition, the duration of the conflicts in Iraq and Afghanistan are unprecedented in the history of this nation. U.S. forces are still engaged in hostilities in both Iraq and Afghanistan after fourteen years, albeit under new operational designations. It is understandable that primary institutional focus has been upon winning the wars, rather than on what appears to be a familiar drug issue at first glance.

Second, the impact of opioids is occurring amidst newly evolving areas of science, with understanding of the link between opioid misuse and combat exposure only developing in the past few years in the medical and social sciences.

However, it is now well accepted that the environment and duration of the OIF/OEF conflicts has contributed to an increase in co-occurring disorders, such as PTSD and substance abuse.¹³⁵ The positive effect of high survival rates on the battlefield from serious wounds has paralleled a corresponding negative increase in PTSD, traumatic brain injury, and depression, conditions which are recognized by healthcare professionals as potentially contributing to substance abuse.¹³⁶ Other contributors to substance use by soldiers reacting to the ongoing strains of war are insomnia, shame, and survivor's guilt.¹³⁷

It is further recognized that multiple deployments have a cumulative effect on the likelihood of mental health and substance abuse. "Service members on their third and fourth deployments report significantly more problems than those on their first or second deployments—more acute stress, psychological and marital problems, and higher rates of using medication for combat stress."¹³⁸ Accordingly, the longer these wars have continued, the greater the risk to the soldiers who have fought them.¹³⁹

The Army has been operating at a high operational pace that has not left much time for institutional reflection on the fact that soldiers who become ensnared by opioid pain medications are not necessarily ill-disciplined or criminal in nature. While in these uncertain waters, the Army has defaulted to its institutional comfort zone--using random urinalysis to find and separate those engaging in unauthorized drug use, just as it has done for forty years. The fact that the opioid issue is distinct and not a disciplinary issue at its core has received little consideration. With the lack of impact in reducing the problem by legacy disciplinary procedures, the time has arrived for innovative approaches.

The Army Surgeon General's Pain Task Force (TF) Report of 2010 proposed action to begin responding to the opioid prevalence in the force. The report contained 109 innovative recommendations, among which were:

The TF recommends implementing standardized screening tools, using a stepped care approach to pain management, increasing access to specialized pain care, offering alternatives to chronic opioid therapy, and implementing pain education programs to address and reduce the reliance on opioid medications. For patients who have developed prescription opioid dependence, there should be ready referral for appropriate substance abuse treatment and the use of office-based opioid agonist treatment should be available as an option for selected patients who would benefit . . . Recommendation 4.1.17.3 Educate providers and chronic pain patients on the signs and symptoms of opioid dependence, addiction treatment options, and stigma issues. Recommendation 4.1.17.4 Ensure that appropriate treatment for opioid dependence, including the use of office-based opioid agonist therapy, is available for those patients who have developed an opioid dependence as a result of pain treatment. Recommendation 4.1.17.5 Ensure that patients with chronic pain who demonstrate, or are deemed at risk for, aberrant behavior have access to structured pharmacy management programs that support opioid and medication pain management.¹⁴⁰

These recommendations are sound and begin to fix the deficiencies in prior Army policy--at least with the active component--which was characterized by distribution of opioids with little oversight by primary care physicians. Many of these recommendations were made operational in September 2010 in the Medical Command (MEDCOM) Operational Order 10-76, Comprehensive Pain Management Campaign Plan (CPMCP).¹⁴¹ However, many of the innovations and recommendations are just coming online and only apply to the active component, failing to address the reserve components, which have many of the same opioid challenges as the active force.¹⁴²

Among the advances proposed under the CPMCP was the establishment of Interdisciplinary Pain Management Centers (IPMC) at eight MEDCOM medical centers in FY 2014, with plans for further expansion to major bases in FY 2015.¹⁴³ IPMCs

provide the highest tier of pain management specialty capability and consultation. Their utility is not only providing direct pain management and rehabilitation treatment to patients at those eight medical centers, but also in acting as a resource for primary care physicians across the Army to consult when making pain medication prescription decisions.¹⁴⁴ This network arrangement raises the level of medical knowledge across the active duty force on pain treatment options and risks, to the benefit of soldiers' health and Army readiness.

One of the challenges to both the Medical Corps and the Army leadership in defining success on this issue will be developing a meaningful set of metrics to measure progress. How does the Army define progress? What does success look like? The 2010 Army Suicide Prevention Report presumed that success would be all of the substance abuse troubled soldiers removed from the Army. But that report did not examine the unique environmental factors contributing to this issue, nor acknowledge that even if every drug troubled soldier existing in 2010 had been instantly discharged that the problem would still exist, because continuing psycho-social, cultural, and prescription practices discussed above would combine to replenish more opioid troubled soldiers. These are policy issues that need to be worked out in a joint planning session with senior Army leaders, medical experts, JAG personnel, unit commanders, drug treatment specialists, and justice and VA experts from civilian society who have been successfully rehabilitating soldiers through Veterans Court programs.

The first step to developing meaningful metrics is understanding the environment, so the Army knows it is measuring the right factors that will make a difference in soldier health and readiness. Only with that environmental assessment

completed can the Army develop a coordinated strategy; otherwise the Army is merely guessing at solutions and hoping for a positive outcome. The fact that the Army currently lacks metrics to measure the effectiveness of its response to the opioid issue has been noted by commentators.

The lack of standardized outcome measures and benchmarks or a system that promotes the development of measures will undoubtedly lead to difficulties in evaluating program effectiveness and impact. Having a set of basic metrics that reflect the overarching goals of SUD [substance abuse disorder] treatment (e.g., sobriety, stabilization, and functionality) would be a good starting point. Some branches of the military (e.g., the Marine Corps) have begun outlining performance measures for SUD programs in their policies.¹⁴⁵

Meaningful medical metrics are a necessity to gauge progress, but as noted, this is not exclusively a medical issue. The effectiveness of Army policies to reduce the harmful consequences of opioid addiction can also be tracked in law enforcement statistics, including measuring outcomes for soldiers after they leave the service.

The Medical Corps is seeking to raise the level of knowledge across the medical profession regarding the dangers of opioids and the availability of alternative pain treatment modalities. This is being conducted through a project for enhanced pain management in the Army Medical Homes at the local Army installation level through designated Primary Care Pain Champions (PCPC).¹⁴⁶ PCPCs are individuals designated within the local healthcare team to receive ongoing education and mentoring from pain specialists. These PCPCs can then act as an initial point of reference and consultation for other Army primary care physicians on best treatment options for soldiers with chronic pain.¹⁴⁷

These are positive planning and initial implementation steps, reflecting the growing medical branch awareness of the seriousness of the opioid problem. In addition

to the direct treatment benefit, it signals an important initial shift in thinking regarding pain management in the Army, under which a bottle of opioids is not always the best answer. But, it is only the beginning and success should not be measured simply by the number who are treated, but also by how few are allowed to slip through the cracks untreated. The Medical Corps can only treat those individuals who are allowed to reach its facilities. Where Army personnel and disciplinary policies bar soldiers with opioid misuse, dependency, and addiction issues from treatment or rehabilitation in favor of quick administrative separation, the best medical facilities in the world do not matter.

The reforms adopted by the Medical Corps in 2010 have not yet had a significant impact on the levels of opioid use in the force, although many of them are still in the early stages of implementation. Testifying before the Senate Committee on Veterans Affairs, Brigadier General Norvell V. Coots, Deputy Commanding General and Assistant Surgeon General for Force Projection indicated that “in 2011, up to 26% of all active duty service members were on at least one opioid medication, with that number dropping slightly to 24% in 2013.”¹⁴⁸ These numbers, which appear to be reflect even greater opioid usage than those cited in the Surgeon General’s briefing to the Vice Chief of Staff of the Army in 2010, still reflect a disconnect between available treatment means, chosen policy ways (focusing largely on discipline and discharges), and desired Army ends (to diminish the opioid threat to soldiers and readiness). To overcome this threat those available treatment means, Army policies, and desired strategic ends must be brought into alignment.

With the study from Walter Reed Research Institute and recent statements by Brigadier General Coots reflecting that the scope of the opioid problem has not

diminished in recent years, it is time for the Army to dedicate resources to strategic planning with the goal of developing a coordinated Army level plan, as opposed to a branch operational plan, where all of its professional branches, commanders, and senior Army leadership are not pulling in opposite directions. The principles of Operational Art and Design, which the Army employs in theater operational planning, are not misplaced as an analogy to the type of environmental study, critical analysis, and planning needed to confront the opioid threat. The lack of results to date is in part a consequence of that lack of coordination and Army level planning.

The current Army response to opioids in the force is akin to a military campaign with uncoordinated land, air, and sea assets operating in an unfamiliar environment. If uncoordinated, these assets can make a lot of noise and break a lot of glass, but fail to attain any long term strategic goals. The same assets, if coordinated toward defined and understood objectives, can have profound effect in attaining the goals in theater. The chances of a positive outcome against a complex and adapting enemy such as opioid addiction/misuse are extremely unlikely without all capabilities being coordinated toward a common goal.

The Surgeon General's 2010 Pain Task Force Report calls for innovative changes to confront this health care crisis. Specifically,

The organization must synchronize a culture of pain awareness, education, and proactive intervention. This requires a unified approach to content, education, and training, as well as leadership and organizational adaption on issues of pain management into the future.¹⁴⁹

The Pain Task Force realized that the health of our soldiers and military families does not end at the installation gate, nor upon discharge, and calls upon a necessary relationship with the Veterans Health Administration as a necessity for continuity of care

and consistency in medical policies toward opioid medications. Integrating the JAG's branch and civilian justice system personnel into this collaboration is a necessity, as it is a legal and social issue impacting both sides of the installation fence, as much as an Army medical issue. If response to this readiness issue remains uncoordinated the lack of progress and murky messaging that has characterized the past decade will continue, to the ongoing detriment of the Army, its soldiers, and civilian communities.

Conclusion

Army success in confronting the opioid threat to force readiness and the civil-military divide will require five steps, each of which can occur concurrently:

- Step I – The Army must initiate an education campaign for commanders and soldiers on the medical and social issues contributing to opioid misuse, dependency, and addiction, as well as upon the existence of effective, new pain treatment and opioid rehabilitation options. This team should propose training and education initiatives to inform soldiers on the dangers of sharing opioid medicines within units.
- Step II – The Army must develop a cross disciplinary team of military and civilian experts to study and address where structural, procedural, legal, medical, technology, and historical barriers exist to successfully prevent and treat opioid dependency and addiction.
- Step III - Medical solutions must be adapted that are also functional in a forward deployed operational force, where many of these opioid issues originated during OEF and OIF. Current proposed solutions are focused largely upon new treatment and monitoring in a garrison Army. Plans for future pain treatment and monitoring in a deployed environment must be developed or the opioid explosion of 2001-2013 will be repeated in the next major conflict.
- Step IV – Initiate policy and regulatory changes that mandate 100% medical monitoring of soldiers prescribed opioids for a period sufficient in medical judgment to mitigate the likelihood of misuse or dependency/addiction. Develop protocols for the screening, identification, treatment and rehabilitation of opioid dependent/addicted soldiers. This does not mandate retention, but providing all soldiers with the opportunity for full drug rehabilitation before they continue service or transition to civilian life is a moral and leadership imperative where opioid use began under military medical direction.

- Step V – Propose joint legislative and regulatory reform initiatives with VA that do not deny soldiers access to drug rehabilitation regardless of characterization of discharge when the soldier’s initial opioid usage originated under military medical care. It is the combined effect of no rehabilitative treatment for opioid troubled soldiers by the Army, coupled with adverse Army discharges that deny those same soldiers access to VA rehabilitative treatment that makes current Army personnel policies particularly damaging and potentially intolerable to civilian communities.

Finally, the Army must engage against the opioid problem across the entire force, in both active and reserve components. By taking the initiative, Army leaders can choose to recognize the unique environment and origins of the opioid threat, adapt innovative medical and personnel rehabilitation policies that have proven effective in the civilian community, and shape the Army’s force readiness future. Delaying action while the problem stagnates or worsens is surrendering the initiative. In warfare, understanding one’s environment, while innovating and maintaining the initiative, are keys to victory. This campaign against opioid misuse, dependency, and addiction is about innovating and adapting to take care of soldiers - or not. The status quo is an Army with internally inconsistent policies, which threaten to lead back to the days of ‘soldier’s disease’, not to a future of healthy soldiers and force readiness.

Endnotes

¹ H. L. Mencken, *The Divine Afflatus, A Mencken Chrestomathy*, 443 (1949), originally published in the *New York Evening Mail*, November 16, 1917.

² For the sake of brevity, all further references to OIF will include the period of service in Iraq that has been separately designated as Operation New Dawn. This is not a paper discussing distinct operational phases, but one concerning how wartime service in Iraq and Afghanistan has impacted opioid use among soldiers, so for readability this shortcut is used.

³ National Institute on Drug Abuse, *DrugFacts: Substance Abuse in the Military Online*, March 2013, <http://www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military> (accessed February 4, 2015).

⁴ C. P. O'Brien, M. Oster , and E. Morden, eds., *Substance Use Disorders in the U.S. Armed Forces* (Washington DC: National Academies Press, 2013), 41, <http://www.ncbi.nlm.nih.gov/books/NBK207273/?report=reader> (accessed February 13, 2015). It is not known whether this annual yearly increase in the Army has continued beyond 2010, due to data unavailability, although recent Senate testimony by Brigadier General Norvell V. Coots, Deputy Commanding General and Assistant Surgeon General for Force Projection, indicated that “in 2011, up to 26% of all active duty service members were on at least one opioid medication, with that number dropping slightly to 24% in 2013; and Sandra Basu, “Greater Alternative Therapy Use Gradually Decreases Opioid Dependence in Military,” *U.S. Medicine Online*, June 2014, <http://www.usmedicine.com/agencies/departments-of-defense-dod/greater-alternative-therapy-use-gradually-decreases-opioid-dependence-in-military/> (accessed February 9, 2015).

⁵ Opioids are drugs that act upon the central nervous system to relieve pain and create a sense of euphoria and well-being. Popular forms used in military medicine are Percocet, and Vicodin, among others described in more detail throughout this paper.

⁶ The opiate use, dependency, and addiction issue exists in other military services as well. The author is a U.S. Army Reserve Judge Advocate General's Corps officer, as well as a Court of Common Pleas Judge in a civilian criminal court in York County, Pennsylvania. In this latter role he presides over a Veterans Court comprised of veterans from all service branches who are facing criminal charges. Within that court, both U.S. marines and U.S. Army soldiers are addicted to opioids, many of whom began their opioid use on prescriptions while on active duty. The scope of this paper, however, focuses upon the scope of the issue solely within the U.S. Army. The Department of the Navy and the Marine Corps have their own programs for responding to addicted marines, which are not discussed within the scope of this paper.

⁷ *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (Rockville, MD, Substance Abuse and Mental Health Services Administration, 2005), Chapter 2, 1, <http://www.ncbi.nlm.nih.gov/books/NBK64157/?report=reader> (accessed February 6, 2015).

⁸ National Institute on Drug Abuse, *What is the History of Opioid Addiction in the United States?*, <http://www.drugabuse.gov/international/question-2-what-history-opioid-addiction-in-united-states#hentoff> (accessed February 4, 2015).

⁹ Tony Horwitz, “PTSD: The Civil War's Hidden Legacy,” *Smithsonian Magazine*, January 2015, 46.

¹⁰ Ibid.

¹¹ Ibid., 48.

¹² Jana Burson, *Pain Pill Addiction: A Prescription for Hope* (Indianapolis: Dog Ear Publishing, 2010), 52.

¹³ Robin Toblin, et al., “Chronic Pain and Opioid Use in US Soldiers after Combat Deployment,” *JAMA Internal Medicine*, August 1, 2014, 174(8) 1400-1401.

¹⁴ NIH Medline Plus, “Chronic Pain: Symptoms, Diagnosis, & Treatment,” Spring 2011, <http://www.nlm.nih.gov/medlineplus/magazine/issues/spring11/articles/spring11pg5-6.html> (accessed January 5, 2015).

¹⁵ Ibid.

¹⁶ Ronald Melzack, "The Tragedy of Needless Pain," *Scientific American*, February 1990, 27-29.

¹⁷ NIH Medline Plus, "Chronic Pain: Symptoms, Diagnosis, & Treatment, 5-6.

¹⁸ Department of Defense, *Medication Management for Physically and Psychologically Wounded Armed Forces Members in Fiscal Year 2011-2102: Report to Congress* (Washington, DC: U.S. Department of Defense, March 14, 2012), 15.

¹⁹ Office of the Army Surgeon General, *Pain Management Task Force Final Report 2010* (Washington, DC, Department of the Army, 2010), 58
http://www.regenesisbio.com/pdfs/journal/pain_management_task_force_report.pdf (accessed January 2, 2015).

²⁰ Alex S. Bennett, Luther Elliott, and Andrew Golub, "Opioid and Other Substance Misuse, Overdose Risk, and the Potential for Prevention Among a Sample of OEF/OIF Veterans in New York City," *National Development and Research Institutes, ISPR*, 2013, published in final edited form in, *Substance Use Misuse Online*, National Institute of Health, July 2013; 48 (10), 894, <http://informahealthcare.com/doi/abs/10.3109/10826084.2013.796991> .

²¹ Department of the Army, *Army Health Promotion Risk Reduction Suicide Prevention Report 2010* (Washington, DC: U.S. Department of the Army, 2010), 83, http://usarmy.vo.llnwd.net/e2/rv5_downloads/hprrsp/HP-RR-SPReport2010.pdf (accessed January 2, 2015).

²² *Pain Management Task Force Final Report 2010* 57.

²³ Mary Jo Larson, et al., "Military Combat Deployments and Substance Use: Review and Future Directions," *Journal of Social Work Practice in the Addictions*, 12:7 (2012), 7.

²⁴ Ann Scott Tyson, "Weight of Combat Gear Is Taking Toll," *Washington Post*, February 1, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/01/31/AR2009013101717.html> (accessed January 4, 2015).

²⁵ *Medication Management for Physically and Psychologically Wounded Armed Forces Members*, 48.

²⁶ Toblin, *Chronic Pain and Opioid Use in US Soldiers After Combat Deployment*, 1400-1401.

²⁷ Annette M. Boyle, "Research Finds Unexpectedly High Rates of Pain, Opioid Use in Recently Deployed Soldiers," *U.S. Medicine Online*, September 2014, <http://www.usmedicine.com/agencies/departments-of-defense-dod/research-finds-unexpectedly-high-rates-of-pain-opioid-use-in-recently-deployed-soldiers/> (accessed January 3, 2015).

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³³ National Institutes of Health, "Pathways to Prevention: The Role of Opioids in the Treatment of Chronic Pain," September 29-30, 2014, <https://prevention.nih.gov/programs-events/pathways-to-prevention/workshops/opioids-chronic-pain> (accessed February 16, 2015).

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³⁵ *Medication Management for Physically and Psychologically Wounded Armed Forces Members in Fiscal Year 2011-2102*, 49.

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³⁷ *Army Health Promotion Risk Reduction Suicide Prevention Report 2010*, 83.

³⁸ Ibid.

³⁹ Eric B. Schoomaker, "Pain and Opioids in the Military We Must Do Better."

⁴⁰ Burson, *Pain Pill Addiction*, 7.

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⁴² Ibid.

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⁵² Ibid.

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⁶⁶ Toblin, *Chronic Pain and Opioid Use in US Soldiers After Combat Deployment*, 1400-1401.

⁶⁷ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 207. Original source of the data is noted by the editors as being personal communication with Ms. Barbara Swailes, Department of Veterans Affairs, March 9, 2012.

⁶⁸ Ibid.

⁶⁹ Soldiers who receive a bad conduct or dishonorable discharge at court-martial are barred from VA benefits, as they do not meet the statutory definition of "veteran." Those who receive an Other than Honorable discharge, the result of an adverse administrative separation, are reviewed by the VHA for eligibility under VA regulations and procedures, with access to benefits, including drug rehabilitation decided on a case by case basis. U.S. Department of Veterans Affairs, M21-1 Adjudication Procedures Manual Rewrite part 3, subpart V, chapter 1, section B, para. 5(c), February 23, 2012.

⁷⁰ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 48.

⁷¹ Ibid.

⁷² The author has USAR soldiers from OIF and OEF charged with opioid use and related offenses as defendants in the Veterans Court over which he presides in his civilian capacity in York, PA. He meets and communicates with other Veterans Court judges across the nation who have the same population of OEF and OIF opioid troubled reserve soldiers appearing in their courts.

⁷³ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 41.

⁷⁴ Bennett, *Opioid and Other Substance Misuse, Overdose Risk, and the Potential for Prevention Among a Sample of OEF/OIF Veterans in New York City*, 1.

⁷⁵ *Army Times*, "Defense Manpower Data Center Statistics," February 16, 2015, 19. On December 31, 2014 there were 498,642 soldiers and cadets on active duty with the regular component, comprising 47.7% of the Army's manpower. On that same date there were 349,881 soldiers in the National Guard and 197,126 in the U.S. Army Reserve.

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⁸⁴ Charles Hoge, *Once a Warrior--Always a Warrior: Navigating the Transition from Combat to Home* (Guilford, CT: Globe Pequot Press, 2010), 24, 32-36.

⁸⁵ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 191.

⁸⁶ Substance Abuse and Mental Health Services Administration, "Behavioral Health Issues Among Afghanistan and Iraq U.S. War Veterans," *In Brief Online*, v. 7, issue 1, Summer 2012, <http://store.samhsa.gov/shin/content/SMA12-4670/SMA12-4670.pdf> (accessed February 5, 2014).

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¹⁰⁰ As used in this context the word 'social' includes the impact on a soldier's family and job relationships from factors such as wartime and redeployment stress, issues of anger management that have been widespread among OEF and OIF veterans, and encounters with law enforcement that arise from the preceding.

¹⁰¹ The 2010 Army Suicide Report cited these as the three major factors throughout the report as underlying the high level of prescription abuse in the Army. *Army Health Promotion Risk Reduction Suicide Prevention Report 2010*, 1-4, 35-87.

¹⁰² Ibid.

¹⁰³ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 192.

¹⁰⁴ Ibid., 43.

¹⁰⁵ *Army Health Promotion Risk Reduction Suicide Prevention Report 2010*, 28.

¹⁰⁶ Ibid., i.

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¹¹⁶ U.S. Department of the Army, *The Army Substance Abuse Program*, Army Regulation 600-85 (Washington, DC: U.S. Department of the Army, December 28, 2012), Para. 7-3(d), 50.

¹¹⁷ “ASAP drug testing is designed to act as a deterrent by utilizing random drug testing which is intended to cover 100% of the unit end strength every year.” Department of the Army, *Army Health Promotion Risk Reduction Suicide Prevention Report 2010* (Washington, DC: U.S. Department of the Army, 2010), 51.

¹¹⁸ Army Regulation 600-85, Para. 7-1(b)(2), 49.

¹¹⁹ *Ibid.*, Para. 1-7(c)(6), 3. “Alcohol and other drug abuse will be addressed in a single program. Rehabilitation will generally be short term and conducted in a manner that supports the military environment.”

¹²⁰ *Ibid.*, Para. 7-12(d), 52.

¹²¹ Army Regulation 600-85, Para. 7-1(b)(2), 49.

¹²² O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 188.

¹²³ Larson, “Military Combat Deployments and Substance Use,” 8.

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¹²⁵ Colonel Paul Barras, telephone interview by author, February 2, 2015.

¹²⁶ U.S. Department of the Army, *Active Duty Enlisted Separations*, Army Regulation 635-200 (Washington, DC: U.S. Department of the Army, September 6, 2011), Para 14-3(a), 99, and 14-12(c)(2), 102; and Army Regulation 600-85, Para 7-1(b)(2), 49.

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¹³⁴ Department of the Army, *Army Health Promotion Risk Reduction Suicide Prevention Report 2010*, 56.

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¹³⁶ Ibid., 7.

¹³⁷ Ibid.

¹³⁸ Ibid.

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¹⁴² O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*.

¹⁴³ Colonel Paul Barras, telephone interview with the author.

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¹⁴⁵ O'Brien, ed., *Substance Use Disorders in the U.S. Armed Forces*, 5

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¹⁴⁷ Colonel Paul Barras, telephone interview by author, February 2, 2015.

¹⁴⁸ Sandra Basu, *Greater Alternative Therapy Use Gradually Decreases Opioid Dependence in Military*.

¹⁴⁹ *Pain Management Task Force Final Report 2010*, 63.