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A Shared Burden: The Military and Civilian Consequences of Army Pain Management Since 2001

Craig Trebilcock

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A SHARED BURDEN: THE MILITARY AND CIVILIAN CONSEQUENCES OF ARMY PAIN MANAGEMENT SINCE 2001

Craig Trebilcock

August 2015

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Comments pertaining to this report are invited and should be forwarded to: Director, Strategic Studies Institute and U.S. Army War College Press, U.S. Army War College, 47 Ashburn Drive, Carlisle, PA 17013-5010.

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PREFACE

The U.S. Army War College (USAWC) provides an excellent environment for selected military officers and government civilians to reflect and capitalize on their career experience to explore a wide range of strategic issues. To ensure that the research conducted by USAWC students is available to Army and Department of Defense leaders, the Strategic Studies Institute publishes selected papers in its "Carlisle Papers" series.

STEVEN METZ
Director of Research
Strategic Studies Institute

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CRAIG TREBILCOCK is a U.S. Army Reserve officer serving in the Judge Advocate General's Corps. In his civilian capacity, Colonel Trebilcock is a judge of the Court of Common Pleas of York County, PA, where he presides over a criminal court docket; he is also that county's Veterans' Treatment Court judge. Colonel Trebilcock holds a master's degree in strategic studies from the U.S. Army War College, and a bachelor's degree in political science and history and a Juris Doctor degree from the University of Michigan.

SUMMARY

The Army has an opioid drug problem that is not going away under current personnel policies and medical practices. The survey results recorded here indicate that senior officers attending the U.S. Army War College (USAWC) recognize that the opioid problem is distinct in nature and origin from those of recreational drug abuse. Yet, these officers are saddled with a legacy drug enforcement structure and outdated procedures that do not track opioid usage across the force and do not address the root cause of the issue. They are commanding units under a regulatory structure that belatedly responds to opioid-related misuse with the same misconduct-focused disciplinary policies as those for recreational drug use, rather than with a proactive medical and personnel approach crafted for this unique problem set that emphasizes prevention and rehabilitation. The USAWC officer survey responses reflect the fact that the majority of these future Army leaders see misuse originating out of prescribing practices, a lack of medical monitoring, and a lack of soldier training and education on the dangers of opioids, rather than from undisciplined soldiers.

This Carlisle Paper is not meant to be the final word, but the beginning of a new conversation. The survey samples were not from random populations, but specifically chosen groups of leaders with specialized knowledge and expertise in this area. The samples presented do not claim to represent the views of all judges or all Army officers. But the trends from their responses are intriguing, as they break from past presumptions and perceived truths regarding opioid use. They suggest a new way of thinking about the Army's opioid problem, as well as its impact on combat readiness and civil-military relations.

The comparison of the two surveys reveals that, in most instances, there is not a significant gap between civilian judge and senior Army officer thinking as to the nature and seriousness of the problem. Rather, military prescription practices and the application of legacy policies that presume separation as opposed to prevention and rehabilitation are creating the cracks for a future civil-military gap to widen. Army procedures that continue to supply opioids on a wide scale, but then transfer the adverse long-term costs of those policies onto civilian society, are not in the best interest of Army readiness, soldier health, or civilian safety and fiscal security. Army policy and regulatory reform is needed to counter these trends successfully. This will require policies different from those in the Army's institutional comfort zone, which have served well in countering recreational drug use for 40 years. To protect the readiness of its force, the Army should consider the path suggested by those it has trained to be innovative and strategic thinkers at the USAWC—a future focused upon increased rehabilitation, soldier education, medical monitoring, and unit-level opioid-readiness tracking.

A SHARED BURDEN: THE MILITARY AND CIVILIAN CONSEQUENCES OF ARMY PAIN MANAGEMENT SINCE 2001

Military and civilian personnel are often viewed as living in separate, but parallel, societies. The Department of Defense (DoD) has its own housing, stores, and recreational facilities. A different code of conduct and higher expectations are placed upon soldiers and military families than on their civilian counterparts. Yet, these two societies do not exist immune from the activities in the other. This is an inevitable consequence of an all-volunteer force drawn from civilian roots, and the ultimate return of Army veterans to their civilian communities after finishing their service. This symbiotic relationship is particularly evident with the growing numbers of Operation ENDURING FREEDOM (OEF) and Operation IRAQI FREEDOM (OIF)/Operation NEW DAWN (OND) veterans who are returning to civilian life with opioid pain medicine dependency, addiction, and misuse issues at the time of their military discharges, resulting in public health, crime, social, and fiscal burdens for the communities receiving them.

There has been a substantial increase in opioid pain prescriptions[1] in the U.S. Army since 2001, and a consequent dramatic increase in soldier prescription misuse. Opioids include opiates such as morphine, codeine, and opium, which are derived from the opium poppy.[2] Opioids also include synthetic pharmaceuticals prescribed to manage pain, which operate on the central nervous system in the same manner as opiates to block pain and cause a sense of euphoria and well-being.[3] Common forms of opioids prescribed to soldiers include Percocet (oxycodone and acetaminophen) and Vicodin (hydrocodone and acetaminophen). All opioids can lead to dependency and addiction with ongoing use.[4]

To examine the impact of Army opioid use on the Army and civilian society, two parallel surveys were conducted of leaders who have experience dealing with soldiers and OEF/OIF veterans with opioid-related issues. The first study group comprised Veterans Court judges[5] who preside over civilian criminal courts in which former military personnel are facing criminal charges arising out of opioid misuse. There are 177 county and municipal level Veterans Courts dispersed across the country from California to New England. The second study group comprised 217 senior Army officers in the ranks of colonel and lieutenant colonel attending the U.S. Army War College (USAWC) in the resident class of 2015. This latter group was chosen because many of these officers have recently been unit commanders with disciplinary responsibility over soldiers with drug problems. They were also chosen because Army War College graduates have a high likelihood of being in Army policymaking or policy-influencing positions after graduation, providing a glimpse into future Army leadership attitudes on the opioid issue.

The goal of the survey[6] was to evaluate, compare, and contrast the levels of awareness and attitudes toward opioid use and misuse between these two groups who exercise leadership and judicial and quasi-judicial[7] authority within their respective societies. Of the 31 percent survey response rate, 44.1 percent of the responding Army officers reported direct personal experience with a soldier who misused or was addicted to opioid drugs. Of those experiences, 80.6 percent were as the affected soldier's unit commander, and 16.1 percent were in another role in the unit chain of command.[8] One

respondent noted an opioid pain prescription addiction while in a leadership position, and another observed his superior commander's suffering opioid misuse or addiction issues, suggesting that this is not an issue merely impacting lower-ranking personnel. The balance of Army respondents were senior staff officers such as judge advocates or medical personnel, and those acting in an investigatory or court-martial/administrative board role.

BACKGROUND

In 2001, prior to the beginning of OEF, the Army did not have a disproportionately large opioid drug problem, with opioid misuse rates consistent in source and scope with other low-level recreational drug misuse among soldiers. However, opioid pain relief prescriptions written by military physicians quadrupled between 2001 and 2009—to almost 3.8 million.[9] While wounds suffered in OEF and OIF/OND accounted for some of this upsurge, a significant growth in deployment-related orthopedic injuries also increased the demand for more pain management.[10] In addition, some military medical practitioners began to prescribe opioids for chronic pain of a lesser severity than the moderate to severe pain threshold recognized as appropriate for such use.[11] With the expanded availability of opioids in the force, Army prescription drug misuse increased five-fold from 2 percent to 11 percent of soldiers from 2002 to 2008.[12] During this same time frame, civilian prescription drug misuse also grew, but less than doubled; it remained below 4 percent of the population.[13] Opioid prescription drugs, in fact, represent the only category of drugs for which soldier misuse exceeds that of civilians.[14]

The growth of medically based opioid use in the Army is an extension of the civilian society's approach to pain management. Of the world's opioids, 80 percent are consumed in the United States, with Americans using 99 percent of the world's hydrocodone (which when combined with acetaminophen, as stated, is popularly known as Vicodin).[15] However, the Army now prescribes opioids at rates far exceeding those of the civilian medical world.[16] These do not reflect merely short term, nominal usage of these drugs either. Army statistics from 2012 show that of all of the soldiers to which military practitioners prescribed opioids, 25-35 percent of them physically depended on opioids at the time of their discharge.[17] Accordingly, the link between Army prescription-initiated opioid use being carried into the civilian world at the time of a soldier's discharge is clear.

Prescription Opioids Impact on Readiness.

For decades, the belief embraced by Army leaders was that soldiers with prescription drug addiction and misuse issues are deficient in character and toughness, needing to be separated from the good soldiers to preserve good order and discipline.[18] However, as Mark Twain observed, "It's not what you don't know that kills you; it's what you know for sure that ain't true."[19] The prescription opioid problem currently eating away at Army readiness is distinct in its origins, growth, and consequences from recreational drug use; yet, this problem is being addressed by the Army as if it derived from substandard soldiers choosing to begin taking opioids from a lack of discipline.

While illegal recreational drugs such as marijuana or cocaine historically have been obtained from illicit sources, opioids are being distributed by licensed military medical professionals through prescriptions. Diversion and illegal sales by drug dealers of opioids certainly occur. There is little doubt, however, that the growth of military opioid use that mushroomed with the beginning of OEF and OIF was medical in origin. In 2010, the Surgeon General briefed the Vice Chief of Staff of the Army that nearly 14 percent of the Army (76,463 soldiers) were using some form of legally prescribed opioid drug, and 25,761 of those same troops were taking more than one Army-provided pain prescription.[20] By 2013, the level of opioids being prescribed across all military branches was at 24 percent of the force, according to testimony before the Senate by Brigadier General Norvell V. Coots, Deputy Commanding General and Assistant Surgeon General for Force Projection.[21] To understand the full scope of this challenge, it is important to note that this 24-percent figure captures only the legally prescribed usage and does not reflect the previously noted additional number of service members misusing these pharmaceuticals without authorization after they have become addicted to or dependent on the prescription drugs.

Accordingly, with the Surgeon General's data reflecting over one in seven soldiers was prescribed opioids in 2010, and nearly one in four military service members across all branches were prescribed opioids as of 2013, the scope of pain pill use among the nation's fighting force is staggering, with a direct impact both upon Army readiness and opioid misuse. The growth in illegal opioid misuse from 2002-08, while the number of lawful prescriptions were quadrupling from 2001-09, was not merely coincidental. Researchers have indicated that the number one driver for the likelihood of opioid misuse is the availability of an opioid prescription, with a person having such a prescription being three times as likely to abuse opioids as a person who has no prescription.[22]

Opioids are a medicine and provide lifesaving relief to those with extreme pain. However, due to their addictive nature, the treatment benefit must be carefully weighed by physicians against health risks. A 2014 research letter from the Walter Reed Research Institute raised the specter that opioids are not always being prescribed within the Army just for serious pain cases. In a survey of a redeploying infantry brigade in 2011, the study determined that 15.1 percent of the brigade members were prescribed opioids by the Army upon their return, but that 44 percent of the soldiers given the drugs did not report the qualifying levels of moderate to severe pain that warrant opioid intervention under accepted military prescription standards.[23] Some of the soldiers given opioids had reported pain levels ranging from zero to minimal in the previous month.

It is not just the number of soldiers given opioids that is worrisome from a readiness perspective. The duration of opioid prescriptions is a source of concern due to the addictive qualities of these medicines. Some soldiers in the study were being prescribed the drugs past the 90-day threshold that defines chronic pain, for which opioids are often not appropriate because of their addictive nature and other adverse health side effects.[24] The findings of the Walter Reed research study, coupled with the previously noted 25 to 35 percent dependency levels at discharge for soldiers who were prescribed opioids, suggest the possibility that this is a problem the Army is growing and perpetuating internally through prescription practices and patterns. Former Army Surgeon General, Lieutenant General Eric Schoomaker, voiced concern in response to the Walter Reed study, noting:

> 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.[25]

The warning of Schoomaker, as the Army's former top doctor, regarding the adverse impact of prescribing opioids for chronic pain warrants serious attention from Army policymakers because of the potential impact on readiness. His warning also suggests the need to reconsider the supposition that it is undisciplined and risk-taking soldiers who are the major drivers of the Army's opioid problem.

Schoomaker is not the only Army leader concerned with the impact of prescription practices upon force readiness and soldier health. Prior unit leaders now attending the USAWC also believe that prescription opioid use can impair their units' readiness. An overwhelming 96 percent of former unit commanders and members of unit chains of command, responding to the survey conducted with the 2015 USAWC class, said "yes" when asked, "Is it important for you as a commander or member of the chain of command to know how many of your unit's soldiers are taking opioid pain prescriptions at any one time?" Only 4 percent responded "no." When also asked, "As a commander or member of the unit chain of command, do you believe the level of opioid use within a unit has an impact on unit readiness?", 70 percent responded "yes," 6.7 percent responded "no," and 23.3 percent selected "I don't know/no opinion."

In other words, more than two-thirds of the officers responding believe that opioid use impacts unit readiness. The fact that a fairly substantial 23.3 percent indicated they did not know, or had no opinion, may well be related to the lack of information provided to Army unit leaders about opioid use within their units. This lack of information is addressed in greater detail in the remainder of this paper.

The survey also sought to explore, by proposing a hypothetical, what the word "readiness" means to these Army leaders in the context of prescription opioid usage. They were asked:

> For Commanders and chain of command, would you be comfortable sending an otherwise 'good soldier' on a combat mission involving performing a security role if they were taking an opioid pain medication at the time?

The responses were:

Yes - 7.1 percent
No - 60.7 percent
It depends on the soldier - 25 percent
I don't know/No answer - 7.1 percent.

Over 60 percent of unit commanders and unit leaders stated that they would not feel comfortable sending a soldier on a mission in a security role if he or she was taking opioids. Yet, information from the Surgeon General's office over the past 5 years indicates that somewhere between 14 to 24 percent of soldiers and military personnel

are being prescribed opioids. That is a huge part of the team to "bench" with the current operational pace.

The preceding three questions taken together reflect the fact that the majority of Army commanders and unit leaders surveyed believe that prescription opioids can impair the effectiveness of soldiers in performing combat missions. They also want to know how many of their soldiers are taking opioids so that they can gauge that readiness impact. These responses make sense, considering that a commander's ultimate responsibility is ensuring his or her unit is ready to carry out the missions it is assigned. The responses are also in accord with the readiness concerns expressed by Schoomaker, who warned that overprescribing opioids can functionally impair America's fighting forces. Having such a large segment of the Army force being potentially not combat-ready in the eyes of commanders due to opioid consumption is a serious readiness issue.

Yet, despite the widespread scope of opioid prescriptions and the expressed concerns by commanders over their impact on readiness, when USAWC officers were asked, "Through what sources did you as commander or member of the chain of command receive information on unit levels of prescription opioid use when you were in that leadership position?" The responses were mixed, as noted in Table 1. The single most-frequent response, at 39.3 percent, was that Army unit leaders did not receive that information.

Q6. Through what sources did you as a commander or member of the chain of command receive information on unit levels of prescription opiod use when you were in that leadership position?

Answered: 28 Skipped: 40

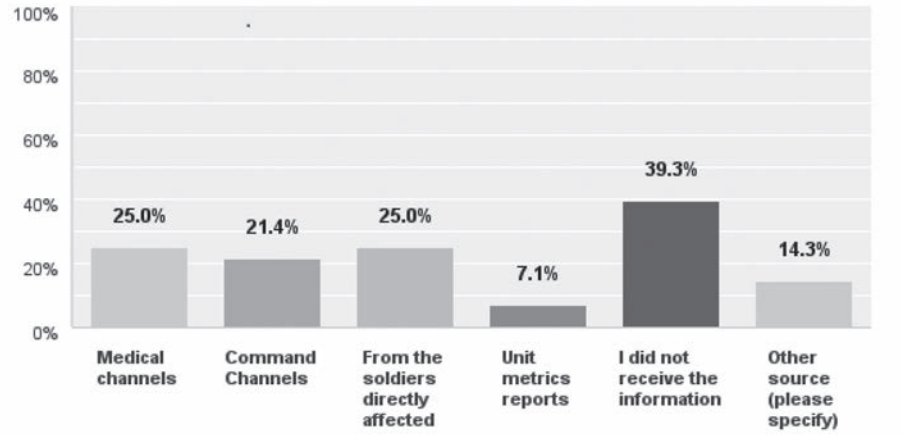


Table 1. Sources of Commander Information on Unit Opioid Use Levels.

These results suggest that unit commanders are not being regularly and reliably informed of the medical readiness of their units when it comes to the adverse impact of prescription opioids. They are receiving information through a variety of uncoordinated sources, but most often they are not receiving information at all. This is a state of affairs that should be of concern to the Army's top leadership. Unit leaders have expressed their belief that there is a causal connection between opioid consumption and readiness levels. Their survey responses reflect that they recognize this consumption can

adversely impact readiness, and they want to know whether their unit is medically fit for their mission. However, they are lacking the information to assess the extent to which their unit readiness is being affected by opioid prescriptions. Only 25 percent of the respondents indicated that they received information about their soldiers' opioid use through medical channels, and 7.1 percent indicated they received information through metrics reports. Typically, opioid use is not a category tracked in unit metrics reports.

This overall gap in knowledge about potentially soldier-impairing conditions is contrary to one of the most basic principles of readiness—an informed commander. In fact, the lack of a metrics system for opioid use is placing commanders in a position in which they regularly and systematically do not have access to the information they need to assess their soldiers' readiness to deploy and fight.

The Army has signaled that possessing such soldier medical information is indeed important, as it requires commanders to track dental exams, flu shots, inoculations, and annual physicals through unit medical metrics and report deficiencies to higher headquarters. Soldiers using opioids can experience clouded thought processes, dizziness, and nausea even with proper use, and die when opioid drugs are improperly used.[26] The side effects these drugs bring, even when dependency and addiction do not occur, are serious and can impair readiness, yet no unit level tracking and reporting exists. This is an area in which greater priority is required to keeping commanders informed, and the Army as a whole should focus greater resources in tracking opioid-related medical readiness.

While health privacy laws such as the Health Insurance Portability and Accountability Act[27] (HIPAA) may currently limit the identification of specific soldiers taking a certain drug, these laws do not preclude a commander from being kept advised of the overall level of opioid prescriptions in his or her unit, without individual identifying information. Knowing whether one's unit has a 4-percent or 24-percent opioid prescription usage level still conveys important information regarding overall unit readiness to the commander, as well as signals the level of need for training and education to unit members on adhering to the prescribed limits in using these drugs.

Rehabilitation Policies and Community Safety.

Due to their addictive quality, opioids can cause physical dependency and psychological addiction for those who take them.[28] Those who become addicted place obtaining more drugs to feed their addiction above all other priorities.[29] That is the biological and psychological nature of addiction, which crosses class, branch, education, rank, and gender lines. This skewing of priorities can often lead the addicted soldier into conflict with his or her chain of command and law enforcement through misbehavior. Civilian judges have long recognized that individuals who might not otherwise engage in criminal conduct will indeed steal, prostitute themselves, sell drugs, or commit other crimes to sustain the drug supply to feed their addiction. Once they are addicted, their brain tells them they must have more of the drug to survive regardless of adverse consequences.

In the second parallel survey, civilian Veterans Court judges were asked to respond to the following statement: "Opioid addiction may lead to criminal behavior in a military service member or veteran who would not otherwise engage in criminality." See Table 2 for the Veterans Court judges' responses.

Strongly Agree	Moderately Agree	Moderately Disagree	Strongly Disagree	Do not know/No Opinion	Total
52.4% 55	41.0% 43	1.9% 2	1.9% 2	2.9% 3	105

Table 2. Judge Responses to Opioid Addiction Prompting Criminality in Soldiers/Veterans.

A total of 93.4 percent of the judges surveyed moderately or strongly agreed that an otherwise law-abiding military service member or veteran can be led to criminal behavior because of becoming addicted to opioids. Only 3.8 percent disagreed, with the balance indicating uncertainty or no opinion. This demonstrates an important principle recognized among criminal judges, that it is not just undisciplined people of poor moral character, or those predisposed to criminal conduct, but also who otherwise would be law abiding are recognized as susceptible to criminal behavior once they are exposed to and become addicted to opioids. Homemakers, college students, doctors, and businessmen appear in civilian criminal courts with opioid-related misconduct that originated in prescription use.

Individual soldier responsibility is a cornerstone of Army culture. Accordingly, USAWC students were asked to react to the statement:

> Opioid addiction may lead to criminal behavior in a soldier (e.g., shoplifting, theft, illegal possession and distribution of drugs, etc.) who would not otherwise engage in criminal acts.

The USAWC student responses are shown in Table 3.

Answer Choices	Responses	
Strongly Agree	14.9%	10
Moderately Agree	62.7%	42
Moderately Disagree	13.4%	9
Strongly Disagree	3.0%	2
No opinion/Do not know	6.0%	4
Total		67

Table 3. USAWC Responses to Opioid Addiction Prompting Criminality in Soldiers/Veterans.

Similar to Veterans Court judges, 77.6 percent of USAWC officer respondents moderately or strongly agreed that soldiers who would not otherwise commit crimes may engage in criminal acts once they become addicted to opioids. A total of 16.4 percent of respondents disagreed with the statement, and 6 percent selected "No opinion/Do not know." While these responses reflect a slightly greater level of disagreement with the statement than among the judges, overall, the views in both groups indicate a general recognition among both civilian and military leaders that once addiction occurs, opioids exert a detrimental social and behavioral hold on people who are not inherently criminal in character. Neither set of responses means that personal responsibility does not attach to those who engage in drug-related misconduct, or that drug addiction should be a defense to criminal conduct. Determining whether the source of the broad-scale opioid problem lies in inherent criminal traits or medical collateral damage is important, because it helps frame whether belated punitive responses or preemptive preventative and rehabilitative policy responses will be most successful in combating the rise of opioid misuse and addiction in the Army.

USAWC students were next asked:

> Do you believe that soldiers who have become dependent upon or addicted to their opioid pain medication prescription have the potential to be medically treated and rehabilitated so that they can successfully return to Army duties?

A significant portion, 85.3 percent, responded "Yes"; 7.4 percent responded "No"; and 7.4 percent indicated "I don't know/No opinion." Thus, in addition to believing that otherwise law-abiding soldiers may engage in misconduct if addicted to opioids, this same group of officers indicated by a large margin that they believe soldiers who became dependent upon or addicted to prescription opioids have the potential to be treated, rehabilitated, and returned to duty. This response is significant, since it seems to suggest that soldiers who are addicted to opioid pain prescriptions may be viewed as qualitatively different by unit leaders from soldiers who engage in recreational drug use. The response is certainly contrary to Army regulatory policy, discussed in detail here, which assumes that soldiers with drug dependency and addiction issues should, in most cases, be separated from the Army.

The next question presented to both USAWC officers and Veterans Court judges concerned the impact, if any, that occurs when rehabilitation is not provided to those who are addicted to opioids. The USAWC officers were first asked to respond to the following statement regarding whether soldiers with an untreated opioid addiction present a safety and law enforcement concern for the Army. Their responses are shown in Table 4.

Q26. Army personnel with an untreated opioid addiction present a safety and law enforcement concern for the Army.
Answered: 68 Skipped: 0

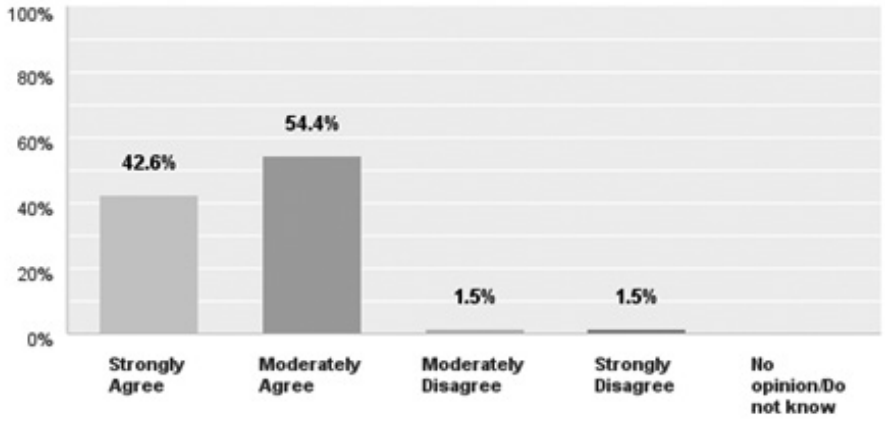


Table 4. USAWC Response on Safety and Crime Threat to Army by Untreated Addicts.

A total of 97 percent of the officers responding either moderately or strongly agreed that untreated opioid addicts are a safety and law enforcement concern in the Army. Only 3 percent disagreed, seeing untreated opioid addiction as not presenting a safety and law enforcement concern. The results did not vary much when this same group of officers was asked what the safety impact would be on civilian communities if Army personnel with addictions are discharged in an untreated state. These results are shown in Table 5.

Q27. Army personnel who are discharged with an untreated opioid addiction present a safety and law enforcement concern for the civilian communities to which they return.
Answered: 68 Skipped: 0

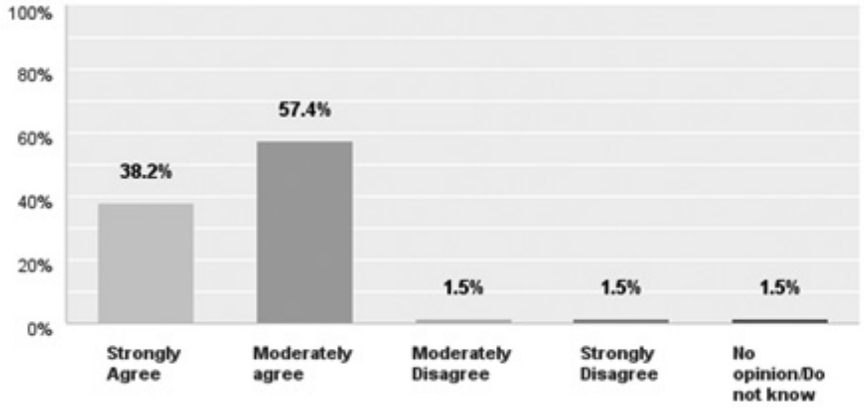


Table 5. USAWC Response on Safety and Crime Threat to Civilians by Untreated Addicts.

A total of 95.6 percent of the USAWC respondents expressed the opinion that soldiers discharged without treatment for an opioid addiction presented a safety and law enforcement concern for the civilian communities to which they return. A total of 3 percent disagreed, and 1.5 percent indicated either No opinion/I don't know. There is apparently little disagreement, then, in the views of these Army leaders that when soldiers are not treated for their opioid addiction, there is a resulting safety and law enforcement risk to both the Army and to civilian communities.

Veterans Courts across the country are being confronted with a growing number of OEF and OIF veterans who are leaving active duty with opioid addictions. Over the past 10 years, criminal court judges have been seeing a growth in their opioid-related caseload from military personnel and veterans, during the same approximate time period that opioid prescriptions and misuse have been peaking in the military. A combined total of 77.2 percent of Veterans Court judges surveyed have seen an increase in opioid and opioid-related crime over the past 10 years from military personnel and veterans. Only 2 percent of judges have seen a decrease; for 20 percent of judges, the caseload of opioid offenders has remained the same. See Table 6.

Q5. Over the past ten years the relative number of military personnel and veterans appearing in my criminal (VTC or traditional) court for opioid-related criminal conduct has:
Answered: 101 Skipped: 5

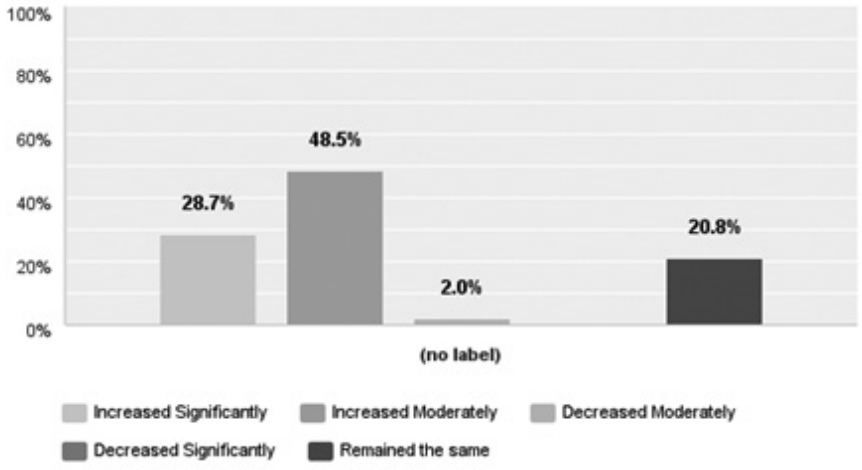


Table 6. Veterans Court Opioid Crime Caseload Levels.

The discharge of soldiers with opioid issues is likewise a safety issue in the eyes of Veterans Court judges, who were also asked about the impact of untreated military personnel with addiction issues returning to their civilian communities. See Table 7.

Q6. When military personnel are discharged from military service with an untreated addiction to opioids it increases crime in the community to which they return.
Answered: 104 Skipped: 2

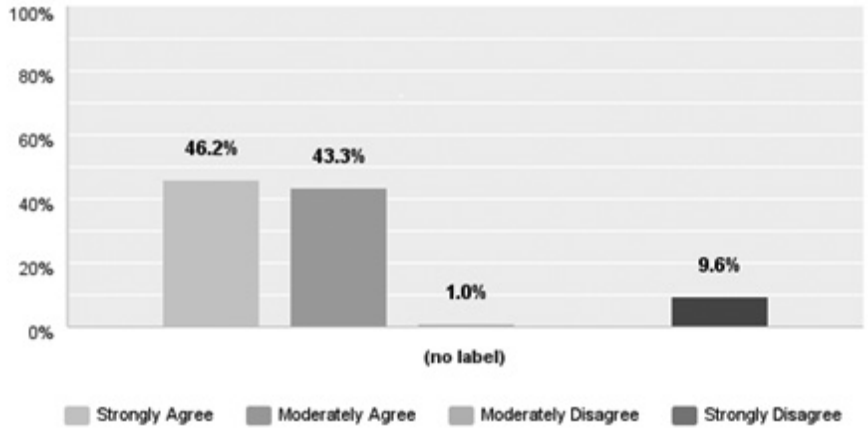


Table 7. Veterans Court Judges on Untreated Military Opioid Addicts Increasing Crime.

A total of 89.5 percent of the judges indicated either moderate or strong agreement with the statement that untreated military opioid addicts returning to civilian communities increase crime. Only 1 percent moderately disagreed, none strongly disagreed, and 9 percent did not know or had no opinion. The responses from both the USAWC officers and judges reflect a strong consensus among civil and military leaders that untreated opioid addicts are a safety and law enforcement risk. The data from civilian judges indicates that the number of opioid-related crime they are seeing from military personnel and veterans has been increasing over the past 10 years.

As previously noted, more than three out of four USAWC officers responding gave the opinion that rehabilitation can return soldiers with a prescription opioid addiction to duty if treated. In light of this strong alignment of views that safety decreases and crime risk increases for both the Army and civilian society when soldiers are not treated for opioid addiction, and that rehabilitation of soldiers is an effective policy option, one would expect that existing Army policies and regulations would seek to maximize rehabilitation for opioid-addicted soldiers and ensure that gaps in rehabilitative care are minimized. To be in alignment with the views of these Army leaders, one would expect Army regulations and policies to reflect principles that:

1. Presume soldiers are to be treated and rehabilitated from prescription opioid addiction for continued service in the force when they have future service potential;

2. For soldiers who cannot or should not be retained—since they do not have potential for future service, in the view of their commander—they will not be released from active duty without drug rehabilitation being first provided, so that they do not present a safety and crime risk to civilian communities;

3. Where soldiers are released from Army control prior to rehabilitation being completed, they will be discharged in a manner that ensures that their treatment and rehabilitation is provided through civilian channels.

The reality, in fact, is that none of these is true.

Army regulations and policies do not ensure that soldiers will receive drug rehabilitative treatment before discharge, nor do these regulations and policies minimize barriers to ensure they will get the needed help at the Veterans Administration (VA) after discharge; the regulations merely presume that such post-discharge help for soldiers **may** occur, but take no responsibility to ensure it will. Sometimes it occurs, but many times it does not. As discussed next, Army personnel practices, in combination with VA eligibility policies, often deny rehabilitation treatment to soldiers who leave active duty with prescription opioid problems. This gap in care, built upon flawed presumptions of later treatment that does not in fact occur, creates a recovery gap for many soldiers and raises potential adverse consequences to civilian society of soldiers returning home dependent on or addicted to and misusing[30] opioids. The Army-to-civilian treatment gap for soldiers with opioid dependency, addiction, or misuse issues exists in part because:

1. Soldiers receiving an Other Than Honorable (OTH) discharge can be denied access to VA drug rehabilitation services.[31] As an OTH discharge is the "presumed" discharge for drug abuse under *Army Regulation (AR) 635-200*,[32] this policy disconnect between two federal agencies works to pass soldiers with prescription opioid addiction and related misconduct issues untreated into civilian society, where they commit crimes, overdose, and strain civil resources. This is not an infrequent or rare occurrence. In a study of 645 veterans seeking admission to civilian Veterans Courts, 200 of them were denied VA services, including rehabilitation, due to adverse discharges[33];

2. Soldiers with substance abuse issues engage in denial once freed from military oversight and supervision, thereafter refusing to seek VA help. The addiction speaks louder than common sense or self-preservation, an inherent characteristic of addiction;

3. Barriers to care exist under which soldiers eligible for VA services do not access them after leaving the Army because of miscommunication or misunderstanding about their eligibility, the availability of programs, frustration over VA waiting lists, and the distance of the veterans in rural areas from VA hospitals.

As such, legacy policies built upon presumptions within the Army that the VA is waiting as a reliable safety net to take care of addicted soldiers discharged into civilian life are misplaced. The VA helps many veterans. But it also misses helping many veterans because of the factors mentioned earlier. When dealing with opioid addictions that both Army leaders and judges recognize lead to safety and security risks for veterans and the communities to which they return, an approach that works sporadically for many, but not all, veterans, is inadequate. Such an inconsistent system may have been tolerated in the past where those slipping between the cracks were undisciplined recreational drug abusers who voluntarily chose to use illegal drugs contrary to military law—an unsympathetic population in many eyes. However, when initial exposure to addictive opioids is occurring for soldiers through military medical channels, and early studies and data are suggesting that widespread and prolonged prescriptions are

a driver of misuse and dependency issues, such a treatment gap is intolerable. While no system may be flawless, current Army policies increase, not minimize, the chance that opioid-troubled soldiers will enter the civilian world without rehabilitation.

Once a soldier becomes physically dependent on or addicted to a drug, Army regulations do not mandate rehabilitative efforts. A soldier is detoxified while on active duty when his or her substance abuse is discovered to ensure he does not overdose, but that is different than treating and rehabilitating a long-term addiction. Rehabilitation is an option at the commander's discretion, with prior duty performance and future duty potential being considerations as to whether full rehabilitation will be provided. It is not purely a medical decision, but a command decision, in which the soldier's prior good-duty performance—indicating potential for future valuable service—is important. From an Army resource allocation perspective this makes some sense when recreational drug abuse is the issue. For why should the Army expend valuable resources to rehabilitate poorly performing soldiers who are voluntarily using illegal drugs? However, with a different and broader perspective, one might ask, why is job performance a dispositive factor in whether one gets drug rehabilitation in the Army if the exposure to the drug originates in prescribed medical treatment?

One does not have to earn a reward to get other forms of medical treatment and therapy in the Army, but drug rehabilitation is not treated as a medical condition from a policy standpoint, but presumptively as an immoral act from which access to rehabilitation must be earned by showing future good-duty potential. This approach arguably had some weight when addictions in the post-Vietnam era resulted from recreational drug use, but that is not the situation confronting the Army today, with opioid misuse and addiction originating from pain prescriptions issued through medical channels.

It is important to make clear that opioid misuse can occur even with the most conscientious prescription patterns and oversight by military physicians. One reason this problem exists is the life-saving efforts of military medicine during wartime that have more soldiers than ever surviving serious wounds. Different persons have different vulnerabilities to addiction because of their biological and social backgrounds, as well as life experiences, among other factors. It is the nature of these drugs acting on the central nervous system to create physical dependency, such that their use creates a high risk of misuse and addiction within the force. They come with great benefit in pain management, but they are also inherently dangerous. Pointing fingers at soldiers or doctors is not helpful. But identifying the unique source of the risk so that risk management policies can be crafted effectively is essential for freeing the Army from the erosion of readiness that is occurring under current policies.

While some substance abuse programs exist in the Army, including for opioids,[34] the Army's substance abuse regulation, *AR 600-85*, in fact presumes rehabilitation for drug dependency and addiction will be performed by an external civilian entity after the soldier is separated. The regulation states:

> 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.[35]

While one of the external treatment programs noted in the regulations can be the VA, the Army's personnel misconduct regulations provide for a presumed level of discharge (OTH) that is a basis for denying VA rehabilitative drug treatment. This results in Kafkaesque logic, in which the very condition that requires treatment is the condition that triggers denial of access to treatment. Drug addicts misbehave, as getting the next drug dose drives their mental processes while in the actively addicted stage. People who are addicted to a drug often steal to have resources to buy the drugs that keep them from suffering withdrawal symptoms; they drive impaired, and they do not fulfill their duty responsibilities, which can be a crime under the Uniform Code of Military Justice (UCMJ). So, creating a system in which the Army imposes a negative discharge for that misconduct and then another federal bureaucracy uses that characterization of discharge as the basis to deny drug rehabilitation for the same condition that triggered the misconduct is a Catch 22 situation that serves to deny drug rehabilitation to the persons who need it the most. When VA uses the discharge to exempt itself from providing drug treatment, the social and fiscal costs shift by default onto local civilian communities, which may not have the facilities or resources to absorb a complex problem that originated at the federal level.

The Army's regulatory focus on removing drug-dependent and addicted soldiers is consistent with the Army priorities of keeping the force strong for its combat missions. For the 40 years following the drug threat to readiness that characterized the Vietnam-era Army, the Army has responded to that threat by removing undisciplined soldiers who engage in such conduct from the force. That is the philosophy underlying the presumptions of separation and OTH discharges contained in *AR 600-85* and *AR 635-200, Enlisted Administrative Separations*. However, when such policies are applied to soldiers whose opioid dependency or addiction arise out of opioid prescriptions issued by military medical practitioners, these same policies may conflict with the Army's other priorities of taking care of soldiers and military families, as well as protecting civil society from safety and security threats.

Where Army prescription policies increase the likelihood of opioid misuse threefold[36] for soldiers, and Army personnel policies then assume that rehabilitation will be provided by external civilian agencies after discharge, an environment has been created in which the risk of opioid dependency and addiction has been heightened within the Army, but the downside cost and long-term risk of those policies are often being transferred onto civilian society. Not only is this approach not good for civilian society, but it also unintentionally contributes to the Army's failing to revise its policies internally, since the opioid-dependent and addicted soldier becomes someone else's problem. It does not need to be that way; the fact that it is that way is the result of legacy Army enforcement policies and procedures being applied to soldiers with prescription opioid problems as if they were recreational drug abusers.

The Army regulations and policies that assume someone else will deal with dependency and addiction issues are not drafted the way they are because the Army does not care what happens to soldiers or civilian society. They are drafted this way to promote good order and discipline within the Army, an organization that must demand the highest performance from its members at all times. However, these regulations were not drafted with the current medical and social crisis in mind; that is, that the effects of a

13-year armed conflict have created a soldier population at high risk of opioid consumption, whose vulnerability to addiction and prescription misuse has been compounded by prescription practices and omissions in medical monitoring.[37] In sum, rules drafted in another time for another purpose are being applied to a different set of circumstances in which they do not fit, and are driving poor outcomes for the Army, soldiers, and civilian society.

This reliance on old policies for a new problem has occurred, in part, because on the surface the issues look similar—involving drugs, soldiers, and misbehavior. However, that is merely the veneer. The core of the problem, which is driving the growth of a military opioid culture undermining readiness and soldier health is a supply side, prescription-drug crisis in which soldiers are following military orders when they begin taking opioids, in contrast to a demand-side driven drug abuse crisis fueled by undisciplined soldiers buying drugs from illicit sources. The latter crisis requires discipline and enforcement. The former requires a prevention focus, soldier and doctor education, and regulatory reform, which promotes rather than creates barriers to rehabilitation. The fact that soldier drug abuse of all other types has remained at approximately 2 percent since 2001, while prescription drug misuse has climbed to 11 percent[38] of the force, reveals that discipline and deterrence do indeed work in the case of illegally provided recreational drugs. Traditional Army urinalysis screening and enforcement mechanisms have kept other illicit drug use at traditionally low levels despite the stressors of extended deployments over 13 years. However, these same policies have not been effective when the substance misuse problem is driven by medical and organizational cultural factors.[39]

To keep applying the same discipline-focused approach to a distinct problem in a manner that has proven ineffective over the past 10 years makes no sense. The Army has not discharged its way out of this readiness problem in over a decade, but it is swelling civilian courts, hospitals, and treatment centers with opioid-addicted soldiers. Perhaps the time for a new approach that addresses the actual underlying drivers has arrived.

Rehabilitation Can Restore Soldiers to Productive Lives.

There are effective policy alternatives for reducing the adverse effect of opioids on the Army beyond merely punishing those with opioid misuse and addiction issues. These alternatives are recognized and embraced by both Veterans Court judges and USAWC officers. Veterans Courts regularly use their authority to compel recent OEF and OIF veterans to obtain substance abuse help from the VA, when those services are available, or through community programs when VA eligibility is denied. A significant 92.5 percent of Veterans Court judges surveyed indicated a belief that Veterans Courts can rehabilitate veterans with opioid issues. Only 4.8 percent responded negatively to the proposition that Veterans Courts can rehabilitate veterans addicted to opioid drugs, and 1.9 percent indicated uncertainty or no opinion.

As noted, *AR 600-85* indicates that civilian society, either in the form of the VA or other unspecified civilian entities, will provide soldiers with the rehabilitation needed to overcome drug dependency[40] and addiction after discharge. In view of this regulatory presumption, USAWC students were given the following statement and asked to agree or disagree with it: "Due to the Army's unique mission, Army personnel who become dependent on or addicted to opioid pain medication should be discharged from the

service, with their drug rehabilitation left to civilian society to handle." For these opinions, see Table 8.

Q23. Due to the Army's unique mission, Army personel who become dependent on or addicted to opioid pain medication should be discharged from the service, with their drug rehabilitation left to civilian society to handle.
Answered: 67 Skipped: 1

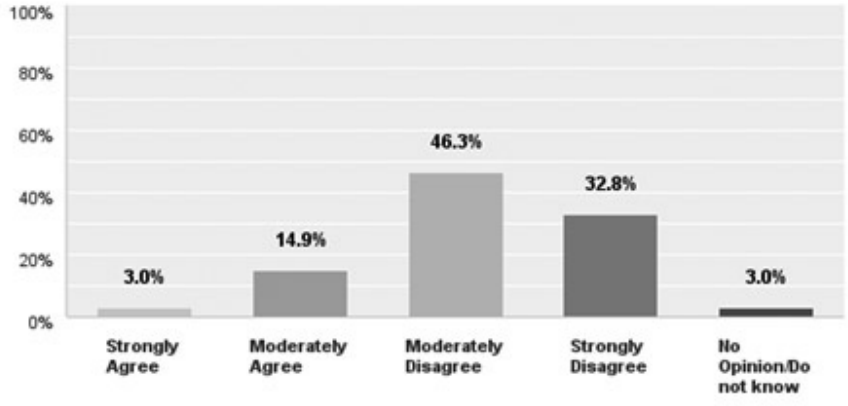


Table 8. USAWC Opinions on Discharging Soldiers for Rehab in Civilian Society.

A total of 17.9 percent of the officer respondents agreed at some level with the concept of having civilian society perform the treatment and rehabilitation on those addicted to opioid pain medication. A total of 79.1 percent of the officers disagreed with the idea of having civilian society responsible for the rehabilitation of soldiers with opioid issues, and 3 percent expressed no opinion. Accordingly, in the context of opioid pain medication, nearly four out of five of the Army's future senior leaders responding did not agree with the principles underlying *AR 600-85,* which assume that discharge and civilian rehabilitation is the appropriate disposition for soldiers with opioid dependency and addiction issues. This divergence in approach suggests that there is a need for considering a different policy response in the case of opioid pain medication addiction and dependency beyond discharging soldiers to be someone else's problem.

The Veterans Court judges were also asked whether, because of the Army's unique mission, soldiers should be discharged and rehabilitation performed in the civilian world. Their rejection of the Army's policy closely paralleled that of the USAWC officers. For the opinions of the judges, see Table 9.

Q11. Due to the military's unique mission, military personnel who become addicted to opioid pain medication on active duty should be discharged from the service, and their drug rehabilitation left to civilian society to handle.
Answered: 102 Skipped: 4

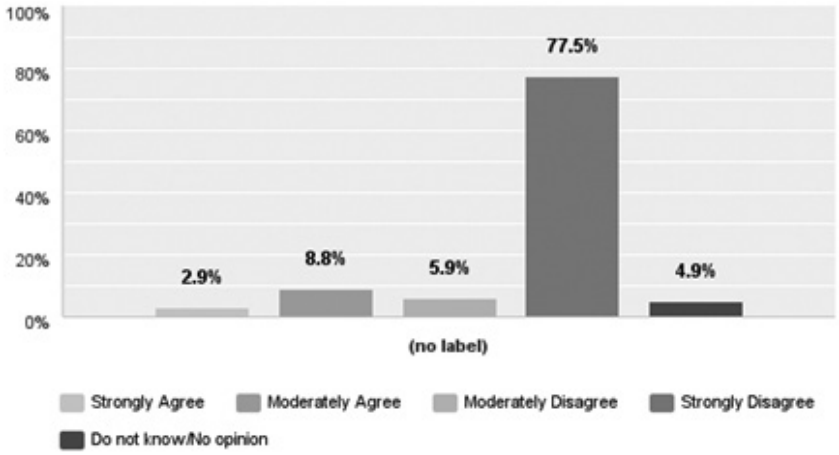


Table 9. Judge Opinions on Discharging Soldiers for Rehabilitation in Civilian Society.

A total of 77.5 percent of Veterans Court judges strongly disagreed with the policy of discharging soldiers for rehabilitation in civilian society. Another 5.9 percent moderately disagreed. The total favoring such a policy was 11.7 percent, with the balance of 4.9 percent being undecided or not having an opinion. The underlying reasons behind these views are not indicated in the survey. However, it would be mono-dimensional to assume that this is merely a discussion over who foots the bill. While money and the cost of rehabilitating soldiers is a significant policy issue, the previously mentioned issues regarding gaps in service once a soldier leaves the Army are a major concern addressed by Veterans Court judges at their annual conferences.

It is also not just an issue of who provides the help, but rather a concern that no one provides the help once the soldier is discharged until it is too late. An issue as serious and unforgiving as opioid addiction has no room for disconnects or miscommunication. It is a high-risk/high-consequence event. Failure to address opioid dependency, misuse, and addiction promptly can lead to tragedy through overdose deaths or criminal conduct that destroy the lives of victims, as well as tear apart military families when the addicted perpetrator is sent to jail.

The survey results indicate that the assumption of the Army's substance abuse regulations is out of alignment with the views of both senior Army officers and civilian judges who inherit the consequences of that policy when soldiers with opioid issues are discharged from the Army without full opportunity for rehabilitation first being provided. The Army should carefully evaluate if its discharge policies place itself at risk

of widening the civil-military gap should the Army continue a policy that presumes the civilian world is willing to remain responsible for an opioid problem originating in large part in military medical practices. This reevaluation is appropriate and vital when there are policy alternatives in which the Army, soldiers, and civilian society all win.

Army legacy disciplinary and personnel policies were designed for recreational drug abuse with a focus upon post-misconduct action. Army records reflect that:

> Over 80% of Army soldiers during the Vietnam War used marijuana, and 45% tried narcotics (34% used heroin; 38% used opium.)[41]

The post-Vietnam Army was ill-disciplined as a result. Punishment and adverse discharges were employed to get rid of bad soldiers and deter future misconduct, and it worked: by 2001, illicit drug use Army-wide was down to approximately 2 percent. Yet, the opioid prescription misuse problem has grown since 2001 despite these legacy policies. If one lets opioid use and misuse expand without medical and rehabilitation countermeasures it inevitably becomes an Army disciplinary issue; the surveys have already reflected that an otherwise law-abiding individuals can devolve into criminal conduct once they become addicted. This does not mean the answer is more discipline, however. Rather, a policy focusing on prevention and earlier medical intervention through monitoring, to prevent prescription use from developing into a disciplinary problem in the first place, is required to counter a problem that is largely medical in origin.

Unlike any other drug use in Army history, the organization knows where the supply is coming from—the post clinic. The Army knows who has the drugs, because soldiers create medical records with each prescription. So, forearmed with this knowledge as to who is at risk, the Army is the sole entity in the best position to intervene and preempt this opioid crisis in a way that neither the VA nor civilian entities can after the soldier has become a medical emergency and a disciplinary and safety threat. Developing new policies that embrace a preemptive and preventative approach is a matter of breaking free from familiar historical practices, setting aside past assumptions about the caliber of soldiers who have dependency or addiction issues, and changing the cultural focus from reactive to preventative.

The Army is an environment different from civil society, with stricter rules of personal conduct and responsibility. Commanders and senior Army leaders by tradition and culture hold soldiers to standards of conduct and personal responsibility that are necessary to preserve unit cohesion in combat and preserve good order and discipline. Excuses and blame shifting are not tolerated in the Army, because the stakes in terms of lives and national defense are too high. Recognizing that personal responsibility is an important value within the organization, USAWC respondents were also asked whether they agreed or disagreed that, "Opioid misuse and/or addiction is a soldier's choice and responsibility that is independent of Army prescription policies." The responses are shown in Table 10.

Q29. Qpioid misuse and/or addiction is a soldier's choice
and responsilbity that is independent of Army prescription policies.
Answered: 68 Skipped: 0

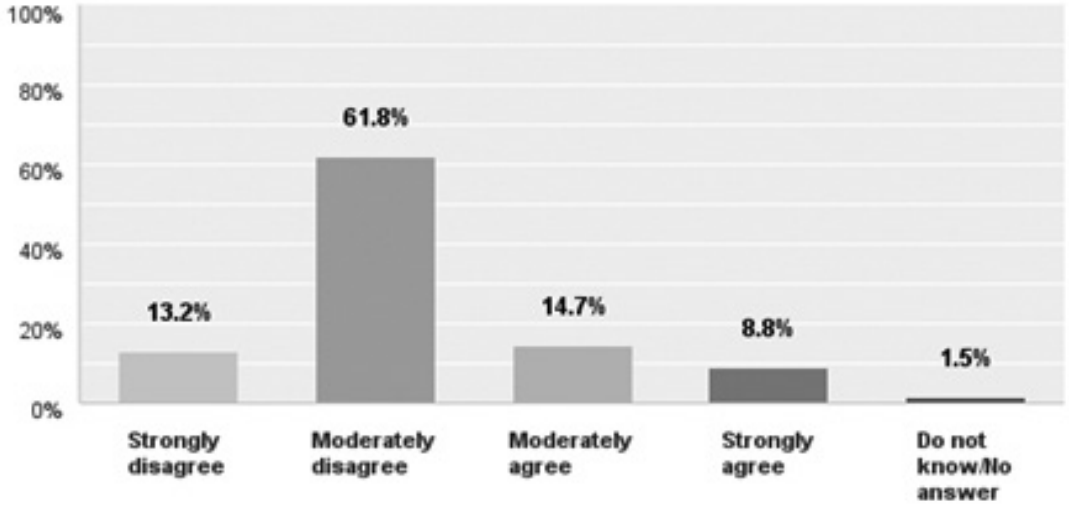


Table 10. USAWC Opinions on Relationship between Misuse/Addiction and Prescription Practices.

A total of 75 percent of the USAWC officers disagreed that opioid misuse and addiction are a soldier's choice and responsibility independent of Army prescription practices. A total of 23.5 percent of respondents believe that misuse and addiction are a soldier's responsibility independent of Army prescription practices, and 1.5 percent did not know or had no answer. These answers reflect most clearly that three out of four senior Army officers view the opioid crisis as directly linked to Army prescription practices and not due to the independent conduct of soldiers choosing to engage in risk-taking illegal drug behavior.

Neither group surveyed suggested, nor does this Paper suggest, that discipline is misplaced for those who break the law, engage in the recreational use of opioids, or reject the opportunity for meaningful rehabilitation . No one can rehabilitate a soldier once that opportunity is given other than the soldier him- or herself. Rather, the surveys indicate that, unlike with mere recreational drug use, prescription opioid misuse is a complex problem unique in its origins, which requires a nuanced and adaptive policy response different from that needed to counter recreational drug abuse. One size fits all is easy and convenient; it just happens to be ineffective and perpetuates the opioid crisis.

Shifting Army Policies on Opioid-Troubled Soldiers.

With both civilian criminal judges and senior Army officers believing that rehabilitation programs can work with soldiers and veterans dependent on, addicted to, and misusing opioids, the USAWC officers were asked: "Do you believe the Army needs to do more to respond to opioid pain medication misuse, dependency, and/or addiction among soldiers?" The responses were:

Yes - 70.6 percent
No - 13.2 percent
I don't know/No opinion - 16.2 percent

Those responding "Yes" were then asked to elaborate what additional actions the Army should take to reduce the adverse impact of opioids. The AWC officers responded as reflected in Table 11, with more than one response being allowed to the question.

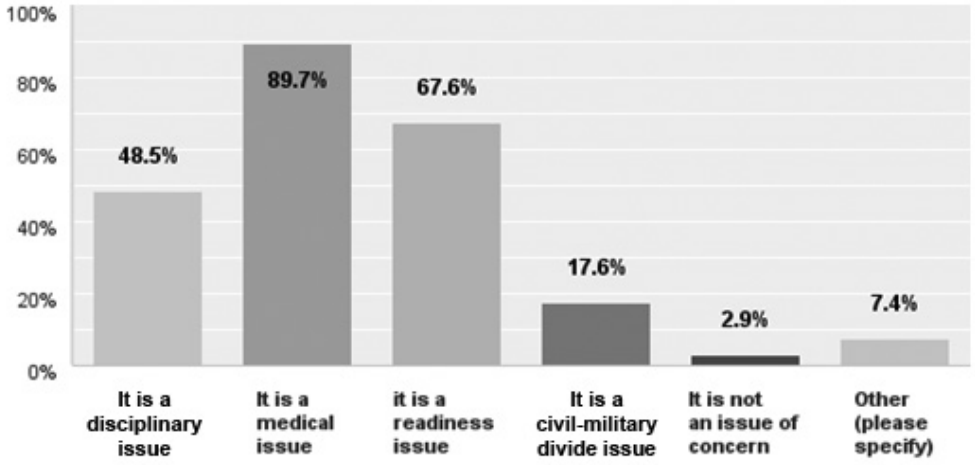
Answer Choices	Responses	
Increase UCMJ and admin separations	15.1%	8
Increase discharge severity for rehab fail	17.0%	9
Reduce # of opioid medicine Rxs	71.7%	38
Increase focus on prevention by medically monitoring soldiers with opioid prescriptions for signs of dependency/addiction	94.3%	50
Provide drug rehabilitation programs for soldiers who become addicted to opioids	66.0%	35
Provide more training and information to soldiers on the dangers of opioid medication	60.4%	32
Other (please specify)	13.2%	7
Total Respondents: 53		

Table 11. USAWC Officer Policy Recommendations to Overcome Opioid Threat.

The most often proposed responses to the opioid problem were medical and treatment oriented. An overwhelming 94.3 percent of the respondents saw preventative medical monitoring of soldiers who are prescribed opioids as an effective policy response. Over 71 percent of the respondents thought that reducing the number of opioid prescriptions was needed. Exactly 66 percent felt additional rehabilitation efforts were needed, and just over 60 percent believed that the Army needs to do more to train and inform soldiers better on the dangers of opioid pain medication. Consistent with the majority of other responses throughout the survey that did not view the opioid problem at its source as a disciplinary one, only 15.1 percent of respondents saw more UCMJ and administrative separation actions as a needed change; 17 percent saw the increase in adverse discharge characterization as being a rehabilitation failure as a needed policy improvement.

These responses contrast with the 2010 policy positions of the Army on the needed action to overcome the prescription drug misuse problem. In the Army's 2010 *Suicide Prevention Report*, the authors cited a lack of garrison leadership and risk-taking soldiers as the two primary reasons for the Army's opioid problem.[42] Medical prescription practices were noted, but not cited as a major contributing factor to soldier misuse levels.

With more than one response possible, the USAWC officers were surveyed how they characterized the nature of the opioid problem in the Army. They were directed to: "Check each of the following that you believe characterizes the use of opioids in the Army today." Their responses as shown in Table 12 were:



Answer Choices	Responses	
It is a disciplinary issue	48.5%	33
It is a medical issue	89.7%	61
It is a readiness issue	67.6%	46
It is a civil-military divide issue	17.6%	12
It is not an issue of concern	2.9%	2
Other (please specify)	7.4%	5
Total Respondents: 68		

Table 12. Characterization of the Opioid Problem by USAWC Officers.

In contrast to the conclusions of the *Suicide Prevention Report*, the survey of USAWC officers indicates that, while nearly half recognize there is a disciplinary component to the opioid problem, nearly nine out of 10 consider it primarily a medical issue. Further, two out of three recognize the impact of the problem as a readiness issue. These responses are in alignment with this group's prior responses, which called for increased reliance on solutions in the realm of prevention, medical prescription reform, and soldier training/education (Table 11), rather than in discharging opioid-troubled soldiers into civilian society where they create a safety and crime risk (Tables 7 and 11).

Policy is not made in a vacuum. The Army is facing potential budget cuts through sequestration that may impact readiness in personnel levels, training, and weapons. In view of this, the survey asked USAWC respondents to react to the statement: "In this period of fiscal austerity, the Army should not dedicate additional funding to opioid drug rehabilitation programs for soldiers."

Q24. In this period of fiscal austerity, the Army should not dedicate additional funding to opioid drug rehabilitation programs for soldiers.
Answered: 68 Skipped: 0

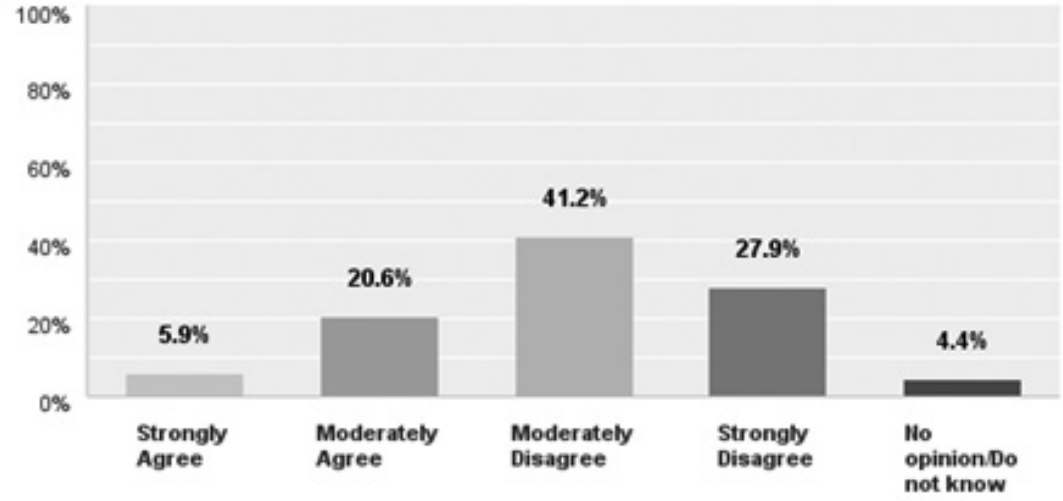


Table 13. USAWC Respondents Responses to Drug Rehabilitation Programs for Soldiers.

Together, a total of 69.1 percent of the respondents moderately or strongly disagreed with the proposition that fiscal constraints mean additional funding should not be allocated to soldier rehabilitation. A total of 26.5 percent agreed that resources should not be increased for rehabilitation, and 4.4 percent had no opinion or did not know. The responses reflect that nearly seven out of 10 senior officers about to graduate from the USAWC view rehabilitation efforts as a priority for resource allocation, even in a period when personnel and equipment cuts may need to be made. Such thinking may well reflect the knowledge gained by these newly trained strategic leaders during their year at the USAWC, that having a technically skilled and well-equipped Army is of dubious value if its personnel readiness is eroded by prescription opioid dependency, addiction, and misuse.

CONCLUSION

The Army has an opioid drug problem that is not going away under current personnel policies and medical practices. The survey results recorded here indicate that senior officers attending the USAWC recognize that the opioid problem is distinct in nature and origin from recreational drug abuse. Yet, these officers are saddled with a legacy drug enforcement structure and outdated procedures that do not track opioid usage across the force and do not address the root cause of the issue. They are commanding units under a regulatory structure that belatedly responds to opiod-related misuse with the same misconduct-focused disciplinary policies as recreational drug use, rather than with a proactive medical and personnel approach crafted for this unique problem that emphasizes prevention and rehabilitation. The USAWC officer survey responses indicate that the majority of these future Army leaders see misuse originating from

prescription practices, a lack of medical monitoring,[43] and a lack of soldier training and education on the dangers of opioids, not from undisciplined soldiers.

This Paper is not meant to be the final word, but rather the beginning of a new conversation. The survey samples were not random populations, but specifically chosen groups of leaders with specialized knowledge and expertise in this area. The samples presented do not claim to represent the views of all judges or all Army officers. But the trends from their responses are intriguing, as they break from past presumptions and perceived truths regarding opioid use and suggest a new way of thinking about the Army's opioid problem, as well as its impact on readiness and civil-military relations.

The comparison of the two surveys reveals that in most instances there is not a significant gap between civilian judge and senior Army officer thinking as to the nature and seriousness of the problem. Rather, military prescription practices and the application of legacy policies that presume separation as opposed to prevention and rehabilitation are creating the conditions for the cracks in a future civil-military gap to widen. Army procedures that continue to supply opioids on a wide scale, but then transfer the adverse long-term costs of those policies onto civilian society, are not in the best interest of Army readiness, soldier health, or civilian safety and fiscal security. Army policy and regulatory reform is needed to counter these trends successfully; that will require policies different from those in the Army's institutional comfort zone that have served well in countering recreational drug use for 40 years. To protect the readiness of its force, the Army should consider the path suggested by those it has trained to be innovative and strategic thinkers at the USAWC—a future focused upon increased rehabilitation, soldier education, medical monitoring, and unit level opioid readiness tracking.

ENDNOTES

1. Opioids include morphine, codeine, and opium, which are a product of the opium poppy. But they also include synthetic pharmaceuticals used to manage pain that operate on the central nervous system to block pain and cause a sense of euphoria in the same manner as opiates. Common forms employed in the Army include Percocet (oxycodone and acetaminophen) and Vicodin (hydrocodone and acetaminophen).

2. Jana Burson, *Pain Pill Addiction: A Prescription for Hope*, Indianapolis, IL: Dog Ear Publishing, 2010, p. 7.

3. *Ibid*., p. 8.

4. *Ibid*., pp. 9-11.

5. Veterans Courts are a new type of court founded in 2008 by Judge Robert Russell of Buffalo, NY. They are criminal courts under the laws of the state in which they sit. Veterans Courts, while protecting society and victims, also seek to ensure that veterans whose misbehavior originates in treatable conditions such as substance abuse or mental health issues receive that assistance. Veterans Courts have a nearly 90 percent success rate, in terms of their participants not committing further crimes after graduation, compared to a 45 percent success rate with traditional criminal courts.

6. A 15-question survey was mailed to the presiding judges of the 177 known Veterans Courts in the United States on January 19, 2015. The survey focused on the experience and opinions of the judges handling the cases of OEF and OIF veterans, many of whom have opioid misuse, dependency, and addiction issues. Veterans Courts were selected for the survey, as opposed to all criminal courts, since defendants

in these courts are typically screened as a condition of entry into these veteran treatment court programs as having a nexus between their military service and their substance abuse and mental health issues. Furthermore, many traditional criminal courts process defendants without ever inquiring or recording if they are veterans. A second survey composed of 29 questions was sent electronically and in hard copy to 216 U.S. Army branch, resident phase, students of the USAWC, Carlisle, PA on March 3, 2015. This group comprised 169 active duty officers, 24 Army National Guard officers, and 23 U.S. Army Reserve officers. The author, who is a USAR member of this class, excluded himself from the survey. The survey sought to gauge the officers' level of knowledge and opinions regarding opioid pain medication use, misuse, and enforcement policies in the Army. Both survey populations were asked the same questions, except where the nature of respective job duties made that impractical. A greater number of questions were asked of Army personnel to determine the nature of their experience, i.e., whether it was in a command or other context, in garrison or during deployment, and other military specific questions.

7. Army commanders exercise adjudicatory and dispositional authority for nonjudicial punishment over soldiers who engage in disciplinary violations, including substance abuse. They also play an active role in deciding whether to initiate and forward charges to court-martial in serious cases. They render the ultimate decision as to whether a soldier should be retained or administratively eliminated from the Army for drug-related misconduct, and what level of discharge the soldier should receive if separated. *Army Regulation (AR) 27-10, Military Justice*, Washington, DC: U.S. Department of the Army, October 3, 2011; *AR 635-200, Active Duty Enlisted Administrative Separations*, Washington, DC: U.S. Department of the Army, September 6, 2011; *AR 600-85, The Army Substance Abuse Program*, Washington, DC: U.S. Department of the Army, December 28, 2012.

8. Of the respondents, 43 percent had personal or direct-duty contact with soldiers who had misused or were addicted to opioids since 2001, 46 percent did not have personal contact, and 11 percent did not know if they had.

9. National Institute on Drug Abuse, "DrugFacts: Substance Abuse in the Military," March 2013, available from *www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military*.

10. *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, p. 48.

11. Robin Toblin *et al*., "Chronic Pain and Opioid Use in US Soldiers after Combat Deployment," *JAMA Internal Medicine*, Vol. 174, No. 8, August 1, 2014, pp. 1400-1401.

12. *Ibid*.

13. "Addressing Prescription Drug Abuse in the United States," Washington, DC: U.S. Department of Health and Human Services, p. 10, available from *www.cdc.gov/HomeandRecreationalSafety/pdf/HHS_Prescription_Drug_Abuse_Report_09.2013.pdf*.

14. "DrugFacts: Substance Abuse in the Military," Bethesda, MD: National Institute on Drug Abuse, March 2013, available from *www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military*, accessed February 21, 2015.

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

16. Toblin *et al*., p. 1401.

17. 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,"

Bethesda, MD: National Development and Research Institutes (ISPR), 2013, published in final edited form in *Substance Use Misuse Online*, Bethesda, MD: National Institute of Health, Vol. 48, No. 10, July 2013, p. 894, available from *informahealthcare.com/doi/abs/10.3109/10826084.2013.796991*.

18. *Army Health Promotion Risk Reduction Suicide Prevention Report 2010*, Washington, DC: U.S. Department of the Army, 2010, pp. ii-iii, available from *usarmy.vo.llnwd.net/e2/rv5_downloads/hprrsp/HP-RR-SPReport2010.pdf*, accessed January 2, 2015.

19. See *www.brilliantlifequotes.com/inspirational/mark-twain/*.

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

21. Sandra Basu, "Greater Alternative Therapy Use Gradually Decreases Opioid Dependence in the Military," *U.S. Medicine Online*, June 2014, available from *www.usmedicine.com/agencies/department-of-defense-dod/greater-alternative-therapy-use-gradually-decreases-opioid-dependence-in-military/*, accessed April 1, 2015.

22. Robert Bray, Kristine Rae Olmstead, and Jason Williams, "Misuse of Prescription Pain Medications in U.S. Active Duty Service Members," *Pain Syndromes – From Recruitment to Returning Troops: Wounds of War IV*, Vol. 91, NATO Science for Peace and Security Series E: Human and Societal Dynamics, Amsterdam, The Netherlands: IOS Press BV, 2012, p. 3.

23. Toblin *et al*., p. 1401.

24. Roger Chou *et al*., "The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop," *Annals of Internal Medicine*, February 17, 2015, available from *annals.org/article.aspx?articleid=2089370*, accessed April 8, 2015.

25. Wayne B. Jones and Eric B. Schoomaker, "Pain and Opioids in the Military: We Must Do Better," *JAMA Internal Medicine*, August 2014, available from *archinte.jamanetwork.com/article.aspx?articleid=1885985*, accessed February 5, 2014.

26. "Pathways to Prevention: The Role of Opioids in the Treatment of Chronic Pain," Bethesda, MD: National Institutes of Health, September 29-30, 2014, available from *https://prevention.nih.gov/programs-events/pathways-to-prevention/workshops/opioids-chronic-pain*, accessed February 16, 2015.

27. The extent to which there is a need for military specific exceptions to HIPAA laws due to the unique responsibility commanders have for soldiers' lives and welfare, as well as mission accomplishment, is beyond the scope of this Paper to explore. It is enough to note that when commanders are being denied information essential to the performance of their mission and to the protection of soldiers placed in positions of personal jeopardy due to the commanders' lack of information about their medical ability to function, there is a defect in the system.

28. Burson, pp. 9-11.

29. *Ibid.,* p. 9.

30. While dependency and addiction are medical terms, "misuse" is a legal construct that can include using a prescription in excess of prescribed limits, using drugs during periods not covered by the prescription, or giving or selling the drugs to another. Since opioids are a controlled substance under federal law, any consumption not in compliance with a medical professional's direction is likely to constitute a crime.

31. Soldiers who receive an OTH discharge as 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, Chap. 1, Sec. B, Para. 5(c), February 23, 2012.

32. *AR 635-200, Active Duty Enlisted Separations*, Para 14-3(a), 99, and 14-12(c)(2), Washington, DC: U.S. Department of the Army, September 6, 2011, p. 102.

33. Evan R. Seamone, "Reclaiming the Rehabilitative Ethic in Military Justice: The Suspended Punitive Discharge as a Method to Treat Military Offenders with PTSD and TBI and Reduce Recidivism," *Military Law Review*, Vol. 208, Summer 2011, p. 32, fn 92.

34. *AR 600-85,* Para 8, p. 54.

35. *Ibid*., Para. 7-1(b)(2), p, 49.

36. Bray, p. 3.

37. The medical monitoring of soldiers issued opioid prescriptions has been a suggested but optional-only guideline for military physicians from 2001 to the present. The Surgeon General's office is currently leading an initiative to make such monitoring mandatory across all Services. Colonel Paul Barras, Director, Office of the Army Surgeon General Comprehensive Pain Management Program, telephone interview with author, February 2, 2015.

38. "DrugFacts: Substance Abuse in the Military."

39. Bennett *et al*., p. 1.

40. Burson, pp. 10-11. The body will chemically and physically adjust itself to require the continued consumption of an addictive substance, such as an opioid, in order to operate normally. This is known as dependency. When there is the added psychological compulsion, or obsession, to obtain the drug, in addition to physical dependency, this is known as addiction.

41. Mary Jo Larson *et al*., *Military Combat Deployments and Substance Use: Review and Future Directions*, Bethesda, MD: National Institutes of Health, February 22, 2012, p. 11.

42. *Army Health Promotion Risk Reduction Suicide Prevention Report 2010.*

43. The Surgeon General's Office is currently considering the implementation of a mandatory medical monitoring program as part of its Comprehensive Pain Management Program. COL Paul Barras, Director, Office of the Army Surgeon General Comprehensive Pain Management Program, telephone interview with author, February 2, 2015. This would be an extension of other reforms contained in MEDCOM Operational Order 10-76, which seeks to increase alternatives to pain management. LTG Eric Schoomaker, U.S. Army Surgeon General, "Operation Order 10-76 (USAMEDCOM Comprehensive Pain Management Campaign Plan)," Fort Sam Houston, TX, U.S. Army Medical Command, September 21, 2010. Unfortunately, since the Order was issued in 2010, there have been no data indicating that the plan has had a significant impact on reducing opioid prescription levels—with the testimony of BG Coots, cited earlier, noting a 24 percent prescription rate military-wide still existing in 2013.

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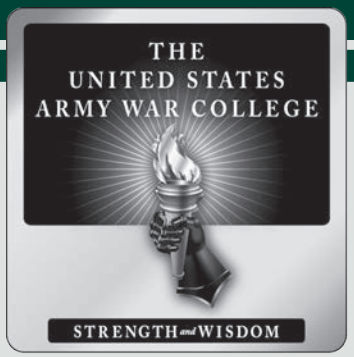

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