

Healing a Broken System: Veterans and the War on Drugs

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Executive Summary

Hundreds of thousands of veterans of the wars in Iraq and Afghanistan are returning with post-traumatic stress disorder (PTSD),¹ traumatic brain injury (TBI),² and other illnesses and injuries³ that often contribute to substance abuse and addiction,^{4,5} fatal overdose,⁶ homelessness⁷ and suicide.⁸ The current generation of veterans joins the large population of Vietnam-era veterans who have struggled with the same problems for decades.⁹

Left untreated, these underlying medical conditions often contribute to violations of the law, especially nonviolent drug offenses.¹⁰ Veterans returning from the wars in Iraq and Afghanistan run a high risk of becoming casualties of America's longest and most costly war: the war on drugs. Effective treatments to treat drug misuse and addiction, as well as PTSD and other service-related conditions, meanwhile, are often underutilized or prohibited as a result of entrenched drug war policies codified at the local, state and federal levels.

This policy brief highlights some less-discussed but deeply troubling issues affecting veterans that are caused or exacerbated by the drug war – and proposes proven, commonsense and cost-effective solutions to improve the health, reduce the likelihood of accidental death, and preserve the freedom of those who have served in our armed forces.

Summary of Recommendations

- The United States Department of Veterans Affairs (VA) and Department of Defense (DoD) must adopt overdose prevention programs and policies targeting veterans and service members who misuse alcohol and other drugs, or who take prescription medications, especially opioid analgesics.
- Veteran treatment programs must greatly expand access to medication-assisted therapies like methadone and buprenorphine, which are the most effective means of treating opioid dependence.
- State and federal governments must modify sentencing statutes and improve court-ordered drug diversion programs to better treat – rather than criminalize and incarcerate – veterans who commit drug law violations. State and federal governments should expand community-based treatment options and explore pre-arrest diversion programs to help veterans *before* they enter the justice system.
- States and the federal government must expand, not obstruct, research and implementation of innovative treatments for PTSD and other psychological and physical wounds of war, including treatment modalities involving Schedule I substances such as MDMA and marijuana.

Iraq and Afghanistan Veterans: Incarceration and the War on Drugs

Roughly 140,000 veterans were incarcerated in state and federal prisons as of 2004 – the last year for which data are available, when the Iraq and Afghanistan wars were in their early stages.¹¹ Tens of thousands more veterans are incarcerated in county jails.¹²

These data only capture a small fraction of veterans of the wars in Iraq and Afghanistan, because few had returned home or been discharged from active service at the time. Sadly, the full magnitude of the problem is likely to emerge in the coming years and decades. As more veterans are discharged after longer and repeated deployments,¹³ the number of incarcerated veterans is likely to increase significantly.^{14,15}

One team of researchers summed up this likelihood: “The high rates of PTSD among veterans returning from Iraq and Afghanistan and the increased enlistment of individuals with more troubled backgrounds (including increased numbers with a criminal history) and less educational achievement, suggests that incarceration rates among the current cohort of AVF [All Volunteer Force] veterans may increase in future years.”¹⁶

Data from a national survey of Iraq and Afghanistan veterans found that 9 percent of respondents reported being arrested since returning from service. “Most arrests were associated with nonviolent criminal behavior resulting in incarceration for less than two weeks....a subset of veterans with PTSD and negative affect may be at increased risk of criminal arrest. Because arrests were more strongly linked to substance abuse and criminal history, clinicians should also consider non-PTSD factors when evaluating and treating veterans with criminal justice involvement.”¹⁷

Research shows that among the greatest predictive factors for the incarceration of veterans are substance misuse and addiction.¹⁸ Suffering from a mental health condition, especially PTSD, is also highly associated with increased risk of incarceration.¹⁹ Incarcerated veterans with PTSD report more serious legal problems, higher lifetime use of alcohol and other drugs, and poorer overall health than those without PTSD.²⁰

Existing literature strongly indicates that “incarcerated veterans may face a level of suicide risk that exceeds that attributable to either veteran status or incarceration

alone.”²¹ Moreover, incarcerated veterans are highly vulnerable to death by overdose after release if they do not receive effective treatment.²²

Veterans who are convicted of criminal offenses, particularly drug felonies, or those who have drug use histories – and their families – face a wide range of punitive policies that limit access to social services that are necessary for their reentry to civilian life.²³

Forty-six percent of veterans in federal prison were incarcerated for drug law violations. Fifteen percent of veterans in state prison were incarcerated for drug law violations, including 5.6 percent for simple possession. While available data is limited, research has shown that this figure has remained constant – with roughly 16 percent of incarcerated veterans behind bars for drug law violations.²⁴

Sixty-one percent of incarcerated veterans met the DSM-IV criteria for substance dependence or abuse. Thirty-eight percent of veterans in state prison received less than an honorable discharge, which may disqualify them for VA benefits.²⁵

“Veterans incarcerated for drug law violations received average sentences that were *one year longer* than those of non-veterans incarcerated for the same offenses.

- United States Department of Justice, Bureau of Justice Statistics, “Veterans in State and Federal Prison, 2004.” 1,4,5,6,11 (May 2007).

The incarceration of veterans tracks the general rates of incarceration in an important and unfortunate way: black and Latino veterans are much more likely to be incarcerated than are white veterans – exemplifying the same racial disparities inherent in the war on drugs.²⁶ Under current VA directives, incarcerated veterans are not afforded any VA care.²⁷ This denial is a missed opportunity for the VA to provide critical services and support for veterans to recover from the psychological wounds that contributed to criminal activity in the first place. The VA should rescind its 2002 directive barring assessment or treatment of veterans incarcerated in U.S. jails and prisons, and should inform incarcerated veterans of all VA-community resources.²⁸

Substance Abuse and Mental Illness Among U.S. Veterans

Two and a half million men and women have served in the Iraq or Afghanistan wars.²⁹

Approximately 50 percent of Iraq and Afghanistan War veterans treated by the VA report symptoms of a mental illness.³⁰

Approximately 30 percent of Iraq and Afghanistan veterans treated by the VA report symptoms of PTSD.³¹

Estimates vary, but one study found that more than 11 percent of current conflict veterans have been diagnosed with a substance abuse condition.³²

According to the VA, 19 percent of current conflict veterans who have received VA care have been diagnosed with substance abuse or dependence.³³

Military personnel and combat veterans have higher rates of problematic substance use than their age peers in the general population.³⁴

Seventy-five percent of Vietnam combat veterans with PTSD met criteria for substance abuse or dependence in a national study.³⁵

Roughly one-third of veterans who seek treatment for substance misuse also meet criteria of PTSD.³⁶

Veterans do not qualify for substance abuse disability benefits unless they also have PTSD.³⁷

Veterans of Every Major War Have Battled PTSD, Addiction and Incarceration

PTSD was added to the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) after the Vietnam War, but the disorder has existed for as long as soldiers have gone to war.³⁸ What was called “soldier’s heart” during the Civil War, “shell shock” during World War I, and “combat exhaustion” or “combat fatigue” during World War II and the Korean War has evolved into what is now known as PTSD.³⁹

Symptoms of PTSD include “strong memories and nightmares, feeling numb or detached, and difficulty sleeping,”⁴⁰ as well as hyper-arousal and hyper-vigilance, and a clinically recognized tendency to self-medicate with alcohol and other drugs.⁴¹

Criminal justice involvement as a result of combat trauma is predictable after a major war. For example, 34 percent of new admissions to 11 U.S. prisons between 1946 and 1949 were WWII combat veterans.⁴²

Combat veterans from Vietnam onwards face an even greater risk of arrest and incarceration than previous generations of veterans because the U.S. now criminalizes behaviors that were not covered under federal and state criminal codes until the 1970s.⁴³ In particular, in 1971 ex-President Richard Nixon declared the war on drugs, which has persisted for more than forty years and led to more than forty-five million arrests.

Consequently, in 1985, 21 percent of all men in state prison and 23 percent of all men in federal prison were veterans – a direct legacy of Vietnam and the escalating war on drugs.⁴⁴ The largest study of Vietnam veterans, the National Vietnam Veterans Readjustment Study (NVVRS), found in 1988 that nearly half of male Vietnam combat veterans afflicted with PTSD had been arrested or incarcerated one or more times, while 11 percent had been convicted of a felony.⁴⁵

PTSD and other psychological wounds of war may also emerge several years after returning from combat.⁴⁶

Experts predict a more dramatic recurrence of these trends as current conflict veterans return home, unless urgent, evidence-based responses to support veterans battling addiction and incarceration are implemented at the local, state and national levels.⁴⁷

Harm Reduction for Veterans Facing Heightened Risk of Overdose and Hazardous Drinking

Veterans who struggle with substance abuse and mental illness are much more likely to die prematurely than their peers who are not afflicted with these conditions.⁴⁸ In particular, Vietnam veterans with PTSD from combat face a heightened risk of dying from a fatal drug overdose.⁴⁹ Media and anecdotal reports suggest that overdose is claiming many veterans of the current conflicts.⁵⁰ Their risk of fatal overdose is especially high given the widespread use of prescription medications, especially opioid analgesics for relief of pain from combat injuries⁵¹ and antidepressants for mental health treatment.⁵²

New data and research have proven what these media and anecdotal reports have demonstrated over the past decade: that veterans returning from the current conflicts are falling victim to preventable overdose when they come home.^{53, 54} A recent national study published in 2012 in the *Journal of American Medical Association* of more than 140,000 Iraq and Afghanistan veterans with pain diagnoses in the past year found that veterans with a co-occurring mental health diagnosis – especially PTSD – were significantly more likely to receive opioids for pain, to engage in high risk opioid use, and to be more susceptible to adverse outcomes, including overdose. In fact, the study found “those prescribed opioids across all mental health categories had a higher prevalence of all adverse clinical outcomes... [including] opioid-related accidents; and overdoses, alcohol - and non-opioid drug-related accidents and overdose, self-inflicted injuries.”⁵⁵

Veterans with a diagnosis of PTSD were at greatest risk of overdose and other adverse outcomes, the study found. The authors write: “Veterans with mental health diagnoses prescribed opioids, especially those with PTSD, were more likely to have comorbid drug and alcohol use disorders; receive higher-dose opioid regimens; continue taking opioids longer; receive concurrent prescriptions for opioids, sedative hypnotics, or both; and obtain early opioid refills. Finally, receiving prescription opioids was associated with increased risk of adverse clinical outcomes for all veterans returning from Iraq and Afghanistan, especially for veterans with PTSD, who were at highest risk of alcohol-, drug-, and opioid-related accidents and overdose, as well as self-inflicted injuries.”⁵⁶

Another group of researchers found that “a significant number of veterans manage their pain by sharing prescriptions (16.3 percent), using alcohol or street drugs (28.9 percent) or any combination of these behaviors (35.3 percent).”⁵⁷ Other research corroborates this, finding: “Veterans in care have a high prevalence of non-medical use of opioids that is associated with substance use, medical status and pain interference.”⁵⁸ The study found that this prevalence among veterans, especially younger veterans, was noticeably higher than the general population.

“Compared with other Iraq and Afghanistan war veterans, those with PTSD exhibited higher-risk opioid use and adverse clinical outcomes, including injuries and overdose.”⁵⁹

- *Journal of the American Medical Association, 2012*

The high rate of prescription of opioids and other medications is now well established. A recent study found that over two-thirds (64 percent) of Iraq and Afghanistan veterans with elevated pain screening scores were prescribed at least one opioid in the past year. Forty-one percent of these veterans were prescribed long-term opioid medications. Of long term opioid patients (who were also given stronger dose medications), one-third were also prescribed sedative hypnotics. The authors concluded that “the use of opioids and sedative-hypnotic therapy should be carefully monitored by prescribing physicians to prevent possible overdose or death.”⁶⁰

The elevated risk of overdose has likewise been demonstrated in the scientific literature. One of the first studies to specifically investigate the extent of the problem found that “Among patients receiving care from the Veterans Health Administration, death from accidental overdose was found to be associated with psychiatric and substance use disorders. The study findings suggest the importance of risk assessment and overdose prevention for vulnerable clinical subpopulations.”⁶¹ The same team of researchers pinpointed this risk, writing, “VHA patients had nearly twice the rate of fatal accidental poisoning compared with adults in the general US population... Opioid medications and cocaine were frequently mentioned as the agents causing poisoning on death records.”⁶²

“Latest accounts estimate that approximately 106,000 Soldiers are prescribed some form of pain, depression or anxiety medications. The potential for abuse is obvious.”

– U.S. Army, “Health Promotion, Risk Reduction, and Suicide Prevention Report 2010 (July 29, 2010)”

Because effective treatment is not available for many of these troops, the elevated risk for overdose will carry into civilian life after they are discharged.

In addition to the many service members and veterans taking medicines by prescription, others may be self-medicating with these drugs.⁶³ Still others report being prescribed several of these medicines at the same time, sometimes with lax supervision from their doctors.⁶⁴ The VA conducted a recent audit of 20 inpatient rehabilitation facilities in its system and found that a majority did not have adequate screening policies for new patients, while a significant minority (roughly 10 percent) of patients who are permitted to administer their own narcotics received more than a week’s supply at a time.⁶⁵

Prescription drugs are often taken alongside alcohol and other substances⁶⁶ – practices that significantly raise the risk of overdose.⁶⁷

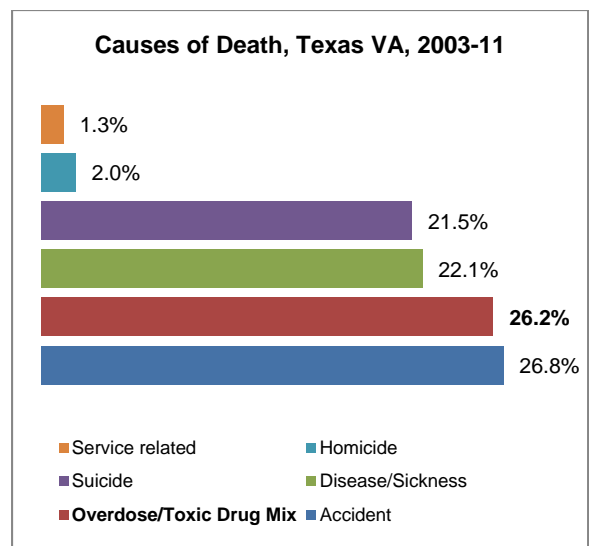
The experience of veterans coincides with that of the general population, among whom nonmedical opioid misuse is on the rise and increasingly linked to accidental death.⁶⁸ Patients who have not developed a therapeutic tolerance to such medicines also face an increased risk of accidental overdose.⁶⁹

While the U.S. military does not divulge full records of the prescription drugs that service members take while deployed, several recent reports paint a grim picture.

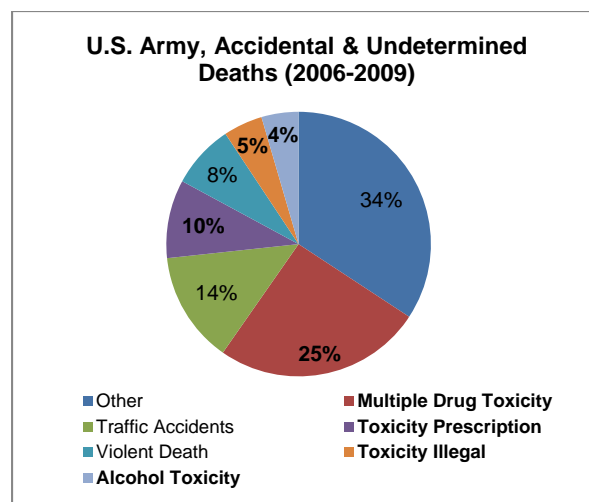
The *Austin American-Statesman* conducted an in-depth investigative report into the causes of death of hundreds of Texas veterans who passed away between 2003 and 2011. After six months of combing through VA data and information obtained through the Freedom of Information Act (FOIA), the newspaper found that overdose was a leading cause of death for these veterans – causing more than a quarter (26 percent) of deaths of returning veterans, far higher than their age peers in the general Texas population (10 percent). While suicides have received much national attention, the *American-*

Statesman’s report found that nearly as many veterans died of overdose as suicide. Most veterans who succumbed to fatal overdose had multiple prescription drugs in their systems.⁷⁰

The army released a comprehensive report in July 2010 documenting health risks among active-duty troops, which found that, in 2009, “there were 146 active duty deaths related to high risk behavior including 74 drug overdoses. This is tragic!”⁷¹ These deaths occurred at a rate of 13 per 100,000 – slightly higher than the overdose death rate among civilians.⁷²



Source: *Austin American-Statesman* (Sept. 29, 2012)



Source: U.S. Army, “Health Promotion, Risk Reduction, and Suicide Prevention Report 2010 (July 29, 2010)”

The army investigated 397 non-combat, accidental deaths of soldiers between 2006 and 2009. Over 45 percent of these – or 188 soldier deaths – resulted from an alcohol or other drug overdose.⁷³ Of the 188 accidental or undetermined deaths caused by drugs or alcohol from FY 2006 – FY 2009, 139 (74 percent) were caused by prescription drugs.⁷⁴

The report further concluded that the unauthorized use of painkillers and other prescription medications among active-duty military personnel tripled between 2005 and 2008. Five times as many soldiers reported abusing prescription medications as illegal drugs.⁷⁵ The report states, “In addition to antidepressant medications, narcotics represent an increasing concern for the force.... Oxycodone (Percocet) and hydrocodone (Vicodin) have become the second and third most frequently used pain management medications.”⁷⁶ Overall, about one in seven U.S. soldiers currently have a prescription for some type of opioid.⁷⁷

The most recent official data are not fully available, but what the army has so far analyzed shows that soldiers’ risk for overdose has been increasing. Of 222 accidental or undetermined noncombat deaths that the army had reviewed as of 2010, at least 92 (41 percent) involved alcohol or other drug use at the time of death, and at least 50 (23 percent) were solely due to alcohol or other drug overdoses.⁷⁸

A *Military Times* investigative report – analyzing 14,000 casualty records provided by the Defense Manpower Data Center pursuant to a Freedom of Information Act request – revealed at least 68 accidental drug deaths were reported by the military in 2009, more than triple the figure from 24 in 2001. Some type of opioid painkiller contributed to one-third or more of these overdose deaths.⁷⁹

In the past decade, at least 430 service men and women have died from alcohol or other drug overdoses. According to the *Military Times*, that means an average of one active-duty service member *each week* is found dead from an accidental drug or alcohol overdose.⁸⁰

Analyses of Defense Department spending on prescription medications confirm this alarming rise in overdose potential. Prescription drug orders (and associated spending) has more than doubled from 2001 through 2009, reaching \$280 million last, according Defense Logistics Agency data.⁸¹ Prescription medication use is far higher among young adults in the

military health system than older peers. For example, psychiatric medication prescriptions increased 42 percent between 2005 and 2009 among people 18-34 participating in the military’s insurance program (Tricare).⁸²

According to another recent survey of health providers for injured military personnel conducted by the U.S. Army Inspector, roughly a third of their patients are “dependent on or addicted to drugs.”⁸³ Survey participants reported that between 25-35 percent of these wounded troops “are over medicated, abuse prescriptions, and have access to illegal drugs.”⁸⁴

In the same survey, most respondents stated that a majority of injured troops arrive to specialized military hospitals (Warrior Transition Units) with prescriptions they had already been given in theater or at demobilization sites.⁸⁵

The Warrior Transition Units have seen at least 30 soldiers and two marines die from overdoses since 2007.⁸⁶

“We’re seeing ... a lot of soldiers that are taking narcotics, a lot of soldiers are taking anti-depressants, psychotropic class medications.”

– BG Richard Thomas, Asst. Surgeon General for Force Projection, “Fighting the Emotional Toll of War,” CNN, March 30, 2010.

These recent reports confirm a trend that emerged early in the course of the two current conflicts and has only worsened. A 2005 military survey found prescription narcotics to be the most widely misused class of drug among members of the armed forces.⁸⁷ VA records reveal that prescription drugs are widely abused by veterans,⁸⁸ especially opioid pain medications and mood disorder medications, such as benzodiazepines.⁸⁹

The Office of the Surgeon General of the U.S. Army Multinational Force surveyed soldiers and found that one in eight was taking prescription medication for a sleeping disorder or combat stress,⁹⁰ and *USA Today* reported in late 2008 that the number of opioid pain prescriptions for injured troops increased from 30,000 to 50,000 per month since the Iraq War began.⁹¹

Overdose can strike anytime, but incarcerated veterans are acutely vulnerable, especially during the period

shortly after their release from jail or prison.⁹²

By far the most commonly abused drug among active duty military and veterans is alcohol.⁹³ A study published in the *American Journal of Preventive Medicine* found that over 43 percent of active duty military reported binge drinking, and nearly 20 percent reported frequent, heavy drinking, within the past month.⁹⁴ More than half of military personnel who binge drink also reported alcohol-related problems, including a significantly greater likelihood of high-risk behavior and alcohol-related violations of the law.⁹⁵

“He survived over there. Coming home and dying in a hospital? It’s a disgrace.”

– Father of Cpl. Nicholas Endicott, who died of an overdose of multiple prescription drugs, including opioids, after deploying twice to Iraq and once to Afghanistan.⁹⁶

These findings echo other studies, including a sample of Iraq and Afghanistan war veterans, of which 40 percent screened positive for hazardous drinking and 22 percent screened positive for possible alcohol abuse, but less than a third of hazardous drinkers received any risk reduction counseling by a VA provider.⁹⁷ Another sample of current conflict veterans reported nearly identical results (39 percent probable alcohol abuse).⁹⁸ Prevalence of alcohol misuse is higher among male veterans of the Iraq and Afghanistan wars who accessed the VA healthcare system than male veterans of other eras.⁹⁹ Iraq and Afghanistan war veterans who screened positive for PTSD or depression were two times more likely to report the misuse of alcohol compared to veterans who screened negative, and alcohol misuse was strongly linked to PTSD symptoms, especially “emotional numbing,”¹⁰⁰ consistent with many prior studies finding that veterans suffering from PTSD self-medicate using alcohol and other drugs.¹⁰¹ Rates of alcohol misuse were strongly correlated with levels of combat exposure.¹⁰²

Among Guards and Reservists, the likelihood of alcohol-related problems increased with those reporting any mental illness or use of medication.¹⁰³ A more recent study of National Guard members who served in the Iraq or Afghanistan wars similarly found high rates of alcohol abuse but low rates of treatment: 36 percent of Guard members surveyed met criteria for alcohol

misuse, of whom only 31 percent reported any mental health treatment, and less than 3 percent received specialty substance abuse treatment. The authors concluded, “Rates of alcohol misuse are high and rates of substance use treatment are low among National Guard service members.”¹⁰⁴ These findings are particularly troubling given the reliance on Guard and Reservist units to support operations in Iraq and Afghanistan, the prevalence of prescription medications for combat injuries, and the potentially lethal effect alcohol can have by itself or in combination with these medications.¹⁰⁵

“I have almost given up hope...I should have died in Iraq.”

– Senior Airman Anthony Mena, before dying of an overdose of multiple prescription drugs, including two opioids, on July 21, 2009, after battling pain, insomnia, anxiety and post-traumatic stress disorder from multiple deployments to Iraq.¹⁰⁶

Despite the widespread and risky use patterns of alcohol, few veterans and service personnel who misuse alcohol receive treatment or harm reduction services. According to one recent study, “Very few veterans who reported elevated alcohol consumption...received specialty substance use treatment in the year after being surveyed.”¹⁰⁷

Recommendations to Prevent Accidental Drug Overdose and Hazardous Drinking

- VA physicians should prescribe naloxone to all veterans who are taking opioid pain medications.^{108,109} Naloxone is an opioid antagonist medication that reverses the respiratory failure that commonly causes death from opioid overdose.
- The VA should improve patient screening, monitoring, supervision, and education, as well as physician training, to guarantee the effective treatment of veterans’ injuries while minimizing the risk of overdose or other adverse drug event.¹¹⁰
- The VA should increase access to methadone, buprenorphine and other medication-assisted therapies among opioid-dependent veterans. When properly administered, medication-assisted therapies decrease the risk of opioid overdose, particularly

when made available to incarcerated veterans who suffer opioid dependence.

- The VA, as well as state and federal correctional facilities, should provide comprehensive overdose prevention education to veterans. Prior to their release from jail or prison, incarcerated veterans should receive naloxone and training in its use.¹¹¹

"These are signs that happen prior to dying...Family members can fail to recognize that this is an impending calamity."

– Dr. Lynn Webster, medical director of Lifetree Clinical Research and Pain Clinic, Salt Lake City¹¹²

- States – and even military bases – should follow the lead of New Mexico, Washington, Connecticut, New York and California and enact laws that provide legal amnesty to persons who report an overdose to emergency medical services. Research shows that many overdose fatalities occur because witnesses delay or forego seeking help out of fear of arrest or other disciplinary consequences.¹¹³ Medical amnesty policies will save lives.¹¹⁴
- Military bases should also adopt naloxone distribution programs, to equip service men and women – and their loved ones – to respond in the event of an overdose. In 2011, U.S. Army medical personnel at the Fort Bragg Military Installation in North Carolina implemented Operation Opioid SAFE. The program provides overdose prevention training and naloxone to active duty soldiers who are returning to the United States from overseas assignments and are at higher risk of opioid overdose.¹¹⁵
- The VA and DoD should improve screening and risk reduction counseling programs for people who misuse or abuse alcohol.¹¹⁶

Medication-Assisted Therapies to Treat Addiction, Reduce Incarceration, and Prevent Overdose Deaths

Veterans and service people with substance abuse disorders face significant barriers to treatment.¹¹⁷ Foremost is the inability to receive the most effective treatments for opioid dependence – methadone and buprenorphine.

The Centers for Disease Control and Prevention,¹¹⁸ the Institute of Medicine¹¹⁹ of the National Institutes of Health,¹²⁰ the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services,¹²¹ the National Institute on Drug Abuse (NIDA),¹²² the World Health Organization,¹²³ and over four decades of government-funded, peer-reviewed medical research¹²⁴ have unequivocally and repeatedly proven that substitution therapies like methadone maintenance are *the most effective* treatments for opioid dependence.^{125,126} Methadone is one of the most widely studied medicines and is employed effectively around the world to treat opioid dependence. Methadone and other substitution therapies lead to better health and social outcomes than any other treatment modality.¹²⁷ Medication-assisted treatments are also cost effective.¹²⁸ These medicines have been proven equally effective in treating heroin or prescription-type opioid dependence.¹²⁹ For these reasons, the above-mentioned medical, research, and public health arms of the federal government urge medical professionals to use medication-assisted therapies to treat opioid dependence.

Yet physicians on the federal payroll within the VA fail to prescribe these highly effective treatments to the majority of veterans who need them.¹³⁰ The prerequisite physician training to prescribe methadone and buprenorphine is simple, inexpensive and can be conducted online with relative ease. Nevertheless, few VA physicians are given the opportunity – or the encouragement – to receive such training. Hospital administrations' lack of commitment and interest in buprenorphine is one reason why physicians do not press for these treatments for their patients. Some physicians – especially primary care physicians, who provide the majority of overall VA care – may feel ill-informed and be deterred from prescribing methadone and buprenorphine. Other doctors may choose not to prescribe because of professional stigma.¹³¹ As a consequence, most veterans are left without effective treatment for their conditions.¹³² “Pharmacotherapies

for opioid use disorders are highly effective. Yet, in the case of the VA, most veterans with opioid use disorders still do not receive any of these highly efficacious treatments.”¹³³

Unfortunately, for many years the VA’s insurance system (CHAMPVA) and the Department of Defense’s insurance (TRICARE) have explicitly prohibited coverage of methadone and buprenorphine treatment for active duty personnel or for veterans in the process of transitioning from DoD care.^{134,135} As a result, veterans obtaining care through the VA, as well as active and recently active military personnel receiving care from the DoD, are outright denied effective treatment for opioid dependence,¹³⁶ often at a critical, early juncture when full-blown addiction could still be avoided.¹³⁷ A recent article published in *Military Medicine*, for example, writes, “Opioid agonist treatment is the recommended first-line treatment for opioid dependence...[but] is generally not a treatment option for active duty personnel.”¹³⁸

The DoD requested that the federal Institute of Medicine (IOM) assess the adequacy of drug prevention and treatment in the military. The IOM released its findings in fall 2012, concluding that “substance use and abuse remain a concern for the military. Many of the medical conditions that prevail in a heavily deployed force have led to frequent prescriptions for controlled substances, increasing the risk for addiction or misuse.”¹³⁹ The IOM specifically documented a shortage of qualified substance abuse treatment professionals in all military branches and components; a lack of confidentiality for service people who seek treatment, creating additional barriers to accessing needed care for fear of disciplinary actions or other negative effects to one’s military career; a lack of integration of substance abuse and mental health treatment services; and the questionable efficacy of military prevention efforts, especially the universal drug testing program.¹⁴⁰

One of the IOM’s strongest critiques was of the military’s denial of medication-assisted treatments like methadone and buprenorphine. The IOM writes, “Best practices for SUD treatment include the use of agonist and antagonist medications... However, the current TRICARE SUD benefit does not permit use of opioid agonist medications for the treatment of addiction and therefore deprives patients access to medications that could help reduce craving and support long-term recover.”¹⁴¹ Consequently, the IOM recommended that the “DoD should move forward to promote evidence-

based treatment modalities, such as the use of agonist and antagonist medications without restrictions.”¹⁴²

Another recent study came to the same conclusions as the IOM, writing, “At present, the active duty military does not permit treatment of opioid use disorders with medications. This policy warrants re-examination, particularly for military members who develop opioid use disorders as a consequence of treatment with opioids for painful conditions incurred in the line of service.”¹⁴³

In a hopeful sign, the DoD announced its intention to revise this misguided policy in December 2011, proposing a change in federal regulation to remove the TRICARE exclusion. In its proposed rule, the DoD recognized that the “prohibition of maintenance treatment of substance dependence utilizing a specific category of psychoactive agent is outdated and fails to recognize the accumulated medical evidence supporting certain maintenance programs as one component of the continuum of care necessary for the effective treatment of substance dependence.”¹⁴⁴ However, after nearly one year, the change is still pending.¹⁴⁵ The VA has not indicated that it is considering a similar for CHAMPVA.

Incarcerated veterans with opioid dependency problems face additional risks and barriers to treatment. These veterans should be able to receive medication-assisted therapies while behind bars and, if necessary, upon release. Indeed, according to the National Institutes of Health, “... all opiate-dependent persons under legal supervision should have access to methadone maintenance therapy...”¹⁴⁶

Whereas Vietnam veterans famously struggled with heroin dependency, more recent veterans are at increased risk of becoming dependent on opioid painkillers.¹⁴⁷ Regardless of when or where they served, all opioid-dependent veterans deserve medication-assisted therapy.

Recommendations for VA Hospital and Vet Center Administrators:

- Require all veterans to be screened for opioid dependence;
- Train physicians who treat veterans, including primary care doctors, how to prescribe methadone, buprenorphine, and other medication-assisted therapies to opioid-dependent persons;

- Ensure the availability of these medication-assisted therapies to all veterans who would benefit from them; and
- Inform veterans that effective opioid-dependency treatment is available through the VA.

State and federal governments, with assistance from the VA, should make methadone and/or buprenorphine available to incarcerated veterans who would benefit from these therapies.

The DoD and VA should eliminate restrictions preventing TRICARE and CHAMPVA, respectively, from covering buprenorphine and methadone for active military, veterans, and their families.

Effective Treatments Obstructed by the Drug War: Medical Marijuana and MDMA

Medical Marijuana

The drug war often stands in the way of effective treatment for veterans and threatens the therapeutic alliance between a patient and their doctor. One of the clearest cases in which the war on drugs is blocking the best course of treatment for many veterans is medical marijuana.

Eighteen states – Alaska,¹⁴⁸ Arizona,¹⁴⁹ California,¹⁵⁰ Colorado,¹⁵¹ Connecticut,¹⁵² Delaware,¹⁵³ Hawaii,¹⁵⁴ Maine,¹⁵⁵ Massachusetts,¹⁵⁶ Michigan,¹⁵⁷ Montana,¹⁵⁸ Nevada,¹⁵⁹ New Jersey,¹⁶⁰ New Mexico,¹⁶¹ Oregon,¹⁶² Rhode Island,¹⁶³ Vermont¹⁶⁴ and Washington¹⁶⁵ – and the District of Columbia¹⁶⁶ currently provide legal protection under state law for seriously ill patients whose doctors recommend the medical use of marijuana. Some 95 million Americans, or roughly 30 percent of the U.S. population, currently reside in a state where marijuana is legal for medical purposes.

Marijuana’s medicinal benefits are incontrovertible, now proven by years of clinical controlled trials of the highest caliber.

While there is a plethora of scientific research establishing marijuana's safety and efficacy, the National Institute on Drug Abuse (NIDA) and Drug Enforcement Administration (DEA) have effectively blocked the standard Food and Drug Administration (FDA) development process that would allow for the marijuana plant to be brought to market as a

prescription medicine. Marijuana is the *only* Schedule I drug that the DEA prohibits from being produced by private laboratories for scientific research. Although DEA has licensed multiple privately-funded manufacturers of all other Schedule I drugs, it permits just one facility – operated by NIDA – to supply marijuana to scientists. The DEA and NIDA have successfully created a Catch-22 for patients, doctors and scientists by denying that marijuana is a medicine because it is not approved by the FDA, while simultaneously obstructing the very research that would be required for FDA to approve marijuana as a medicine.

NIDA has refused to provide marijuana for three studies with Food and Drug Administration and Institutional Review Board approval, including a study approved by the FDA last year that would have examined medical marijuana for veterans suffering from post-traumatic stress disorder (PTSD). Dr. Sue Sicely, University of Arizona, wants to study the effects of marijuana on PTSD symptoms. Unfortunately, Sisley and other researchers have been effectively barred from conducting research due to NIDA’s refusal to grant them a federally-approved source of research-grade plant material.

Ample evidence indicates medical marijuana effectively treats PTSD symptoms¹⁶⁷ with none of the deliterious and potentially dangerous side effects of many prescription pharmaceuticals. According to one recent study, “Cannabis may dampen the strength or emotional impact of traumatic memories through synergistic mechanisms that might make it easier for people with PTSD to rest or sleep and to feel less anxious and less involved with flashback memories.”¹⁶⁸

Because of the intransigence of relevant federal US agencies, much research into marijuana as a treatment for PTSD comes from abroad. Israel, for example, has been at the forefront of this research.¹⁶⁹ An open-label pilot study of Israeli combat veterans found that the “use of medical cannabis was associated with a reduction in PTSD symptoms.”¹⁷⁰

Several controlled, double-blind, peer-reviewed studies show smoked marijuana’s potential to relieve chronic, neuropathic pain – a difficult-to-treat type of nerve pain associated with cancer, diabetes, HIV/AIDS, spinal cord injury and many other serious conditions. These studies found that marijuana consistently reduced patients’ pain levels to a comparable or better degree than currently

available treatments.¹⁷¹ The researchers conducting the studies concluded, “The results from these four studies have been convergent, with all four demonstrating a significant decrease in pain after cannabis administration. The magnitude of effect in these studies...was comparable to current therapies.”¹⁷²

Not only is medical marijuana effective for treating chronic and intractable pain, but inhaled marijuana has also been found to complement prescription opioid pain medicines well, enhancing the efficacy of (and safely interacting with) these more powerful narcotic medications. An important recent study reported that their subjects' pain “was significantly decreased after the addition of vaporized cannabis”, and suggested that cannabis treatment “may allow for opioid treatment at lower doses with fewer [patient] side effects.” The authors concluded that their results “demonstrate that inhaled cannabis safely augments the analgesic effects of opioids.”¹⁷³

Such findings are increasingly common, prompting a recent journal commentary to note, “There is sufficient evidence of safety and efficacy for the use of [marijuana] in the treatment of nerve pain relative to opioids...[that] where medicinal cannabis is legal, physicians who treat neuropathic pain with opioids should evaluate their patients for a trial of cannabis and prescribe it when appropriate prior to using opioids.” The commentary went on to suggest that, “Prescribing cannabis in place of opioids for neuropathic pain may reduce the morbidity and mortality rates associated with prescription pain medications and may be an effective harm reduction strategy.”¹⁷⁴

A recent literature review of medical marijuana’s efficacy for treating pain found that, of 38 studies included, “71 percent (27) concluded that cannabinoids had empirically demonstrable and statistically significant pain-relieving effects, whereas 29 percent (11) did not.” Of major significance, the review concluded, “[F]or notoriously difficult to treat conditions ... cannabinergic pain medicines, particularly inhaled cannabinoid botanicals, are one of the only treatments that have been shown to be safe and effective with the highest levels of evidence.”¹⁷⁵

Another recent, authoritative review article summarizing the state of the research indicating smoked marijuana reduces symptoms of chronic/neuropathic pain and other conditions – and does so with an acceptable safety profile. The article recommends that doctors be allowed

to weigh the benefits against risks of medical marijuana therapy – just as they do with any other medicine.¹⁷⁶ Not only has the scientific community confirmed marijuana’s medicinal benefits, but it has also concluded that marijuana has a wide margin of safety as a medicine, meaning that it typically poses fewer risks to patient health and well-being than many conventionally-prescribed treatments.¹⁷⁷ Reports by the Institute of Medicine, World Health Organization, and other well-regarded scientific and medical institutions have demonstrated that marijuana, by contrast, is unlikely to produce physiological dependence, and there is no amount of marijuana that can result in an overdose.¹⁷⁸ In the words of the IOM, “the acute side-effects of marijuana use are within the risks tolerated for many medications.”¹⁷⁹

In fact, new research suggests that marijuana may aid some in recovery from addictions to alcohol and other drugs. Confirming earlier findings, one recent study of medical marijuana patients found that some “have been engaging in substitution by using [marijuana] as an alternative to alcohol, prescription and illicit drugs.”¹⁸⁰ The top two reasons listed by participants as reasons for substituting marijuana were “less adverse side effects” (65 percent) and “better symptom management.” (57.4 percent). A published survey of applicants for the medical use of marijuana in California conducted by RAND Corporation similarly found that “half of the applicants reported using marijuana as a substitute for prescription drugs.”¹⁸¹

Marijuana may also have a beneficial impact in suicide prevention. A group of researchers estimated the effect of medical marijuana laws on suicide rates. Their analysis revealed that “the passage of a medical marijuana law is associated with an almost 5 percent reduction in the total suicide rate, an 11 percent reduction in the suicide rate of 20- through 29-year-old males, and a 9 percent reduction in the suicide rate of 30- through 39-year-old males.”¹⁸²

However, medical marijuana’s legal status puts this safe medicine out of reach for many veterans. Most veterans lack access to medical marijuana, forced by the drug war to turn to the streets to access the medicine that works best for them.

What is more, it is well documented that veterans are self-medicating with marijuana to relieve PTSD symptoms. As one study writes, “It seems obvious from more recent studies of clinical and non-clinical

populations that cannabis is used by a significant number of PTSD patients in the attempt to cope with their symptoms.¹⁸³ The study concluded, “Multiple effects associated with cannabis resin appear to act synergistically to reduce some symptoms of PTSD and might offer potentials for new psychopharmacological treatments. Therefore, PTSD subjects may opt to self-medicate by using cannabis.”¹⁸⁴

Recently, the VA changed its policy and will no longer penalize veterans who are legally participating in a state medical marijuana program. Previously, many veterans had been cruelly denied opioid pain medications or other needed care just for testing positive on a drug test for medical marijuana – even when such use is legal in their state.¹⁸⁵ Accordingly to the new VA position, “VHA policy does not administratively prohibit Veterans who participate in State marijuana programs from also participating in VHA substance abuse programs, pain control programs, or other clinical programs ... patients participating in State marijuana programs must not be denied VHA services.”¹⁸⁶

However, the VA bans its doctors from recommending marijuana to their patients or completing state forms required for their patients to enroll in a state medical marijuana program.¹⁸⁷ Its official policy states, “It is VHA policy to prohibit VA providers from completing forms seeking recommendations or opinions regarding a Veteran’s participation in a State marijuana program.”¹⁸⁸ Many veterans as a consequence are left with no option but to visit a private doctor at their own expense.

The US has a duty to provide unfettered access to whatever medicine works best for returning veterans. To allow the war on drugs to hinder or prohibit access to such medicine is ineffective and morally indefensible.

Spotlight on New Mexico

New Mexico’s law, *The Lynn and Erin Compassionate Use Act*, was passed in 2007. The clear intent of the law is to provide relief from pain and suffering caused by debilitating permanent and chronic conditions.

PTSD was approved as a qualifying condition in New Mexico in 2009. Today nearly 3,000 New Mexican residents with Post-Traumatic Stress Disorder are actively enrolled in the state’s Medical Cannabis Program. Thirty-seven percent of medical marijuana patients in New Mexico indicate PTSD as the primary condition for which they are seeking relief – making

PTSD the most common medical condition for which New Mexico patients use medical marijuana.¹⁸⁹ They are military veterans, patients living with disabilities, and victims of serious trauma and violent crime. More than 175,000 military veterans call New Mexico home,¹⁹⁰ including some who have relocated to New Mexico specifically to have legal access to medical cannabis for PTSD. It is not known exactly how many of these veterans are part of the state’s Medical Cannabis program.

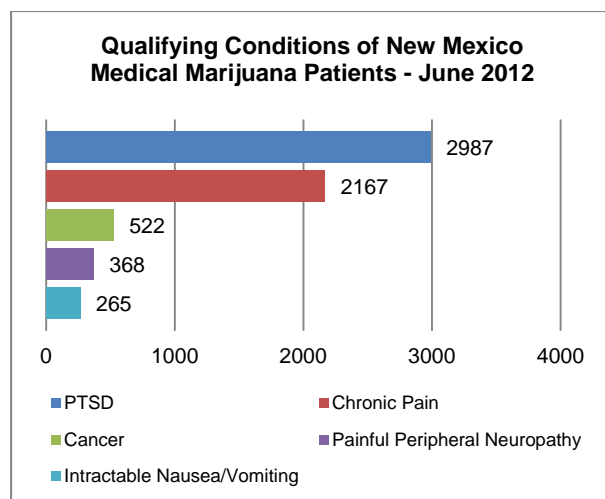
"I've run the gamut of all the different medications at the VA, and basically I was at my limit. The medications were turning me into a zombie, I couldn't relate to my daughter. Medical cannabis made me a father and a husband again. It's been a blessing."

- Decorated U.S. Army veteran Paul Culkin, a New Mexico medical marijuana patient who suffers from PTSD after serving as a bomb squad staff sergeant in Iraq.¹⁹¹

Patients deserve access to effective medical treatments – whether they have just come home from combat or are suffering debilitating symptoms from other trauma. Patients also deserve, above all, the freedom to choose the safest and most effective treatment for their disabling conditions.

"When I returned home from Afghanistan I was diagnosed with PTSD. I worked with my doctor and tried many prescription drugs. Taking handfuls of pills every day, every one with a different set of side effects was hard on my body, and I still experienced some symptoms. Cannabis was not my first choice of medicine, but I tell you first hand, this medicine works for me. Cannabis allows me to leave my house and has helped me to return to work."

-Col. Michael Innis, Purple Heart recipient



Source: New Mexico Department of Health 2012.

In fact, many psychiatrists report that pharmaceutical cocktails currently prescribed to sufferers of PTSD have limited efficacy, have significant debilitating side-effects, and have in many cases proven deadly.¹⁹² Given these facts, along with the experience of thousands of patients whose quality of life has been improved by medical marijuana, it should continue to be an available treatment for sufferers of PTSD.

There is movement to include PTSD in other states with medical marijuana laws with regulations allowing the addition of medical conditions. However, thus far, attempts have failed in Arizona, Colorado and Oregon.

“The right to safe and non-toxic medicine means much more to me than I can express in words. Incorporating medical cannabis into my treatment for my PTSD helps me sleep, helps me manage my physical pain, and helps me enjoy my family.”

- "Nathan," an Air Force veteran who suffers from PTSD, Las Cruces, New Mexico

After an attempt to add PTSD as a qualifying condition in Colorado was denied veterans have rallied as vocal supporters of Amendment 64, the successful initiative that passed in November 2012 that will regulate, tax and control marijuana in the state. A coalition of veterans’ groups in the state issued a statement saying that “Passage of Amendment 64 would ensure that Coloradans 21 and older who suffer from PTSD are no

longer subject to arrest and prosecution for using marijuana. Our brave soldiers – and the many non-soldiers who suffer from PTSD – deserve legal and safe access to marijuana, which has been proven to be therapeutically effective in treating this condition.”

MDMA: Promising Research Continues Despite Drug War Obstacles

Another currently prohibited substance that holds great potential for treating PTSD symptoms is MDMA.

MDMA-assisted psychotherapy is an innovative treatment that combines traditional psychotherapy with the administration of MDMA (3,4-methylenedioxymethamphetamine), a synthetic compound widely recognized for its ability to decrease fear and defensiveness while increasing trust and empathy.¹⁹³ MDMA is an effective and powerful tool for both the clinician and the patient. Because of MDMA’s unique effect of diminishing fear and enhancing interpersonal trust, it appears to be an ideal adjunct medicine to traditional psychotherapy for PTSD.

MDMA-assisted psychotherapy allows people with chronic, treatment-resistant PTSD to relive, and confront, their traumatic memories in the context of a safe and controlled clinical setting, and often for the first time. The substance is only administered a handful of times over the course of a year or more of therapy. Conventional pharmaceutical treatments for PTSD often have unwanted or even dangerous side effects and require daily administration of drugs for months or often indefinitely. As noted above, safe and effective treatment options for PTSD are limited: Only two selective serotonin reuptake inhibitors (SSRIs) – paroxetine (Paxil®) and sertraline (Zoloft®) – are currently marketed as PTSD medications; other medications such as benzodiazepines and antipsychotics, are being used off-label.¹⁹⁴ The medicines have limited efficacy and potentially life-threatening side effects, especially when used in combination with opioid pain medications. MDMA, like marijuana, has no such side effects.

MDMA has been approved for use in clinical research and has “been administered to over 500 human subjects in clinical studies without a single serious adverse event occurring as a result of the drug.”¹⁹⁵ A seminal 2010 study published in the *Journal of Psychopharmacology* found that 83 percent of patients with chronic, treatment-resistant PTSD who received MDMA-assisted

psychotherapy experienced a significant reduction in the severity of their PTSD symptoms in comparison to placebo, as measured by the Clinician-Administered PTSD Scale (CAPS).¹⁹⁶ A long-term follow-up study that will be published later this year reported that these symptom reductions were sustained, on average, more than three and a half years later.¹⁹⁷

“It’s basically like years of therapy in two or three hours. You can’t understand it unless you’ve experienced it.”

-Former Army Ranger and MDMA-assisted psychotherapy study participant (March 2009).¹⁹⁸

Such findings have been replicated by several additional studies.¹⁹⁹ Another randomized controlled MDMA-assisted psychotherapy study concluded, “This novel treatment method can be safely applied in an outpatient setting (including an overnight stay for safety reasons, after each MDMA session) with no drug-related serious adverse events occurring.”²⁰⁰ The researchers found that “there was clinically and statistically significant self-reported (PDS) improvement... [and] CAPS scores improved further at the 1-year follow-up.”²⁰¹

Additional research studies are underway or being planned in the United States, Canada, Israel, United Kingdom and Australia. If results continue to be promising, MDMA-assisted psychotherapy could be approved by the FDA by 2020 – provided researchers find the necessary funding. In August 2012, the DEA approved an application to proceed with a revised study protocol of MDMA-assisted psychotherapy for veterans, firefighters and police officers with service-related PTSD.²⁰² The study was cleared by the FDA and an Institutional Review Board in February 2012 and is currently underway.²⁰³

Despite the demonstrated safety and efficacy of MDMA, the drug war continues to obstruct or halt the progression of this vital research. Researchers write, “There are several limitations impeding the use of MDMA as an adjunct to psychotherapy. Negative stigmatizations of the drug exist because of its common association with recreational drug use...”²⁰⁴ Before MDMA was made a Schedule I controlled substance, it was used successfully to treat Vietnam veterans with PTSD; it is time that MDMA’s status be reevaluated in

light of the pressing needs of the current generation of veterans and others who suffer trauma.²⁰⁵

Unlike marijuana, federal government agencies seem much more inclined to allow research into MDMA to proceed. Yet bureaucratic, legal and cultural barriers created by the drug war continue to slow down the pace of this critical research and prolong the day when all veterans who need it will have access to MDMA-assisted psychotherapy.

Recommendation for state and federal government agencies:

- States should adopt medical marijuana programs and ensure that PTSD, pain and other conditions affecting returning veterans are included as designated qualifying conditions for these programs.
- States with existing medical marijuana programs should add (or retain) PTSD and chronic pain as qualifying medical conditions.
- Federal government agencies must promote, not impede, research into fully understanding and applying the lifesaving potential of marijuana and MDMA to treat PTSD and other chronic conditions.
- Federal funding for research and development of both of these promising treatments is warranted and necessary.
- The federal government should refrain from interfering in state medical marijuana programs, and ultimately move toward permitting medical marijuana on a national level through its removal from the current schedules of controlled substances.
- The VA should rescind its directive banning its physicians from recommending medical marijuana to their veteran patients or completing requisite forms for their patients to enroll in a state medical marijuana program.
- Because self-medication is common among veterans who currently lack access to medical marijuana, the VA should consider changing policies that might penalize such veterans for positive marijuana drug test results.

Towards a Health-Centered Approach to Helping Veterans Struggling with Drug Misuse: A Critical Review of Veterans Courts

As states run increasingly crowded jails and prisons with steadily shrinking budgets,²⁰⁶ it is time to rethink how the criminal justice system handles veterans who commit nonviolent crimes, often as a result of untreated substance abuse or mental health disorders. Emphasizing community-based treatment over incarceration has proven both effective and cost effective.

A handful of jurisdictions are moving in this direction. One response, perhaps the dominant approach, has been to allow more veterans to participate in so-called veteran treatment courts. In 2008, Buffalo, New York, began the first treatment court devoted exclusively to veterans.²⁰⁷ Using the “drug court” model and principles,²⁰⁸ the Buffalo court works with the VA and other support services to divert veterans charged with nonviolent offenses away from incarceration and into treatment. Upon successful completion of the year-long program, graduates have their charges expunged from their record.²⁰⁹

Similar courts have been established in communities across the country.²¹⁰ Such programs may operate as stand-alone courts, or through existing special docket courts.²¹¹ State and federal legislation in recent years has also called for the creation of court diversion programs serving veterans.²¹²

It is heartening that the Buffalo veterans’ court coordinates with the VA to provide integrated substance abuse and mental health services.²¹³ Yet according to SAMHSA, as of mid-2009, the Buffalo court was the only court program that exclusively serves veterans.²¹⁴ Most others are grafted onto existing drug court programs.²¹⁵

While the desire to provide veterans with treatment instead of incarceration is well founded, because veteran treatment courts are modeled after drug courts, they suffer from many of the same serious shortcomings.

Drug courts were certainly developed in an attempt to develop more humane and effective interventions in the lives of people struggling with drug problems. Such courts have undoubtedly helped many people find their way to a more stable and productive life outside of the criminal justice system.

But the evidence to date is clear: while drug courts will help some, many more will continue to be arrested and incarcerated for their drug use. It is imperative that policy makers expand the discussion of sensible drug policy beyond simply whether or how much to fund drug courts. Indeed, it is critical that policy makers understand the several critical shortcomings of the majority of the nation’s drug courts, as underscored by government-funded research conducted to date.

The real problem with the drug court approach is the fact that drug courts exist within a drug war framework. Drug courts claim to treat drug use as a health issue, but they cannot because they are required to enforce laws criminalizing drug use – and therefore punishment ultimately trumps treatment. As a result, drug courts have actually made the criminal justice system more punitive toward addiction – not less.

For example, although relapse is a common and predictable occurrence during treatment, drug courts often punish people who suffer a relapse by pulling them out of treatment and putting them in jail for several days or weeks. By contrast, in a medical setting, relapse calls for intensified treatment.²¹⁶

Therefore, it is critical when localities and states establish drug courts (1) to also develop many other interventions besides drug courts and (2) to adopt court practices and policies that will reduce the role of punishment in responding to drug use.

Recommendation: Do not require a veteran to be arrested or to plead guilty to access treatment.

To keep costs down and produce the best offender outcomes, it is in counties’ best interests to develop and expand alternatives to incarceration other than drug courts. Drug courts are expensive, small programs that suck up more resources than other alternatives and that can handle only a tiny fraction of potentially eligible people. Drug courts may also drive incarceration, since they depend (often quite heavily) on jail sanctions and ultimately send “failed” participants to serve time behind bars.

Most diversion programs in the country, including many, if not all, of the emerging veterans’ treatment courts, require veterans to plead guilty to criminal charges before being directed to treatment.

Yet the consequences of an arrest and conviction can be lifelong and devastating, including disenfranchisement, restrictions on licensure and employment, restrictions on housing, denial of public benefits, disqualification for financial aid, inability to adopt or foster a child, a forfeiture of one's assets and/or property, the loss of other privileges and opportunities, as well as the use of arrest data in background checks for employment, housing, and credit access.²¹⁷

The burdens of criminal conviction and arrest intensify the struggles veterans face on the road to recovery and rehabilitation. In 2003, an estimated 585,355 U.S. veterans were denied the right to vote because of a prior criminal conviction.²¹⁸ Inability to secure housing and employment because of a criminal record or recent incarceration is a major cause of veterans' overrepresentation among the U.S. homeless population.²¹⁹ According to the National Alliance to End Homelessness, veterans comprise 11 percent of the general population, yet one in three homeless people in the United States today are veterans.²²⁰

A better alternative to reduce drug arrests of veterans is to allow law enforcement officers to issue a warning and/or treatment referral to an individual in possession of a small amount of an illicit substance who does not pose a substantial risk to public safety, or by assigning case workers and services to some of the individuals most often arrested for these same petty offenses. Efforts to divert combat veterans at the intersection of justice systems are taking place at the local level as well. A number of law enforcement agencies have become involved in designing pre-booking diversions that are veterans-specific.²²¹

In these programs, local law enforcement agencies may divert veterans to appropriate VA care instead of booking and arresting them, when such a disposition is in the interest of the veteran and public safety. Importantly, pre-booking and pre-arrest diversion approaches may spare veterans a criminal record that can exacerbate the difficulties of readjustment after returning home. What is more, such approaches may be more successful in engaging and retaining veterans in treatment, as research has shown that veterans "who were recently arrested were less likely to engage in treatment."²²²

The Chicago Police Department became the first to design and implement a 40-hour, veterans-specific training program based on the Crisis Intervention

Training model, which provides law enforcement officers with a set of tools to structure responses to community members in mental health crisis.²²³ These models follow the recommendations of SAMHSA and other experts that identify several points for intervention among veterans along the justice continuum, including at first contact with local law enforcement.²²⁴ The Los Angeles and San Francisco Police Departments have begun similar efforts.²²⁵

Seattle's Law Enforcement Assisted Diversion (LEAD)²²⁶ and San Diego's Serial Inebriate Program (SIP)²²⁷ are additional examples of such pre-arrest diversion programs in action for the general public.

More generally, states and localities should implement and expand pre-plea and pre-conviction diversion programs for people arrested for a low-level drug offense in order to prevent the collateral consequences that hinder those with a past conviction, including barriers to employment²²⁸, public housing, welfare and student loans.²²⁹

Recommendation: Create a continuum of interventions.

Diversion programs should exist along a continuum – from pre-arrest, pre-plea and pre-conviction diversion and advancing to post-conviction diversion – in order to reduce criminal justice involvement and stretch limited resources the furthest.²³⁰

State and local governments should work to leverage all available resources to expand access to treatment, for example, by:

- allocating a sizeable percentage of realignment funds to support services, including drug treatment;
- including alcohol and drug treatment services in your county's healthcare reform plans²³¹;
- directing federal Byrne Justice Assistance Grants; and/or
- diverting civil asset forfeiture funds to drug treatment.²³²

Above all, these governments should expand access to alcohol and other drug treatment outside of the criminal justice system and for pre-arrest, pre-plea and pre-conviction diversion, in order to reduce costs to the criminal justice system and allow health systems to more effectively manage these health issues.²³³

Recommendation: Embrace medication-assisted therapies

Local and state governments should expand and protect access to demonstrated alcohol and other drug treatments, including medication-assisted treatments (such as methadone and buprenorphine), where medically indicated²³⁴. Many, if not most drug court programs refuse to allow clients to participate in or remain on methadone, buprenorphine or other medication-assisted therapies,^{235, 236} despite the fact that the National Association of Drug Court Professionals (NADCP) urges its members to make use of medication-assisted therapy.²³⁷

Such prohibitions belie uncontroverted medical evidence (and the recommendations of federal agencies and commissions as well as the professional body representing every drug court in the country). More importantly, such prohibitions are a certain recipe for high rates of drug relapse and criminal recidivism.²³⁸ Drug courts must allow clients who would benefit from medication-assisted therapies to access them without prejudice.

“Medications such as methadone, buprenorphine, and naltrexone have been shown to clearly improve treatment outcomes for opioid-addicted individuals over detoxification followed by counseling and rehabilitative services alone. Similarly, naltrexone, acamprosate, and disulfiram have been shown to improve the outcome of treatment for alcohol dependence... The data fully justify the conclusion that medications should be considered as an integral part of any drug court treatment program. Given these data, to deny drug court participants the option of receiving medications for their treatment is in our opinion unethical.”²³⁹

- National Drug Court Institute, National Association of Drug Court Professionals

Recommendation: Reserve drug treatment for those who need it

Drug treatment should be reserved for those who need it, and treatment approaches should be tailored based on individual needs²⁴⁰; with a variety of other interventions and non-incarceration sanctions made available for

people arrested for a low-level drug offense or who have a positive drug test but who do not need treatment.

Recommendation: Improve drug court practices.

It’s critical that local and state governments implement policies that protect the rights and improve the outcomes of veterans in the criminal justice system, which translates into more effective and cost-effective policies.

Recommended policy improvements to drug and other “problem-solving” courts:

- Reserve drug courts for the people who commit more serious **non**-drug offenses that appear to be motivated by addictive-behavior²⁴¹ – **not** the people who commit simple felony drug possession offenses – and for those who pose a higher risk to public safety or who have lengthier criminal histories²⁴² [to cut incarceration costs significantly and to keep more serious offenders under close supervision, rather than those with a history of only petty offenses like drug possession];
- Adopt objective admission criteria and reduce the prosecutor’s role as gate-keeper.²⁴³ Drug courts tend to operate by the rules and practices imposed by a particular judge and drug court team. Thus, drug courts vary widely between, and sometimes within, jurisdictions in terms of the clients they accept, the treatment they offer, the sanctions they impose, and their requirements for successful completion.²⁴⁴ Many drug courts “cherry pick” for the least-addicted or “easiest” offenders to inflate their success rates. As a matter of fairness, drug courts should adopt more uniform standards of operation and criteria for admission.²⁴⁵ As a matter of public safety and fiscal efficiency, drug courts should dedicate their limited judicial and treatment resources for the more seriously addicted offenders with more extensive criminal histories, who require the most intensive treatment and supervision.²⁴⁶ Less expensive and restrictive diversionary options than drug court should be provided for veterans who commit minor offenses.²⁴⁷
- Use a pre-plea rather than a post-plea model²⁴⁸ [to prevent the barriers that accompany a criminal record]. To minimize or avoid the effect of collateral sanctions and consequences, new veterans’ treatment court programs—and those

already in operation—should adopt deferred adjudication or deferred sentencing procedures. Also known as pre-plea or pre-adjudication diversion, such programs allow a defendant to enter treatment without pleading guilty or receiving a sentence of guilt. If he or she succeeds in treatment, the charges are dismissed. According to the National Association of Criminal Defense Lawyers, “A pre-plea, pre-adjudication program preserves due process rights, allows defendants an opportunity to seek treatment ... provides a strong incentive for successful completion ... [and] permits informed, thoughtful decision-making by defendants and counsel.”²⁴⁹

- Limit the use of incarceration, including “flash incarceration,” as a response to low-level drug offenses and positive drug tests, and provide services or other sanctions instead, in order to reduce costs and improve outcomes for people convicted of drug offenses.²⁵⁰ Short jail sentences for participants who relapse during treatment are a central and common practice of most drug courts.²⁵¹ The efficacy of jail sanctions (as opposed to non-jail sanctions) is not supported by research evidence.²⁵² Moreover, the harms posed by jail are manifest: drugs, risky drug-taking behaviors, infectious diseases, violence, and stress are endemic to the nation’s jails.²⁵³ In short, jail sanctions – even short term – are unlikely to help and may compromise the physical and mental health of veterans.²⁵⁴ Accordingly, incarceration should play no role in efforts to provide substance abuse or mental health treatment;²⁵⁵ indeed, “each instance of incarceration may actually increase the likelihood of future incarcerations.”²⁵⁶
- Ensure due process protections and enhance the role of defense counsel.²⁵⁷
- Evaluate individuals’ success based on several measures (including stability, employment, and family participation); do not use drug tests as the singular measure of “success” or “failure”.²⁵⁸
- Improve data collection, research rigor, and implementation of demonstrated best practices.²⁵⁹ No systematic, much less uniform, collection or evaluation of drug court data exists. As a result, little is known about how they operate, whom they serve, or how well they perform.²⁶⁰ In other words, drug court programs largely operate without

meaningful oversight or accountability. Drug courts must begin keeping reliable data and have independent evaluators assess that data to determine how effectively drug courts are providing needed treatment, reducing criminal recidivism, improving client functioning and employability, promoting healthier lifestyles, reuniting families, and saving taxpayer dollars.²⁶¹

- Improve overall treatment quality and employ opioid maintenance treatments and other evidence-based therapies.
- Use drug tests as a treatment tool, not as punishment.
- Empower treatment professionals in decision-making. Most drug court judges are not trained as treatment professionals and possess no specialized knowledge of alcohol or other drugs.²⁶² Nevertheless, drug court judges frequently decide the type and length of treatment clients receive without adequate input from or deference to the considered opinions of substance abuse and/or mental health professionals. Courts should require—and follow—the recommendations of qualified health professionals who have adequately assessed the needs of the client.²⁶³
- Reduce turnover of trained and experienced court, probation and treatment staff to improve program continuity and consistency.
- Ensure that punishment for “failing” the program is not worse than the original penalty for the offense.
- Work to establish other local alternatives outside the drug court for those who want and need access to treatment but do not warrant intensive court resources (e.g., probation-supervised treatment).

In conclusion, governments should develop alternatives to court-based diversion, and reserve veteran courts for more serious offenders while improving those courts’ practices.

Conclusion

Post-traumatic stress disorder and traumatic brain injury have been called the “signature wounds” of the wars in Iraq and Afghanistan.²⁶⁴ Substance abuse, too, must be counted among the signature wounds of the current conflicts. Returning veterans suffering from these wounds have increasingly become casualties of the U.S. war on drugs, a war that emphasizes punitive measures such as incarceration over treatment and rehabilitation.

The VA system holds great promise for delivering integrated, individualized treatment programs that address the PTSD-, TBI- and substance abuse treatment needs of veterans.²⁶⁵ But much work remains to be done by the VA, the DoD, other public and private health providers, and criminal justice agencies.

These bodies must improve and greatly accelerate efforts to prevent veterans from succumbing to drug overdoses, and include incarcerated veterans in national suicide prevention efforts.²⁶⁶

They must also expand and improve access to methadone, buprenorphine, and other medication-assisted therapies for veterans who are opioid dependent, whether they are in community-based treatment or behind bars.

Veterans must have access to the safest and most effective treatment for their condition. For many veterans, such treatment includes medical marijuana or MDMA. State and federal government agencies should accelerate, not impede, research into these highly promising interventions. However, sufficient evidence already exists to support a dramatic expansion of these medications to all veterans currently in need. Accordingly, state and federal government agencies should ensure that patients have safe access to these treatment options.

Finally, drug courts, which are increasingly opening their doors to veterans, should be considered as only one of several interventions to meet the varied and unique needs of veterans in the criminal justice system. Governments should expand access to community-based treatment and explore pre-arrest diversion schemes instead of relying exclusively, or primarily, on expensive and unproven veterans’ courts. Veterans’ treatment court programs should only be part of a broader continuum of treatment alternatives and should operate on a pre-plea or pre-adjudication basis, so that

veterans can be spared the lingering collateral consequences of justice involvement and better reintegrate into society without barriers to employment, education, housing, and other basic needs. If such courts are established, they should improve upon the practices of drug courts and serve veterans with more serious offenses.

Nearly all of the recommendations contained in this report were endorsed in 2010 by the US Conference of Mayors, representing our nation’s cities. Ranging from alternatives to incarceration to allowing veterans access to methadone, medical marijuana and other promising treatments, to urgently preventing overdose, the nation’s mayors issued a resolution calling on state and federal government entities to ensure veterans receive adequate treatment, rather than being criminalized and falling victim to the war on drugs.²⁶⁷

In pursuing these goals, we can begin replacing the failed war on drugs at home with proven, effective public health approaches that save lives while building stronger families and communities. The veterans of our foreign wars deserve no less; indeed, they deserve a great deal more.

ENDNOTES

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- Wisconsin; and several other communities. In 2008, SAMHSA and the National GAINS Center at the Center for Mental Health Services funded pilot jail diversion programs for veterans in six states (Colorado, Connecticut, Georgia, Illinois, Massachusetts, and Vermont). In 2008, SAMHSA and the National GAINS Center at the Center for Mental Health Services funded pilot jail diversion programs for veterans in six states (Colorado, Connecticut, Georgia, Illinois, Massachusetts, and Vermont). SAMHSA recently awarded additional grants totaling over \$10 million over five years for six more veteran diversion pilots in the states of Florida, New Mexico, North Carolina, Ohio, Rhode Island, and Texas for new state and local jail diversion pilot programs for veterans. See, for example, Center for Mental Health Services, National GAINS Center, Substance Abuse and Mental Health Services Administration, "CMHS Jail Diversion and Trauma Recovery Program Priority to Veterans 2011." <http://gainscenter.samhsa.gov/pdfs/veterans/JDTR_Brief_3_11.pdf>; and Substance Abuse and Mental Health Services Administration (SAMHSA). "SAMHSA Awards \$10 Million in Grants for Jail Diversion and Trauma Recovery with Priority to Veterans." <<http://www.samhsa.gov/newsroom/advisories/090929grants3824.spx>>
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