



THE OPIOID CRISIS IN AMERICA
Domestic and International Dimensions

PAPER SERIES | JULY 2020

**Assessing and improving
the government's
response to the
veterans' opioid crisis**

John Hudak

BROOKINGS

Assessing and improving the government's response to the veterans' opioid crisis

John Hudak
Brookings Institution

THE OPIOID CRISIS IN AMERICA Domestic and International Dimensions

*A paper series from the
Foreign Policy and Global Economy & Development programs at Brookings*

Acknowledgements

The author thanks Abigail Mason for her assistance with this paper.

The Brookings Institution is a nonprofit organization devoted to independent research and policy solutions. Its mission is to conduct high-quality, independent research and, based on that research, to provide innovative, practical recommendations for policymakers and the public. The conclusions and recommendations of any Brookings publication are solely those of its author(s), and do not reflect the views of the Institution, its management, or its other scholars.

Brookings recognizes that the value it provides is in its absolute commitment to quality, independence and impact. Activities supported by its donors reflect this commitment and the analysis and recommendations are not determined or influenced by any donation. A full list of contributors to the Brookings Institution can be found in the Annual Report at www.brookings.edu/about-us/annual-report/.

Executive summary

Over the past two decades, opioid use and abuse have created a public health emergency in the United States. As hundreds of thousands of Americans have died from accidental overdoses or suicide, public health and elected officials have sought policy solutions. With the goals of reducing opioid-related deaths, overprescribing, and opioid use disorder (OUD), state and federal policymakers have enacted policies to improve funding, expand research, identify and expand best practices, and investigate the causes of the current crisis.

As part of the significant attention paid to this issue, policymakers often identify groups that are especially vulnerable to OUD. Among those vulnerable groups are veterans. By virtue of service to our country, especially in a period of ongoing war, veterans report higher rates of severe pain and chronic pain than the general population. Those realities create an environment where opioid therapies can become widespread and lasting. For veterans who are also disproportionately likely to experience mental health conditions such as post-traumatic stress disorder (PTSD), opioid use can present additional challenges such as dependence.

While combatting the opioid crisis requires federal, state, local, and private efforts, the veterans' population presents a unique opportunity for federal policymakers to play an outsized role. Although it should be noted that state, local, and private actors also play important roles in helping veterans deal with OUD and aid in the prevention of opioid misuse. However, more than 9 million veterans are enrolled in the Veterans Affairs (VA) health care program, accessing more than 1,200 facilities in all 50 states, Washington, D.C., and territories.¹ This allows the federal government to enact changes to health care programming that can have a direct impact on a significant percentage of veterans.

This paper will offer a policy analysis and status update on the opioid crisis among veterans. It will proceed in four parts. First, it will describe the scope and depth of the opioid crisis among the veteran population, with key attention paid to the unique risks that the veterans' experiences pose. This section also highlights some of the challenges VA has faced in addressing this crisis among its patient population. Second, it will review the major legislative achievements over the past five years that address the opioid crisis, with attention paid to the extent to which veterans' issues were dealt with directly. Third, it will review the responses by VA and other federal departments and agencies to address opioid use disorder and opioid related deaths among veterans. This section will also focus on agencies' responsiveness to legislative mandates from Congress. Fourth, it will look ahead to additional changes that can be enacted to assist veterans dealing with OUD and to improve the ability of VA to reform to meet the needs of the opioid crisis.

Veterans and the battle against opioid use disorder

Opioid use disorders happen for a variety of reasons and affect all groups of the American population. Although having an opioid prescription is not a necessary nor sufficient condition for developing OUD, it can contribute to risk, especially among those suffering from multiple physical and mental health conditions, including overuse and abuse of other substances including alcohol. Nor is one's own opioid prescription necessarily the cause of one's abuse of opioids or an overdose. As a 2020 article in the *Journal of Law Medicine and Ethics* notes,

“while opioid prescribing likely contributed to the incidence of opioid use disorder, presumably by making opioids more accessible, data do not demonstrate that most people with this condition began in a doctor’s office.”² However, an oversupply of prescription opioids can create additional opportunities for OUD via one’s own prescription, diversion to illegal markets, and/or unsafe combinations of substances. In other cases, substance use expands beyond prescription opioids to illicit opioids like heroin.

One group especially at risk for developing opioid use disorders are individuals who report chronic pain. For decades, doctors relied on opioid therapies as a go-to treatment for individuals experiencing severe and/or chronic pain. Over the past 10 years, the United States has seen acute fallout from such prescribing habits. According to the Centers for Disease Control and Prevention (CDC), the number of opioid prescriptions in the United States peaked in 2012, with more than 255 million prescriptions issued that year—a rate of 81.3 prescriptions dispensed per 100 Americans.³ As America has begun to address the opioid crisis, the number of prescriptions and prescribing rates have decreased significantly. However, in 2018, there were still about 170 million opioid prescriptions issued in the United States.

Those numbers are staggering across the broader American population, and among one of the most vulnerable groups in this environment is America’s veterans. America’s veterans face a variety of health challenges related to age and service.

Service- and combat-related injuries affect a serious number of America’s more than 18 million veterans.⁴ A 2016 National Institutes of Health (NIH) study showed that veterans were over 44 percent more likely to report “severe pain” in the past three months than non-veterans.⁵ The numbers for chronic pain among veterans is even more alarming. In 2015 testimony before the Senate Veterans’ Affairs Committee, Dr. Carolyn Clancy, the Department of Veterans’ Affairs Interim Undersecretary for Health described the depth of that problem: “While about 30 percent of the Nation’s adult population experiences chronic pain, the problem of chronic pain in VA is even more daunting, with almost 60 percent of returning Veterans from the Middle East and more than 50 percent of older Veterans in the VA health care system living with some form of chronic pain.”⁶

In addition to chronic pain, America’s veterans also suffer from high rates of Post-Traumatic Stress Disorder. According to VA’s National Center for PTSD, 11 percent to 20 percent of veterans serving in the wars in Afghanistan and Iraq have PTSD in a given year; that figure is about 12 percent for veterans of Operation Desert Storm.⁷ And research has shown that OUD is higher among chronic pain patients who have PTSD.⁸ The relationship among OUD, PTSD, and chronic pain presents a critical risk among veterans who have outsized incidence of the latter two conditions.

The risks chronic pain, PTSD, and OUD present among veteran populations have come to fruition. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2018, 562,000 veterans reported opioid misuse in the previous year—505,000 with prescription pain misuse and 59,000 with heroin use.⁹ While those overall numbers have been decreasing, opioid misuse among younger veterans increased significantly from 2016-2018. In 2018, veterans aged 18-25 reported prescription pain reliever misuse at a rate of 10.1 percent, nearly double the 5.5 percent incidence in the general U.S. population.¹⁰ Among veterans with OUD, other substance use disorders, and/or other physical and mental health conditions, the risks to human life is real. In 2019, VA Secretary Robert Wilkie noted that “veterans are twice as likely to die from accidental overdose compared to the general U.S. population.”¹¹ And while those accidental overdoses could come from a variety of substances

and the interaction of opioids and non-opioids, opioids–prescription and illicit–contribute to a non-trivial portion of those accidental overdoses.

However, stigma exist across society about dealing with mental health challenges, including substance use disorders, anxiety, depression, PTSD, and more. Those stigmas are significant among veterans and active-duty servicemembers. A 2008 RAND Corporation Study found that in a survey of active-duty service members and veterans, a significant number noted stigma or other fears such as employment challenges as barriers for seeking mental health care.¹² Such findings were echoed in a 2011 Government Accountability Office (GAO) report which noted, “The key barriers we identified from the literature that may hinder veterans from accessing mental health care from VA, which were corroborated through interviews with VA and VSO officials, are stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing mental health care, and concerns about VA’s care.”¹³

The result is a population of America’s heroes who need mental health care and ultimately do not get it. This reality was reflected in a 2018 report from the National Academy of the Sciences, Engineering, and Medicine, which found that in a survey of veterans, about half in need of mental health care did not receive it.¹⁴

The vulnerability of the veteran community to OUD is unquestionable, and the magnitude of the problem gripping those who served is severe. As the opioid crisis grew in severity, it also began to capture broader attention from public health officials, the medical community, policymakers, media, and the public. And while the crisis is multifaceted, multicausal, and difficult to resolve, efforts across governments in the United States have taken root. Some of the policy changes have been successful in dealing with different aspects of the broader public health issue, and to varying extents, the veteran population has been part of that conversation.

Veterans Affairs challenges in addressing the opioid crisis

As a medical provider, VA hospitals struggle to catch up with the challenges its patient population faced in the battle against opioid use disorder. This experience is similar to the experiences faced by public and private health care systems across the country. However, VA’s delays in adequately addressing OUD among veterans and its own internal operations that contributed to the crisis put at risk a uniquely vulnerable population. And the challenges the department faced with a growing population of veterans with OUD and its own pain management prescribing practices were both well documented. These problems also arose while VA dealt with a series of other management and standardization of care problems system wide.

Despite the complexity of many of these challenges within VA—on issues related to opioids and those unrelated—it is important to explore some of those problems to put the broader challenge into context. That context also helps clarify the foundation for and goals of subsequent reforms and identify areas in which more work can be done.

In 2004, VA issued a Mental Health Strategic plan intended to address a variety of new and ongoing challenges among veterans. This strategic plan included management level changes and reforms as well as the allocation of hundreds of millions of dollars for funding-specific mental health services across the VA system. The start of wars in Afghanistan and Iraq in the early-2000s was part of the impetus for this reform, recognizing that VA would soon face new challenges and a new group of combat veterans. Ultimately, “the mental health strategic plan

was designed to address gaps in mental health services provided to veterans across the country. Some of the service gaps identified by the VA were in treating veterans with serious mental illness, female veterans, and veterans returning from combat in Iraq and Afghanistan.”¹⁵

However, a November 2006 report from GAO highlighted that the efforts to increase funding for mental health services, including substance use treatment, failed to meet promises. Underfunding across the system was rampant, and even though “VA had identified them as having gaps in substance abuse and/or mental health services prior to the implementation of the mental health strategic plan,” millions of dollars of funding earmarked for substance abuse treatment went unallocated.¹⁶

Those challenges in VA endured throughout a decade in which hundreds of thousands of American servicepeople were deployed in theaters of war at any given time, many serving multiple tours and enduring serious physical and mental health injuries. By March 2010, GAO issued a subsequent report sounding the alarm on gaps in VA’s ability to meet the substance abuse needs of veterans. That report, titled “VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans” highlighted four key barriers to veterans accessing care for substance use disorders. They include the inability to hire/retain substance use treatment personnel, a limited number of beds available for treatment, limited use of medication-assisted therapies because of a lack of knowledge and training among VA staff, and limited knowledge about treatment efficacy.¹⁷

As thousands of veterans of the Afghanistan and Iraq wars returned home with battle injuries including chronic pain, PTSD, and ongoing or new substance use disorders, the VA was unprepared and ill-equipped to offer adequate care.

And in addition to the challenges existing among veterans seeking or in need of treatment, the staffing and management problems were compounded by a series of controlled substance-related scandals at VA. During the 2010s a series of allegations among VA hospitals and clinics showed a series missing or stolen pharmaceuticals, missed compliance checks of controlled substance handling, and according to an NBC News report, it led to nearly 100 investigations by the VA Office of Inspector General (OIG).¹⁸

Ultimately, VA is an institution charged, in part, with providing health care to millions of veterans every year. When veterans faced the prospect of a substance use disorder, VA was inconsistent in its ability to meet veterans’ needs, and ultimately a series of missteps ranging from leadership to practitioners created a system that failed to protect veterans from a growing public health crisis: the opioid epidemic.

The congressional response to the veterans’ opioid crisis

In response to the growing opioid crisis among America’s veterans, GAO, the VA OIG, Congress, and the media revealed myriad problems within VA and its facilities. To its credit, VA responded with well-intentioned, major reforms including the adoption of a Mental Health Strategic Plan (2004), the issuance of the Uniform Mental Health Services in VA Medical Centers and Clinics handbook (2008), and the issuance of Clinical Practice Guidelines (CPGs) for chronic pain and opioid therapy (2010; updated in 2017). However, problems continued to persist with respect to VA’s ability to deal with the crisis.

As broader attention was paid to the extent and impact of the opioid crisis, members of Congress began to take note and began proposing legislation to help deal with the challenges. Early efforts sought to expand the availability of MATs and the expansion of funding for substance abuse programs, as well as smaller-scale reforms. However, from a legislative perspective little was being passed that sought to deal systematically with the broader opioid crisis—causes and effects. In addition, little attention was paid to the specific needs of veterans and other vulnerable groups being harmed by opioids.

Comprehensive Addition and Recovery Act (CARA) of 2016

Congress would eventually begin working on a broader, comprehensive bill that would bring together Democrats and Republicans, advocacy organizations, and existing legislative ideas (in Congress and from the outside). In general, efforts between a Republican Congress and a Democratic president (Barack Obama) often hit a stalemate because of policy differences, politics, and polarization. However, the opioids crisis remained largely buffered from the typical factionalism of American politics.

On July 13, 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA), and nine days later President Obama signed it into law.¹⁹ CARA would institute some of the most far-reaching reforms related to opioids in the history of Congress. The law focused on pharmaceutical opioids and heroin and attacked the problem from a variety of perspectives. It included reforms to improve treatment, training (for medical professionals, first responders, and law enforcement), education, prevention, and evidence-based research. It authorized new task forces and commissions. It again expanded access to MATs and overdose reversal drugs, recognizing the important role first responders play in combatting the crisis.

The law also allocated funding to federal agencies and states. However, this faced challenges in Congress with funding levels not as high as the White House preferred, prompting President Obama to issue a signing statement that noted: “I am deeply disappointed that Republicans failed to provide any real resources for those seeking addiction treatment to get the care that they need. In fact, they blocked efforts by Democrats to include \$920 million in treatment funding.”²⁰

Finally, the law also recognized specific, vulnerable groups who required specific attention in the midst of the opioid crisis. Provisions of CARA were meant to address challenges faced by pregnant women, new mothers, families, incarcerated individuals, and veterans. The attention and specific carve-out for veterans occurred because of bipartisan efforts from key advocacy groups and members of Congress who recognized the importance of this community in the policy conversation.

The law took critical steps toward addressing the challenges veterans face and the reforms were significant. The law implemented changes to veterans’ care, research, practitioner guidelines and expectations, VA management and organization, and evidence-based researcher. Among the many reforms, there were 12 key areas of reform to assist veterans:

- Improve/expand the Opioid Safety Initiative
- Update the Clinical Practice Guidelines (CPGs) for chronic pain and opioid therapy
- Improve education around CPGs, evidence-based research, and patient screening
- Improve information/data capabilities department-wide, particularly with regard to patient care around OUD
- Improve the use and access to state Prescription Drug Monitoring Programs (PDMPs) and issue a report to Congress on progress

- Designate Pain Management Teams in all facilities and each facility to issue a report to VA on progress
- Establish a centralized Office of Patient Advocacy
- Improve education around the existing, facility-level Patient Advocacy Program
- Charge GAO to conduct a study/issue a report on the use of opioids in treatment in VA
- Charge GAO to conduct a study/issue a report on the Patient Advocacy Program
- Establish the Creating Options for Veterans' Expedited Recovery (COVER) Commission and issue a report.
- Make treatment for OUD cheaper for veterans
- Pilot a broader program for complementary and integrative health
- Improve the quality of VA personnel, particularly in the area of pain management practices

Many of the VA-specific reforms reflected weaknesses that had been discovered in the VA system through, OIG investigations, Congressional oversight, GAO studies, media inquiries, and patient complaints. Two areas in particular highlight the need for specific reform and the responsiveness of CARA to those extant needs.

SUPPORT Act

The next significant step Congress took to address the opioid crisis came in 2018. In October of that year, Congress passed the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.²¹ This legislation—like CARA is broad in scope, not focused specifically on veterans' needs. However, the law did take specific steps that improve service for veterans and incorporates veterans' needs into broader efforts.

Although not the first of its kind, the SUPPORT Act works to make sure that veterans have a seat at the table and take an active part in the conversation around opioid use, treatment, and recovery. This is important beyond simply that voice being heard, but it helps normalize the idea that veterans are victims of the opioid epidemic and by giving them a seat at the table to advocate for those veterans, it helps break the stigma and silence that surrounds veterans' struggles.

This law assists veterans in three key ways. First, it requires VA to interface its prescribing data into state-based PDMPs. The PDMP system requires a two-way flow of information. Not only must medical professionals consult the database, but they must also contribute to it in order to have the most timely, effective, and comprehensive information on the dispensing of prescription drugs to patients. This is especially true for veterans. Some veterans cycle in and out of VA health systems based on income, employment, family status, or personal preference. Some veterans get healthcare from both VA and private sources. Older veterans may supplement Medicare coverage with VA benefits. Thus, a veteran's health profile may be spread broadly inside and outside of VA.

Second, the SUPPORT Act established a comprehensive peer support counseling program for women veterans. Women make up a minority share of America's veterans and are often overlooked as composing a unique subset within the veteran community. A focus on women within the conversation around veterans and opioids is critical, given that NIH has shown that a significantly higher percentage of female veterans report experiencing severe pain in a given year than male veterans.²² In addition, according to SAMHSA, female veterans are more likely than male veterans or female non-veterans to report the non-medical use of pain relievers and

overall illicit drug dependence or abuse.²³ The same report found female veterans are significantly more likely than male veterans to report a major depressive episode, any mental illness, and serious mental illness.

Third, under the SUPPORT Act, Congress established the Interdepartmental Substance Use Disorders Coordinating Committee (ISUDCC). This committee, coordinated by the Secretary of Health and Human Services and the Drug Czar, includes a representative appointed by the Secretary of VA. The committee is charged with appointee subcommittees to address specific policy needs and to issue a broader report that includes recommendations to strengthen existing programs, develop new programs, and to coordinate more effectively across agencies to combat substance use disorders.

VA MISSION Act

The third major piece of legislation that dealt in part with veterans and the opioid crisis was the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act.²⁴ The MISSION Act was also signed into law in 2018 to modernize and improve VA facilities and improving care for veterans. Whereas CARA and the SUPPORT Act were broad pieces of legislation focused on substance abuse, with provisions dedicated to veterans, the MISSION Act is a veterans-focused law, with provisions dedicated to substance use programming.

First, the MISSION Act focuses on significant challenges that were not fully addressed in CARA and other efforts. The law requires the VA Secretary to issue and improve opioid prescribing practices and ensure improved education and compliance among practitioners. Education around prescribing practices seems straightforward, but serious flaws in practitioners' knowledge and behaviors have been uncovered via investigations and studies.²⁵ In addition, the law expands and seeks to ensure VA practitioners' access to state PDMPs, by requiring states to allow individuals who are either licensed or meet the qualifications to be licensed to have access to the database without penalty.

Second, the law requires the VA Secretary to designate at least "peer specialists in patient aligned care teams at medical centers of the Department of Veterans Affairs to promote the use and integration of services for mental health, substance use disorder, and behavioral health in a primary care setting."²⁶ This program is focused on treatment in a narrow set of areas including substance use disorders. It charges the department to roll out this program in a staged manner, but ultimately for the peer support program to be system wide. It also requires the department to ensure "gender-specific services," sensitive to the unique needs of female veterans.²⁷

Third, the MISSION Act makes strides to improve the recruitment and retention of personnel. This charge is broad and reflects the challenges that all parts of VA face in hiring, retaining, and rewarding staff.

In the course of two years, Congress took significant steps to address the opioid crisis broadly and with specific attention paid to vulnerable groups including veterans. Such reforms were long overdue and as the legislative progeny described above highlights, the battle against the opioid crisis is a multi-faceted, complex, and ongoing effort. CARA, the SUPPORT Act, and the MISSION Act will not solve all of the challenges that the opioid crisis presents and the veterans community endures. However, they were important steps. The next critical piece of providing better, safer, more comprehensive care to veterans involves assessing how well VA has responded to these legislative reforms and the extent to which Congress has helped or hindered to implementation of its dictates.

Assessing the implementation of veterans' provisions of opioid legislation

In response to the opioid crisis, VA has taken significant steps over the past 20 years in an effort to expand treatment and prevention, improve infrastructure, increase education among practitioners and patients, and expand research on veteran-specific issues. As new generations of combat and non-combat veterans rely on VA and private health systems to deliver care, the charge to understand veterans' specific needs has grown.

As mentioned above, VA has taken steps to improve its efforts sometimes through internal mandates and at other times because of legislative changes. How, then, has VA responded to these new mandates, and where has the department succeeded?

Improving VA's opioid policies and care provisions

The VA has successfully instituted a number of reforms in response to recent legislation that will have significant effects on the ability of the medical system to assist veterans facing OUD and to ensure others receive treatments that avoid ultimately developing OUD.

First, VA launched the Opioid Safety Initiative (OSI) in 2012 and expanded it nationwide in 2013. The goal of the OSI was to increase education among patients and practitioners, expand urine testing of patients, rely on the PDMP, identify veterans at high risk for OUD, and improve prescribing practices, among other changes. Research shows that the implementation of the OSI has led to a decreased number of high-dose opioid prescribing and an overall improvement in opioid prescribing practices.²⁸

However, the OSI includes guidance on tapering, leading to mandatory tapering among patients, including those using long-term, high dosage opioid therapies. Such tapering guidelines are controversial within the scientific community. Evidence of the benefits of tapering programs is either limited or not demonstrated in the literature.²⁹ Research shows that rapid tapering, including mandatory tapering, increases the risk of negative outcomes in patients including increased pain, withdrawal, self-harm, and other physical and psychological conditions. This pushed HHS to issue guidance in 2019 that sought to limit tapering to specific situations, while monitoring patients for adverse effects.³⁰

While OSI offers more blanket tapering guidance, other sources suggest a patient-centered approach that focuses significantly on conversations and consultation with patients, and patient consent to tapering. Manhapra, et al (2017) notes, "The process should also assure that patients feel that they are treated with dignity and respect, are involved in decision process and remains engaged in continued treatment... Forced involuntary tapers can result in poor outcomes and patients feeling abandoned."³¹ OSI guidance that pushes tapering, without a full appreciation for a patient's case creates not only risks in the delivery of safe and adequate care. It also creates an ethical challenge for doctors. Such guidance can push physicians "to uphold the interests of institutions (many of which have power over the physician's livelihood, at least indirectly)."³² Yet, "if a prescriber adheres to institutional pressure to reduce dose despite sincere concern that doing so harms the patient, it is clearly unethical for the provider."³³

While careful monitoring of prescribing practices among VA physicians is important, and updated guidance is always necessary to reflect the most up-to-date research, some recommendations can lose sight of the importance of patient-centered care. Such concerns are especially critical in the context of opioid therapies.

Despite the improvements the OSI brought to the VA system, problems still existed, and Congress urged VA to expand and improve the initiative via CARA. In response, VA expanded and improved the Opioid Safety Toolkit which includes information and educational materials for both practitioners and patients about opioid use, opioid use disorders, drug interactions, evidence-based research related to the issue, best practices for safe prescribing, and resources for seeking help for OUD.

In addition, and as part of the mandate to improve the OSI, VA—in conjunction with the Department of Defense (DOD)—issued the updated Clinical Practice Guideline for Opioid Therapy for Chronic Pain (CPG).³⁴ VA describes the CPG as including “objective, evidence-based information on the management of chronic pain. It is intended to assist healthcare providers in all aspects of patient care, including, but not limited to, diagnosis, treatment, and follow-up. The system-wide goal of this guideline is to improve the patient’s health and well-being by providing evidence-based guidance to providers who are taking care of patients on or being considered for” long-term opioid therapy.³⁵ The 2017 CPG ultimately updates the previous version from 2010 by incorporating the most up-to-date research (through the end of 2016) as reviewed by a panel of experts organized by VA and the DOD. That research is then translated into a clearinghouse of information as well as practitioner guidelines to assist in the assessment and treatment of patients, ensure safe prescribing practices, improve the patient experience, assist in providing education materials for patients and practitioners, and improve outcomes in the VA system.

Next, CARA charged VA to create a separate Office of Patient Advocacy to monitor the Patient Advocacy Program. The Patient Advocacy Program is a critical one within VA that allows patients to file complaints or to report other behaviors within the VA system that create problems for care. Patient advocates are charged with entering the complaint information into a centralized system—Patient Advocate Tracking System (PATS)—and investigate the complaint in an effort to resolve it. This new office would focus the management of the nearly three-decade-long dysfunctional program³⁶ from the previous organizational structure—operating in the larger VA Office of Patient Centered Care and Cultural Transformation. It has designated a director for the office and carries a mandate of improving training, information, and coordination among the VA facilities’ patient advocates.³⁷ And while the goal of the legislation was to stand up the office within one year of passage, VA opened it within 18 months in February 2018.

Multiple pieces of legislation have urged VA to improve access to and use of the Prescription Drug Monitoring Program (PDMP) in the states. VA has worked to expand practitioners’ access to the PDMP, while continuing to educate personnel about its value and importance. As part of the revised 2017 CPG, guidelines included use of the PDMP, especially in conjunction with urine testing in order to assess both patient history as well as patient risk for misuse or an OUD. This move came just after VA’s October 2016 directive (no. 1306), which was updated again in October 2019, that clearly outlined VA personnel’s responsibility to use the PDMP, the conditions under which it should be used, and how it assists doctors in developing safe and effective treatment plans.³⁸ These efforts are important steps in expanding the knowledge base among VA personnel, making clear the goals of VA leadership, and standardizing practice (and expectations around practice) at all VA facilities.

Recent legislation also commissioned a series of reports to study and improve a variety of programs around veterans and opioids. Three, in particular, have been completed in a timely manner and provided excellent recommendations for improvements. The 2016 CARA legislation mandated that GAO conduct a review of the Patient Advocacy Program and its effectiveness as well as a study of the use of opioid therapies at VA. In addition, that legislation

established the Creating Options for Veterans' Expedited Recovery (COVER) Commission and charged it to release a report.

GAO completed its study of the Patient Advocacy Program and issued its report in April 2018. In May 2018, GAO also issued its report from the study of VA's opioid therapy practices. Each of these highlighted challenges within the system and made recommendations as to necessary improvements to meet the needs of patients and the mandate from Congress (more on this in the next section).

In the Summer of 2018, the COVER Commission members were appointed. They included a wide variety of individuals with diverse backgrounds who could offer key input to areas of mental health and substance use disorders, but with a specific focus on veterans.³⁹ This commission issued its final report in February 2020. The Commission used surveys, focus groups, and other techniques to understand the real needs of veterans with regard to mental health care, substance abuse treatment, and access to VA treatment options, among other items. Ultimately, the COVER Commission made 10 key recommendations that would improve the infrastructure, services, training, education, and research at VA in ways that better reflect patients' mental health needs.⁴⁰

Finally, there have been funding changes over the past several years that have focused federal money on assisting VA, states, non-profits, researchers, and others to attack the opioid crisis among veterans. While VA obviously sits at the center of research, training, education, information, and treatment for the veteran population, many other federal agencies have directed funds, funding programs or portions of programs to the needs of veterans.⁴¹ Numerous agencies within the Department of Health and Human Services (HHS), including the National Institute for Health (NIH), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC) have directed funding to assist with the understanding and treatment of OUDs in the veteran population.

Those agencies are not alone. The DOD, as the producer of America's veterans, has worked actively and with funding to study and improve the transition of soldiers to civilian life. That transition process is holistic and mental health care is only part of the myriad issues that the Pentagon must consider. However, given the use of opioids in the treatment of soldiers with injuries, and the rise in OUDs among active-duty service members, DOD has worked closely with VA to improve treatment and prevention among these men and women.

In addition, funding from the Department of Justice (DOJ) has been used to establish programs like Veterans Treatment Courts. Veterans Treatment Courts function as alternatives to incarceration for individuals suffering from substance use disorders. The goal is for the court to have a greater understanding of the mental health and substance abuse needs of veterans and allow that knowledge and experience to assist in determining treatment alternatives that are culturally sensitive.

In fact, the Veterans Treatment Court program has seen success and growth throughout the country. The program was established initially in New York in 2008 and since has grown to more than 500 courts nationwide. For much of the Obama administration, the program, operated out of DOJ's Bureau of Justice Assistance saw modest growth in annual appropriations.⁴² However, in 2018 Congress passed and President Trump signed the FY2018 appropriations legislation that dramatically increased funding to \$20 million annually. While those increases are significant, more must be done. In an effort to expand and improve the program, Congress passed the Veterans Treatment Court Improvement Act in 2018 in September of that year, which charged VA with hiring additional staff to assist with the program across the country.

Ongoing challenges to meeting veterans' needs during the opioid crisis

Despite some of the successful reforms coming out of the recent legislation related to veterans and opioids, weaknesses still exist. Broader reforms and efforts are needed across the VA system, even in the wake of significant legislation. Those problems do not rest solely at the feet of VA. Presidential leadership and greater congressional intervention is necessary, as well. While VA's challenges in this area are numerous, I will highlight some key issues that demonstrate the seriousness and complex nature of what faces VA and its patients.

The prescription drug monitoring program

It has been long documented that VA has faced severe compliance challenges around practitioners using the PDMP in treatment of patients with chronic pain. Legislative efforts to change those policies had little effect. Initial guidance from VA to practitioners was vague around the requirements to use the PDMP. Additionally, bureaucratic challenges within VA and between VA and the states (who administer PDMPs) is well documented.

A 2018 GAO report highlights these challenges in which VA doctors licensed in one state and practicing at a VA facility in a different state, often cannot access the relevant PDMP. In other areas, nurse practitioners cannot access the requisite PDMP because of state rules. Finally, facilities that serve patients in different states (facilities like those in Kansas City, St. Louis, or Cincinnati to name a few), can use the PDMP in the state in which the facility is in but not the state PDMP where a patient lives.⁴³

Those logistical challenges are real. However, the problem with compliance with using PDMPs goes beyond circumstances in which state rules or licensure create roadblocks. The figures for compliance failure are staggering. The same 2018 GAO report found that among a random sample of the medical files of veterans receiving opioid therapy, only 26 percent had their name checked in the relevant PDMP.⁴⁴ Similarly, a VA Office of Inspector General investigation found similar failures. The 2019 report estimated that of the 779,000 opioid patients, about 73 percent of them (567,000) did not have their names checked in the relevant PDMP.⁴⁵

These shortcomings put the lives of hundreds of thousands of veterans at risk. Suicide, OUD, and accidental overdoses can occur when effective opioid prescribing practices are not followed. To echo the point that the failures of VA to comply with PDMP requirements are more than just the product of bureaucratic red tape, the 2019 OIG report directs blame at VHA management and stewardship. The report notes there were, "inadequate national VHA oversight and monitoring led to insufficient local monitoring and accountability at VA medical facilities ... [and that] this lack of effective national and local oversight and monitoring occurred because VHA officials did not always consider PDMP queries a high priority..."⁴⁶

In response to the recommendations of the 2019 OIG report, VA updated Directive 1306 regarding requirements for querying PDMPs. While the steps in the updated directive were in the right direction, they came far too late, as VA management under-prioritized a program with proven results.

Patient advocacy program

Since its inception in 1990, the Patient Advocacy Program has faced challenges. A 2017 report from the VA OIG found serious problems in the Patient Advocacy Program. Among those

problems were “patient advocacy policies out-of-date and no standardization guidance,” “inadequate program and data controls,” and “insufficient human capital management.”⁴⁷

These issues highlight how systemic the problems were in this program. Management of this program was causing myriad failures throughout the system. CARA’s establishment of the Office of Patient Advocacy was one step toward improving the program. Another was updated patient advocacy guidance. This guidance issued in Feb. 2018 directly responded to the OIG’s concerns over out-of-date and non-standardized policies.⁴⁸ It clarifies responsibilities within the system and seeks to ensure that patient advocates in one VHA facility operate in the same manner as peers at another facility.

A subsequent report, commissioned by Congress under CARA, from GAO in 2018 echoed some of the concerns voiced by the OIG more than a year earlier.⁴⁹ The GAO report highlighted the challenges that out-of-date and unclear guidance under which the Patient Advocacy Program had been operating under. In response to that specific concern, VHA noted that updated guidance from just weeks before the issuance of the GAO addressed those concerns.

However, the GAO report went beyond concerns over having up-to-date guidance around the internal operations of the program. The report also noted that VHA had failed to direct VA facilities as to how large of a staff should be included in the program. This led to dramatic variation from facility to facility in terms of patient advocates per patient.⁵⁰ Beyond staff levels, the report highlighted the challenges surrounding training needs, data entry compliance and practices, and the use of data to analyze program efficacy.

In addition to the charges from Congress for GAO to conduct studies, CARA also required greater information about the patient advocacy program to be distributed to veterans. However, even a cursory look at the phone directories of VA Medical Centers around the country shows that while many include the contact information for that facility’s patient advocate or equivalent, dozens of those medical centers do not even post the phone number for those offices.

Federal funding shortfalls and unfunded mandates

One area where government has failed to meet its obligations to veterans during the opioid crisis involves federal funding. Despite three major pieces of legislation addressing opioids, they often came with relatively modest increases in funding, and many came with mandates that agencies were expected to accommodate with existing funds—funds that were often already insufficient to meet existing mandates.

Although subsequent appropriations bills have, in some areas, boosted funding for certain programming, the ideal place to allocate additional funding would have been the initial legislation. The blame for this issue falls directly at the feet of Congress. VA and other agencies dealing with the opioid crisis have been asked to institute numerous reforms in an effort to assist individuals facing OUD and their families, but Congress frequently fails to give those agencies the tools they need to carry out that mission.

In fact, in the three pieces of legislation mentioned above—CARA, the SUPPORT Act, and the MISSION Act—included numerous, explicit examples of a mandate with no additional funding. Some of that funding directly affected veterans’ programming. Others were unrelated to veterans but highlighted the challenges that many federal agencies face in trying to deal with the opioid crisis while being handcuffed by a frugal Congress. In CARA, Congress sought an expansion of programs used for “assisting veterans with military emergency medical training to meet the requirements for becoming civilian healthcare professionals” and also charged

DOJ with evaluating the efficacy of its Opioid Abuse Grant Program. Both mandates explicitly came with no additional appropriation.⁵¹

The former seeks to transition veterans with effective job skills, able to assist in combatting and dealing with the opioid crisis. The latter program seeks to use the type of program evaluation that is critical for management. However, Congress disincentivizes DOJ from performing that evaluation or draws funding from other areas of administration in order to meet the new mandate.

Similarly, under the SUPPORT Act, Congress included numerous unfunded mandates including the preparation of a report the “Peer Support Counseling Program for Women Veterans.”⁵² Finally, the MISSION Act, charged VA with setting up a pilot program for medical scribes across the system, while Congress failed to appropriate additional funding for the program.⁵³

Those unfunded mandates do not tell the entirety of the story of Congress letting down veterans, insufficiently addressing the opioid crisis, and leaving VA and other departments and agencies left holding the bill for legislative mandates. Additionally, underfunded mandates can be just as problematic and even more pervasive. CARA, the SUPPORT Act, and the VA MISSION Act combine for over 400 pages of legislative text including hundreds of specific mandates from Congress. Many of those come with additional increases in appropriations, but often—as GAO and OIG reports show about VA (and other agencies)—Congress expects more than it spends the money to address. Those challenges complicate government-wide efforts to address the opioid crisis, especially efforts to address the crisis among vulnerable communities like veterans.

Opioid policy reforms to meet the needs of America’s veterans

Numerous reforms need to take place for America to meet the complex needs of the opioid crisis, its victims, and their families. There are also a significant number of changes that need to happen simply to meet the needs of a sub-population like veterans. Below, I propose seven reforms that will help overcome the challenges that exist in the current system and better position VA to serve its patients.

Funding congressional mandates

Congress must work closely with agencies to understand their mission, the needs they have to meet that mission, and the areas in which they are underfunded. Congressional hearings focused primarily on where VA needs additional support in dealing with the opioid crisis is essential. It is clear that there is a significant number of mandates that are unfunded or underfunded, but Congress needs to be made aware of what those funding shortfalls translate to in terms of patient outcomes.

VA as well as non-profit veterans’ health groups and other advocacy organizations can evaluate the effectiveness of current or potential programming. In many cases, this work has already been done.⁵⁴ In other areas, more work must be done. Beyond increased funding, some of the reforms that agencies need are not budgetary, but require legal changes to give agencies the authority they need to implement changes. An assessment of needed structural reforms can be just as important as added money.

Leadership on this issue within Congress is essential. Reforms related to veterans' issues occupy a unique space in American politics: it is generally non-partisan. Few elected officials lament additional funding to assist veterans, and that de-politicized environment is doubly assisted when discussing the opioid crisis. Members must take advantage of that unique political setting to advance additional funding for this effort.

Taking staffing challenges seriously

One ongoing challenge that VA faces is an inability to hire and retain personnel throughout the medical system. Numerous challenges are facing VA in terms of hiring including human capital management, location, and relative pay among others. GAO has made recommendations regarding how the department can improve hiring and retention.⁵⁵ VA must make headway on those recommendations, including better compensation and incentives to work within the system.

Vacancies in staffing from facility management to physicians and nurses to support staff create serious risks for a facility's ability to meet the needs of its patients. This issue is particularly problematic in the context of the opioid crisis. Because of the complex risk assessments involved in dealing with chronic and/or severe pain patients, the need for screenings like urine testing, requirements to consult PDMPs, in addition to standard clinical needs, this area of medicine requires additional time and strategy when crafting a treatment plan. Understaffing, particularly in areas relevant to opioid treatment, can rush the delivery of treatment and lead to mistakes that can cost lives.

Taking seriously commission recommendations

Congress appoints advisory boards, commissions, committees, and working groups frequently in all areas of public policy. One of the risks to those institutions is a Congress and/or agency that accepts a report and fails to act on it. Recent legislation has appointed several commissions to meet in order to deal with the opioid crisis, in some cases with a specific focus on veterans. Congress must take the recommendations of these committees as a mandate for future legislation.

The COVER Commission has issued its findings. In addition, GAO and the VA OIG has highlighted some of the challenges and necessary reforms within the department. Congress has been responsive to the areas of concern and types of reforms highlighted in those reports; however, greater responsiveness to this expert-level evaluation is necessary. Congress should hold hearings with relevant officials including COVER commissioners, the inspector general, and outside groups that support veterans' issues to prepare the next wave of (funded) reforms based on the latest analysis.

The Interdepartmental Substance Use Disorders Coordinating Committee is currently assessing government-wide effectiveness and efficiency in dealing with the opioid crisis. This committee has the authority to appoint subcommittees to deal with areas that require specific or specialized attention. This committee should focus a portion of its attention to vulnerable communities that see unique or outsized challenges with regard to prevention, treatment, and recovery from OUD. One of those subcommittees should focus on opioid use and abuse among veterans and active duty service members and how VA, DOD, and other relevant agencies can coordinate more effectively to serve those individuals.

Ultimately, the recommendations of the ISUDCC will require a combination of legislative and executive action, and when the committee issues its first and subsequent reports, Congress, agencies, and the president must be keenly aware of their obligations and powers to put those

recommendations to work. It must be a joint effort across government to improve coordination, communication, efficiency, and effectiveness.

Putting evidence-based research and data to work

VA has at its disposal an enormous amount of data about patients, practitioners, personnel, facilities, management, and a bevy of other internal operations. It presents the department with a treasure trove to identify weaknesses and strengths, to streamline operations, to identify bad actors, and to evaluate program performance. In many areas, the department put these data to work in order to understand what is happening within the system, and that is particularly true within VHA.

However, despite the availability of data and even the internal analysis of it, VA is often slow to make reforms based on the information that is revealed and struggles to rein in bad practices, compliance problems, and management failures. VA has been effective at reforming its patient advocacy program, issuing updated guidance around prescribing practices, and issuing comprehensive clinical guidelines. However, as has been highlighted on numerous occasions in a variety of areas within the VA medical system, simply issuing guidance does not ensure personnel educating themselves sufficiently with that new guidance nor compliance with that guidance. In areas such as these, the department is well positioned to assess the effectiveness and responsiveness to new rules and programming.

For years, GAO has recognized the management problems throughout the VA system. In response to those findings, VA leadership under multiple presidents has sought to deal with those challenges. However, management failures within VA and particularly the VA medical system have continued and are chronic and systemic. VA efforts at broader management reform have not yet resolved the myriad challenges the system faces; however, in a system as mammoth as VA medical, effective management is the critical centerpiece of an effective institution.

Addressing unnecessary bureaucratic hurdles

The VA medical system is a complex combination of two large bureaucracies: government and health care. This mix can lead to serious hurdles that can cause insufficient care, mistakes, management failures, and undesired outcomes. This paper is not the setting to identify each of the bureaucratic challenges that VA faces, but one in particular highlights the archetype of the type of ongoing challenge that creates an unnecessary problem because of intergovernmental rules.

As noted above, the state-administered Prescription Drug Management Program creates significant challenges within VA. In reality, there are two, largely unrelated problems that emerge around PDMP consultation within VA hospitals. The first is entirely internal: compliance. The second problem is more external: intergovernmental bureaucracy.

Despite guidance from 2019 that clarifies the obligations of relevant VA health care professionals with regard to PDMP querying, there are likely to remain compliance problems, and VA should use data analytics to monitor this activity, investigate non-compliance, and take disciplinary action where necessary.

Congress, VA, and states must work more effectively to overcome these hurdles. There is little reason why waivers cannot be granted efficiently, memoranda of understanding cannot be entered into and/or Congress cannot devise a sufficient program to generate complete state-level compliance with VA personnel needs for querying relevant PDMPs. Given the value of PDMP consulting, such action must be an immediate priority. Because many veterans receive

health care from both VA and non-VA sources and because OUD carries with it broader social costs beyond the patient and his or her health care setting, it is in the interest of federal, state, and local officials to devise a comprehensive and permanent fix to this issue.

Overcoming bureaucratic challenges within VA requires first the identification of relevant parties with responsibility over a problem, analyzing the problem, devising an effective resolution plan, and implementing that plan. Each of these bureaucratic challenges will look different, involve different actors, and thus require different strategies, but effective management should be able either to fix the problem or work within the proper institutional constructs to find a solution. Problems like those associated with querying the PDMP is not just a bothersome example of red tape; it is a failure that costs the lives of veterans every year.

Acknowledging the opioid crisis as a long-term health policy challenge

As governments and medical systems begin to round the corner on dealing with the opioid crisis, one key risk threatens to derail effort: complacency. As OUD diagnoses drop and opioid-related deaths decline, it will be important to understand that much work lies ahead. The number of annual drug-related deaths in the United States is staggering (around 70,000 yearly), many of which involve opioids primarily or the interaction of opioids and other substances. Even if that number (and the relative number among veterans) declines by 20 percent, that would still mean 56,000 Americans will die from drug overdoses each year. That number is unacceptable.

A decline in the number of opioid-related deaths does not signal a reason for agencies, or especially Congress, to divert attention from the problem. If anything, it will signal that processes are working in the field and that greater focus, funding, and effort could reduce those figures even more. Lessons are learned in the public health arena all the time regarding the importance of continued effort and education regarding a disease, disorder, or other health care problem. The current COVID-19 pandemic highlights what happens when the attention of leadership is diverted and the public begins to ignore government warnings: the problem can worsen. Opioids use will remain a public health challenge in the United States for a long period of time and the future must include a recommitment to the cause of using science and policy to address it.

Mobilizing opioid policy responses during periods of crisis

Research has demonstrated that pain patients facing mental health crises are more likely to develop an OUD. Individual crises happen all the time for a variety of reasons specific to a given patient, his environment, and his situation. However, other periods in time systematically affect environments that can impact the mental health of significant portions of the American population. At the time of the writing of this paper, America faces several. We are in a pandemic that has generated unprecedented social distancing and the need to quarantine. Millions of Americans have been diagnosed with a new disease that medicine knows little about, and that disease has killed well over 100,000 people. In addition, the pandemic has caused a recession that included the sharpest job losses since the government has maintained such records. Meanwhile, multiple incidents of police violence have generated unrest and protesting in communities across America that highlights the daily struggles that systemic racism creates for communities of color.

Any one of these situations can be and will be a mental health stressor for many Americans. For veterans and others who have a history of an OUD or for pain patients without an OUD but in the middle of an opioid therapy regimen, the risk of an opioid misuse increases. Combined with many otherwise healthy patients avoiding hospitals and other medical facilities out of fear

of contracting COVID-19, one can suspect that some number of patients in need of mental health services and/or substance abuse treatment will not receive it or will delay receiving it.

Congress must recognize the risks that the current set of crises (as well as future national crises) can have a significant and negative impact on the national effort to combat the opioid crisis. Congress should have addressed this issue in a serious, comprehensive way during the early passage of emergency legislation to deal with the pandemic and recession. However, the institution failed to do so. Any future legislative packages intended to address the fallout of these crises must take into account the reality that while COVID-19 is a public health emergency, the associated mental health challenges will be a profound problem throughout the country. State and local governments and public health agencies, including VA, must make clear to Congress the depth of this challenge, the stress that it is putting on facilities and practitioners, and the need for assistance to maintain progress in combatting opioids.

Conclusion

The opioid crisis is a serious public health emergency that has touched the lives—directly or indirectly—of most Americans. Many Americans have lost friends or family members to suicide or accidental overdose. Meanwhile, millions have either experienced OUD or have a loved one who has. The depth and breadth of the opioid crisis often pushes the public to lose sight of especially vulnerable groups who can struggle significantly with this disorder.

Veterans face a clash of factors that make them particularly vulnerable to substance use disorders, including OUD. Higher incidences of chronic and/or severe pain, PTSD, and other mental health challenges creates an environment in which veterans can be prime candidates for the use of opioids to treat pain, while also making them high risk patients for adverse outcomes.

The Department of Veterans Affairs' Veterans Health Administration, like many other public health agencies and private health care systems, has struggled to address the opioid crisis adequately. As rates of OUD and opioid-related deaths have skyrocketed over the past two decades, the VA system has taken significant steps to reform systems, practice, and management in ways that can address the problem. At the same time, Congress has stepped in on multiple occasions, particularly over the past four years, to assist public health agencies, state and local governments, and researchers to design and implement reforms that can stem the tide.

Significant progress has been made at VA to improve prevention and treatment among veterans with an OUD—moves that have saved lives. Yet, problems still exist, and veterans are dying at alarming numbers because of opioids. This report offers a series of reforms that Congress, VA, other federal agencies, and state and local governments can take to continue addressing the opioid crisis among American veterans. Changes in management; better funding for programming and staffing; the use of data to identify and address problems and to reinforce best practices; embracing recommendations from researchers, investigators, and commissions about necessary improvements; and a focus on how current conditions can impact—positively or negative—the effort to combat the opioid crisis can all help save additional lives.

It is incumbent on elected officials, bureaucrats, doctors and other health care professionals, and patients to work together to find effective strategies to address the ongoing problems VA has had in dealing with the opioid crisis. At the same time, those same actors need to be

nimble to adjust policies and approaches in ways that reflect the ever changing public health environment around opioids and the communities they impact.

References

- ¹ "About VHA," Veterans Health Administration, U.S. Department of Veterans Affairs, June 10, 2009, <https://www.va.gov/health/aboutvha.asp>.
- ² Stefan G. Kertesz, Ajay Manhapra, and Adam J. Gordon, "Nonconsensual Dose Reduction Mandates are Not Justified Clinically or Ethically: An Analysis," *The Journal of Law, Medicine & Ethics* 48, no. 2 (June 2020): 259-267, <https://doi.org/10.1177/1073110520935337>.
- ³ "U.S. Opioid Prescribing Rate Maps," Centers for Disease Control and Prevention, March 05, 2020, <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html/>.
- ⁴ CNN Editorial Research, "Department of Veterans Affairs Fast Facts," *Cable News Network*, March 25, 2020, <https://www.cnn.com/2014/05/30/us/departement-of-veterans-affairs-fast-facts/index.html>.
- ⁵ Richard L. Nahin, "Severe Pain in Veterans: The Effect of Age and Sex, and Comparisons With the General Population," *The Journal of Pain* 18, no. 3 (March 2017): 247-254, doi:10.1016/j.jpain.2016.10.021.
- ⁶ *VA Opioid Prescription Policy, Practice and Procedures: Testimony before the Committee on Veterans' Affairs, 114th Cong. (2015)* (statement of Dr. Carolyn Clancy, M.D.).
- ⁷ "How Common is PTSD in Veterans?" National Center for PTSD, U.S. Department of Veterans Affairs, accessed June 18, 2020, https://www.ptsd.va.gov/understand/common/common_veterans.asp.
- ⁸ Alicia E. López-Martínez et al., "Chronic pain, posttraumatic stress disorder, and opioid intake: A systematic review," *World Journal of Clinical Cases* 7, no. 24 (December 2019): 4254-4369, doi:10.12998/wjcc.v7.i24.4254.
- ⁹ "2018 National Survey on Drug Use and Health: Veterans," Substance Abuse and Mental Health Services Administration, accessed June 18, 2020, https://www.samhsa.gov/data/sites/default/files/reports/rpt23251/6_Veteran_2020_01_14_508.pdf.
- ¹⁰ Ibid.
- ¹¹ Department of Veterans Affairs, "VA equips 200,000 Veterans with lifesaving naloxone," November 5, 2019, <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5349>.
- ¹² Terri Tanielian and Lisa H. Jaycox, eds., *The Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008).
- ¹³ U.S. Government Accountability Office, *Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, GAO-12-12 (Washington, DC: Government Accountability Office, 2011), <https://www.gao.gov/assets/590/585743.pdf>.

¹⁴ The National Academies of Sciences, Engineering, and Medicine, “VA Provides Mental Health Care to Veterans of Recent Iraq and Afghanistan Wars of Comparable or Superior Quality to Other Providers, Yet Substantial Unmet Need Remains,” January 31, 2018, <https://www.nationalacademies.org/news/2018/01/va-provides-mental-health-care-to-veterans-of-recent-iraq-and-afghanistan-wars-of-comparable-or-superior-quality-to-other-providers-yet-substantial-unmet-need-remains>.

¹⁵ U.S. Government Accountability Office, *Spending for Mental Health Strategic Plan Initiatives Was Substantially Less Than Planned*, GAO-07-66 (Washington, DC: Government Accountability Office, 2006), 9, <https://www.gao.gov/new.items/d0766.pdf>.

¹⁶ *Ibid*, 3.

¹⁷ U.S. Government Accountability Office, *VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veterans*, GAO-10-294R (Washington, DC: Government Accountability Office, 2010), <https://www.gao.gov/new.items/d10294r.pdf>.

¹⁸ Associated Press, “Opioid Theft, Missing Prescriptions Prompts Investigation of VA Hospitals Staff,” *NBC News*, February 20, 2017, <https://www.nbcnews.com/storyline/va-hospital-scandal/opioid-theft-missing-prescriptions-prompts-investigation-va-hospitals-staff-n723291>.

¹⁹ Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695 (2016). The House passed the bill by a margin of 407-5, and the Senate passed the bill by a margin of 92-2.

²⁰ Statement by the President on the Comprehensive Addiction and Recovery Act of 2016 (July 22, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/07/22/statement-president-comprehensive-addiction-and-recovery-act-2016>.

²¹ Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018). The bill passed the House by a margin of 396-14. The Senate passed the bill by a margin of 98-1.

²² “Pain: U.S. Military and Veterans,” National Center for Complementary and Integrative Health, National Institutes of Health, accessed June 18, 2020, <https://www.nccih.nih.gov/health/pain/veterans>.

²³ Michael R. Pemberton et al., “Prevalence of Past Year Substance Use and Mental Illness by Veteran Status in a Nationally Representative Sample,” *CBHSQ Data Review* (November 2016), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DR-VeteranTrends-2016/NSDUH-DR-VeteranTrends-2016.pdf>.

²⁴ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018). The House passed the bill by a margin of 347-70. The Senate passed the bill by a margin of 92-5.

²⁵ See for example, VA Office of Inspector General, *Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*, VA OIG 17-01846-316 (Washington, DC: Office of Inspector General, 2017), <https://www.va.gov/oig/pubs/VAOIG-17-01846-316.pdf>.

²⁶ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1477 (2018).

²⁷ This system would be expanded a few months later under the SUPPORT Act.

- ²⁸ Lewei A. Lin et al., “Impact of the Opioid Safety Initiative on Opioid-Related Prescribing in Veterans,” *The Journal of the International Association for the Study of Pain* 158, no. 5 (May 2017): 833-839, doi:10.1097/j.pain.0000000000000837.
- ²⁹ Stefan G. Kertesz, Ajay Manhapa, and Adam J. Gordon, “Nonconsensual Dose Reduction Mandates are Not Justified Clinically or Ethically: An Analysis,” *The Journal of Law, Medicine & Ethics* 48, no. 2 (June 2020): 259-267, <https://doi.org/10.1177/1073110520935337>.
- ³⁰ U.S. Department of Health and Human Services, *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*, (Washington DC: Department of Health and Human Services, 2019), 1-5, [https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page version__HHS Guidance for Dosage Reduction or Discontinuation of Opioids.pdf](https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page%20version__HHS%20Guidance%20for%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf).
- ³¹ Ajay Manhapa, Albert A. Arias, and Jane C. Ballantyne, “The conundrum of opioid tapering in long-term opioid therapy for chronic pain: A commentary,” *Substance Abuse* 39, no. 2 (2018): 152-161, doi:10.1080/08897077.2017.1381663.
- ³² Stefan G. Kertesz, Ajay Manhapa, and Adam J. Gordon, “Nonconsensual Dose Reduction Mandates are Not Justified Clinically or Ethically: An Analysis,” *The Journal of Law, Medicine & Ethics* 48, no. 2 (June 2020): 264, <https://doi.org/10.1177/1073110520935337>.
- ³³ Ibid.
- ³⁴ Department of Veterans Affairs and Department of Defense, *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (Washington, DC: VA/DoD, 2017), <https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf>.
- ³⁵ Ibid, 5.
- ³⁶ VA Office of Inspector General, *Audit of VHA’s Patient Advocacy Program*, VA OIG 15-05379-146 (Washington, DC: Office of Inspector General, 2017), <https://www.va.gov/oig/pubs/VAOIG-15-05379-146.pdf>.
- ³⁷ The mandate for this office came as a 14-part directive in Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 768-769 (2016).
- ³⁸ Veterans Health Administration, *Querying State Prescription Drug Monitoring Programs (PDMP)*, VHA Directive 1306(1) (Washington DC: Department of Veterans Affairs, 2019), https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3283.
- ³⁹ “The COVER Commission’s Legislative Tasks,” U.S. Department of Veterans Affairs, January 24, 2020, <https://www.va.gov/COVER/legislative-tasks.asp>.
- ⁴⁰ Creating Options for Veterans Expedited Recovery Commission, *COVER Commission Final Report* (Washington, DC: U.S. Department of Veterans Affairs, 2020), <https://www.va.gov/COVER/docs/COVER-Commission-Final-Report-2020-01-24.pdf>.
- ⁴¹ There are multiple programs across agencies which are directed specifically at veterans and opioid use, and many more programs in which work on the issue of veterans and opioids would qualify under a larger umbrella of potential funding recipients. They are too many to list here, although the government’s [grants.gov](https://www.grants.gov) and [usafunding.gov](https://www.usafunding.gov) website provide the universe of such opportunities.

⁴² Lisa N. Sacco, *Federal Support for Drug Courts: In Brief*, CRS Report No. R44467 (Washington, DC: Congressional Research Service, 2018), <https://fas.org/sgp/crs/misc/R44467.pdf>.

⁴³ U.S. Government Accountability Office, *Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed*, GAO-18-380 (Washington, DC: Government Accountability Office, 2018), 20, <https://www.gao.gov/assets/700/692061.pdf>.

⁴⁴ *Ibid.*

⁴⁵ VA Office of Inspector General, *State Prescription Drug Monitoring Programs Need Increased Use and Oversight*, VA OIG 18-02830-164 (Washington, DC: Office of Inspector General, 2019), 8, <https://www.va.gov/oig/pubs/VAOIG-18-02830-164.pdf>.

⁴⁶ *Ibid.*, iii.

⁴⁷ VA Office of Inspector General, *Audit of the VHA's Patient Advocacy Program*, VA OIG 15-05379-146 (Washington, DC: Office of Inspector General, 2017), 6, 8, <https://www.va.gov/oig/pubs/VAOIG-15-05379-146.pdf>.

⁴⁸ Veterans Health Administration, *VHA Patient Advocacy*, VHA Directive 1003.04 (Washington, DC: Department of Veterans Affairs, 2018), https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5970.

⁴⁹ U.S. Government Accountability Office, *Improved Guidance and Oversight Needed for the Patient Advocacy Program*, GAO-18-356 (Washington, DC: Government Accountability Office, 2018), <https://www.gao.gov/assets/700/691244.pdf>.

⁵⁰ This was a similar finding to the 2017 OIG report.

⁵¹ Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 702, 740 (2016).

⁵² Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 4093 (2018).

⁵³ VA MISSION Act of 2018, Pub. L. No. 115-182, 132 Stat. 1479 (2018).

⁵⁴ An ideal example of this effort involves the program evaluations around the Opioid Safety Initiative and the number of interventions it has allowed throughout the VA system.

⁵⁵ U.S. Government Accountability Office, *Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, GAO-18-124 (Washington, DC: Government Accountability Office, 2017), <https://www.gao.gov/assets/690/687853.pdf>.