Hospitals & Asylums

Mental Illness, Substance Abuse, Use and Suicide during COVID-19 at the VA HA-7-7-21

By Anthony J. Sanders

The COVID-19 pandemic has been associated with a 40% increase in mental health and substance use disorder, including an 11% increase in suicidal ideation by adults. Preliminary statistics indicate a -6% decline in suicides in the United States and -2% decline globally although there is 50% increase in suicide attempts by adolescents. The reduction in suicide statistic may however be deceptive because of high rates of utilization of two medically negligent methods of suicide- untreated COVID-19 alone or assisted by 10% mortality in contagious hospitals, and augmented susceptibility to respiratory depression and death from opioid overdose, reported to have increased 20% 2019-2022 in the United States. The global public health response to the COVID-19 pandemic must be held responsible for the intentionally hopeless and counter-intelligent retaliatory, mind altering substance, intimate partner violence "suicide attack" intent upon denying the public necessary information that "hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus" to sell (child) defective vaccines. Primary suicide risk factors are a history of depression, insomnia and other mental illnesses, hopelessness, substance use or abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants. The abuse of certain mind-altering substances must be incorporated into the literature on mental illness – dimethoxymethyl-amphetamine (DOM) causes a three day panic attack followed by six months severe mental illness if not washed off with water, pseudo-ephedrine and statin drug brain shrink makes people illiterate and the brain damage, especially from statins becomes infected, a third form of toxic mental fuzz that causes one to wake up at 3 am has become a leading cause of suicide. Pneumovax is recommended for all adults over or under age 65 to prevent pneumococcal infection of heart, lung and brain damage, especially in shell shocked Veterans with PTSD and TBI diagnosis. Cannabis is recommended to be legalized to fully recover from PTSD and as safer alternative to opioids for chronic pain. The FBI, DEA and ONDCP are condemned for their suicide attack. Pain management specialists and their pharmacists shall enable the vast majority of health professionals to boycott DEA registration.

1. COVID-19 Suicide Attack

In 2019, 51.5 million adults had a diagnosable mental illness, an 18% increase over 2008 and 5% over 2018 the prior year. These mental health challenges have accelerated during the COVID-19 pandemic, particularly for vulnerable populations. In June 2020, adults reported anxiety disorder symptoms at 3 times the level reported in 2019 and depressive disorder at 4 times the level reported in 2019. . In a recent study of U.S. adults, more than 40% of respondents reported adverse mental health or increased substance use in June, 2020. The COVID-19 pandemic has been associated with mental health challenges, including suicidal ideation. In June 2020, about 11 percent of CDC survey respondents reported seriously considering suicide in the prior 30 days. This rate was significantly higher among young adults, minority racial/ethnic groups, black respondents, unpaid caregivers, essential workers and people receiving treatment for preexisting psychiatric conditions are disproportionally impacted (Substance Abuse Mental Health Services Administration FY 22) by rising "germaphobia" defined as a malinformed or irrational fear of germs and/or their treatment – specifically everyone must be informed hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus. Surprisingly,

preliminary reports indicate that although mental illness diagnosis and reports of suicidal ideation are up, the actual suicide rate in the initial months of the COVID-19 pandemic declined -6% in the United States (Deisenmhammer et al '21) and -2% globally (Pirkis et al '21), however adolescent suicide attempts increased 50% in the United States (Hill et al '20). The reduction in suicide statistic may however be deceptive because of high rates of utilization of two medical methods of suicide. One, instead of using the plethora of safe and effective over-the-counter remedies for coronavirus, the public health authorities hopelessly refuse to advertise in the news media, the suicidal maniac can simply allow the infection to descend into their lungs and kill them, whereby the cause of death is ruled COVID-19, or they can utilize hospital treatment for COVID-19 that comes with a mortality rate reported to be as high as 10% by the VA – suicide death by untreated coronavirus alone or under hypocritical and contagious hospital care. Two, since the pandemic fatal overdoses increased 20% between 2019 and 2020, especially synthetic opioid – fentanyl – and also psycho-stimulant overdose – methamphetamine and pseudo-ephedrine (SAMHSA FY 22). These deaths are ruled accidental because COVID-19 presents such an obvious vulnerability to respiratory depression and death from opioid overdose, and public health authorities non-self-incriminate in regards to their incessant "suicide attacks" under color of COVID-19, intentional suicide is overlooked. The VA treats all overdoses as suicide attempts and may wish to challenge preliminary suicide reduction statistics.

The CDC Division of Violence Prevention *Preventing Suicide: A Technical Packs of Policy Programs and Practices* lists suicide risk factors: Individual level: history of depression, insomnia and other mental illnesses, hopelessness, substance use or abuse, certain health conditions, previous suicide attempt, violence victimization and perpetration, and genetic and biological determinants. Relationship level: abusive, high conflict or violent relationships, sense of isolation and lack of social support, family/ loved one's history of suicide, financial and work stress. There has been a dramatic escalation of pseudo-ephedrine brain shrink abuse by heartbreaking intimate partner violence counterintelligence efforts under color of Office of National Drug Control Policy (ONDCP) grants to CDC and DOJ, pushing "two bag meth" combined with a temporomandibular joint (TMJ) discomfort causing psychiatric anti-anxiety drugs, immediately before and during the COVID-19 pandemic, to the point where the US Supreme Court has not published since June 20, 2019. Pseudo-ephedrine cures viral and bacterial sinusitis, including coronavirus, but the brain shrink side-effect is unacceptably illiterate. This alternates between statin brain shrink concealing heart attacks. These intimate partner violence counterintelligence attacks utilizing mind altering substances are so prone to suicidal ideation, because they not only chemically induce mental illness and/or addiction and withdrawal, but interfere with the family, residential and romantic, nucleus of society, to such an extent, that intimate partner violence, especially involving malevolent substance abuse with mid altering substances, must be construed as a "suicide attack" masterminded by the exact same FBI/DEA, ONDCP agents who dosed the 9-11 suicide attackers. Community level: inadequate community connectedness, heightened by COVID-19 social distancing and lockdowns, barriers to health care (e.g., lack of access to providers and medications) brought to a feverish pitch by the felony monopolization of the news media to sell ineffective vaccines and completely censure necessary medical information that hydrocortisone, eucalyptus, lavender, peppermint or salt help water cure coronavirus. Societal level: availability of lethal means of suicide, unsafe media portrayals of suicide, stigma associated with help-seeking and mental illness (Stone et al '17). As mentioned above, COVID-19 presents a potentially lethal means of suicide by itself and with contagious medical assistance, sworn by public health authorities to not treat COVID-19 by any means but one or two pricks with an ineffective vaccine, and COVID-19 augments the lethality of opioid induced respiratory depression.

The Werther Effect (the negative consequences of media's portrayal of suicide) first noted with the publication of Goethe's *The Sorrows of Young Werther* in 1774, has been well established and implementing recommendations for improvement for media reporting are key to reducing this effect (Ortiz & Khin, 2018). The Werther Effect needs to be expanded to include the overwhelming sense of hopelessness that "fake news" and in particular COVID-19 vaccine propaganda monopolized global media and government induces on the informed and uninformed public. The uninformed public may die from COVID-19 waiting to be vaccinated or due to the ineffectiveness of the vaccine. The informed public is ignored and cannot get the necessary message across that hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus, and is violently retaliated against, usually involving exposure to mind altering substances, that heighten the suicidiality of the intentional media induced sense of hopelessness in regards to ending the pandemic without informing the public how to treat their allergic rhinitis. One cannot even find asylum from the COVID-19 lockdowns and political persecution in Australia and New Zealand, where the populace is largely unaffected because the naturally growing eucalyptus trees cure coronavirus, however not entirely due to the ineffectiveness of their news media to inform the public to hang out in eucalyptus groves, rub, suck on or boil eucalyptus leaves, and the equal right of germaphobic governments to attribute their health on the imposition of abusive quarantines on immigrants, who are not treated to a eucalyptus tree. With no sane asylum to be found anywhere in the world, suicidal ideation comes into play. With rates of severe mental illness and suicide twice as high as normal, the United Nations, original author of the UN Controlled Substances Drug Schedule, is the poster child of this counter-intelligent and hopeless abuse of dope, from which there is no appeal after denial by the International Court of Justice, but Mental Health Services and family leave, not believed to be molested.

Conversely, responsible media reporting can have a protective effect (Papageno Effect) noted by the intervention of three characters to counsel Papageno in Mozart's *The Magic Flute* (Sisask & Varnik, 2012). Implementing research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes, and behaviors is critical. The U.S. Air Force implemented a public health, universal approach which significantly lowered suicide rates through comprehensive organizational changes including communication efforts (Knox et al. 2010). This model also included gatekeeper training which has been shown to reduce suicidal ideation and deaths by suicide while positively affecting the knowledge, skills, and attitudes of trainees through improving communication (Isaac et al., 2009). Community efforts promoting responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide is also crucial. VA proactively screens for symptoms of depression, post-traumatic stress disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk; believing (1) suicide is preventable, (2) suicide requires a public health approach, combining community-based and clinical approaches, and (3) everyone has a role to play in suicide prevention (VHA '21: 13). In response to the COVID-19 pandemic the VA has not exhibited any better or more independent command of the English language than the news media or public health authorities, and this brings into question the wisdom of their mental health program.

In regards to the suicidal hopelessness of COVID-19 vaccine dominated news media and public health coverage it is medically necessary to inform everyone with allergic rhinitis they have been sentenced to be flogged to avoid persecution of baptism (John 1: 26)(Luke 3: 7)(1 Peter 3: 21)(Mark 6: 24). Hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus. The swiftest and most effective remedy is to swim in a chlorinated, saline or mineral water pool, or repeatedly submerse the head in an Epsom salt bath until cured, this remedy also treats methicillin resistant

Staphylococcus aureus (MRSA). Eucalyptus or lavender cure influenza. Mentholyptus cough drops cure both influenza and coronavirus, with a little nose washing, and keep the infection out of the lungs. To end the COVID-19 pandemic the most effective methods would be to stock public restrooms with eucalyptus, lavender or peppermint soap and inform everyone to wash their face and nose To make hospital treatment and return to school safe, eucalyptus humidifier (diffuser) aromatherapy is the needed to sterilize public airspace of both coronavirus and influenza.

Before continuing with conventional mental health instruction it is necessary to inform the public of the hazards of exposure to certain common mind altering substances frequently involved in the etiology of mental illness and severe mental illness, for the purpose of hygiene. The substance of absolute most concern is called dimethoxymethylamphetamine (DOM) or STP. DOM causes a three day panic attack, followed by six month recovery from several mental illness (Elvin-Lewis ’77: 405, 407, 408, 411, 410) if not washed off with water, or blood. DOM exposure, by FBI informants, is suspected in all cases of severe mental illness, suicide, and especially rampage shootings, with much greater success at preventing copycat killers, than gun control, without a military grade gun cleaning. Pseudo-ephedrine and statin drugs cause the brain to shrink. Pseudo-ephedrine (Sudafed, Sudagest etc.) causes insomnia, illiteracy, senility and inability to reject propaganda or overturn false criminal charges. Pseudo-ephedrine is the height of COVID-19 hypocrisy because it is indicated to clear the sinuses of bacterial and viral infections and is a highly effective oral treatment for coronavirus, but the brain shrinkage is not only an unacceptably severe side-effect, but escalation in its abuse preceded the pandemic and is almost certainly the reason the public health response has been and remains so intoxicated with the two dose cure, millions of people died waiting for, and continue to get allergic rhinitis and die because it does not prevent reinfection. Recent literature and the COVID-19 quarantine and cell phone GPS bug (take out the battery) related domestic violence experience, emphasize that there is a third common toxic cause of insomnia, that causes the exposed group of persons to wake up around 3 am angry with the toxic exposure to mental fuzziness, and 3 am has become competitive with midnight as the most common time to commit suicide (Cunningham '20)(McCarthy '19). Statin drugs cause senility and illiteracy; unless the patient is inoculated with Pneumovax the statin consumer invariably becomes swiftly infected with dementing pneumococcal meningitis that becomes reinfected after antibiotic treatment because the brain does not regrow fast enough; Pneumovax is necessary to prevent brain wasting chronic meningitis from statin drug consumption, whether one time, habitual, voluntary or involuntary. This makes Pneumovax, to cure and prevent pneumococcal meningitis, the only safe drug treatment for mental illness, prescribed to all people over or now under age 65 to prevent pneumococcal infection of heart, lung and brain damage. All of these substances come clean in the wash, but re-exposure by violent intimate partners and/or their, or independent, organized crime is a seriously depressing problem, brain damage does not help to solve, wherefore it is necessary to have prior knowledge of these hazards to mental health.

2. Pneumovax to Cure and Prevent Meningitis in All Mental Illness and TBI Diagnosis

It is highly advised that Pneumovax be administered to all working age adults to cure and prevent pneumococcal infection of heart, lung and brain damage. In regards to VA health care Pneumovax is particularly recommended to treat and prevent infection of traumatic brain injury (TBI) and mental illness, possibly naturally caused by untreated infection of undiagnosed mild TBI from the sound of gunfire and explosions, opportunistically exacerbated by cruel exposure to mind altering substances. After the Civil War veterans complained of an irritable heart, WWI Veterans were shell shocked with

PTSD like symptoms, WWII and Korea War Veterans were well adjusted. Since Vietnam, as many as one third of soldiers have been suffering Post Traumatic Stress Disorder (PTSD). WWI veterans are thought to have suffered from opportunistic meningitis after suffering mild traumatic brain injury, that was cured with the invention of antibiotics in WWII and Korea, however, subsequently the drug war intoxicated United States has only engaged in unjust wars and the troops are insulted by the war crimes they took part in, and untreated by the war criminals perpetuating such a system. National Center for PTSD (NCPTSD) was created in 1989 in response to a Congressional mandate (P.L. 98 -528, 98 Stat. 2686, 1984). In 2014, NCPTSD received a separate appropriation that had two goals: to establish a PTSD brain bank to facilitate PTSD research, and to enhance access for rural Veterans. From 2015 through 2019, the Center had an average of 129 competitively-awarded research grants and produced an average of 307 peer-reviewed publications per year. At the end of 2020, the Brain Bank had acquired 280 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression, and controls without depression or PTSD) and 22 fixed hemispheres; 156 individuals have enrolled in our antemortem donor program. NCPTSD strives to better understand the neurobiology, epidemiology, prevention, psychotherapy and pharmacological treatment of suicide risk in individuals with PTSD (VHA '21: 229).

NCPTSD needs to stop dangerously looking into pharmacological ways to tolerate injustice, before they incite more violence with hard drugs like pseudo-ephedrine and anti-depressant addiction and learn to tolerate marijuana and boycot DEA registration. Veterans with PTSD must write legal briefs, that are not suicide notes, to bring about closure, know what to say and do war crime justice. Post-traumatic Stress Disorder (PTSD) is a serious, worldwide public health problem. In the United States the lifetime prevalence of PTSD in the general population is between 6 and 10%, and between 13 and 31% in US military veterans (Atwoli et al '15). PTSD is typically a chronic condition, and is associated with high rates of psychiatric and medical co-morbidity, disability, suffering, and suicide (Perkonigg et al '00). Food and Drug Administration (FDA)-approved pharmacological treatments for PTSD are currently limited to two selective serotonin reuptake inhibitors (SSRIs): sertraline and paroxetine. Current Department of Defense (DoD) and Department of Veterans Affairs (VA) best practice guidelines for treatment of PTSD recommend psychotherapy over pharmacotherapy. However, the majority of military veterans with PTSD who receive one of the best practices psychotherapies for PTSD, which were determined efficacious through clinical trials, do not remit or reduce symptoms below clinical thresholds by the end of treatment (Resick et al '92)(Bremner et al '96).

The VA Medical Benefits Package under 38CFR17.38 provides for Mental Health Services under 38CFR17.98, 38USC§1712A, §1720H, §1720I, Public Law 114-2, *Clay Hunt Suicide Prevention for American Veterans Act* and Executive Order (EO) 13822, issued on January 9, 2018. Veteran demand for VHA mental health care continues to grow, with approximately 1.72 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2020. Across VA settings of care, more than 525,000 Veterans were seen in 2020 for a substance use disorder diagnosis. The proportions of VHA health-service users who receive mental health treatment are highest among younger Veterans and decline with age. The proportions are also slightly higher for women as compared to men in older age groups with the gap declining in Veterans younger than age 35. Reflecting the size of the cohort of male Veterans over age 65, 61% of all users of VHA services in specialty mental health settings in 2020 were men over age 50. The Office of Mental Health and Suicide Prevention (OMHSP) now includes the Veterans Crisis Line (VCL) and PREVENTS. VA proactively screens for symptoms of depression, PTSD, problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk. VHA mental health care rests on the principle that it is

an essential component of overall health care, and it requires the availability of a continuum of services, including self -help resources, telephone crisis intervention services, outpatient care, residential care (known as Mental Health Residential Rehabilitation Treatment Programs), and acute inpatient care. Program requirements for the full range of mental health services that VHA delivers are specified in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (the Uniform Mental Health Services Handbook), published in 2008 and amended in 2015 (VHA '21: 104, 108).

The number of outpatient mental health encounters or treatment visits more than doubled between 2006 and 2019 (from 10.7 million to 21.8 million), and during the COVID-19 pandemic VA provided 20.4 million encounters and telephone visits in 2020. Between 2006 and 2020, the number of Veterans who received mental health care from the VHA grew by 85%. In FY 2006, 20% of VHA users received mental health services, and in 2020, the figure was 29%. In 2020, 223,000 women Veterans received VHA mental health care, representing approximately 42% of all women VHA patients, a threefold increase since 2005. VHA is a recognized leader in evidence-based psychotherapy (EBP) training with 16 EBP training programs that address PTSD, depression, SUD, serious mental illness (SMI), and suicide prevention, as well as cross-cutting issues such as chronic pain, insomnia, motivation for treatment, relationship distress, and problem-solving skills. In 2017, VA began offering emergent mental health services to former Service members with Other than Honorable administrative discharges. In 2020, 3,246 Service members with an "other than honorable" discharge received mental health services. VA projects a 30% growth in inpatient and outpatient mental health care during the period from 2017 through 2030 (an increase from 17.8 million to 25.4 million). In 2019, VA already provided 21.8 million outpatient mental health encounters or treatment visits. The projection for 2024, demonstrating high demand for mental health services. During the same period, the inpatient-bed-days-of-care measurement is expected to be stable at about 3,450,000 (VHA '21: 109-111).

Veteran demand for VHA mental health care continues to grow, with approximately 1.72 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2020. Programs provide proactive screening for symptoms of depression, Post-traumatic Stress Disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk. VA employs a mental health workforce of more than 20,000 psychiatrists, psychologists, social workers, nurses, counselors, therapists and peer specialists. A major focus of this request is expanding the Veterans Crisis Line (VCL), which since its launch in 2007, has answered more than 3.5 million calls and initiated the dispatch of emergency services to callers in imminent crisis nearly 100,000 times. Demand for chat and text services have increased by over 59% during the COVID-19 pandemic (VHA '21). From 2019 to 2022, the utilization of Mental Health services by the Post-9/11 Era Combat Veteran population is expected to increase by 19% for inpatient services and increase by 30% for ambulatory. However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of Mental Health Residential Rehabilitation and Compensated Work Therapy services peaks between ages 50 and 60 then drops off dramatically by age 65 (VHA '21: 406). Suicide prevention is a VA top clinical priority, founded on a comprehensive public health approach to reach all Veterans. The budget includes $598 million, an increase of $287 million (+92%) above the 2021 enacted level, for suicide prevention outreach and related activities, including funding to increase the capacity of the Veterans Crisis Line. Funding for mental health in total grows to $13.5 billion in 2022, up from $12.0 billion in 2021. The budget also fully funds the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019

(P.L. 116-171) which authorized the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program to reduce Veteran suicide through a community-based grant program that provides or coordinates suicide prevention services. Additionally, the 2022 budget funds the projected costs of the provision of emergent suicide care authorized by the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (P.L. 116-214). The National Suicide Hotline Designation Act of 2020, requires the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone number for the National Suicide Prevention Lifeline (VHA '21: 134).

3. Suicide

Suicide is an increasing mental health crisis that not only plagues the United States, but all nations across the globe. The World Health Organization projects that 1.53 million people worldwide will die by suicide in the year 2020, with 10–20 times that number making a suicide attempt that year. In 2017, nearly 50,000 people died by suicide in America alone. Suicide was the second leading cause of death for all Americans ages 10–34, the fourth leading cause of death for Americans ages 35–54, and the death rates for suicide have increased yearly in the United States since 2005 (Cunningham et al '20). Veterans commit suicide at a rate 1.5 times higher than the general population. Many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for 2 years or more (Department of Veterans Affairs, 2020). Because only 37% of Veterans are enrolled in VA health care, it is not statistically significant that 65% of Veterans who committed suicide had not visited the VA. Due to the statistical and moral significance of the provision of mental health treatment to Veterans with other than honorable discharges, who would not otherwise be eligible for medical treatment at the VA, one compensation petitioner is inclined to think ever so slightly charitably about VA mental treatment.

Veterans commit suicide at a rate 1.5 times higher than the general population (Department of Veterans Affairs, 2020). PTSD bias to get compensation and infiltration by FBI/DEA dimethoxymethyl-amphetamine (DOM) informants in both VHA research and DEA registered health practice that washes off with water aside, the two major reasons for a 50% higher suicide rate in Veterans can be attributed to greater access to two methods of committing suicide - high rates of gun ownership and opioid prescription for chronic pain (paying). Safe messaging is an important part of community outreach strategies. Further, lethal means safety education is a critical area within community-based prevention strategies. An education campaign targeting firearm retailers led to increased use of materials promoting firearm safety and its association with suicide with retailers accepting that they have a role in preventing suicide (Vriniotis, et al., 2015). Goals to delay gun access during periods of immediate risk for suicide were shown to be feasible to implement, and effective and reducing immediate access to lethal means access has been shown to be most effective when implemented alongside other suicide prevention strategies (Sarchiapone et al., 2011). Firearms need to be taken away from Veterans who are perceived by themselves or others to be acutely mentally ill, for their own safety. The average length of time between suicidal ideation and actual suicide is usually less than 10 minutes (Stone et al '17). Opioids need to be treated the same way. The VA treats all drug overdoses as suicide attempts.

It is advertised that many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for 2 years or more (Department of Veterans Affairs, 2020). Because only 37% of Veterans are enrolled in VA health care, it is not statistically significant that 65% of Veterans who committed suicide had not visited the VA. Contrary to claims made by the VHA FY 22 budget submission, greater mental health

and staff FTEs per 1,000 patients have not been shown to be associated with lower risk for suicide in peer reviewed literature (Richardson, McCarthy, & Katz, 2017), nor have increases in mental health staffing been associated with decreases in suicide rates. Signs of Suicide and the Good Behavior Game were the only programs found to reduce suicide attempts in schools. Several other programs were found to reduce suicidal ideation, improve general life skills, and change gatekeeper behaviors (Katz, et al., 2013)(VHA '21: 141-142). It is important that these references to mental health and suicide prevention programs stop advertising trademarks, cite the literature in a "bibliography" as the VHA FY 22 failed to do after fraudulently pimping mental health staffing with their otherwise excellent, if overzealous, research, and submit their professional teachings to public criticism, until knowledge regarding toxic exposure to mind altering substances is used to redress both mental health and drug enforcement arms of the mental problem regarding the contemporary slave trade. Professional mental health treatment is generally thought to be placebo in regards to mental health and detrimental to physical health because their prescribing habits are not registered with DEA mind altering substance exposure, but tend to engage in all sorts of physical tortures, e.g, serious and lethal side-effects of psychiatric drugs and sleep aids and intimate partner violence utilizing anti-depressant addicts. Unlike professional mental health treatment, peer support has been shown to be helpful, although, or perhaps because, it has not been correlated to a reduction in suicide. Peer support is one of the 10 fundamental components of recovery according to the National Consensus Statement on Mental Health Recovery and all Veterans with SMI (Serious Mental Illness) must have access to peer support services, either on-site or within the community. Studies have found improvements, for individuals who received peer support services as part of their mental health care services, in treatment engagement, treatment retention, reduction in symptoms of mental illness, improvements in abstinence from addictive substances, and improvements on quality of life measures (Bassuk et al. 2016)(Chinman et al. 2015) (Ashford et al. 2019)(McCarthy et al., 2019)(VHA '21: 126).

Intimate Partner Violence (defined as physical, verbal, emotional, psychological, stalking and sexual abuse) is a national health epidemic with far-reaching bio-psycho-social consequences. It is significantly correlated with increased risks for other public health issues including suicide and homicide, homelessness, and substance abuse. The Veterans Health Administration (VHA) Intimate Partner Violence Assistance Program (IPVAP) was launched in January 2014, in response to recommendations provided in the *VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program* (IPVAP)(2013). VHA Directive 1198, Intimate Partner Violence Assistance Program was published in January 2019, requiring every VA medical facility to implement and maintain an Intimate Partner Violence Assistance Program to ensure that Veterans, their intimate partners, and employees impacted by IPV (experiencing or using) have access to services including education, resources, assessment, intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated. To date, the program established a designated IPVAP Coordinator at over 94% of VA medical facilities and is striving for 100% coverage (VHA '21: 225). It is significant that the VA recognizes that legal representatives, health and government employees often "use" IPV to torture their petitioner or patient, using their solicited actively corruptible family, lover, landlord, caregivers, roommates, eg. intimate partners against them, or vice-versa as in a violent psychiatric drug consuming patient counseled and armed to attack, or organized combination of these two crimes.

4. VA Approved Psychiatric Drug and Proposed Cannabis Treatment for PTSD

VA has a set of recommended treatments for PTSD, including counseling or medications, but it is

known these treatments may not work for everyone. VA Research is developing and testing new treatments for Veterans with military-related PTSD, so that every affected Veteran has the opportunity to get relief from their symptoms. ORD has developed a strategic plan to examine the efficacy and effectiveness of new medications for PTSD, specifically to increase the possible treatments over the currently limited two approved medications. The drug prazosin, used widely in VA to help ease nightmares from PTSD, did no better overall than placebo pills. (VHA '21: 559). Clozapine is the most efficacious medication available for the treatment of schizophrenia and is the only medication proven to reduce the suicidality of schizophrenic patients. The FDA has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. The National Clozapine Registry provides VA with the tools to authorize, track and report the safe prescription and administration of clozapine for Veterans with serious mental illnesses (VHA '21: 671). There are four SSRIs/SNRIs that are recommended for PTSD: Sertraline (Zoloft), Paroxetine (Paxil), Fluoxetine (Prozac) and Venlafaxine (Effexor). Although these drugs do not cause life-threatening withdrawal symptoms like benzodiazapine, the tranquilization borders on idiocy and withdrawal tends to aggravate serious aggressive behavior, that is often exploited by organized criminal administration of these drugs to cause intimate partner violence.

The U.S. Department of Veterans Affairs now offers a psychedelic ketamine drug to treat post-traumatic stress disorder while marijuana remains off limit. Ketamine variants have made headlines over the decades for their multiple roles as sedatives, recreational hallucinogens and for their impressive track records for mitigating suicidal depression. The Spravato version, which was approved by the U.S. Food and Drug Administration in March, requires patients to remain under professional observation for two hours following ingestion. It is however psychologically addictive and has side-effects on the urinary tract and gall bladder (Cox '19). The first FDA-regulated, placebo-controlled, double-blind study on smoked cannabis among veterans with diagnosed PTSD revealed improvements among those receiving doses with higher levels of THC, an active component in the herbal drug. The study, conducted by the Multidisciplinary Association for Psychedelic Studies, or MAPS, indicated levels of improvement among participants using smoked cannabis blends with a 9 percent THC concentration. Improvements were also found using samples containing 11 percent CBD, as well as a sample containing 8 percent THC and 8 percent CBD. A fourth group, which also reported improvements, used a placebo. THC, or delta-9-tetrahydrocannabinol, is the intoxicating, or psychoactive, ingredient of cannabis strains that produce the euphoric “high” effect. CBD, or cannabidiol, is one of the non-intoxicating cannabinoids in the cannabis plant. CBD-only products have been widely adopted in multiple states for medical, therapeutic and recreational uses. That study found that over the course of a year the cannabis users “reported a greater decrease in PTSD symptom severity...” Additionally, cannabis users were more than 2.5 times as likely to no longer meet the diagnostic criteria for PTSD as those who did not use cannabis. One of the biggest advantages is that veterans with PTSD can use cannabis at self-managed doses, at least in the short term, and not experience a plethora of side effects or a worsening of symptoms (South '21)(Bonn-Miller et al '21).

VA clinicians are not allowed to recommend medical marijuana. VA clinicians may only prescribe medications that have been approved by the U.S. Food and Drug Administration (FDA) for medical use. At present most products containing tetrahydrocannabinol (THC), cannabidiol (CBD), or other cannabinoids are not approved for this purpose by the FDA. Cannabis, also commonly referred to as marijuana, has been legalized for widespread medical use in 20 states and two U.S. Territories. Marijuana has been legalized for both medical and recreational use in 16 states, Washington D.C., and two U.S. territories. It is legal for extremely limited medical use, such as terminal cancer therapy, in 11

states. Federal laws, meanwhile, still prohibit the possession and sale of cannabis, while both the Department of Defense and the Veterans Administration prohibit the use or prescribing of it. The organization's May 2018 study analyzed MDMA treatment on 26 first responders, mostly combat veterans, over two, day-long psychotherapy sessions. In a one-month follow-up, 68 percent of participants reported that their PTSD symptoms had been "effectively eliminated" (South '21).

Given increasing use of medical cannabis among US military veterans to self-treat PTSD, there is strong public interest in whether cannabis may be a safe and effective treatment for PTSD. The present study is the first randomized placebo-controlled trial of smoked cannabis for PTSD. All treatment groups, including placebo, showed good tolerability and significant improvements in PTSD symptoms during three weeks of treatment, but no active treatment statistically outperformed placebo. There is some preclinical evidence that at least two of the active compounds in cannabis, delta-9-tetrahydrocannabinol (THC; the primary constituent responsible for intoxication from cannabis) and cannabidiol (CBD; one of the non-intoxicating cannabinoids in cannabis), can positively impact processes that underly PTSD pathology (Loflin et al '17). Specifically, administration of CBD in rats and mice dampens cue-elicited fear responses (Lemos et al '10), while administration of THC and THC+CBD appears to block reconsolidation of fear memory (Stern et al '15). Likewise, both THC and CBD when administered alone facilitate fear extinction learning (Das et al '15), which is a critical component for recovery from PTSD (Holmes et al '13). This work suggests that THC and/or CBD could modify how patients with PTSD experience and respond to reminders of trauma. Military veterans with PTSD are overwhelmingly choosing smoked cannabis to self-treat PTSD and related conditions. Moreover, herbal cannabis varies significantly across plants in its THC and CBD content. While both cannabinoids could hold therapeutic value, unlike THC, CBD is non-intoxicating and does not carry significant risk of abuse. In addition, CBD may temper the anxiogenic effects of THC in cannabis preparations that contain both CBD and THC (Loflin et al '19).

Individuals were eligible for study enrollment if they (1) were a US military veteran, (2) met DSM-5 criteria for PTSD with symptoms of at least six months in duration (index trauma did not have to be related to military service). (3) had PTSD of at least moderate severity based on a CAPS-5 score of = >25 at baseline assessment, (4) were at least 18 years of age, (5) reported they were willing and able to abstain from cannabis use two-weeks prior to baseline assessment, which would be verified by urine toxicology screens at screening and baseline, and agreed to abstain from using non-study cannabis during the trial, (6) were stable on any pre-study medications and/or psychotherapy prior to study entry, and (7) agreed to comply with study procedures. *Exclusion criteria*. Study participants were excluded if they (1) were pregnant, nursing, or of child bearing potential and not practicing effective means of birth control, (2) had a current or past serious mental illness (e.g., personality disorder, psychotic disorder) determined by the SCID-5-RV (First et al '15), or self reported a positive family history (first-degree relative) of psychotic or bipolar disorder (3) were determined at high risk for suicide based on the C-SSRS (Posner et al '08), (4) had allergies to cannabis or other contraindication for smoking cannabis, (5) had a current diagnosis or evidence of significant or uncontrolled hematological, endocrine, cerebrovascular, cardiovascular, coronary, pulmonary, gastrointestinal, immunocompromising, or neurological disease, (6) met DSM-5 criteria for moderate-severe Cannabis Use Disorder on the CUDIT-R (= >11), (7) screened positive for any illicit substance other than cannabis during the two-week screening, or (7) were unable to provide informed consent.

Study drug was obtained from the National Institute on Drug Abuse (NIDA). Four concentrations of cannabis from NIDA included: High THC = approximately 12% THC and < 0.05% CBD); High CBD

= 11% CBD and 0.50% THC; THC+CBD = approximately 7.9% THC and 8.1% CBD, and placebo = < 0.03% THC and < 0.01% CBD. Samples of each batch were tested and confirmed for their concentration levels by an independent third-party analytical testing laboratory in Phoenix, Arizona. The independent testing lab found in two separate analyses that the High THC batch was just 9%, At the beginning of each stage, participants were asked to visit the clinic site for four hours on two successive days and self-administer under supervision of study staff one dose of the cannabis preparation that they were randomly assigned to in that Stage. Vital signs for safety were collected during these visits (i.e., blood pressure, pulse). The study provided participants a total of 37.8 grams (1.8 grams/day)for the three-week *ad libitum* treatment period along with a metal pipe for treatment delivery (smoked). Participants were asked to refrain from using non-study cannabis, and return any remaining study cannabis that was not used each week. All AEs were coded by Systems Organ Class. The study physician then rated all AEs by severity (mild, moderate, severe) and study relatedness (i.e., possibly related, probably related, not related). AEs rated possibly related and probably related were collapsed into one "related" category. Additional safety measures included the 15-item Marijuana Withdrawal Checklist (MWC) and the Columbia-Suicide Severity Rating Scale (CSSR-S) (Posner et al., 2011). 13 total participants terminated from the study early due to an AE (8.4%). The most common AEs reported (i.e., those with >10% frequency) were cough (12.3%), followed by throat irritation (11.7%) and anxiety (10.4%). One participant who received CBD in Stage 1 (5.0%) reported treatment-related suicidal ideation. One participant from each treatment condition (3.6% - 5.9%) reported treatment-related suicidal ideation in Stage 2. Only participants assigned to High THC in Stage 1 reported a significant increase in mean self-reported withdrawal symptoms after one week of cessation from the assigned treatment in Stage 1. There was no significant change in withdrawal symptoms from the end of Stage 2 treatment to one-week follow-up. All four treatment groups, including placebo, achieved significant within-subject reductions in total CAPS-5 Total Severity scores from Stage 1 baseline (visit 0) to end of treatment (visit 5). Specifically, participants who received placebo in Stage 1 reported a mean reduction of 13.1 points (SD = 12.10, $p < .001$, $d = -1.30$), participants who received High THC reported a mean reduction of 15.2 points (SD = 11.3, $p < .0001$, $d = -1.99$), High CBD participants reported a mean reduction of 8.4 points (SD = 10.09, $p < .05$, $d = -.79$), and THC+CBD participants reported a mean reduction of 8.5 points (SD = 9.88, $p < .05$, $d = -.83$). Consistent with previous work (Ware et al '15), participants in the current study reported a general preference for cannabis types that included significant quantities of THC (Bonn-Miller et al '21).

5. Substance Use Disorders

National Center for Health Statistics (NCHS) indicate that approximately 81,230 drug overdose deaths occurred in the United States in the 12 -months ending in May 2020. This represents a worsening of the drug overdose epidemic in the United States and is the largest number of drug overdoses for a 12-month period ever recorded. The recent increase in drug overdose mortality began in 2019 and continues into 2020, prior to the declaration of the COVID-19 National Emergency in the United States in March. Deaths appear to have accelerated during the COVID-19 pandemic. Synthetic opioids are the primary driver of the increases in overdose deaths. The 12-month count of synthetic opioid deaths increased 38.4 from the 12-months ending in June 2019 compared with the 12-months ending in May 2020 (HAN Archive, 2020). There are many studies to support the life saving potential of naloxone (Bird et al. 2016)(McDonald & Strang, 2016)(Walley et al 2013)(Wheeler et al. 2015). Within VA, an analysis of the impact of academic detailing on naloxone prescribing between October 2014 through September 2016 found a beneficial effect with the average number of naloxone

prescriptions being seven times greater among providers with at least one OEND-specific academic detailing visit (Bounthavong et al., 2017). Increasing naloxone availability is included in the Office of National Drug Control Policy (ONDCP)'s Federal National Drug Control Strategy and is included in a Surgeon General Advisory from 2018 (VHA '21: 113-114). The VA and DOD are trying ONDCP for their marijuana robbery to push methamphetamine grants, that have annihilated both the Department of Justice, rendering the US Supreme Court illiterate since June 20, 2019 and Centers for Disease Control and Prevention (CDC) federal, state and global COVID-19 response via the Injury Prevention and Control Program that gave ONDCP grants asylum, since the program was expelled from the White House, with only a small office to intoxicate the President with pseudo-ephedrine. The potential lethality of the undercover fentanyl bedspreads of the FBI and DEA (DOM) also require considerable approbation in the continuing use of opioid prescriptions and disclosure of any information to these UN conventional terrorist organizations.

VA/DoD Clinical Practice Guideline for Management of Substance Use Disorder (SUD) (2015) is authorized under 38USC§1701, 38CFR§17.38 and 38CFR§17.80. The military has a zero tolerance policy for UN controlled substances, while the VA is fond of prescribing opioid withdrawal medicines, without legalizing marijuana, as is advised to provide a safer alternative to alcohol, tobacco and opioids, for the informed consent of military and civilian population alike. As detailed in the National Drug Control Strategy – National Treatment Plan for Substance Use Disorder (NDCS- NTP) (Office of National Drug Control Policy (ONDCP), 2020), among the over 20 million individuals who met criteria for a SUD in 2018, roughly 89% did not receive specialized SUD treatment. Among Veterans receiving care within the Veterans Health Administration (VHA), over 520,000 had a SUD diagnosis in 2020 with less than 30% receiving SUD specialty services. The Office of Mental Health and Suicide Prevention (OMHSP) is responsible for national policy, management, and oversight specific to substance use disorders within VHA. SUD cannot be characterized by use of any one substance but often involves the use of multiple substances. The number of Veterans served within VHA with amphetamine, cannabis, cocaine, and alcohol use disorders is rising. Veterans with an amphetamine use disorder has increased by 71% since 2016 and a 31% increase in cannabis use disorder. Overdose deaths associated with stimulants including methamphetamine are increasing. Amphetamine use disorder diagnoses among those served in VHA increased 71% from 2016 through 2019 with cocaine use disorders increasing by 5%. During 2019, 65.8% (8,872) of Veterans newly enrolled in VHA Vocational services had a SUD diagnosis (VHA '21: 120, 128, 130). To do cannabis and the more severe, ICD and DSM recognized mental illness of tobacco withdrawal justice the VA should not hesitate to diagnose tobacco addicts for statistical and voluntary residential treatment purposes, if they should want to improve their health by trying to quit tobacco, and think they would benefit from residential treatment.

Veterans within VHA with Substance Use Diagnosis

Substance	2016	2017	2018	2019
Alcohol	363,763	388,933	393,531	416,590
Cannabis	103,815	112,910	123,754	135,766
Cocaine	69,524	70,407	72,258	73,272
Opioid	66,851	69,142	71,471	71,327

Amphetamine	25,549	30,085	37,290	43,720

Source: VHA '21: 121

6. Cannabis v. Opioids for Chronic Pain

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and the 10th Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) both require multiple symptoms of significant psychiatric distress, social impairment, and adverse consequences associated with cannabis use for an individual to be diagnosed with CUD. The VA has currently found low-strength evidence that cannabis preparations with precisely defined THC - cannabidiol content (most in a 1:1 to 2:1 ratio) may alleviate neuropathic pain but insufficient evidence in populations with other types of pain. The applicability of these findings to current practice may be low, in part because the formulations studied may not be reflective of what most patients are using – opioids (Kandagara '17). Currently, the Centers for Disease Control and Prevention recommends the use of evidence- based non-pharmacologic therapy – such as physical therapy, exercise therapy, and psychologic interventions – and non-opioid pharmacologic therapy as the preferred modalities to treat chronic pain (Abrams et al '11). Death, seen with opioids have not been described with cannabis use in the literature. Indeed, there is no good-quality data examining what impact cannabis use actually has on opioid use and opioid-related adverse effects. A growing body of cross-sectional literature suggests negative opioid-related correlates among individuals who use cannabis and opioids concurrently. These include opioid misuse a greater number of opioid refills; a longer duration of opioid use; a higher dose of opioid medication prescribed; and endorsement of using opioids without prescription (Degenhardt et al '15). One recent study found that pain scores and opioid use decreased over 6 months in a chronic pain population who initiated cannabis treatment, however confidence is limited by lack of a control group and large number of participants lost to follow-up (St. Louis '16).

Cannabis use has become more common among United States (US) adults, with the prevalence of adults reporting past-year cannabis use nearly doubling between 2001 and 2013 to one in 10 adults (Hasin et al '15). Young adults ages 18-29 are nearly 4 times more likely to have used cannabis in the past year than adults ages 45-64 (Kandagara et al '17). In the past, use had been limited to inhalation or ingestion of parts of the whole plant of the genus Cannabis. More recently, many more formulations of cannabis have become available in recreational and medical cannabis dispensaries including an array of edibles, oils, tinctures, as well as plant extracts with varying ratios of the 2 active ingredients of cannabis: tetrahydrocannabinol (THC) and cannabidiol (CBD). There are also 2 purely synthetic cannabinoids available in the US by prescription only (dronabinol and nabilone) (Kandagara et al '17: 6). It should be noted that edible cannabis preparations are significantly more potent, “dopey”, somnolent, sedating and longer lasting than smoked cannabis. To avoid certain diverticulitis from eating marijuana plant parts it is necessary to strain edible cannabis products after they have been emulsified in butter or oil, to prepare “ghee” for baking. THC serum concentration in the range of 7 to 10 ng/mL is comparable to a blood alcohol concentration of 0.05% on degree of impairment (Grotenhermen et al'07).

Medical cannabis used for chronic pain over one year appears to have a reasonable safety profile. The detailed listing of adverse events to medical cannabis will enhance clinical decision-making. The average daily dose of dried herbal cannabis used by patients with chronic pain was 2.5g/day. Medical cannabis use over one year was associated with improvements in pain, function, quality of life and

cognitive function. The cannabis group included 141 (66%) “current cannabis users”, 58 (27%) “ex-cannabis users”, and 16 (7%) “cannabis-naive users”. Controls included 70 (32%) “ex-cannabis users” and 146 (68%) “cannabis-naive users”. Compared with cannabis users, more control patients were using opioids (55% in cannabis group vs 66% in the control group), antidepressants (47% vs 59%), or anticonvulsants (44% vs 55%) at baseline. Sixty-seven patients receiving study cannabis and 34 control patients discontinued the study before the full year of follow-up. Due to the small number of cannabis-naive patients in the study, the safety of medical cannabis use in cannabis-naive individuals cannot be addressed. Twenty-eight (13%) patients in the cannabis group reported at least 1 SAE, compared with 42 (19%) in the control group. Compared with baseline, a significant reduction in average pain intensity over 1 year was observed in the cannabis group (change = .92; 95% CI=62–1.23) but not in the control group (change = .18; 95% CI=−.13 to .49). Greater improvement of physical function was noted in cannabis users than in controls (2.36 point greater improvement at 6 months, 95% CI=.84–3.88; and 1.62 points at 1 year, 95% CI=.10–3.14) (Ware et al '15).

Several studies have proven the effectiveness of marijuana on non-cancer pain, specifically related to MS and neuropathic pain such as fibromyalgia, peripheral diabetic neuropathy, spinal cord injury and HIV. They also insufficient evidence for the use of medical cannabis for pain related to other conditions such as cancer, rheumatoid arthritis, and musculoskeletal pain. Patients used cannabis for almost all symptoms associated with fibromyalgia with no reported worsening of symptoms (strong relief reported by 81% for sleep disorders to 14% for headaches). 68% of patients reported reduction in pharmacological treatment (not otherwise specified) when they started using cannabis. 2 hours post-cannabis use, VAS (100 mm) scores showed significant mean reduction in pain (37.1 mm reduction) and stiffness (40.7 mm reduction), $P<.001$. Participants continued their current pharmacologic regimen; at baseline (users vs non-users), analgesic/anti-inflammatory drugs used by 75% vs 64%, antidepressants used by 50% vs 61%, anxiolytics used by 36% vs 36%, opioids used by 21 vs 39%, myorelaxants used by 4% vs 21%, hypnotics used by 18% vs 29%. For patients with chronic pain, mostly neuropathic, a significant reduction in pain was noted for THC and 1:1 THC/CBD combinations in comparison with placebo or CBD alone (Ware et al '15).

Approximately 30% of Americans currently experience chronic pain, a rate that increases with age (Ward et al '14). Chronic pain is more prevalent and of greater intensity in the Veteran population than in the general population. This places Veterans at risk for harms from opioid medication, especially opioid use disorder (OUD) (VHA '21: 558). Veterans who use VA healthcare have twice the risk of medication overdose deaths than non-Veterans (VHA '21: 664). Recent studies suggest that 45-80% of individuals who seek cannabis for medical purposes do so for pain management and among patients who are prescribed long-term opioid therapy for pain, an estimated 6-39% are also using cannabis (Reisfield et al '09)(Degenhardt et al '15). Among Veterans receiving treatment within VHA who died from an opioid overdose, the rate increased from 14.5 per 100,000 person years in 2010 to 21.1 per 100,000 person years in 2016 (Lin et al., 2019). While rates of overdose increased, among those who died from an opioid overdose, the percent receiving an opioid prescription in the 3 months prior to death decreased. The increases in opioid overdoses were largely driven by synthetic opioid (e.g., fentanyl) and heroin overdoses. This suggests VHA’s expansive safe opioid prescribing efforts has had an impact while showing the need to target future efforts more directly to address opioid use disorders and use of illicit substances. Additionally, there is significant concern with rising rates of stimulant overdoses, specifically methamphetamine. While there was a slight decline in the number of overdose deaths during 2018, review of preliminary death data for 2019 and 2020 suggest a reversal of those trends with rising overdose rates. During 2017, over 4,500 Veterans died from a drug overdose with

the majority categorized as unintentional. Less than half of the VA medical centers reported the ability to access residential admission for SUD treatment within seventy-two hours and only slightly more than 61% were able to access admission within thirty days. At the end of 2020, sixty-eight Domiciliary SUD programs were in operation with 1,873 beds focused specifically on intensive, medically monitored residential SUD treatment (VHA '21: 121, 124).

President Trump's 2018 Initiative to Stop Opioids Abuse and Reduce Drug Supply and Demand directly contributed to a 19 percent reduction in the number of patients receiving opioids. Overall, there was a 32 percent decline since 2017. VA's Stratification Tool for Opioid Risk Mitigation (STORM) uses VHA administrative data and predictive modeling to help improve opioid safety by identifying patients at the highest risk for overdose or suicide-related events and assigning them a risk score. STORM is updated nightly and provides risk scores and risk mitigation strategies for patients with an active outpatient opioid prescription or who have an opioid use disorder. In 2020, almost 12,300 reviews were completed on these patients. The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose, and training on the rescue response, including provision of naloxone. Since implementation of the OEND program in 2014, over 31,700 VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 534,900 naloxone prescriptions have been dispensed to over 285,700 Veterans (as of April 2021). Through April 2021, as documented through spontaneous reporting of overdose reversal events as well as through a national note template, over 1,800 overdose reversals with naloxone have been reported, with an additional 146 reversals reported from naloxone in AED Cabinets and carried by VA Police. In 2018 VA dispensed a naloxone prescription for 1 in 5 patients on high dose opioids compared to 1 in 69 patients in the private sector (Guy et al, 2019).

7. Specialized Pain Management and Pharmacy

The Pain Management Program in Specialty Care Services (SCS) expanded through funding established with the enactment of P.L. 114 -198, title XI, the Jason Simcakoski Memorial and Promise Act, also referred to as *Jason's Law,* to form the Pain Management, Opioid Safety Program (PMOP) office (VHA'21: 110-113). The 2022 budget provides $621 million for VA's "Opioid" Prevention and Treatment programs, including programs in support of the Jason Simcakoski Memorial and Promise Act, referred to as "Jason's Law." VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management and to directly address treatment of opioid use disorder and prevention of opioid overdose. The increased funding in 2022 will help to staff the PMOP office and allow for more targeted funding of pain management and opioid safety programs primarily at the facility level with national support to ensure successful implementation. In addition, funding will be used to support continued growth and replenishment of VA's Opioid Overdose Education and Naloxone Distribution, which provides naloxone and education to VA patients at-risk for opioid overdose. In the literature, to justify chronic pain management prescriptions for dangerous opioids, it is necessary to inform the public of certain curative medicines, because there is no better form of pain management than curative treatment, and few more excruciating infectious conditions than toxic shock syndrome from the combination of *Streptococcus* spp. and methicillin resistant *Staphylococcus aureus* (MRSA) that can be greatly reduced by Pneumovax to both cure and prevent pneumococcal infections by *Streptococcus* spp. Epsom salt bath is safe and indicated for the relief of mild to moderate pain and is highly effective at treating methicillin resistant *Staphylococcus*

aureus (MRSA). Doxycycline cures painful conditions caused by MRSA infections, especially those of the digestive tract that are resistant to Epsom salt baths, multiple sclerosis (MS) and amytrophic lateral sclerosis (ALS) and other neurodegenerative disorders possibly caused by Lyme disease. The healing of broken bones cannot be accomplished without a diet that is high in calcium and phosphorus and is greatly accelerated by a diet that rich in meat and milk, if the patient has the heart for it.

In general, severely mentally ill patients do not want marijuana, however legalizing marijuana is an important step towards making a complete recovery, especially for prior consumers, but also psychologically for everyone making a clean break from malevolent exposure to mind altering substances and the armed regime extraordinarily under the undereducated and scientifically invalid influence of drug control, who abuses WHO. Isolated DEA registered "general" practitioners and their patients are particularly vulnerable to torture by mind altering substances, in particular DOM, whilst pharmacists, hospitals and their patients tend to chronic pain with bouts of severe pain coinciding with unlawful disclosure. The FY 22 Indian Health Service budget held 80% of people who committed suicide had visited a clinician in the past year, but only 20% had visited a hospital, where there is some safety in numbers, against DOM. To prevent the majority of severe mental illness caused by DOM exposure, and opioid overdose propaganda for the masses, to prevent torture by the infringing FBI/DEA/ONDCP third party, it is advised that the majority of medical practitioners, other than "pain management specialists and their pharmacists", who have not legitimate use for opioids, to join psychiatrists and online pharmacies to boycott DEA Registration identity theft completely because they they have no legitimate use to prescribe their patients any listed Controlled Substances whatsoever under 21CFR§1300.11. Furthermore, to prevent home invasion and excruciatingly painful tortures, it is extremely important that the address requirement be overruled for all prescription labels and data entry, especially involving controlled substances, and maybe all personally identifying patient and physicians information reported to the DEA, if this could be done accountably under 21CFR§1306.05 whereas a person cannot be used to render a territory immune from military intervention under Art. 28 of the Fourth Geneva Convention Relative to the Protection of Civilians in Times of War (1949).

For the VA to prescribe and provide PTSD and chronic pain patients with therapeutic marijuana, with a consciounse that is clean of DEA registered infringement, whether or not marijuana is legal in their state, it is minimally necessary for Congress and the Attorney General to repeal marijuana from Schedule I(c)(17) of the CSA under 21USC§812(c). Otherwise, it is comforting to know that the rational action of legalizing and prescribing marijuana, to neutralize the fundamental scientific error in the so-called Drug Schedule of an unlawful infringement on the practice of medicine, tends to have a pacifying effect on the DEA, whose severe mental illness from misguided drug control efforts, concealing a propensity by law enforcement to win their cases by impairing judgment with mind altering substances, is at least focused on the medically lost hard drug users. The DEA would not be offended if their DEA registered health care practitioners prescribed marijuana for PTSD and chronic pain. To take corrective action against the obvious infringement, DEA registration should be limited to pain management specialists and their pharmacists, to whom VA mental health providers could refer their recovering PTSD patients who want marijuana.

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