DEATHS AND POISONINGS ON THE RISE
Since 2001, the number of active-duty troops who have accidentally killed or nonfatally poisoned themselves with drugs or alcohol has risen dramatically:

<table>
<thead>
<tr>
<th>Year</th>
<th>Accidental drug or alcohol overdose deaths</th>
<th>Nonfatal drug overdoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>80</td>
<td>2,000</td>
</tr>
<tr>
<td>2002</td>
<td>90</td>
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<tr>
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<td>100</td>
<td>2,400</td>
</tr>
<tr>
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<td>110</td>
<td>2,600</td>
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<tr>
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<td>160</td>
<td>3,600</td>
</tr>
<tr>
<td>Total:</td>
<td>800</td>
<td>22,012</td>
</tr>
</tbody>
</table>

Sources: Defense Manpower Data Center, U.S. Army Center for Health Promotion and Preventive Medicine

BRYAN SMITH/STAFF

THE NUMBERS
To establish military-wide figures for accidental drug overdose deaths, Military Times staff members analyzed casualty data from the Defense Manpower Data Center. The figures in the story reflect active-duty deaths categorized as accidental, undetermined or pending that involved drugs and/or alcohol.

Because of the focus on accidental overdoses, the analysis did not include suicides, or deaths from at-risk behaviors such as inhaling chemical solvents or cleaning products. Military Times excluded deaths in which the cause could not be verified as drug- or alcohol-related.

For questions or comments, contact database reporter Brendan McGarry at 703-750-8665 or bmcgarry@miltime.com.

Last decade is that the effect of opioids, like methadone, is enhanced when it’s co-ingested with a benzodiazepine,” said Dr. Bruce Goldberg, a professor and director of toxicology at the University of Florida.

Some experts peg the spike in prescription-drug use to the tens of thousands of physically and mentally wounded returning from two war fronts over the past decade.

Goldberger pointed to the challenges of treating those returning from the war zones. “PTSD patients suffer from anxiety disorders, so they would be prescribed drugs like Xanax, but also may be seeking treatment for pain, so they’re being prescribed drugs like methadone,” he said. “It’s really a very complicated medical situation.”

Dr. Lynn Webster, medical director of Lifetree Clinical Research and Pain Clinic in Salt Lake City, who has written extensively about safe prescribing practices, encouraged family members to be extra vigilant and closely monitor loved ones on these medications, particularly at night. Be on the lookout for heavy snoring or long pauses between breaths, he said.

“These are signs that happen prior to dying,” he said. “Family members can fail to recognize that this is an impending calamity.”

Military doctors respond
Drug deaths have become an urgent concern for the Army in recent years.

The Army has recorded a spate of drug-related deaths in the Warrior Transition Units, the special-care units created to provide troubled soldiers with close supervision. At least 30 soldiers in the WTUs have died since 2007.

The Army report released July 29 on suicide and the health of the force found that 74 soldiers died of drug overdoses in 2009 alone, a rate of 13 per 100,000 active-duty soldiers, somewhat higher than civilian rate.

A key risk factor, Army officials say, is the simultaneous use of numerous drugs at once, known as "polypharmacy."

In 2009, Army Surgeon General Lt. Gen. Eric Schoomaker issued a sweeping new policy to overhaul how the Army prescribes, distributes and monitors the riskiest drugs. One Army official said a service-wide policy change to further improve oversight of polypharmacy is expected in August.

Noel Koch, former deputy under-secretary of defense for wounded warrior care and transition policy at the Pentagon, said he saw "repeated evidence of excessive drug use" at military treatment facilities across the country during his brief tenure.

Koch, who was asked to resign his post in April for reasons that remain unclear, said he briefed senior military leaders on his concerns about drug use among troops.

"You'd be staring at kids, you'd get this 50-meter stare. You'd have to raise your voice to get their attention," he said. "In Vietnam, the enemy turned our people into drug addicts. This time, caregivers are doing it."
Chiarelli: Prescription overuse has led to epidemic

By Andrew Tilghman
atilghman@afpc.osd.mil

Years of wholesale dispensing of prescription drugs have created an Armywide drug abuse epidemic — and the Army brass is blaming itself for letting it spiral out of control.

That’s the conclusion of Army Vice Chief of Staff Gen. Peter Chiarelli, who set out to take a hard look at the Army’s suicide problem.

What he found was the Army’s suicides are tied to a larger ill — prescription drug use and abuse. Drugs are a key factor in many of the Army’s suicides, accidental deaths and criminal investigations, according to the Army report released by Chiarelli on July 29.

And current efforts to detect and deter drug abuse are frequently failing, the report concluded.

“We face an Armywide problem,” Chiarelli, the Army’s vice chief of staff, wrote in an introduction letter to the sweeping 350-page report.

“What we witnessed firsthand were real indicators of stress on the force and an increasing propensity for soldiers to engage in high-risk behavior. This report validates a central conclusion ... risk in the force cannot be mitigated by suicide prevention alone,” Chiarelli wrote.

Army doctors may be inadvertently contributing to the force’s drug problem, the report concluded. Currently there is no time limit placed on prescriptions usage. “As a result, the soldier may use, abuse or distribute the drug long after the medical condition for which the drug was prescribed has resolved,” according to the report.

Two wars and the high-operational tempo have imposed severe stress on individual soldiers. But perhaps equally important is what the report calls “the lost art of garrison leadership” resulting from the Army’s unyielding focus on prosecuting two wars.

“Make no mistake — these are leader concerns,” Chiarelli wrote.

“I call on each of you to thoroughly study this report and work together with me to promote health, reduce risk-taking behavior and impose good order and discipline in the force.”

The report’s findings included:

■ About one-third of all soldiers are taking a prescription medication and 14 percent — or one in seven — of the entire Army population currently has a prescription for an opiate pain killer.

■ Roughly one third of Army suicides involve prescription drugs.

■ Prescription drugs have caused an estimated 139 Army deaths from 2006 through 2009.

■ The rate of soldiers facing random drug tests has dropped from 94 percent in 2002 to 86 percent in 2009.

■ Only 18 percent of Army drug test samples are actually tested for prescription drug abuse.

■ About 38 percent of soldiers who tested positive for drugs in recent years had tested positive at least once before.

■ About 30 percent of soldiers with drunken driving arrests and 40 percent of those testing positive for drugs were not sent to drug treatment programs, as regulations mandate.

The report contains dozens of vignettes spotlighting individual soldiers who were prescribed drug “cocktails,” instances of where drugs contributed to suicides and accidental deaths, and examples of leadership failures to identify and track troubled soldiers.

Although Army rules call for a soldier to be forced out of the service after a second positive drug test, thousands of soldiers have remained in the force despite multiple violations. That’s mainly due to the high operational tempo of recent years — someone comes up hot and no one has time to deal with it.

“It’s not overlooking — it’s that busy,” one Army official said.

The Army estimates that about 25,000 soldiers have drug problems but have never been treated in the Army Substance Abuse Program.

“The scope of the drug problem in today’s Army is distinct from those linked to past wars. During the Vietnam era some 40 years ago, many troops were using illegal drugs like marijuana and heroin, which were both commonly found in Southeast Asia at the time. The Army’s new report, however, demonstrates a different kind of drug epidemic,” according to the report.

See EPIDEMIC next page
YourArmy

Report links suicide spike to Army’s focus on war

By Kelly Kennedy
kellykennedy@staff.rtd.com

After releasing a 300-page report designed to address the Army’s record suicide rates, Gen. Peter Chiarelli, the service’s vice chief, acknowledged that the wars have caused leaders to lose sight of the needs of their soldiers.

Chiarelli said Army leadership made the wars in Iraq and Afghanistan its first priority, but that means sergeants have learned more about training for war than about the personal resources their troops may need, such as financial assistance or substance-abuse counseling.

“We prioritized, as you would want us to, to fight our nation’s wars,” Chiarelli said during a Pentagon briefing July 29. “Now as we come back … it’s time for the Army to take a long look at itself.”

Last fiscal year, 239 soldiers killed themselves; 160 of them were on active duty. Another 146 soldiers died due to high-risk activities, including 74 drug overdoses. And 1,713 soldiers tried to kill themselves, but were saved by a friend or by medical intervention.

The overall Army suicide rate in fiscal 2009 was 20.2 per 100,000, marking the first time the Army has eclipsed the national suicide rate of 19.2 per 100,000. But the Army rate has been rising markedly since 2007.

The report will go out to all command sergeants major and battalion commanders to be used as educational material all the way down the chain of command.

Chiarelli said the Army’s biggest problem is a lack of accountability; soldiers who commit crimes slip through the cracks.

From 2001 to 2009, there were 64,000 felony and death investigations, and 72 percent of those involved drugs. In 2009, there were 74,646 criminal offenses including 16,997 that involved drugs and/or alcohol. That does not include Article 15 offenses, which involve nonjudicial punishment.

Chiarelli said he expects 7,500 National Guard and reserve troops to test positive for marijuana in 2010. And no one is sure how many disciplinary and administrative actions have been taken because commanders and law-enforcement officials don’t always report them.

And, according to the report, only 30 percent of those involved in a DUI receive referrals for treatment, while 3,000 soldiers are expected to test positive for drugs for the second or third time in 2011.

The report also estimates that 25,283 soldiers since 2001 who would have been administratively separated in previous years for high-risk behavior remained in the ranks.

The cracks have grown wide enough that one chapter of the report is called, “The Lost Art of Leadership in Garrison.”

Many of today’s younger and midgrade soldiers joined after 2001, when the nation was already at war. “Before 2001, the focus was on the soldier,” an Army official said.

Epidemic

From previous page

places more emphasis on prescription drugs as a problem among today’s troops.

Looking ahead

The report includes dozens of recommendations for Army leaders.

For example, the report suggests that increasing random drug testing to include 100 percent of the force could reduce drug use. More than 78,000 soldiers were not drug tested in 2009, the report said.

Sending drug-sniffing dogs into barracks would help identify drug use among troops, the report suggested.

Army doctors should impose a one-year expiration date on all prescriptions to prevent soldiers from continuing to obtain dangerous drugs after they are no longer medically necessary, the report said.

The Army medical command should research the link between anti-depressants and suicide. Although outside research has shown “contradicting” results, there is some evidence suggesting that anti-depressants — in particular Paxil, also known as paroxetine — may increase suicidal thoughts or behavior, particularly among young adults.

The Army should “conduct research to identify appropriate antidepressant medications that are beneficial to the treatment of depression and anxiety, but that will not increase risk for suicidal behavior,” the report recommends.

The Army should create a new discharge code for soldiers with drug problems. Many of those soldiers are currently separated under Chapter 14, for general misconduct. A new discharge code specifically identifying those with drug problems would help commanders track the problem across their command.

Specifically, the new codes should include a Chapter 14a for alcohol misconduct, Chapter 14b for drug misconduct and Chapter 14c for other misconduct.

The report also recommends extending the window of time that commanders can invoke Chapter 11 (for entry-level misconduct) from soldiers’ first six months to 18 months.

Federal privacy laws were cited as a
“Now they’re so focused on the war fight, when they come home they’re not familiar with the services available to their soldiers.”

Officials say it’s hard to nail down the suicide problem: While combat stress is a significant issue, most soldiers who have killed themselves have deployed only once or have never deployed, and they are usually on their first enlistment.

But 87 percent do have one or more significant stressors. More than half of those have relationship issues, almost half have behavioral health diagnoses, about a third have legal or law-enforcement problems, a quarter have an adjustment disorder and a fifth have a substance-abuse diagnosis.

Army leaders “failed to hold soldiers accountable for their actions and allowed for risk-taking behavior — sometimes with fatal consequences,” Chiarelli wrote in the introduction to the report.

Chiarelli said Chapter 3 of the report, which gives details about soldiers who committed suicide, is an attempt at transparency.

Some of the scenarios seem familiar — a deployment, a break-up and a suicide. Some seem obvious — a private who deployed twice, had a history of suicidal gestures, had tried to kill his wife and himself, was diagnosed with deep depression and a personality disorder, threw away all of his possessions and euthanized his pet, and ultimately shot himself.

Each story also offers up an action plan for leaders dealing with similar situations. In the case of the soldier who euthanized his pet, it was this: “Left unchecked, at-risk soldiers may continue to spiral toward high-risk behavior and death. Early intervention is essential.”

A similar study released 15 months ago brought 245 recommendations, and 240 have been implemented. This latest report has 247 recommendations, about 240 of which have already been implemented. Chiarelli emphasized resiliency training and said each recruit receives 10 hours of it in basic training, including developing personal strengths, addressing weaknesses and learning basic life skills, such as money management and proper behaviors in a good relationship.

“It is not the deployments that [are] causing this problem,” Chiarelli said. “It’s all the stressors that you see. For us to blame this on the wars is just wrong.”

The report, he said, will allow leaders to better understand who is at risk and how to help them.

“Soldiers need firm, consistent leadership,” he said.

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Staff writers Brendan McGarry and Kelly Kennedy contributed to this report.
Medicating the military

Use of psychiatric drugs has spiked during the current conflicts. Concerns are surfacing about suicide and other dangers

By Andrew Tilghman and Brendan McGarry

At least one in six service members is on some form of psychiatric drug. And many troops are taking more than one kind, mixing several pills in daily “cocktails” — for example, an antidepressant with an antipsychotic to prevent nightmares, plus an anti-epileptic to reduce headaches — despite minimal clinical research testing such combinations.

The drugs come with serious side effects: They can impair motor skills, reduce reaction times and generally make a war fighter less effective. Some double the risk for suicide, prompting doctors — and Congress — to question whether these drugs are connected to the rising rate of military suicides.

“It’s really a large-scale experiment. We are experimenting with changing people’s cognition and behavior,” said Dr. Grace Jackson, a former Navy psychiatrist.

A Military Times investigation of electronic records obtained from the Defense Logistics Agency shows DLA spent $1.1 billion on common psychiatric and pain medications from 2001 to 2009. It also shows that use of psychiatric medications has increased dramatically — about 76 percent overall, with some drug types more than doubling — since the start of the current wars.

Troops and military health care providers also told Military Times that these medications are being prescribed, consumed, shared and traded in combat zones — despite some restrictions on the deployment of troops using those drugs.

The investigation also shows that drugs originally developed to treat bipolar disorder and schizophrenia are now commonly used to treat symptoms of post-traumatic stress disorder, such as headaches, nightmares, nervousness and fits of anger.

Such “off-label” use — prescribing medications to treat conditions for which the drugs were not formally approved by the FDA — is legal and even common. But experts say the lack of proof that these treatments work for other purposes, without fully understanding side effects, raises serious concerns about whether the treatments are safe and effective.

The DLA records detail the range of drugs being prescribed to the military community and the spending on them:

- Antipsychotic medications, including Seroquel and Risperdal,

where Dr. James R. Langdon, a military psychiatrist at Walter Reed Army Medical Center, said he has prescribed antidepressants to service members. Seventeen percent of the active-duty force, and as much as 6 percent of deployed troops, are on antidepressants, Brig. Gen. Loree Sutton, the Army’s highest-ranking psychiatrist, told Congress on Feb. 24.

In contrast, about 10 percent of all Americans take antidepressants, according to a 2009 Columbia University study.

**Suicide risks**

Many of the newest psychiatric drugs come with strong warnings about an increased risk for suicide, suicidal behavior and suicidal thoughts.

Doctors — and, more recently, lawmakers — are questioning whether the drugs could be responsible for the spike in military suicides during the past several years, an upward trend that roughly parallels the rise in psychiatric drug use.

From 2001 to 2009, the Army’s suicide rate increased more than 150 percent, from 9 per 100,000 soldiers to 23 per 100,000. The Marine Corps suicide rate is up about 50 percent, from 15.7 per 100,000 Marines in 2001 to 24 per 100,000 last year. Orders for psychiatric drugs in the analysis rose 76 percent over the same period.

“There is overwhelming evidence that the newer antidepressants commonly prescribed by the military can cause or worsen suicidality, aggression and other dangerous mental states,” said Dr. Peter Breggin, a psychiatrist who testified at the same Feb. 24 congressional hearing at which Sutton appeared.

Other side effects — increased irritability, aggressiveness and hostility — also could pose a risk.

“Imagine causing that in men and women who are heavily armed and under a great deal of stress,” Breggin said.

He cited dozens of clinical studies conducted by drug companies and submitted to federal regulators, including one among veterans that showed “completed suicide rates were approximately twice the base rate following antidepressant starts in VA clinical settings.”

But many military doctors say the risks are overstated and argue that the greater risk would be to fail to fully treat depressed troops.

For suicide, “depression is a big risk factor,” too, said Army...
‘Any soldier can deploy on anything’

Pentagon rules bar some drugs from combat zone, but oversight is suspect

By Andrew Tilghman
asth@morningtimes.com

Sgt. Chuck Luther wasn’t on any psychotropic drugs when he deployed to Iraq in October 2006, settling in at Camp Taji with the 1st Cavalry Division during the war’s darkest days, shortly before the surge began.

But after a few months, he was shaken by the deaths in his unit.

“I started having nightmares ... having to go and pick up the body bags at the gate and deliver them to the mortuary affairs units; nightmares about getting killed, getting blown up,” Luther recalled.

He told his command he was depressed, angry and having trouble sleeping. They sent him to a social worker who suggested he begin taking psychotropic drugs.

But the social worker, a lieutenant colonel, lacked the legal authority to prescribe such drugs.

“He sent me to a captain, a psychiatrist who could actually prescribe medicine,” Luther said. “We had five minutes of face time. We call it ‘checking the box’ in the military. He says, ‘I heard you’re having thoughts of suicide, I hear you’re having anger. We’re going to try this. Just go over to the pharmacy and pick it up.’”

Luther returned to his trailer that night with four bottles of pills: Selexa, an antidepressant; Seroquel, an antipsychotic; Ambien, sleeping pills; and the anti-anxiety drug Valium.

Sending drugs downrange

In late 2006, the Pentagon issued a rule barring troops who were taking some drugs from deploying to a combat zone. They include “antipsychotics used to treat bipolar and chronic insomnia symptoms, lithium and anticonvulsants used to control bipolar symptoms.”

The rule came in response to a congressional mandate to tighten mental health screening for deployed troops. Doctors say they help ensure that troops can handle the demands of deployment while also having access to the medical supervision and follow-up care these drugs can require.

But the rules are ambiguous; drugs specifically mentioned in the policy are, in fact, making their way to the war zones, according to deployed troop data maintained by Tricare.

“One Tricare official said some drug shipments to clinics in U.S. Central Command, which oversees the Iraq and Afghanistan war zones, ‘fall into a black hole.’

“Another official, Rear Adm. Tom McGuiness, chief pharmacy officer for Tricare, acknowledged in an interview that ‘the records aren’t great in the forward units.’

See DOWNRANGE Page 14

Could meds be responsible for some suicides?

By Andrew Tilghman
asth@morningtimes.com

Doctors at Fort Carson, Colo., released Pfc. Ryan Alderman from a military psychiatric ward with a stack of prescriptions for antidepressants, anticonvulsants and antipsychotics.

A week later, the troubled soldier added to that cocktail some drugs he wasn’t prescribed — painkillers and Valium.

And early on the morning of Nov. 20, 2008, the 21-year-old was found dead in his barracks.

An autopsy ruled his death a suicide — one of at least 128 the Army reported in 2008. But his father disagrees and thinks the death may have been an accidental overdose.

“They had him in a stupor where he could hardly talk. He was slurring his words. What killed him was all those drugs they gave him,” said Tim Alderman, who visited the Fort Carson psychiatric hospital a week before his son died.

It remains unclear whether Ryan Alderman intended to take his life — and, if so, whether the drugs he was on contributed to that decision.

“He’d talked about suicide, but I don’t think that’s what he did here,” the elder Alderman said. “I think it was accidental.”

Such deaths fuel criticisms of psychiatric drugs in general and military psychiatry in particular.

“I feel flat out that psychiatrists are directly responsible for deaths in our military, for some of these suicides,” said retired Col. Bart Billings, a former Army psycholo-
Washington
Medicating
From Page 12

Reserve Col. (Dr.) Thomas Hicklin, who teaches clinical psychiatry at the University of Southern California, said, “To withhold the medications can be a huge problem.”

Nevertheless, Hicklin said the risks demand strict oversight. “The access to weapons is a very big concern with someone who is feeling suicidal,” he said. “It has to be monitored very carefully because side effects can occur.”

Defiant officials initially have denied requests by Military Times for copies of autopsy reports that would show the prevalence of such drugs in suicide toxicology reports.

‘Then it’s over’

Spc. Mike Kern enlisted in 2006 and spent a year deployed in 2008 with the 4th Infantry Division as an armor crewman, running patrols out of southwest Afghanistan.

Kern went to the mental health clinic suffering from nervousness, sleep problems and depression. He was given Paxil, an antidepressant that carries a warning label about increased risk for suicide.

A few days later, while patrolling the streets in the gunner’s turret of a Humvee, he said he began having serious thoughts of suicide for the first time in his life.

“I had three weapons: a pistol, my rifle and a machine gun,” Kern said, “I started to think, ‘I could just do this and then it’s over.’”

That’s where my brain was: ‘I can just put this gun right here and pull the trigger and I’m done. All my problems will be gone.’

Kern said the incident scared him, and he did not take any more drugs during that deployment. But since his return, he has been diagnosed with PTSD and currently takes a variety of psychotropic medications.

Other side effects cited by troops who used such drugs in the war zones include slowed reaction times, impaired motor skills, and attention and memory problems.

One 35-year-old Army sergeant first class said he was prescribed the anticonvulsant Topamax to prevent the onset of debilitating migraines. But the drug left him feeling mentally sluggish, and he stopped taking it.

“Some people call it ‘Stupamax’ because it makes you stupid,” said the sergeant, who asked not to be identified because he said using such medication carries a social stigma in the military.

Being slow — or even “stupid” — might not be a critical problem for some civilians. But it can be deadly for troops working with weapons or patrolling dangerous areas in a war zone, said Dr. John Newcomer, a psychiatrist professor at Washington University in St. Louis and a former fellow at the American Psychiatric Association.

“A drug that is really effective and it makes you feel happy and calm and sleepy ... might be a great medication for the general population,” Newcomer said, “but that might not make sense for an infantryman in a combat arena.

“If it turns out that people on a certain combo are getting shot twice as often, you would start to worry if they were as ‘heads up’ as they should have been,” Newcomer said. “There is so much on the line, you’d really like to have more specific military data to inform the prescribing.”

Military doctors say they take a service member’s mission into consideration before prescribing.

“Obviously, one would be concerned about what the person does,” said Col. C.J. Diebold, chief of the Department of Psychiatry at Tripler Army Medical Center in Hawaii. “If they have a desk job, that may factor in what medication you may be recommending for the patient (as opposed with) if they are out there and they have to be moving around and reacting fairly quickly.”

Off-label use

Little hard research has been done on such unique aspects of psychiatric drug usage in the military, particularly off-label use.

A 2009 VA study found that 60 percent of veterans receiving antipsychotics were taking them for problems for which the drugs are not officially approved. For example, only two are approved for treating PTSD — Paxil and Zoloft, according to the Food and Drug Administration. But in actuality, doctors prescribe a range of drugs to treat PTSD symptoms.

To win FDA approval, drug makers must prove efficacy through rigorous and costly clinical trials. But approval determines only how a drug can be marketed; once a drug is approved for sale, doctors legally can prescribe it for any reason they feel appropriate.

Such off-label use comes with some risk, experts say.

“Patients may be exposed to drugs that have problematic side effects,” Newcomer said, adding that -“it would be a disservice to not use the benefit, fit, fail,” said Dr. Robert Rosenheck, a professor of psychiatry at Yale University who studied off-label drug use among veterans. “We just don’t know. There haven’t been very many studies.”

Some military psychiatrists are reluctant to prescribe off-label.

Downrange

How Meds Enter the War Zones

— Many troops receive prescription medications in bulk bottles before deploying. Military medical facilities often dole out six-month supplies as part of predeployment preparations. These drugs go overseas in personal baggage.

— Many troops receive prescription refills through the TriCare Mail Order program, which sends individual prescriptions through the U.S. Postal Service. This is especially common for troops on longer deployments. These drugs are sent to individual military postal addresses, just like any other care package from home.

— Medical treatment facilities in theater receive bulk drug shipments through routine logistic channels. These drugs are purchased by the Defense Logistics Agency in Philadelphia and initially shipped to Landstuhl Regional Medical Center in Germany. From there, they are sent to fill individual orders from medical facilities downrange for troops who start taking medications while deployed.

— Troops also can order any and all drugs online. For those willing to spend their own money, the Internet is a source for drugs that medical officials may be unwilling to provide.

Most medical professionals agree that the use of mental health drugs is uniquely complex in military medicine, especially in combat zones.

Military physicians must consider not only the health of the individual patient, but also their duty to the mission, said Grace Jackson, a psychiatrist and former Navy lieutenant commander who resigned her commission in 2002 because she was uncomfortable with the military’s heavy and growing use of psychotropic drugs.

“There has always been an added complication with military medicine,” Jackson said. “The physician in uniform takes two oaths — an oath to serve the patient and an oath to serve the nation, commander in chief and the larger military. Where do you draw the line between performance enhancement and the treatment of pathology?”

Oversight questioned

The issue of psychiatric drug use in the war zones has begun to attract attention on Capitol Hill.

In November, Sen. Ben Cardin, D-Md., asked Defense Secretary Robert Gates for details on how many troops serving in Iraq and Afghanistan have been prescribed antidepressant medications while deployed.

Gates agreed to provide the data later this year, Cardin said.

“We are concerned about the appropriate use of medicine with the proper protocols for those who are in combat zones,” Cardin said in an interview. “What we are trying to do is get the statistical information to get a better handle on what is being used and whether we are following the best medical protocols.”

Luther said drug use was common among troops he served with, and many passed around these controlled substances — technically a crime under state and federal law — just like any other piece of essential gear shared among a tightly knit unit.

“We didn’t just share MREs and water; we shared Ambien, too,” Luther said. “One time another soldier said, ‘Hey, I’m running out of my Ambien and I can’t get it...
“It’s a slippery slope,” said Hicklin, the Army psychiatrist. “Medication can be overused. We need to use medication when indicated and we hope that we are all on the same page ... with that.”

Combinations of drugs pose another risk. Doctors note that most drugs are tested as a single treatment, not as one ingredient in a mixture of medications.

“In the case of poly-drug use – the ‘cocktail’ – where you are combining an antidepressant, an anticonvulsant, an antipsychotic, and maybe a stimulant to keep this guy awake — that has never been tested,” Breggin said.

Newcomer agreed. “When we go to the literature and try to find support for these complex cocktails, we’re not going to find it,” he said. “As the number of medications goes up, the probability of adverse events like hospitalization or death goes up exponentially.”

Looking for answers

Pinpointing the reasons for broad shifts in the military’s drug use today is difficult. Each doctor prescribes medications for the patient’s individual needs.

Nevertheless, many doctors in and outside the military point to several variables — some unique to the military, some not.

A close look at the data shows that use of the antipsychotic and anticonvulsant drugs, also known as “mood stabilizers,” are growing much faster than antidepressants.

That may correlate to the challenges that deployed troops face when they arrive back home and begin to readjust to civilian social norms and family life.

“The ultimate effect of both of these drugs is to take the heightened arousal — the hypervigilance and all the emotions that served you once you were deployed — and help to turn that back down,” said Dr. Frank Ochberg, former associate director for the National Institute of Mental Health and a psychiatry professor at Michigan State University who reviewed the Military Times analysis.

Dr. Harry Holloway, a retired Army colonel and a psychiatry professor at the Uniformed Services University of the Health Sciences in Bethesda, Md., said the increased use of these medications is simply another sign of deployment stress on the force.

“For a long time, the ops tempo has been completely unrelied and unrestrained,” Holloway said. “When you have an increased ops tempo, and you have certain scheduling that will make it hard for everyone, you will produce a more symptomatic force. Most commanders understand that and they understand the tradeoffs.”

Washington

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Washington

Military kids taking more psychiatric drugs
Prescriptions increase as families struggle with repeated deployments

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Before his father deployed to Iraq, Daniel Radenz was a well-adjusted fifth-grader earning straight As and Bs in school near Fort Hood, Texas.

But shortly after Army Lt. Col. Blaine Radenz left home in June 2008, his 11-year-old son became withdrawn and anxious. His grades at school slipped and his mother noticed mood swings. The child’s longtime pediatrician referred him for counseling.

A psychiatrist at Fort Hood’s Darnall Army Medical Center prescribed the antidepressant Celaexa. Daniel also saw a psychologist there. Doctors added to and changed Daniel’s drug regimen, but his problems grew worse, said his mother, Tricia Radenz.

Daniel started cutting himself and once used his own blood to write “the end” on a bathroom wall at school. One day in band class, he began hallucinating and ran into the hall, where teachers found him crouched and hitting and scratching his face.

On June 9, 2009, Daniel hanged himself from a bunk bed in his home.

“I really feel the drugs played a significant role in Daniel’s death,” said Tricia Radenz, a 41-year-old emergency-room nurse.

It’s impossible to know precisely why a 12-year-old chose to take his own life. But the boy’s problems — and the use of powerful psychiatric drugs to treat them — highlight a concern for a growing number of military families who are struggling with the impact of long, frequent deployments on their children left at home.

The use of psychiatric medications by military children is on the rise. Overall, in 2009, more than 300,000 prescriptions for psychiatric drugs were provided to children under 18 who are Tricare beneficiaries.

That’s up 18 percent since 2005, according to data provided to Military Times — a period when the under-18 population increased by less than 1 percent. And some drug categories have shown even higher rates of increase — antipsychotic drugs are up about 50 percent and anti-anxiety drugs are up about 40 percent.

That mirrors a similar trend in the active-duty force, which has seen a 76 percent increase in prescriptions for psychiatric medications since the start of the war in Afghanistan.

Dr. Patricia Lester, a psychiatrist at University of California, Los Angeles, said the rise in drug use among children tracks with studies she and others have done showing how repeated deployments are taking a toll on military kids.

“There is a consistent story coming out showing that these kids have more distress,” Lester said.

“And it’s not just the period of deployment. It appears to be during re-integration as well.”

Two new studies link parents’ deployments to their children’s lower academic achievement scores and to increased mental and behavioral health problems.

In one study, Rand Corp. researchers matched soldiers’ records with children’s academic achievement and lower scores among military children whose parents were cumulatively deployed for 19 months or more since 2001.

In the mental health study, led by a professor of pediatrics at the Uniformed Services University of the Health Sciences, researchers found that when a parent was deployed, outpatient visits among children ages 3 to 8 for pediatric behavioral disorders rose 18 percent, and for stress disorders by 19 percent, compared with military children whose parents were not deployed.

Prescription psychiatric drugs can help treat some of those behavioral disorders. But many of those drugs come with potential side effects, Lester said.

“Whenever one is prescribing medication, there is a risk-benefit analysis that has to occur, and the parents and patient need to be included in that,” Lester said.

Suicide risks
Tricia Radenz said nobody ever warned her about the suicide risks associated with the drugs her son was taking.

“The psychiatrist never once told me Celaexa was a risk. He said he’d had great success with this drug,” Radenz said in an interview.

“Any antidepressant carries the warning, but I didn’t find out the seriousness until after he died,” she said.

Celexa, along with Wellbutrin, which Daniel was also taking at the time of his death, carry “black box” warnings from the Food and Drug Administration — the FDA’s most serious warning — about increased risks for suicidal thoughts and behavior.

Moreover, neither drug is recommended for children, although doctors may legally prescribe them after determining that they may benefit individual patients.

Experts say any medication should be matched with intensive therapy or counseling as a way to monitor for side effects and treat underlying problems that drugs cannot address.

Radenz said Daniel saw the psychologist and psychiatrist once or twice a month. She said the psychiatry department didn’t respond to her pleas for help when she called after Daniel had cut himself at school and used his blood to write on the bathroom wall.

The mother left a phone message with the psychiatry department,
Washington

MEDICATIONS ON THE RISE

Tricare prescriptions for several psychiatric medications have risen steeply among children under 17:

<table>
<thead>
<tr>
<th>Prescriptions by drug class:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulant/ADHD</td>
</tr>
<tr>
<td>Antidepressant</td>
</tr>
<tr>
<td>Anticonvulsant/mood-stabilizer</td>
</tr>
<tr>
<td>Antipsychotic</td>
</tr>
<tr>
<td>Anti-anxiety</td>
</tr>
</tbody>
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Total for the above medications:
- 2009: 308,683 prescriptions
- 2005: 325,000 prescriptions

Source: TriCare Management Activity

JOHN BREITSCHEIDER/STAFF

December 27, 2010  Army Times  13

Lt. Col. Blaine Radenz and his wife, Tricia, hold the last school portrait of their son Daniel Radenz. Daniel took his own life at 12 years old after battling depression and being prescribed psychiatric medication while being treated at Darnall Army Medical Center at Fort Hood, Texas.

with details about what had happened, asking that someone call back for an appointment. Nobody returned her call, she said.

“I was essentially staying with him 24/7,” Radenz said. “I was outside the bathroom if he was in there. He was sleeping with me.”

She said that after she was unable to get help from the child psychiatry department, she e-mailed her husband in desparation, and he came home from Iraq on emergency leave May 25.

Daniel was thrilled to see his father. For days as the family spent time together, Radenz said, Daniel laughed and joked and said many times: “I’m so glad Dad is home.”

Daniel’s father went to the local clinic and asked why his wife’s phone calls had not been returned, even by June 1. He told them he was on emergency leave because of his son’s decline.

The clinic staff apologized, Tricia Radenz said, and explained that no one was checking the answering machine because the staff was overwhelmed.

Her son’s death a week later “was completely preventable, had he received competent care instead of being herded through the system like a piece of cattle at an auction,” she said. “I want someone held accountable, and I don’t want anyone to ever have to go through this again.”

Officials at Darnall Army Medical Center said they conducted an investigation into Daniel’s treatment, but a spokeswoman declined to disclose any of its findings. However, the spokeswoman said, “rest assured that all medical treatment was thoroughly evaluated” and “any lessons learned as a result of that review have been incorporated into our practices here at Fort Hood.”

Tricia Radenz knows nothing can bring her son back.

“But why can’t they say they were wrong? That they’ve made changes? All I want is to know they’ve corrected their process that cost me my son.”

“No other family should ever have to endure the agony my family suffers daily. My husband made more than the ‘ultimate sacrifice’ ... he sacrificed his son to serve.”

‘This keeps him safe’

Not all families have such tragic experiences. Some families see psychiatric drugs as a life saver.

One Army wife and mother of a 12-year-old boy said the medications her son takes are the only thing keeping him out of an institution. Diagnosed with bipolar disorder, the child is a stable seventh-grader who takes five different medications every day.

“‘This keeps him at home. This keeps him safe,’” said the mother, who spoke with Military Times about her son’s treatment but asked not to be identified.

The wife of a Special Forces soldier who has deployed often during the past decade, the mother said her child’s problems typically get worse, if only temporarily, after his father goes overseas.

“When my husband leaves, the first seven days, seven to 11 days, are very hard on him. He’s very sad. He’s withdrawn. He rages more frequently. But once we get past that period of time, he is the same as he always is.”

The family’s frequent moves have taken a toll on her son. His problems first surfaced when they moved to Japan when the child was 6. And the move back, at age 9, led to an attempted suicide and his initial diagnosis of early-onset bipolar disorder.

“That was the hardest move we’ve ever gone through,” the mother recalled. “It was the loss of his friends. He said, ‘My world was taken away from me.’”

Over the past five years, doctors have prescribed 34 different drugs for the boy, she said.

“You just have to find the right combination. The problem is that it takes so long. The doctors say, ‘Let’s try this one. Let’s try that one. Let’s make this one a little stronger.’ It’s craziness,” she said.

Her child’s current drugs include Abilify, an antipsychotic; Wellbutrin, an antidepressant; Adderall, a stimulant; Tegretol, an anticonvulsant; and Clonidine, a sedative.

Her son sees an off-base civilian therapist once a week and receives better care and treatment than he did from the on-base counselors, she said. In addition, she also sees an on-base psychiatrist who typically sees the child for about 15 minutes and focuses on medication.

“He doesn’t really know much about my son; he just gives out medications. He relies on the parents. He’s asking me: ‘What kind of medications is he on?’ I’m like, ‘You’re the doctor, shouldn’t you know? Look at the file.’”

The mother is happy to say her son experiences few side effects these days. But she said she has “long-term concerns. Will he become dependent on these antidepressants and antipsychotics because his young brain has been soaked in them for so many years? My priority now is to keep my son stable so he’s not suicidal.”

That view is familiar to many experts.

“Many members of the pediatric psychiatric community are concerned about the increases [in the use of psychiatric drugs]. They have concerns about the side effects and the lack of data showing their effectiveness of those medications in children,” said Josephine Johnston, a researcher with the Hastings Center, a New York-based research group.

“It’s just not as simple as you want it to be,” Johnston said. “You can tell a story about how imperfect these drugs are, or how the system doesn’t provide the kind of integrated care that many families want. But the truth is, it’s hard for these families to find anything that works really well.”

Staff writer Brendan McGarry contributed to this report.