Accidental overdoses alarm military officials

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Jun. 6, 2010 - 06:16PM | Last Updated: Jun. 6, 2010 - 06:16PM |
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The 30 soldiers and two Marines overdosed while under the care of special Army Warrior Transition Units or the Marine Corps Wounded Warrior Regiment, created three years ago to tightly focus care and attention on troops suffering from severe physical and psychiatric problems as a result of combat.

Most of the troops had been prescribed "drug cocktails," combinations of drugs including painkillers, sleeping pills, antidepressants and anti-anxiety drugs, interviews and records show. In all cases, suicide was ruled out.

Army officials say the deaths are often complicated by troops mixing medications with alcohol, taking their own medications incorrectly or without a prescription.

It is unclear how many troops across the entire military have died from drug toxicity. Pentagon officials have not provided information about accidental drug deaths across the military despite a Military Times Freedom of Information Act request submitted nearly two months ago. Data on military deaths is compiled by the Armed Forces Institute of Pathology and maintained at the Pentagon's Defense Manpower Data Center.

The Army deaths have shocked that service's medical community and prompted an internal review. But despite a "safety stand down" in January 2009, the number of fatalities continued to rise last year — to 15 in 2009, up from 11 the year before. Meanwhile the total number of soldiers assigned to the 29 WTUs nationwide dropped from about 12,000 to about 9,000.

The internal review found the biggest risk factor may be putting a soldier on numerous drugs simultaneously, a practice known as polypharmacy. According to an Army analysis from June 2009, about 9 percent of WTU patients — 800 soldiers — were prescribed a combination of drugs that included pain, psychiatric and sleep medications.

As a result, the Army medical community has begun to question the widespread practice of polypharmacy and has quietly overhauled the way it prescribes, distributes and monitors the riskiest drugs.

Indeed, in a hand-written postscript to a major policy change in April 2009, Army Surgeon General Lt. Gen. Eric Schoomaker took note of the problem with a warning neatly written beside his signature.

"Closer oversight of polypharmaceutical use by our patients can be life-saving," he wrote.

New rules and guidance to reduce drug toxicity deaths over the past two years include:

* Warning Army doctors to be "judicious in the use of psychoactive medications."

* Requiring soldiers to sign consent forms stating that they fully understand the potential risks related to the drugs.

* Prohibiting some soldiers from using more than one doctor to obtain medications.

* Reducing standard prescriptions for high-risk soldiers from 90-day supplies to a seven-day supply.

* Establishing alcohol-free zones in WTU barracks and issuing no-alcohol orders to some

heavily medicated soldiers.

Schoomaker identified drugs that "alone or in combination … may prove lethal."

"These high-risk medications include, but are not limited to, narcotic analgesics, anxiolytics, and anti-seizure and insomnia medications," according to his April 2009 memo.

Robert Moore, a spokesman for Warrior Transition Command, which oversees the WTUs, told Military Times that none of the fatalities resulted from a soldier taking his medications as instructed. Rather, they involved soldiers who took too much medication, took medication without a prescription, or mixed medication with alcohol or illegal drugs.

"These are individuals," he said. "They will make some of their own decisions."

Moore said the rate of deaths has decreased due to the series of new safety measures. So far this year, two soldiers have died from accidental drug overdoses, and several cases are pending, according to interviews.

Nevertheless, the problem has become a priority for the Army's top leaders.

"With two drug-related deaths thus far this year, we are not content that we are solving this problem, and continue to look at every possible avenue to further reduce the risk of such events not only in the WTUs but across our force," Army Vice Chief of Staff Gen. Peter Chiarelli told Military Times earlier this month.

The military has a computer system designed to warn doctors when individuals receive drugs that may cause adverse reactions. But doctors are able to easily override the warning notification and allow patients to receive high-risk combinations, military records show.

The details underlying each death are unique. Sgt. Gerald Cassidy died in 2007 after writing in his journal that he was unsure how much methadone he had taken, his family said.

Warrant Officer Judson Mount died in April 2009 after trying a new, higher dosage patch that releases the narcotic painkiller fentanyl, his mother said.

And Spc. Franklin Barnett died in June 2009 shortly after spending a weekend with his wife and children and appearing to be in good health, his wife said.

Unlike those casualties in Iraq or Afghanistan, the fatalities here can be avoided through better management of the health care units, said Col. (Dr.) Steven Swann, command surgeon for the Warrior Transition Command.

"Losing a soldier in combat is an expected and understood cost of … war. But these [deaths] should be preventable," Swann said. "We will do everything we can … — more policies, more programs, more controls — to prevent every single one of these."

Meds on the rise

During the past decade — for nearly all of which the U.S. has been at war on two fronts — the military community has seen a dramatic rise in the use of the types of medications linked to the WTU deaths. For example, the military health care system's prescription orders for painkillers nearly tripled, while those for anti-seizure medications rose 68 percent, according to a recent Military Times analysis of Defense Logistics Agency data.

Many of those drugs have a similar fundamental effect on the body, slowing the central nervous system and increasing the risk that a patient's heart or breathing will stop during sleep.

"Using alcohol and illicit drugs in combination with high-risk medications increases the potential for adverse events and death," Schoomaker's memo said.

The spate of deaths fuels criticism that the military medical community — and the American medical community at large — puts too much emphasis on pharmaceutical drugs rather than other forms of treatment.

"There is a direct correlation in the increase of use of these medications and these sudden deaths," said Dr. Bart Billings, a retired Army colonel and psychologist in San Diego who treats troubled troops and has testified before Congress about the risks linked to prescription drugs. "These are healthy young people who are dying in their sleep because some physician prescribed a combination of medications that killed them."

Many such drugs are tested and approved for use individually, but research on combinations is limited.

"These medications were not tested in combination with other medications," Billings said. "They were tested only on what they would do on their own."

Billings believes the safest and most effective treatment includes various forms of talk therapy in which troops forge personal relationships with counselors while trying to identify, understand and deal with their mental health problems.

But some military doctors caution against blaming drug use in general and note that most people respond well to painkillers and psychiatric medications.

"The reasons we use these drugs is because they work," Swann said. "They are effective at managing people's pain and managing their depression."

Corps drug deaths

The Marine Corps has wrestled with similar problems.

"Medication risk management is one of the recurring hot-button topics," said Navy Capt. William Tanner, the head doctor for the Marine Corps' Wounded Warrior Regiment.

Last year, a spate of drug thefts in the barracks at Camp Lejeune, N.C., prompted the Corps

to give Marines a lock box to secure prescription drugs, Tanner said.

Some Marines with traumatic brain injuries receive personal digital assistants to help them keep track of their daily drugs.

The Corps also is developing a program that brings doctors, caseworkers and Marine officials together once a week to discuss each patient and their medications.

"We don't have a great treatment for PTSD," Tanner said. "There are studies and recommended treatments, but none of them are great. It's hard to tell a doctor what to do. He's going to do what he thinks is best for the patient, regardless of what the guidelines say."

Suicide semblance

An accidental drug overdose initially can be confused with suicide. After Sgt. Robert Nichols died in 2008 at the WTU at Fort Sam Houston, Texas, the Army Criminal Investigations Division grilled his wife for possible evidence that his death was self-inflicted.

"The CID guys were like ‘Well, you know, was there anything that was on his plate that was too much to handle? Was there anything bothering him?' " said Susan Horn, who now lives in Dallas. "You didn't have to be Albert Einstein to see where they were going with that. I thought, are you really trying to suggest this? This man? No."

Nichols, who deployed in 2007 to a base south of Baghdad, sustained a traumatic brain injury after a mortar round landed near him, his wife said.

An investigation later concluded that Nichols' death was an accident. Medical records show he was taking a cocktail of 11 drugs, including Percocet, Valium, the antidepressant Celexa, the antipsychotic Seroquel, and Depakote, an anti-seizure drug used to treat major depression and bipolar disorder, according to his wife.

Some psychiatric medications involved in the accidental overdoses come with warning labels about an increased risk for suicidal thoughts and actions.

The Army estimates that about 5 percent of suicides involve prescription drugs, documents show.

When the cause of death is unclear, the military can consult a forensic psychiatrist, who examines in detail the victim's life and activities and apparent frame of mind in the hours before death. Law enforcement investigators can also be involved.

But final determinations are not always clear cut, said Army Col. David Benedek, who teaches psychiatry at the Uniformed Services University of the Health Sciences, a Defense Department school in Bethesda, Md.

Accidents and suicides, he said, "are difficult distinctions to make sometimes, particularly if

someone doesn't leave a note or indicat in any way that they were contemplating suicide."

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