The VA killed thousands of vets and fueled the national opioid crisis by recklessly throwing pills at a problem

by ART LEVINE

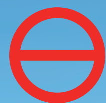


illustration by FOREAL

THANK YOU FOR YOUR SERVICE

LATE ONE SUMMER NIGHT IN 2014, KEVIN KELLER BROKE INTO HIS BEST FRIEND'S HOME. Keller was a U.S. Navy vet wracked with constant pain, and because his right arm had been crippled by a stroke, he had to use his left hand to scrawl a note of apology to his buddy: "Marty, Sorry I broke into your house and took your gun to end the pain! FU VA!!! Can't take it anymore." He then drove to his nearby Veterans Affairs outpatient clinic in Wytheville, Virginia, and pounded on the locked doors of the medical office, probably out of frustration or as a final protest, since the facility had been closed for hours. Keller then put the barrel of his friend's 9 mm pistol to his head and shot himself.

Grieving friends told *The Roanoke Times* that Keller couldn't handle how the VA was weaning him off painkillers. His doctors had told him cutting back would extend his life, but Marty Austin, whose gun Keller stole that night, told the paper, "He did not want a longer life if he was going to be miserable and couldn't do anything because of the pain."

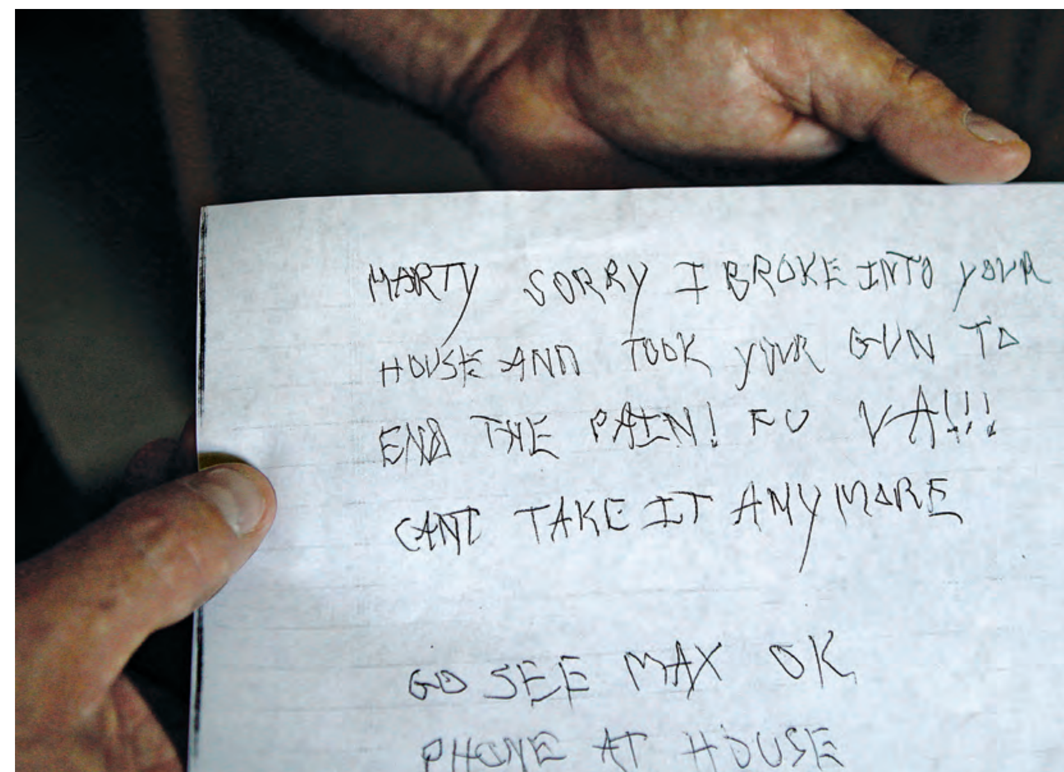
Suicides like Keller's and the widespread despair behind them are yet another tragic element of a national opioid crisis blamed for most of the 64,000 fatal drug overdoses a year. Opioids, mostly illegally obtained counterfeit pills and heroin, now account for 63 percent of all drug deaths in the U.S., with fatalities climbing at an astounding rate of nearly 20 percent a year. In fact, the estimated number of drug deaths in 2016 topped the total number of soldiers killed in the Iraq and Vietnam wars. There's a grim irony in that statistic, because the Department of Veterans Affairs has played a little-discussed role in fueling the opioid epidemic that is killing civilians and veterans alike. In 2011, veterans were twice as likely to die from accidental opioid overdoses as non-veterans. One reason, as an exhaustive *Newsweek* investigation—based on this reporter's book, *Mental Health, Inc.*—found, is that for over a decade, the VA recklessly overprescribed opiates and psychiatric medications. Since mid-2012, though, it has swung dangerously in the other direction, ordering a drastic cutback of opioids for chronic pain patients, but it is bungling that program and again putting veterans at risk. (It has also left untouched one of the riskiest classes of medications, antipsychotics—prescribed overwhelmingly for uses that aren't approved by the Food and Drug Administration (FDA), such as with post-traumatic stress disorder.)

"I am going CRAZY because of the pain and burning up with anger at the VA."

A key role in spreading opiate use was played by Purdue Pharma, the OxyContin manufacturer convicted of hiding the drug's addictive properties. It gave $200,000 to the VA pain management team that essentially turned the VA into its propaganda arm, according to secret corporate documents obtained by *Newsweek*. The team helped develop the initial VA–Department of Defense guidelines that concluded opiates "rarely" cause addiction. A 2001 budget plan outlining Purdue's marketing schemes hailed "additional corporate initiatives and partnering efforts [that] were very successful with the Veterans Administration" and other major health organizations in promoting the phony campaign, "Pain: The 5th Vital Sign."

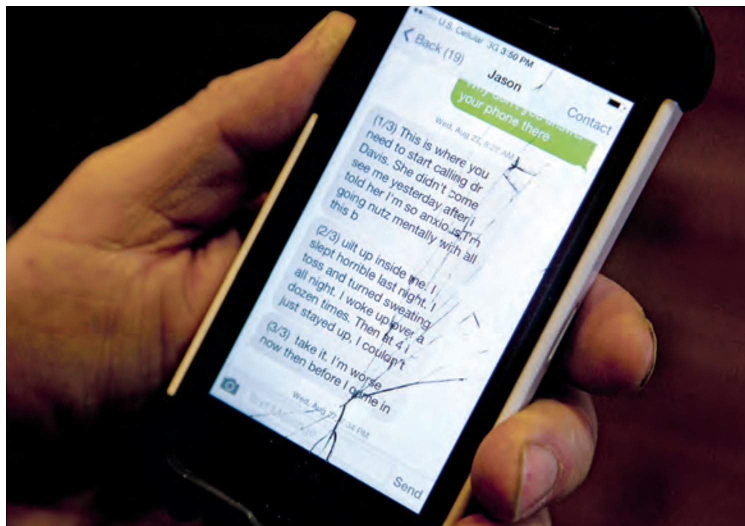
Today, the number of patients affected by the VA's swinging opiate pendulum is staggering: 60 percent of veterans who fought in the Middle East and 50 percent of older veterans have chronic pain. Since 2012, though, there has been a 56 percent drop to a mere 53,000 chronic pain VA patients receiving opioids—leading to swift, mandated cutoffs regardless of patient well-being and with virtually no evidence that it's a safe approach. For a taste of the kind of indifferent care vets with chronic pain are getting, consider Marine veteran Robert Rose. He is now mostly confined to a wheelchair, suffering from severe spine, neck and knee injuries from his military service—but until he was cut off from opioid pain medications last year (despite not abusing them), he didn't need a wheelchair and was able to play with his grandkids and build finely crafted woodworks. The primary care

REBECCA BARNETT STONE/THE ROANOKE TIMES (2)


MARTY SORRY I BROKE INTO YOUR
HOUSE AND TOOK YOUR GUN TO
END THE PAIN! FU VA!!!
CANT TAKE IT ANY MORE

GO SEE MAX OK
PHONE AT HOUSE

PAINFUL GOODBYE
Austin, above, lost his best friend, Keller, when he took his own life in July, leaving behind a suicide note, left. Keller apparently couldn't handle how the VA was weaning him off painkillers.



BITTER PILLS
The parents of Simcakoski show a text from their son. At right, his wife and daughter. A former Marine, Simcakoski was taking 16 different VA-prescribed drugs before he died.

DARREN HAUCK/CENTER FOR INVESTIGATIVE REPORTING (3)

doctor at the Mountain Home, Tennessee, VA Medical Center told a hobbled, diabetic Rose and his wife during an office visit in May, "You should continue smoking, as it will help you with the stress and frustrations you are dealing with now. And you should continue to drink Mountain Dew, as the sugar molecules will attach to the pain receptors and block the pain you are experiencing without pain medications."

Rose is ignoring that advice and raging against how he and other veterans are being treated—and mistreated: "I am going crazy because of the pain and burning up with anger at the VA, the [Centers for Disease Control and Prevention] and [the Drug Enforcement Administration (DEA)] for what they're doing to so many Americans and veterans."

'Don't Fix the Problems'

IN A CEREMONY IN THE EAST ROOM OF THE WHITE House in late June, President Donald Trump signed a law making it easier for the Department of Veterans Affairs to remove bad employees and protect whistleblowers. He was joined by his new Veterans Affairs secretary, Dr. David Shulkin, and Sergeant Michael Verado, who lost his left arm and leg to an improvised explosive device in Afghanistan in 2010, but had to wait 57 days for a properly fitted prosthetic and over three years for the VA to correctly equip his home with accessibility equipment—making him a living symbol of the agency's wait-time scandals.

"In just a short time, we've already achieved transformative change at the VA—and believe me, we're just getting started," the president declared. "For many years, the government failed to keep its promise to our veterans. Veterans were put on secret waitlists, given the wrong medication, given the bad treatments and ignored in moments of crisis for them. Many veterans died waiting for a simple doctor's appointment. Yet some of the employees involved in those scandals remained on the payrolls.... Today, we are finally changing those laws to help make sure that the scandal of what we suffered so recently never, ever happens again—and that our veterans can get the care they so richly deserve."

To some VA critics, Trump's selection of Shulkin to head the agency makes it unlikely that significant changes will be made. "For veterans who voted for Donald Trump, this is going to feel like a bait and switch," says Benjamin Krause, founder of DisabledVeterans.org. "Keeping Shulkin will keep a host of flunkies and criminals who should have been part of the whole 'drain the swamp' promise."

The fetid VA swamp has been spreading for years under the last three VA secretaries, including Shulkin. It's an institution long notorious for vicious retaliation against whistleblowers and a penchant for falsehoods, obfuscation and delay, as well as rampant cover-ups of unsafe and sometimes deadly conditions—or even fraud—by the VA's watchdog agencies. This is all kept from view by what some longtime employees call "the code"—the institutional silence and protection offered wrongdoers. Likening it to the mob's "omertà," one high-ranking VA administrator, who insisted on anonymity, tells *Newsweek*, "You don't break 'the code,' or your career is over.... It's a fearful environment."

"The code," that VA official says, "is designed to do this: don't fix the problems."

Shulkin's media office declined repeated requests for an interview with the VA secretary by this reporter to discuss the rampant problems at the VA, but he has made some progress in cleaning up the department—while demonstrating a shrewd feel for public relations. *The Boston Globe* reported in mid-July that the highly rated (by the VA) Manchester, New Hampshire, VA hospital had to close an operating room because exterminators couldn't get rid of flies, and thousands of patients couldn't make appointments for vital, sometimes life-saving, treatments because of a breakdown in scheduling specialized care outside the VA. Whistleblowers had been complaining about this for years, to no avail, but a few hours after the *Globe* story broke, Shulkin removed the two top administrators.

But even this response was more symbolic than substantive. Many other shocking abuses have been ignored by Shulkin and his predecessors. In 2016, 34 whistleblowers turned to the Scripps News Washington Bureau and its Cincinnati TV affiliate, WCPO, to report such problems as surgeons allegedly being pressured to use blood- and bone-splattered instruments as "sterilized" by the Cincinnati VA hospital's then–acting chief of staff, Dr. Barbara Temeck. Those complaints were backed by hundreds of dangerous incidents chronicled in internal documents given to Scripps. (Temeck has denied the allegations, although she was demoted after Scripps reported that she improperly prescribed opiates to the wife of her regional supervisor.) The VA's investigators didn't interview any of the whistleblowers quoted in the press and concluded that there were no safety problems at that VA Medical Center, a position Shulkin's VA still holds.

> They are essentially prescribing HEROIN pills."

All told, nearly 2,000 VA whistleblowers were forced in fiscal year 2016 alone to appeal to an independent federal agency, the Office of Special Counsel (OSC), to protest retaliation while reporting fraud or unsafe conditions—more than the next four problematic federal departments combined. As *The Boston Globe* reported in September, these employee complaints included nursing home residents at the Bedford, Massachusetts, Veterans Affairs Medical Center allegedly being starved of food for hours or left to lie naked in bed amid the squalor of soiled sheets.

Shulkin has established a new office given a mandate to protect whistleblowers, but that hasn't yet halted the retaliation. "I don't know of a single instance when a VA employee has been held accountable for harassing whistleblowers," says Krause.

This turf-protecting has perhaps been most apparent in the VA's belated response to the national opiate crisis it helped usher in. The VA doesn't even keep an accurate count of how many veterans have died of legal or illegal drug overdoses, even though it officially launched an Opioid Safety Initiative in 2013 that has brought the VA's opiate prescribing down 30 percent. Nor does it regularly monitor opiate use by its patients who seek legal or illegal drugs outside the VA.

The VA overmedication epidemic, which wasn't on the reform priorities list Shulkin released in May, has become especially urgent because of its apparent link to the 20 suicides a day of veterans in the U.S.

Even those earlier VA figures may be a gross understatement. When the VA released in September state-by-state data, it showed, for example, that Arizona had a suicide rate as high as 53.6 per 100,000 across all age groups, nearly 40 percent higher than what the VA was reporting nationally. These troubling suicide rates—at least double the civilian rate—haven't been stemmed by all the VA's suicide-prevention efforts (including the slowly improving crisis line, 1-800-723-8255). For Arizona veterans between 18 and 34, the suicide rate was an astonishing 76.8 per 100,000, twice as high as the national rate for all veterans. The average

THE PAIN MERCHANTS
For over a decade, the VA recklessly overprescribed opiates. Since mid-2012, it has swung dangerously in the other direction, ordering a drastic cutback of opioids for chronic pain patients, again putting veterans at risk.

DARREN HAUCK/CENTER FOR INVESTIGATIVE REPORTING

suicide rates were especially high in some rural areas across the country, the new VA report said.

Even if the VA has done relatively little to reform prescribing, it's becoming more evident that medications play some role in all these tragedies. For instance, a 2016 study by researchers at the South Texas Veterans Healthcare System found a nearly 400 percent increase in overdoses and suicidal behavior by Iraq and Afghanistan war veterans given too many psychotropic and opiate medications, a practice known as "polypharmacy"—receiving five or more drugs affecting the central nervous system. Another recent study of veterans' suicides between 2004 and 2009 found that the suicide rate was twice as high for those patients receiving the highest doses of opioids compared to low doses, although no causal link was established for the meds.

This drug free-for-all has gotten so bad that Republican Senator John McCain of Arizona reintroduced a bill called the Veterans Overmedication Prevention Act. It demands that the VA commission an independent study to analyze all the suicides and accidental overdoses of veterans who have died in the last five years, and itemize all medications they received. McCain said in May that the ultimate goal is to "ensure doctors develop safe and effective treatment plans for their veteran patients." Given the reality of today's VA and its past failures, that worthy goal seems unlikely to be achieved anytime soon.

The VA hasn't fully acknowledged its role in the alarming opiate addiction rates among veterans. A 2012 *JAMA* (formerly the *Journal of the American Medical Association*) study showed that veterans with mental health disorders and PTSD were three times more likely to receive opioids for pain diagnoses than other veterans. "They are essentially prescribing heroin pills; the effects of these opiates are indistinguishable from heroin, and the VA jumped on this campaign to encourage highly addictive prescribing," says Dr. Andrew Kolodny, co-director of Brandeis University's Opioid Policy Research Collaborative. In Huntington, West Virginia, a city so gripped by addiction that 28 people overdosed from heroin in a four-hour period last year, the local VA prescribes take-home opiates to roughly 18 percent of its patients—a rate that's about 230 percent higher than the national average for all adult male patients. When told about this figure, Kolodny said, after a shocked pause, "Wow! That's very problematic." He then added, "These are iatrogenic—medically caused—addictions by the VA. The chickens are coming home to roost."

"These are medically caused ADDICTIONS by the VA. The chickens are coming home to roost."

In West Virginia and most other states, the VA worsened the nation's opioid crisis by essentially ignoring it—the VA didn't even start reporting all patients getting opiates to state databases until the end of 2015, a delay that allowed those patients to do more doctor-shopping and drug-dealing to and with civilians. VA pharmacies were finally compelled to share prescribing records by a federal opioid abuse law passed in July 2016, but by the end of last year, 18 state VA programs still weren't reporting.

In May 2016, the board chairman of the American Academy of Family Physicians wrote a letter to Shulkin, then head of the VA's health agency, the Veterans Health Administration, pleading for the department to impose mandatory opiate reporting on all VA programs. Speaking more than a year later, the AAFP's president, Dr. John Meigs, tells *Newsweek* his organization has still not heard back from Shulkin or anyone else at the VA. "Prescription drug–monitoring programs are among the important vehicles for preventing patients from abusing opioid medications and, as such, are a cornerstone of the American Academy of Family Physicians' advocacy on dealing with this epidemic," he declares.

The disaster is likely to worsen under the Trump administration because of its assaults on Medicaid and Obamacare; this affects veterans as well, since fewer than half of the nation's 22 million veterans receive their care from the VA. (In late August, the administration left no doubt it wanted to destroy the Obamacare marketplaces by announcing it would cut by 90 percent the advertising needed to promote enrollment and slash funds by 40 percent for helpful "navigators" to help people sign up for the program.) Nearly as troubling, the looming denial of care is aggravated by the suicides, overdoses and illegal use of opioids that are all compounded by draconian new federal pain medication restrictions on chronic pain patients. So when New Jersey Governor Chris Christie's federal opioid commission released its initial report at the end of July calling for swift federal action, his home state newspaper, the *Newark Star-Ledger*, pointed to the "elephant in the room.... The obvious fact that Donald Trump's team is striving as hard as it can to gut Medicaid and make it even more difficult to get

treatment." (Trump referred to the opioid crisis as a "national emergency" on August 10, but the federal government hasn't yet taken the steps needed to invoke emergency powers that could allow for more spending or loosen bureaucratic restrictions on providing medication-assisted addiction treatment, such as Suboxone, which cuts overdose fatalities.)

'What if He Were Your Son?'

IN 2013, AFTER THE CENTER FOR INVESTIGATIVE reporting (CIR) exposed skyrocketing rates of opiate prescribing by the VA, some of its physicians told a House veterans subcommittee they were pressured to prescribe the addictive painkillers—even to patients they hadn't examined. Dr. Pamela Gray, a primary care physician fired from the Hampton, Virginia, VA hospital, said, "There are multiple instances when I have been coerced or even ordered to write for Schedule 2 narcotics when it was against my medical judgment." VA officials deny there were any systemic problems in their prescribing practices, yet in May 2014, the VA inspector general found that clinicians were ignoring guidelines for safe take-home opiate prescribing, with one out of 10 chronic pain opioid users also receiving benzodiazepines in the course of a year—and 92 percent got them at the same time. This is a flagrantly dangerous mixture that the federal government flagged as a lethal combination—while the FDA has recently added new warnings that it could cause "respiratory depression, coma and death."

And that's what happened to Marine Corps veteran Jason Simcakoski, who was taking 16 different VA-prescribed opiates, benzodiazepines, an antipsychotic and other sedating drugs before he died. By the time he checked himself into the Tomah, Wisconsin, VA's inpatient psychiatric unit in the summer of 2014 for help with anxiety and a pill addiction, VA leadership had known for years that there were deadly overprescribing problems there. But they didn't begin to address the crisis until the CIR broke this story in January 2015: "Opiates handed out like candy to 'doped-up' veterans at Wisconsin VA," leading to the deaths of over 30 veterans. The story laid out how opiate prescribing had quintupled since Dr. Michael Houlihan—nicknamed by vets "the Candy Man"—became chief of staff in 2005, while the number of patients served dropped. Nationwide, opiate prescribing increased

"Veterans died of drug overdoses at TWICE the rate of civilians."

270 percent across the VA system since 9/11, CIR discovered, while the patient load had increased less than 40 percent by 2013. The latest guidelines at the time for sensible opiate prescribing were routinely ignored at Tomah and many other VA facilities, and Houlihan's reckless prescribing was exacerbated by his penchant for terrorizing any clinician and staffer who opposed him. This was especially notable in his firing of a psychologist who had objected to the excessive doping of patients, then faced relentless harassment from his supervisor—and later killed himself after he lost his job.

Noelle Johnson, a Veterans Affairs pharmacist fired from Tomah after she refused to fill high-dosage opiate prescriptions, notes that the VA's archaic software didn't flag any dosage or interaction warnings for the 1,080 morphine pills in 30 days she was pressured to prescribe a patient with "psychological pain." She says, "My bosses tried to strong-arm pharmacists." She adds that she got the same kind of pressure at her new post with the Des Moines, Iowa, VA.

Although it was obvious that Jason Simcakoski was an addict, the VA kept shipping him bagfuls of opiates and benzos and antipsychotics, and he was also dosed with the stimulants Adderall and Ritalin, which worsened his mood, behavior and insomnia. His doctors prescribed those for a questionable diagnosis of attention deficit hyperactivity disorder, just one of at least a dozen or so diagnoses slapped on him over the years, along with bipolar personality disorder and PTSD.

"With all these medications, he went downhill real fast," says Jason's father, Marvin Simcakoski. His weight ballooned from 180 to 250 pounds, and he was too ashamed to go into a restaurant on those rare days he went into town—he'd only order food from drive-thru windows. Near the end, he couldn't even bend down to tie his shoes.

When Jason died in August 2014 of what the local medical examiner called "mixed drug toxicity," he had just been obeying his doctors' orders: He was already taking 14 different medications, including high-risk opiates, benzodiazepine tranquilizers and the sedating antipsychotic Seroquel. Yet just two days before his death, Jason was also given Suboxone, an opiate typically used to reduce dependence on other narcotics. This was soon followed by a powerful migraine medication, Fioricet, that posed

BRENDAN SMIALOWSKI/AFP/GETTY

THE GRAVELY ILL
A soldier in places flags at graves in Arlington National Cemetery. The VA doesn't even keep an accurate count of how many veterans have died of legal or illegal drug overdoses.

a risk of respiratory failure or death when combined with Suboxone and several of his other drugs. He was ingesting this drug cornucopia despite the well-known dangers of potentially fatal interactions between Suboxone and all three benzodiazepines he was taking—Valium, Restoril and Serax—and with some of his other high-risk medications.

Marvin Simcakoski told a joint congressional field hearing on the Tomah scandal in March 2015 that he'd spent years trying to save his son, but he says his fears were dismissed by VA doctors as ignorant second-guessing. "I was always told that I wasn't their patient, even though I was his dad, who truly cared about him a lot more than they did!" His voice quaking with an anger, he added, "What I would like to know is, if Jason was their son, would they have had him on all of these meds?"

After that congressional hearing, the VA announced it was conducting a criminal investigation; that probe and other investigations led to a few Tomah medical officials getting vilified in the press, and eventually facing employment sanctions. Houlihan was fired more than a year after Jason died, but he was practicing medicine until January 2017, when he agreed to surrender his license as part of a deal with state regulators to drop their investigation of him.

Jason's father and widow took their campaign against the VA's medication practices to D.C. They worked with Democratic Senator Tammy Baldwin of Wisconsin on legislation to curb and monitor opiate overprescribing, and appeared at a news conference in June 2015. The Jason Simcakoski Memorial Opioid Safety Act was signed into law in July 2016.

Heather hopes the bill will save lives, but she and other VA critics know there are weaknesses in the new plan to rein in overmedication: weak oversight of staff, worsened by the VA's electronic records and drug-interaction alerts that too often fail to work, and on-screen drug warnings that are widely ignored. In 2015, the VA paid over $1 million to the widow of former paratrooper Ricky Green, who died after getting his opiates and tranquilizer dosages cranked way up after back surgery. The VA pharmacists admitted under oath that their software hadn't flagged the higher dosages or that Green had a sleep apnea condition that fatally interacts with the drugs.

The VA's entire make-shift health software system—known as VistA—is so bad Shulkin announced in June that the VA was purchasing a brand-new commercial system at an estimated cost of $16 billion; it's based on one recently bought by the Defense Department so that, in part, as their electronic health records are rolled out, they can be shared seamlessly, but that won't necessarily fix the problems with the VA's pharmacy software. Even more troubling, Chris Miller, the department's executive in charge of modernizing the Pentagon's software using the same contractor as the one hired by the VA then sent over to advise the VA, but he fled, appalled over mismanagement, within weeks of his appointment in early June. "The people problems are not resolved and the user problems are not resolved just because you have a new tool coming on board," a VA official says. "The people problems are at the core of the demise of the VA."

That's one reason no one knows how many vets have been killed by accidental prescription overdoses in the past decade, although a handful of rigorous studies suggest the death toll is in the thousands. One of the very few scholarly reports on accidental overdose deaths of veterans, done by University of Michigan and VA researcher Amy Bohnert in 2011, used 2005 data to conclude that 1,013 patients receiving VA services died annually through unintentional overdoses, mostly from prescription medications. At that time, legal opioids, present in nearly a third of the accidental overdose deaths, were the most common substances involved, while non-narcotic psychiatric drugs and sedatives were involved in 22 percent of the deaths she studied. (Across all civilian and military populations, legitimately manufactured opioid medications account now for only 15 percent of opioid fatalities.) When the Austin-American Statesman looked at Texas records in 2012, nearly 20 percent of all deaths of veterans getting VA benefits they studied were due to mostly accidental overdoses of prescription drugs—not from suicides.

Despite the Tomah and other tragedies, veterans continued to die from overdoses in VA hospitals and residential treatment facilities, sometimes abetted by drug-peddling employees—while the agency failed to accurately track the drug-related deaths of veterans. *The Lowell Sun* reported last year that two veterans grappling with addictions who lived in VA residential facilities in Massachusetts died of opiate overdoses within weeks of each other. Their deaths are now the focus of a VA criminal investigation into drug dealing by a ring of employees and patients at the hospital. Administrators initially denied anything was amiss, and the African-American whistleblower who helped expose the alleged drug ring revealed in February that he had been demoted, and harassed by colleagues—including finding on his desk a teddy bear with a noose around its neck and the sign, "Go home or die."

MALIGN NEGLECT
The VA's overmedication epidemic wasn't on the list of reform priorities Shulkin, above, released in May. And the disaster is likely to worsen under the Trump administration because of its assaults on Medicaid and Obamacare.

FROM TOP: JIM WATSON/AFP/GETTY; CHIP SOMODEVILLA/GETTY; PHOTO COURTESY OF REBEKAH COLEMAN

Lethal Cutbacks

FOLLOWING THE TOMAH OVERPRESCRIBING SCANDAL, the VA said it would follow tougher new DEA guidelines on opiate prescribing that, some advocates say, harm patients with legitimate pain issues. That's in part because those patients are now required to see their doctors in person once a month for refills—a near-impossible task because of the backlog and delays throughout the VA system. Equally troubling, the crackdown on opiate prescribing—a swing from one dangerous extreme to another—may be contributing to an increase in heroin and illegal opiate medication use among veterans, as well as suicides from pain-wracked veterans in poorly monitored withdrawal. (Even with new opioid guidelines, the number of veterans with opioid-use disorders increased 55 percent from 2010 to 2015.)

"The one thing the VA is very good at is throwing PILLS at the problem."

Although the VA boasts that those tougher guidelines have led to a decline of nearly a third in opiate prescribing, it doesn't track veterans who have turned to heroin and illegal prescriptions as a result of the cutbacks—or notice the devastation this crackdown is causing. It has become increasingly clear that too many VA doctors are focusing on taking patients off opioids without offering appropriate addiction counseling or addressing how they're needlessly hurting all the chronic pain patients they're taking off these meds. "They're not focusing on patient-centered care; they're focusing on numbers," one VA staffer says. At one point, this employee says, a doctor in a major VA medical center was spotted crying in the hallway because he was obligated by administrative fiat to kick a chronic pain patient off opioids in a way that he knew would hurt his patient.

Even when patients realize they're endangering themselves, the VA's clinicians too often don't offer much meaningful help. Take Mallory Dinkel, an Air Force infantry soldier who had her leg and hips

BREAKING THE CODE
In VA hospitals all over the country, dissidents such as Marine Corps veteran Coleman, right, with his children, are still punished for trying to save lives or fight fraud.

severely damaged in an attack on her Humvee in Kuwait in 2004, but returned for multiple combat tours in Iraq before being medically discharged in 2013. Grappling with PTSD and a poorly understood form of chronic pain, complex regional pain syndrome, she stepped up her rotating use of prescription morphine, Percocet and other drugs until she was forced in January 2016 to quickly unwind all opioids. "It was awful: I was constantly vomiting, sweating, having migraines and getting the shakes," she says, unable to move from her couch for two weeks except to crawl to the bathroom. "Nothing was mentioned about addiction, and I didn't get treatment." All she got before going cold turkey on her own—despite the risks of sudden withdrawal without medically supervised tapering—were two one-hour classes on the dangers of opiates and how to inject herself with naloxone to prevent overdoses. "The VA didn't do a thing," she says, turning to costly, unproven ketamine infusion treatment for depression and pain relief through a family friend's center that she can no longer afford. "I'm battling on my own now."

Can't Stop, Won't Stop

THE CALLOUS INDIFFERENCE OF BOTH THE VA AND Congress to the overmedication crisis has only recently started to change, and that's just for opiates, not antipsychotics. What has gotten worse in the last decade is the VA's determination to hide the truth. The Senate governmental affairs committee's Republican majority, for instance, concluded in May 2016 about the Tomah VA Medical Center debacle: "The overprescription, retaliation, veterans' deaths, and abuse of authority at the Tomah VAMC did not occur in a vacuum. Veterans, employees, and whistleblowers tried for years to get someone to address the problems. The Tomah VAMC is a microcosm of both the VA's cultural problems with respect to whistleblower retaliation and the VA Office of Inspector General's disregard for whistleblowers."

These whistleblowers are notably skeptical about the various reform and accountability gestures such as public waiting lists offered by Shulkin. Take Shea Wilkes, then a mental health administrator at the Shreveport, Louisiana, VA hospital who was busted back down to social worker after, in 2014, he exposed 37 wait-time deaths among those people on a secret mental health waiting list of 2,700 patients. While noting that the VA has now seemingly been able to provide some same-day crisis mental health services, as promised, he says that all too often patients can't get prompt, regular counseling: "The one thing the VA is very good at is throwing at the problem."

"You don't break the 'code,' or your career is over... It's a FEARFUL environment."

In VA hospitals all over the country, dissidents such as Brandon Coleman are still punished for trying to save lives or fight fraud. He is a bearded, blunt-talking addiction therapist formerly with the Phoenix VA and a disabled Marine Corps veteran who severely shattered the bones of his left foot during a training accident at Camp Pendleton that led to nine failed surgeries, and he felt he had to file a formal federal whistleblower complaint in December 2014 over the maltreatment of veterans at that notorious VA hospital. With his past as a meth addict who came close to shooting himself in 2005, he was alarmed that the understaffed ER was allowing suicidal or homicidal patients in crisis—often brought over by addiction counselors—to simply wander off. One patient killed himself in the parking lot after being ignored by the staff.

"It crushes me when a veteran successfully commits suicide," he says—and since 2011, at least six of the addicts he counseled killed themselves before he was pushed out of his job early in 2015. "There are dozens and dozens who commit suicide in the Phoenix area each year," Coleman says. After going public with his concerns in January 2015, a specialized yearlong outpatient program he ran in the evenings for addicted veterans with criminal convictions was shut down by Phoenix VA administrators, he was forced to take administrative leave, and he was investigated for purportedly threatening a colleague.

In May 2016, the independent OSC sided with Coleman. It gave him a generous financial settlement that allowed him to pay off all his debts and help his kids buy a home and cars. He was reinstated as an addiction specialist at an outpatient clinic unaffiliated with the Phoenix system, and he was able to restart his life-changing program for addicted vets. During more than a year of forced leave, he became an informal leader of the nation's countless VA whistleblowers. He sums up his travails this way: "I kicked the VA in the nuts, and I won my case." Today, he rides around in a prized new classic car, a blue 1968 Mustang, with a license plate that reads, "THX VA."

Coleman may now be in a position to stop the abuse of whistleblowers—he's a staff member of the new VA whistleblower protection office. While his appointment is perhaps the most positive indicator yet that the VA might try to reform, that's a heavy burden to place on him. He's gotten well over 50 calls and emails from desperate staffers turning to him for help since his appointment was announced.

DARREN HAUCK/ CENTER FOR INVESTIGATIVE REPORTING

THE CANDY STORE A view of the VA hospital in Tomah, Wisconsin. The VA didn't even start reporting all patients getting opiates to state databases until the end of 2015.

For example, one new test case Coleman and his colleagues are reviewing involves an MIT-trained Tomah VA engineer, Jae Pak, who was fired after trying to halt an allegedly shoddy, unsafe series of delayed hospital repair projects—by a company friendly with administrators—that were way over budget. He faced a spurious disorderly conduct charge (the case was dismissed). Equally troubling, critics say, he was forced out under the watch of a new Tomah hospital director, Victoria Brahm, and a new regional VA chief, Renee Oshinski, who both, while at regional headquarters allegedly downplayed for nearly a decade the prescribing and retaliation campaign led by Houlihan, Senate investigators found; the officials claimed they responded appropriately.

One added weapon for reform could be a new bill moving slowly through Congress designed to quickly discipline or remove administrators who harass whistleblowers. It is named after Christopher Kirkpatrick, the psychologist who killed himself after being driven out of his job at Tomah for protesting deadly prescribing.

For now, patients at VA sites such as the Phoenix and St. Louis hospitals (where the chief of psychiatry, Dr. Jose Mathews, was forced out in 2013 after reporting that suicidal patients were ignored by staff) continue to see honest, dedicated clinicians and other employees get punished.

What Coleman will do about such alleged retaliation and cover-ups remains to be seen. With a quick search on Google News, it seems there's a new retaliation or health scandal reported every few days, although most never get much media attention. So even before Coleman's appointment was publicly announced, he told *Newsweek*: "I still get two to four calls a week from VA whistleblowers I have never met who are crying, scared and losing their careers all for merely telling the truth. It has not stopped because the VA has never been made to stop."

→ *Adapted from the new book* Mental Health, Inc.: How Corruption, Lax Oversight, and Failed Reforms Endanger Our Most Vulnerable Citizens, *by Art Levine.* *© by Art Levine, 2017. Published by The Overlook Press, Peter Mayer Publishers, Inc., OverlookPress.com. All rights reserved.*

Antipsychotic Reaction

THE RECKLESS OVERPRESCRIBING OF ANTIPSYCHOTICS IS CREATING A DEADLY COCKTAIL FOR TOO MANY VETS

THE LAST TIME JANETTE LAYNE saw her husband alive, Sergeant Eric Layne was dozing on their couch with the TV on. That was in January 2008. Because of his mounting outbursts of rage and paranoia since returning from Iraq, psychiatrists at two Veterans Affairs hospitals had been prescribing him increasing doses of a drug cocktail for post-traumatic stress disorder that included the powerful antipsychotic Seroquel. Although not approved by the FDA for such "off-label" uses, Seroquel is among the most prescribed drugs in its class and at its peak brought in more than $5 billion a year for its manufacturer, AstraZeneca, despite side effects ranging from diabetes to sudden cardiac arrest.

Eric kept complaining of headaches and tremors—concerns that were discounted by the VA medical staff—while he gained weight, had trouble breathing and was so oversedated that, Janette says, he had become a "zombie." Two weeks after he returned from a specialized inpatient PTSD program that increased his medication, he was dead. "All these doctors and medics and Ph.D.s kept telling us that he was fine," Janette says. "We trusted the doctors."

Critics of the VA estimate that more than 400 combat veterans and other military personnel have died suddenly after being overmedicated with PTSD "cocktails." These fatalities aren't systematically monitored or studied. The few military and VA inquiries into this issue have largely blamed these mysterious deaths on suicides and natural causes—or, in a few cases, on some inexplicable "drug toxicity."

During the same post-9/11 years that antipsychotic prescribing increased at the VA, it was in the early stages of an initiative to cut down on prescribing for PTSD patients receiving potentially addictive benzodiazepines such as Klonopin, Xanax and Restoril. Meanwhile, the department allowed the use of Seroquel to jump more than 770 percent between 2001 and 2010, although, according to the Associated Press, the number of patients increased only 34 percent.

Over $1.8 billion was spent by the VA from 2001 through the first half of 2015 on the two most prescribed antipsychotics for PTSD, Risperdal and Seroquel, although they were never proved effective or even approved by the FDA for use with the disorder. Seroquel remains the most heavily prescribed antipsychotic in the VA system, with nearly 800,000 prescriptions annually.

All of AstraZeneca's marketing of Seroquel for off-label uses, as the Justice Department found when it reached a $520 million settlement with the company in 2010, has continued to pay off. The drug remains off-label for PTSD, anxiety, insomnia and depression in youth, but virtually no one in the VA appears to be paying attention. As a psychiatrist at the Huntington VA hospital tells this reporter, "The drug companies pushed these new drugs for everything from alopecia to hemorrhoids to lumbago."

That push ignored the data. "The evidence for using antipsychotics with PTSD patients isn't very good, and the potential side effects can be deadly," says Dr. J. Douglas Bremner, the chief of Emory University Medical School's Clinical Neuroscience Research Unit.

Part of the VA's reluctance to rein in the high-risk, off-label prescribing of antipsychotics traces back to "the code," but also to the undue influence of the drug industry. Some of the earliest work that pushed Seroquel on veterans came from Dr. Mark Hamner, the director of psychopharmacology research and PTSD clinical care at the Ralph H. Johnson VA Medical Center in Charleston, South Carolina. With support from AstraZeneca, he researched a series of long-unpublished studies boosting Seroquel.

AstraZeneca was apparently so pleased with Hamner's work that it funded directly or served as a "collaborator" with the VA on two additional 12-week studies on Seroquel for PTSD symptoms. For nearly a decade or more, the studies' outcomes were known only to Hamner and, presumably, AstraZeneca. Retired Brigadier General Dr. Stephen Xenakis, a pioneering PTSD researcher who reviewed Hamner's studies for *Newsweek*, thinks he knows why the results weren't made public for years: "AstraZeneca clearly delayed publishing because the data in general is weak." Hamner denied that his ties to the company played any role in his publishing delays.

The drug industry and VA officials have kept veterans and their families ignorant about many of the dangers posed by these psychiatric medications. Seroquel and other antipsychotics can induce sudden cardiac arrest that, although a rare side effect, often causes brain death in under five minutes. Atypical antipsychotics have been identified in over 100 studies since the 1990s as perhaps the single riskiest class of drugs for inducing a particularly dangerous form of arrhythmia. Dr. Fred Baughman, a retired California-based neurologist who launched a campaign raising alarms about Seroquel-related deaths in West Virginia, was blunt in his many press releases and letters to medical journals, starting in 2008: "There is an epidemic of sudden deaths occurring throughout the U.S. military."

His determination to discover what led to the medication-linked deaths didn't seem to be matched by the VA's Office of the Inspector General, which concluded there was no link between Seroquel and other leading antipsychotics with sudden cardiac death in its report on the death of Eric. All of the inspector general's work ignored the most salient medical research and the VA's prescribing guidelines in place since 2004. "They turned a blind eye to the medical consensus," says Baughman of the inspector general's report.

The most telling sign of a cover-up, he contends, is the failure to mention the most thorough review then available: an Expert Opinion on Drug Safety journal review, published several months before the inspector general's report. "It took an overt act of omission to miss this article," he says, noting how widely it was cited in the medical literature. Xenakis, the former Army psychiatrist, is just as blunt: "They cherry-picked the studies." The VA's Office of the Inspector General declined to reveal what medical guidelines or scientific research was reviewed before releasing its report.

Dr. Grace Jackson, a former Navy psychiatrist and author of *Rethinking Psychiatric Drugs*, says after reviewing the inspector general's report and White's prescription history, "This is a whitewash that sanitizes [White's] medical records. It's a complete embarrassment. The way these drugs were used was overkill."

Nearly a decade after the inspector general ignored the drugs' cardiac dangers, the VA's new Psychotropic Drug Safety Initiative, modeled in part on its opiate campaign, still hasn't flagged the cardiac risk of Seroquel, the agency's most prescribed antipsychotic. "It's outrageous," Xenakis says of this omission. "People are talking about reform in the VA, but with these kinds of things, it really exposes how far we have to go to change basic practices, culture and attitudes." —*ART LEVINE*

"There is an epidemic of SUDDEN DEATHS occurring throughout the U.S. military."

BJARTE RETTEDAL/GETTY