

**STATEMENT FOR THE RECORD OF
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
PRESCRIPTION MISMANAGEMENT AND THE RISK OF VETERANS SUICIDE**

JUNE 10, 2015

By the time Justin Minyard discovered the video of himself stoned, drooling and unable to help his daughter unwrap her Christmas presents, he was taking enough OxyContin®, oxycodone and Valium every day to deaden the pain of several terminally ill cancer patients.

“Heroin addicts call it the nod,” the former Special Forces soldier says of his demeanor in that video. “My head went back. My eyes rolled back in my head.

I started drooling on myself. My daughter was asking why I wasn’t helping her, why I wasn’t listening to her.”

Seeing that video jolted Minyard out of a two-year opiate stupor. He asked a Fort Bragg pain specialist to help him get off the painkillers his primary care physician had prescribed. “I was extremely disappointed in myself,” he says. “I knew I couldn’t do that to my family again.”¹

A study published in the Journal of American Medicine in 2012 noted veterans of Iraq and Afghanistan with mental health diagnoses, mostly post traumatic stress disorder (PTSD), are significantly more likely to receive prescriptions for oxycodone, hydrocodone, and other opioids than those with symptoms of pain and no mental health issues. The study notes, these powerful drugs had the worst outcomes with patients with mental health diagnoses, such as addictions, overdoses, and other risk use patterns. Veterans from these wars suffering from pain and PTSD-prescribed opioids may be at a higher risk for misuse.²

Chairman Coffman, Ranking Member Kuster, and distinguished Members of the committee, on behalf of National Commander Michael D. Helm and the more than 2 million members of The American Legion, we thank you and your colleagues for the work you do in support of service members, veterans and their families.

The American Legion and veterans at large are frustrated when we hear stories about veterans who are slipping through the cracks of the system. For example, when we hear about veterans with a history of substance abuse and suicidal thoughts being left alone in a waiting room inside

¹ 1 Excerpt “On the Edge” The American Legion Magazine story by Ken Olsen, April 1, 2014

² JAMA: [Association of Mental health Disorders with Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan](#), March 7, 2012

a VA Medical Center, or where a veteran was able to obtain drugs from a hospital visitor and later died from an overdose, is unconscionable and unacceptable³.

What We're Doing to Help:

The American Legion has long been concerned with the unprecedented numbers of transitioning veterans who are suffering from post traumatic stress disorder (PTSD) and traumatic brain injury (TBI) which are commonly known as the “signature wounds” of the war on terror. These veterans are also returning home with other complex injuries such as burns, visual impairments, spinal cord injuries, amputations, and musculoskeletal injuries resulting in them living in chronic pain on a daily basis. In addition to the numerous injuries and illnesses that plague returning servicemembers they are also faced with the daunting task of navigating their way through a transition process that can be fragmented and confusing.

To address these ongoing problems, The American Legion created a TBI and PTSD Committee in 2010 to investigate the existing science, medical procedures, and alternative treatments being offered to servicemembers and veterans who are suffering with TBI and PTSD within the Departments of Defense (DOD) and Veterans Affairs (VA) healthcare systems.⁴

In July 2010, The American Legion testified in front of this committee at a hearing entitled *Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs*. In our testimony, The American Legion made the following seven recommendations to improve suicide and mental health efforts for the Departments of Veterans Affairs (VA) and Defense (DOD).⁵ These recommendations still stand today.

- *Congress should exercise oversight on VA and DOD programs to ensure maximum efficiency and compliance.*
- *Congress should appropriate additional funding for mental health research and to standardize DOD and VA screening, diagnosis and treatment protocols.*
- *DOD and VA should expedite development of a Virtual Lifetime Medical Record for a single interoperable medical record to better track and flag veterans with mental health illnesses.*
- *Congress should allocate separate Mental Health funding for VA's Recruitment and Retention incentives for behavioral health specialists.*
- *DOD should establish a Suicide Prevention Coordinator at each military installation and encourage DOD and VA to share best practices in research, screening and treatment protocols between agencies.*
- *Congress should provide additional funding for Telehealth and virtual behavior health programs and providers and ensure access to these services are available on VA's web pages for MyHealthyVet, Mental Health and Suicide Prevention as well as new technologies such as Skype, Apple I-Phone Applications, Facebook and Twitter.*

³ [Modern Healthcare: Deaths at Atlanta VA Hospital Prompt Scrutiny](#)

⁴ Resolution 25: [TBI and PTSD Ad Hoc Committee](#): October 2010

⁵ HVAC: [Subcommittee on Oversight and Investigation Hearing](#)-July 14, 2010

- *DOD and VA should develop joint online suicide prevention service member and veteran training courses/modules on family, budget, pre, during and post deployment, financial, TBI, PTSD, Depression information.*

In September 2013, The American Legion launched a [Suicide Prevention Web Center](#) on its national website to provide veterans and their families with life-saving resources and programs during their time of transition and need. The American Legion’s online Suicide Prevention Web Center builds on several suicide-prevention initiatives launched in recent years by the Department of Defense (DOD) and the Department of Veterans Affairs (VA). The center houses specific suicide-prevention data, statistics, programs and resources organized for veterans, families and the community.

Also in September 2013, The American Legion released a report titled “*The War Within*”⁶ which included findings and recommendations based on three years of comprehensive research by The American Legion’s PTSD/TBI Committee. The key findings from the report include:

- *VA and DOD have no well-defined approach to the treatment of TBI*
- *Providers are merely treating the symptoms*
- *DOD and VA research studies are lacking for new non-pharmacological treatments and therapies such as virtual reality therapy, hyperbaric oxygen treatment, and other complementary and alternative medicine (CAM) therapies.*

The report recommended that Congress increase DOD and VA budgets to improve the research, screening, diagnosis, and treatment of TBI and PTSD, as well as accelerate their research efforts to properly diagnose and develop evidence-based treatments for TBI and PTSD.

At a House Veterans Affairs Committee hearing last April, then National Commander Daniel M. Dellinger told Congress that Department of Veterans Affairs (VA) leadership must be held accountable for mistakes that result in preventable deaths at its medical facilities. At the Atlanta VA Medical Center, Past National Commander Dellinger outlined the organization’s most serious concerns:

*“[T]wo veterans died of an overdose, and one committed suicide, that was attributed to mismanagement and an inability to get the mental health care they needed in a timely manner. Veteran suicides continue to plague our nation at 22 per day, with no clear strategy from VA on addressing suicides proactively. Veterans with traumatic brain injury and post-traumatic stress disorder are being overprescribed with medications, and VA is demonstrating reluctance toward looking at complementary and alternative medicine because giving out pills is faster than providing veterans the therapy sessions they need. Servicemembers returning to civilian life are falling through the cracks due to [DOD] and VA’s inability to create a single, interoperable medical record”.*⁷

⁶ [The War Within](#)

⁷ [House Committee On Veterans Affairs :A Continued Assessment of Delays in VA Medical Care and Preventable Deaths-](#) April 9, 2014

Also last April, The American Legion submitted testimony for the record to a Senate Committee on Veterans' Affairs hearing entitled *Overmedication: Problems and Solutions*. In testimony, The American Legion stated:

*“There are no single treatments guaranteed to cure all ailments. With a national policy that respects and encourages alternative therapies and cutting edge medicine, veterans have the best possible shot to get the treatment they need to continue being the productive backbone of society their discipline and training prepares them to be.”*⁸

The American Legion believes all possibilities should be considered in the attempt to find treatments and cures for these conditions affecting significant numbers of veterans, including alternative medicine. If alternative medical treatments are shown to be effective than those treatments should be made available to all veterans.

That is why in April 2015, The American Legion testified in support of H.R. 271: The Cover Act, which would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental illnesses of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department of Veterans Affairs medical facilities within the community.

However, problems within VA continue. Based on a clinical review at the Tomah VA medical center, patients were 2.5 times more likely than the national VA average to be prescribed high dose opioids. Additional details showed patients at Tomah were prescribed benzodiazepines and opioids at the same time, a practice known to cause complications, nearly twice as much as other VA medical centers.⁹

Based on a Department of Veterans Affairs Office of Inspector General (VAOIG) report entitled *Alleged Inappropriate Opioid Prescribing Practices Chillicothe VA Medical Center*, VAOIG substantiated that¹⁰:

- VA physicians were not consistently documenting medication effectiveness prior to renewing prescriptions for patients at increased risk for adverse medication effects or diversion.
- VAOIG also found that physicians were not consistently documenting use of the Ohio Automated Prescription (Rx) Reporting System, a state prescription drug monitoring program.
- According to Veterans Health Administration policy, patients on chronic opioid therapy are to be evaluated every 1 to 6 months. Although renewing opioid prescriptions without examining patients is not a violation of law or VA policy, a minimum review of patient information is required. However, VAOIG review of 88 patients for whom opioids were prescribed in 2013 and 2014, and who were at increased risk for complications or abuse

⁸ [STATEMENT OF THE AMERICAN LEGION TO THE COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE HEARING ON "OVERMEDICATION: PROBLEMS AND SOLUTIONS"](#)

⁹ [weau.com: http://www.weau.com/home/headlines/Another-VA-scandal-Suspected-opiate-abuse-in-Tomah-Veterans-Affairs-Medical-Center-297280791.html](http://www.weau.com/home/headlines/Another-VA-scandal-Suspected-opiate-abuse-in-Tomah-Veterans-Affairs-Medical-Center-297280791.html)

¹⁰ [VAOIG Report No. 14-00351-53](#)

of opioids, revealed that physicians did not appropriately assess patients before renewing opioid prescriptions.

The results of this report indicate VA still has work to do in terms of evaluating their opiate prescription practices. The American Legion will continue to examine this practice as our Veterans Benefit Centers (VBCs) continue to travel the country interacting with the veterans and VA staff throughout the VA healthcare system.

The American Legion believes that ensuring the health care of our nation veterans who are at risk of suicide is paramount¹¹, which is why The American Legion fully supported the “Clay Hunt Suicide Prevention for American Veterans Act” or the “Clay Hunt SAV Act”, signed into law in February. Under this act, the VA and DOD are required to review their mental health care programs annually to ensure their effectiveness, offer special training on identifying those veterans who are at risk of suicide to their mental health providers, and to improve the process regarding medical records and prescriptions to ensure seamless care to transiting servicemembers. This act also requires DOD and VA to submit to independent reviews of their suicide prevention programs and make information on suicide prevention more easily available to veterans. It also offers financial incentives to psychiatrists and other mental health professionals who agree to work for the VA and help military members as they transition from active duty to veteran status. This is a first step towards creating a better treatment environment for veterans struggling with suicide, but it will require full attention and oversight from Congress and Veterans Service Organizations (VSOs) to ensure it is effectively implemented.

Conclusion

Overuse of opiate prescriptions clearly creates problems for veterans within the VA healthcare system. The American Legion believes more robust use of complementary and alternative medicine will help to alleviate some of those problems, and therefore supports legislation like the COVER Act and others. The entire VA mental healthcare system deserves extra attention as veterans struggle with suicide, and the Clay Hunt SAV Act is a step towards getting it that attention.

VA has begun to address over prescription of painkillers and has increased efforts in support for suicide prevention but they need to continue to partner with veteran service organizations, such as The American Legion to improve outreach. The American Legion is fully committed to work with DOD and VA in providing assistance to increase awareness.

As always, The American Legion thanks this committee for the opportunity to explain the positions and concerns of the more than 2 million veteran members of the nation’s largest wartime veterans service organization. Questions concerning this testimony can be directed to Warren Goldstein in The American Legion Legislative Division (202) 861-2700, or wgoldstein@legion.org

¹¹ Resolution No. 196: [Suicide Prevention for American Veterans Act](#) – AUG 2014