"VETS WE FORGET"

ADF VETERANS AND PRESCRIPTION MEDICATION

"My review of the information on the cause of death for ADF veterans', provides a very clear and recurring timeline. Veterans' are discharged suffering physical and mental injuries sustained whilst serving in the ADF. They are prescribed high risk combinations of medications including opioids, benzodiazepines, and antidepressants. The Penington Institute shows that these medications are the leading cause of drug deaths in Australia. Excessive alcohol use is common, which combined with these medications increases exponentially the risk of accidental or intentional overdose, and death. Tragically these medications are found as the cause of death or a contributing factor in the death of many veterans. Not all deaths are classified as suicide, however the excessive level of medication use indicates it as being a systemic issue in both suicide and non-suicide deaths. The medication is funded by DVA through the RPBS." **Patrick O'Connor** – Author *Prescribed Deaths*

Australian Government
Department of Veterans' Affairs

Veterans' MATES

Veterans' MATES www.veteransmates.net.au was established in 2004 by DVA to address common 'real life' prescription medication issues with the medication funded by DVA through the Repatriation Pharmaceutical Benefits Scheme (RPBS). The medication issues include veterans' hospitalisation, accidental and intentional overdose deaths. *MATES* is an acronym for 'Medicines Advice and Therapeutics Education Services'.

33,000 veterans are taking *5 or more medications*, and 4 of the most prescribed medications are 1) opioids e.g. OxyContin and Endone, 2) benzodiazepines e.g. Valium (Diazepam) and Ativan, 3) antidepressants e.g. Prozac and 4) antipsychotics e.g. Seroquel XR.

The risks of combining these medications is well documented in the Veterans' MATES information sent to doctors:

"Risk of overdose is greatest and most dangerous when benzodiazepines are combined with other sedatives, such as alcohol or opioids."[i]

"Patients taking benzodiazepines and opioids together have a 15-fold increase in risk of death compared to patients taking neither medicine."[ii]

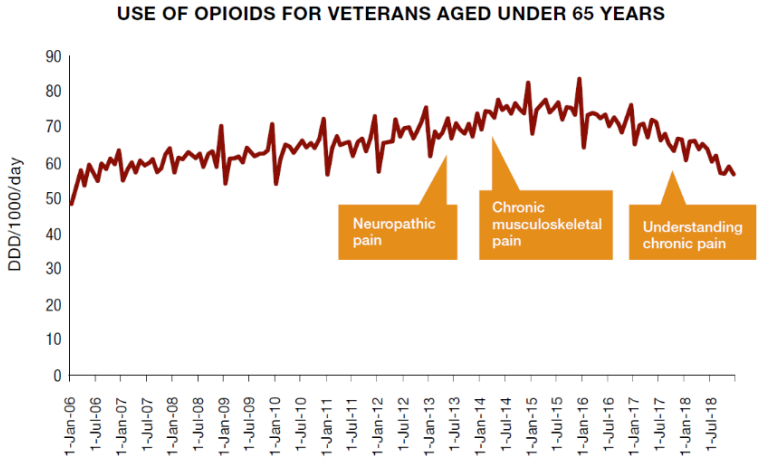
"...the importance of not combining opioids with benzodiazepines or other medicines that depress the central nervous system."[iii]

"Caution is needed when using combinations as there is greater risk of toxicity and death. Additive toxicity can also occur when gabapentinoids are combined with other centrally acting medicines such as benzodiazepines and alcohol."[iv]

Veterans' MATES is a strategy to get veterans' off high risk medications and combinations of medications, without publicly admitting it is an issue, warning the veterans' who are at risk or admitting any responsibility for the veterans' who die from medications DVA fund.

Veterans' MATES even measure success in hypothetical lives saved "***At least 140 premature deaths avoided***"[v].

They also measure the reduction in usage in high risk drugs e.g. opioid usage in the 2019 Veterans' MATES Annual report:



How does it work?

Veterans' MATES use RPBS data to identify which veterans are prescribed dangerous medications. Veterans' MATES then contact the doctors and pharmacists of these veterans and sends them information on the life-threatening risks of the medications and provides recommendations on 'deprescribing' these drugs. The 2020 Veterans' MATES annual report states "*1.5 million targeted messages individually tailored for each DVA client's health care needs have been sent to General Practitioners.*"

The veteran is also contacted; however, Veterans' MATES *does not include any information on the life-threatening medication risks that they are exposed too in these communications*. They simply encourage them to review their medication use with their GP or pharmacist. 'Informed Consent' to take medication requires the person to be informed of all the potential risks and side effects. By providing the funding for these deadly prescription cocktails, DVA funds the cause of death for many veterans without warning them of the risks or enabling them to give informed consent to expose themselves to these risks. This failure exposes DVA and the doctors to legal liability.

Veterans' and prescription medication deaths

Bradley Carr

In 2007 Brad joined the army and during his service he was deployed to Afghanistan. Injured and suffering from PTSD due to his combat duties he was medically discharged in 2012. He was also suffering from excessive alcohol use and addiction to the dangerous opioid medication that he was prescribed, all was known to the ADF. The ADF effectively moved him on and passed his ongoing care to DVA.

DVA made him wait 6 years to receive a gold card to enable him to get funded medical treatment. He had been prescribed a cocktail of opioids and benzodiazepines, Australia's deadliest prescription medications, including Oxycontin, Endone and Valium since his ADF service. This was given to a veteran who was already opioid dependent and was drinking to excess.

His medical records note his doctors were aware of the risk of suicide. Brad had overdosed twice on these medications, but his doctors kept prescribing them and even tripled the doses in late 2018. He died on Anzac Day 2019, the cause of death was mixed drug toxicity including Oxycodone (Opioid) and Diazepam, funded by DVA.

Matthew Tonkin

Matthew Tonkin enlisted in the ADF on his nineteenth birthday, as a rifleman in the Royal Australian Infantry. He served for four years, including a deployment to Afghanistan. Whilst in the ADF Matthew incurred physical injuries that caused ongoing pain, and he developed PTSD from combat duties. He was treated for both conditions with a cocktail of medication by the ADF including; Oxycodone (opioid), Diazepam (benzodiazepine), Alprazolam (benzodiazepine), Quetiapine (antipsychotic), Tramadol (pain medication), Ibuprofen (pain medication) and Paracetamol (pain medication).

When he was discharged from the ADF in December 2013 he had already been treated by the ADF for four opioid and benzodiazepine overdoses and other medication issues. He had been diagnosed with having psychological dependence on the medications. Despite this he was continued to be prescribed the same medications, funded by DVA, after his discharge.

In 2019 the Western Australia Corner's Court found that "*within a relatively short time, the deceased developed an addiction to oxycodone and sedative drugs [benzodiazepines], which he began to seek actively and to abuse to the point of oblivion. The addiction became apparent to his treating doctors...*" This is while he was in the ADF.

8 months after discharge in July 2014, Matthew Tonkin died at age 24 from opioid toxicity in Perth WA. He also had alprazolam and diazepam in his system. The coroner ruled it an accidental death.

Ian Turner

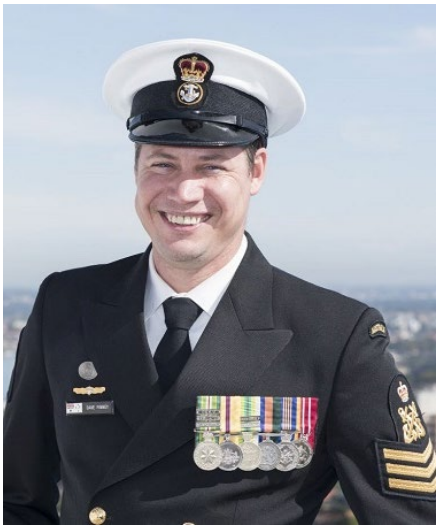
Sgt Ian Turner was a highly trained soldier who served for more than 16 years and his service included numerous deployments to Afghanistan and Iraq. He witnessed multiple deaths of fellow soldiers which contributed to Ian suffering from PTSD, anxiety, depression, and alcohol dependency.

In the months leading up to his death, he was hospitalised after an overdose of prescription drugs. The 35-year-old father-of-two took his own life on July 15, 2017 after being given a bulk prescription of 400 pills in a matter of weeks. Sgt Turner died of an overdose of prescription medication, funded by DVA.

"Counsel assisting the Coroner, Kristina Stern SC, questioned Dr Malik about the decision to give Sergeant Turner effectively unlimited prescriptions of the high dosages of medication he was on. Dr Malik responded that even if the prescriptions were changed to daily, Sergeant Turner could still have stockpiled the drugs, and said that if a person was intent on committing suicide they could do so with non-prescription medications."[vi] Ensuring the safe prescribing of medication is a legal obligation.

Still serving at the time of his death, Sgt Turner was in the process of moving towards a medical discharge from the army.

David Finney

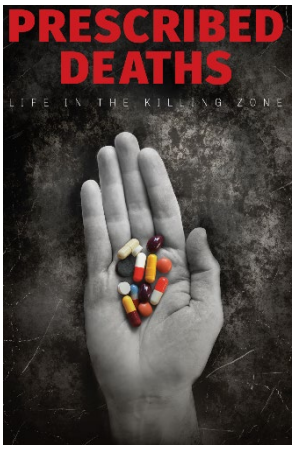


David Finney had a 20-year career in the Royal Australian Navy. David experienced numerous traumatic incidents during a decorated career as a mechanic: fighting a fire onboard HMAS Tobruk in 2004, getting caught in a riot during peacekeeping operations, and rescuing refugees and recovering bodies, including children, from the ocean.

The navy discharged David in 2017 after he developed PTSD, he was also suffering from excessive alcohol use. He continued to receive medical support from DVA, and he was prescribed a large cocktail of medication including Ativan (benzodiazepine), Lorazepam (benzodiazepine), Fluoxetine/Prozac (antidepressant), Quetiapine (antipsychotic), Seroquel XR (antipsychotic) and Prazosin (alpha blocker).

David experienced several overdoses on his prescribed medications, yet his doctors continued to provide prescriptions for the same medications, despite also using alcohol to excess. On February 1 2019, David took his own life after a crippling battle with Post-Traumatic Stress injury and alcohol.

Consumer Medicines Information (CMI)



The CMI is the information resource provided by the Australian Department of Health to educate and remind people of the warnings needed to prevent medication related harm and death. DVA and Veterans' MATES advises veterans to get information on medications risks from the CMI "*Asking your pharmacist or doctor for a Consumer Medicine Information (CMI) leaflet for each of your medicines*."

An independent report released in 2020 titled *Prescribed Deaths*[vii], details how medically acknowledged risks and side effects known to the Department of Health, have not been included in the CMIs for a wide range of high-risk medications. The side effects and risks include death, addiction, dependence, withdrawal symptoms, coma, overdose, drug to drug interactions and abuse.

The medications researched include opioids, benzodiazepines, antidepressants, antipsychotics, and codeine. The head of the TGA Professor John Skerritt has rejected 2 formal requests to have these side effects added to CMIs, from ACT Attorney General Shane Rattenbury MLA, and the report's author Patrick O'Connor. A complaint has been relodged with Greg Hunt, Minister for Health.

The outcome is that veterans' have not been made aware of the risks that should have been in the CMIs and Veterans' MATES material. As a result, they have not been able to take the necessary steps to avoid adverse drug events and death or provide informed consent to expose themselves to these risks.

Even though the total deaths from benzodiazepine medications like Valium is approaching **10,000 lives lost**, not a single CMI warns of the risk of death.

The CMI warning for mixing alcohol with the medication only states to be aware of "*drowsiness, confusion, dizziness and unsteadiness*". Whilst RACGP guidelines warn of "*respiratory depression, heavy sedation, coma and death*".

Tragically the Valium CMI does not even mention opioids or the risk of death when combined.

Julie-Ann Finney

Julie-Ann Finney is the mother of David Finney. She is leading the call for a royal commission into veteran suicides.[viii]

"*I call on the Australian Government to establish a Royal Commission with wide terms of reference to examine and make recommendations regarding the Australian Veteran suicide rate and what can be done in practical terms to address this tragic situation*." – **Julie-Ann Finney**

The issue of prescription medication is common in many veterans' accidental deaths and suicides, medication that was provided by the ADF and DVA. Julie-Ann believes that there are a series of questions that need to be asked in relation to medication prescriptions to veterans':

- After reviewing the RPBS data, why has DVA and Veterans' MATES not informed each veteran of the life-threatening risks their medications expose them too? Why are only the doctors warned and *not* the veterans' as well?

- What warnings did ADF and DVA give each person about the deadly risks of these medications when first providing them? How did they record each persons informed consent to expose themselves to these risks? Why has the prescribing of these medications been allowed to veterans' who have known issues of alcohol use?

- Why has the ADF and DVA continued to provide these medications, even though for over 20 years they have been aware that they are used to attempt and complete suicide? In multiple cases doctors continued to prescribe these medications, even after a suicide attempt by overdose on these very medications. Why has no investigation been undertaken into the prescribing these medications?

"The DVA practice of prescribing the very medication that many veterans have used to end their lives, and the failure to warn them of the dangers, is a cover up that must be exposed. Only a Royal Commission will expose the full extent of veteran's deaths at the hands of DVA prescribed medications." - **Julie-Ann Finney**

This issue is believed to be an area that the Morrison Government is concerned would be uncovered in a royal commission into veteran suicides. Please support the petition www.change.org/VetsWeForget

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[i] https://www.veteransmates.net.au/topic-41-therapeutic-brief
[ii] https://www.veteransmates.net.au/topic-48-therapeutic-brief
[iii] https://www.veteransmates.net.au/topic-48-therapeutic-brief
[iv] https://www.veteransmates.net.au/topic-58-therapeutic-brief
[v] https://www.veteransmates.net.au/what-is-veterans-mates
[vi] https://www.abc.net.au/news/2020-10-20/soldier-admitted-ptsd-alcohol-dependency-prior-to-death/12785148
[vii] www.prescribeddeaths.com.au
[viii] https://www.facebook.com/people/Julie-Ann-Finney/100000476400321