

Congress of the United States
Washington, DC 20515

June 11, 2008

Dr. James B. Peake
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420-0002

Dear Mr. Secretary:

I am writing to request information about the Department of Veterans Affairs' (VA) policies, procedures and statistical data regarding Post Traumatic Stress Disorder (PTSD), suicide, and other veterans' mental health issues.

A growing body of evidence suggests that there are significant problems with the way the VA identifies and tracks and serves veterans in need of mental health services. As the Member of Congress who represents the West Los Angeles VA Medical Center (West LA VA) — the largest VA Medical Center in the nation — I am particularly troubled by recent developments.

A study released by the RAND Corporation on April 17, 2008, found nearly 20 percent of military service members who have returned from Iraq and Afghanistan — 300,000 in all — report symptoms of Post Traumatic Stress Disorder or major depression, yet only slightly more than half have sought treatment. The report also found that many service members indicated they did not seek treatment for psychological illnesses because they fear it will harm their careers, and that even among those who do seek help for PTSD or major depression, only about half receive treatment that researchers consider "minimally adequate" for their illnesses.

The analysis concluded that a major national effort is needed to expand and improve the capacity of the mental health system to provide effective care to service members and veterans. According to RAND, "Addressing PTSD, depression, and TBI among those who deployed to Afghanistan and Iraq should be a national priority... The systems of care available to address these injuries have been improved significantly, but critical gaps remain." RAND researchers concluded the effort must include the military, veteran and civilian health care systems, and should focus on training more providers to use high-quality, evidence-based treatment methods and encouraging service members and veterans to seek needed care.

The Department of Defense also released its own statistics last month indicating the number of troops with new cases of PTSD increased by about 50% in 2007 — an increase believed to be caused, in large part, by longer and more frequent deployments in Iraq and Afghanistan.

Given these findings, current VA practices appear to deviate from what experts are telling us what is needed. As you know, it was revealed last month that a psychologist in charge of a PTSD program at a VA medical center in Texas directed staff members to refrain from

diagnosing PTSD because so many veterans were seeking government disability payments for the condition. The psychologist, Norma Perez, said in an email, "Given that we are having more and more compensation-seeking veterans, I'd like to suggest that you refrain from giving a diagnosis of PTSD straight out... We really don't or have time to do the extensive testing that should be done to determine PTSD." Instead, Ms. Perez asked staff members to diagnose a less severe condition, adjustment disorder, which reduces a veteran's eligibility for disability payments.

In light of these recent developments, I have continuing questions about whether veterans seeking treatment at the West LA VA are receiving the appropriate care needed to address their mental health needs.

On April 24 and 25 last year, VA's Central Office of Mental Health Services conducted a site visit at the West LA VA. The site visit was prompted after five patient deaths occurred within a six-month period.

The VA consultation team identified 10 major items of concern after their visit, including several serious deficiencies in the mental health program. These problems included a fragmented and confusing program structure, staffing shortages and an absence of overall safety, security and coordination.

The team also identified an additional area of particular importance, the failure to follow the VA's Self Medication Policy and Procedures. As you might know, a 27 year-old returning Iraq veteran named Justin Bailey overdosed on his prescribed methadone while living in the Domiciliary program at the West LA VA Medical Center. The VA concluded his case was handled poorly and Justin should not have been prescribed the large dose of methadone to self administer that ultimately killed him.

Mr. Bailey's case has become a symbol of the flaws in the mental health programs at the VA. *5 Deaths at a V.A. Complex Draw Lawmakers' Concern*, New York Times (April 3, 2007). Following his suicide, in January 2007, Rep. Mike Michaud introduced HR 5554, known as the Justin Bailey Veterans Substance Use Disorders Prevention and Treatment Act of 2008. Mr. Bailey's father, Tony Bailey, testified in August 2007 before the Senate Committee on Veterans' Affairs about the circumstances of his son's death.

This disturbing fatality — and new reports of agency-wide problems providing appropriate mental health care for returning veterans — raise important questions about treatment at the West LA VA facility. I would like to request the following information in order to answer these questions:

- The total number of suicides or suicide attempts at the West LA VA since 2003. Please provide the date and circumstances of each event and the specific cause of death or injury.
- A detailed description of the changes put in place in the mental health program at the West LA VA following the investigation by the VA Central Office of Mental Health Services. Please include the amount of new money dedicated to the

program, as well as any staffing changes, program changes, screening and security measures taken. In addition, please provide a description of the VA's suicide prevention protocols, and any data about outcomes since the program has been changed.

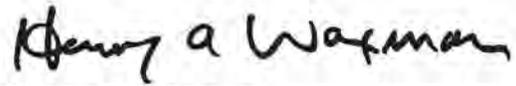
- A detailed description of the screening process for veterans who use the West LA VA, including hospital patients, inpatients and outpatients. Please include information on how soon a full mental health evaluation is performed after a veteran presents themselves at the VA. Also include how the VA intervenes and provides services after a diagnosis of a mental health issue, including PTSD.
- As you know, the California Department of Veterans Affairs has reported there are more veterans living within 50 miles of the West LA VA than in 42 other states. Please provide a description of the VA's outreach efforts in and around the area, including the number of veterans brought into programs since 2003 as a result of these outreach efforts.
- A description of healthcare quality assurance reviews related to PTSD, suicides and suicide attempts. Please indicate who conducts these reviews and whether they are performed internally. Please provide any reports of quality assurance that have been conducted since Justin Bailey's death.
- Please describe how the West LA VA assists veterans in obtaining healthcare and benefits once they return from combat. How does the VA coordinate with DOD and with the Veterans Benefits Administration to ensure eligibility for services and the delivery of services? What is the average wait time from the point eligibility is established to the delivery of healthcare services?
- Please provide statistics on the number of returning veterans who have been treated at the West LA VA Medical Center and diagnosed with PTSD or other mental health issues since 2003. What percentage of these veterans has a primary diagnosis of a mental health issue? What percentage has a primary diagnosis of a mental health issue? Have these statistics changed since 2003?

Please provide these materials to the Committee by July 11, 2008.

The Committee on Oversight and Government Reform is the principal oversight committee in the House of Representatives and has broad oversight jurisdiction as set forth in House Rule X. An attachment to this letter provides additional information about how to respond to the Committee's request.

If you have questions regarding this letter, please contact Brian Cohen of the full Committee staff at (202) 225-3976.

Sincerely,

A handwritten signature in black ink that reads "Henry A. Waxman". The signature is written in a cursive, slightly slanted style.

Henry A. Waxman

Chairman

Committee on Oversight and Government Reform

HAW:lp
Attachment