June 18, 2008

The Honorable James B. Peake
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420-0002

Dear Mr. Secretary:

I am writing to request information about the quality of mental health care at the West Los Angeles VA Medical Center (West LA VA).

In April 2007, after reports of five patient deaths within a six-month period, the Central Office of Mental Health Services for the Department of Veterans Affairs conducted a site visit at the West LA VA. The VA team identified 10 major items of concern during their visit, including several serious deficiencies in the mental health program.[1]

One of the deaths that prompted the VA review was the suicide of Justin Bailey, a 27 year-old returning Iraq veteran who overdosed on his prescribed methadone while living at the West LA VA. The VA concluded his case was handled poorly and Mr. Bailey should not have been prescribed the large dose of methadone that ultimately killed him. Mr. Bailey's case has received national attention, becoming a symbol of the flaws in the mental health programs at the VA.[2]

The disturbing suicide of Mr. Bailey and the findings of the VA site visit to the West LA VA, combined with new reports of systemic, agency-wide problems providing appropriate mental health care for returning veterans, raise important questions about treatment at the

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[1] Department of Veterans Affairs, *Report on Site Visit of Greater Los Angeles Medical Center — Desert Pacific Healthcare Network, Apr. 24-25, 2007* (2007).

[2] *5 Deaths at a V.A. Complex Draw Lawmakers' Concern*, New York Times (Apr. 3, 2007).

facility. To assist the Committee in examining these issues, I request that you provide the Committee with the following information:

1. The total number of suicides and suicide attempts at the West LA VA since 2003. Please provide the aggregate annual numbers and specify the date and circumstances of each event and the specific cause of death or injury.

2. 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 funding newly dedicated to the program, as well as any staffing changes, program changes, and screening and security measures taken, and identify the funding sources from which these resources are derived. In addition, please provide a description of the VA's current suicide prevention protocols and any data about outcomes since the program has been changed.

3. A detailed description of the screening process for inpatient and outpatient veterans who use the West LA VA. Please include data, for each year since 2003, on how soon a full mental health evaluation is performed after a veteran seeks care at the West LA VA. In addition, please include information on how the West LA VA intervenes and provides services after a diagnosis of a mental health issue.

4. A detailed description of the VA's outreach efforts in and around the region, including the number of veterans brought into West LA VA programs each year since 2003 as a result of these outreach efforts.

5. A description of the results of, and the response of the West LA VA to, all health care quality assurance reviews and reports — included those conducted internally, those conducted by the VA, and those conducted by other outside experts or auditors — related to post-traumatic stress disorder (PTSD), suicides and suicide attempts, or other mental health issues at the West LA VA since 2003. Please also provide copies of these reviews and reports.

6. A description of how the West LA VA assists veterans in obtaining health care and benefits once they return from combat. Please include information indicating how the West LA VA coordinates with DOD and with the Veterans Benefits Administration to ensure and expedite eligibility for services and the delivery of services and information indicating the average wait time from the point eligibility is established to the delivery of health care services. Please provide a breakdown of this data for each year since 2003.

7. Statistics on the number of returning veterans who have been treated at the West LA VA and diagnosed with PTSD or other mental health issues since 2003, including information

on what percentage of these veterans have a primary diagnosis of a mental health issue and what percentage have a primary diagnosis of a physical health issue. Please provide a breakdown of this data for each year since 2003.

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.

Please provide these materials to the Committee by July 11, 2008. If you have questions regarding this letter, please contact Brian Cohen of the Committee staff at (202) 225-3976.

Sincerely,

Henry A. Waxman
Chairman

Enclosure

cc: Tom Davis
Ranking Minority Member