TONY BAILEY FATHER OF JUSTIN BAILEY, IRAQ WAR VETERAN

STATEMENT OF TONY BAILEY
FATHER OF JUSTIN BAILEY, IRAQ WAR VETERAN
FOR PRESENTATION BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
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Mr. Chairman and members of the committee:

I would like to tell you about my son, Justin Bailey, who died on January 26, 2007, at the West LA VA Hospital. He was 27 years old. Justin was seeking treatment for PTSD and drug abuse.

Justin joined the Marine Corps in December 1998, approximately 6 months after graduating from high school. He was in the infantry and was due to separate from the marines in January 2003, but was involuntarily extended due to the impending war. Justin was with the first wave of troops that arrived in Iraq when the war started in 2003. He fought in Nasarija and returned to Camp Pendleton in June 2003. While Justin was in Iraq, he sustained an injury to his groin. He underwent two different surgeries at the Naval Hospital at Camp Pendleton about six months apart. In between surgeries, he waited around basically doing nothing until he was discharged in April 2004.

After his discharge, Justin still complained of pain from his injury, and he was diagnosed with PTSD. He had trouble sleeping, nightmares, and short term memory loss. He began taking prescription drugs that were prescribed by the VA. Over approximately the last two and a half years, the VA prescribed the following different drugs: alprazolam (xanax), diclofenac, quetiapine fumarate, buspirone, benztropine mesylate, aripiprazole, hydrocone, acetaminophen, olanzapine, hydroxyzine pamoate, divalproex, magnesium hydroxide, clonazepam, lithium carbonate, trazodone, prazosin, bupropion, levalbuterol tart, lorazepam, oxycodone, omeprazole, ibuprofen, doxepin, amitriptyline, temazepam, mirtazapine, and methadone. It doesn't appear as if the drugs were monitored effectively and in my opinion he was given drugs and sent on his way instead of being properly diagnosed and treated. He also began using illicit drugs.

In November 2006, Justin checked himself into the West LA VA Hospital. According to his medical records, Justin went in taking xanax and hydrocone for pain, and two weeks later was on xanax, buproprion and trazodone, which are antidepressants, prazosin, and methadone, which he was given for pain. Justin had been on xanax since 2004. We were later told by medical staff after Justin's death that xanax is inconsistent with the treatment of PTSD. Justin's pain medication had been changed to methadone, which received an FDA alert in November 2006 and has been highly publicized due to its addictive and unpredictable nature. The FDA alert explained the risks of methadone and cautioned the medical community to ensure that the benefits of prescribing methadone outweigh the risks.

After his two weeks in the hospital, Justin was sent to the domiciliary, which is described by the VA as a residential substance abuse program.

On the night of January 26th I learned that Justin was being taken to the ER at the hospital. He had just received his new prescriptions the day before. And now he had died of an apparent overdose of his prescription drugs.

Looking back, I was very happy for Justin that he made the decision to get help and that he was going to the VA for help. I assumed that being a large VA facility they would be best equipped and would have the most experience with PTSD and related drug abuse issues. I also assumed that Justin would only receive his prescriptions in small individually controlled dosages. I was wrong.

Despite warnings from friends and family and notations in his medical record that Justin had a tendency to over-medicate himself on prescription drugs, the LA VA hospital determined that after a mere two weeks at their hospital that he had the ability to self administer medications. The day before he died, he was given five different prescriptions in dosages of 14, 15 and 30 days.

Two days after Justin died, my wife and I visited the hospital and were greeted with a total lack of sympathy and faced bureaucratic hassles to get basic information. And despite the VA's touting of its electronic medical records, we went on a wild goose chase throughout the hospital looking for Justin's records.

We met with his medical staff. The PTSD professionals indicated that Justin had missed several of his PTSD appointments, but they did nothing but reschedule a new appointment. They should have made face-to-face contact with him. Patients with PTSD and substance abuse are notoriously difficult to reach. They also indicated that although they knew that Justin had problems with over-medicating on prescription drugs, they had to listen to the patient when it came to his care. And, they told us that Justin had not seen a psychiatrist since being in the domiciliary. He had been there approximately six weeks already, and a psychiatrist had not yet been assigned to him. We found it disturbing that the primary care physician and RN continued to give Justin prescriptions that he had been prescribed in the hospital, without evaluating him to see if the drug interactions were okay or the drug treatment was even effective.

We left the hospital with unanswered questions. We went from place to place and got nowhere. I can only imagine what it must be like for a veteran with mental illness. Every office that we visited seemed to act independently without knowledge of what others were doing. There was obviously inadequate communication between offices and medical staff, but yet that seemed to be the norm and didn't concern the people that we spoke to. The only communication network that did seem to function well in this hospital was the communication to the organ donation people. I received a phone call four hours after my son died at 2:30 in the morning in which I was asked questions about the condition of my son and specifically about his eyes.

Other than some classes required by the domiciliary program, it functioned as a residential facility. And while many veterans need a place to stay as they transition to civilian life, Justin was there primarily for drug treatment, and he needed more.

I will tell you that after our experience with the hospital, they are making some changes,

including reducing dosages, surprise inspections, and increased weekend staffing. It is my hope that the changes will remain in effect and that these changes will occur system-wide.

I cannot express the emotions that I feel over Justin's death and the thought that all of this could have been prevented. I don't believe that this facility is equipped to deal with PTSD and drug abuse problems, which are so prevalent.

I believe with some veterans, there is a lag between their return from war and their acknowledgement and/or diagnosis of PTSD, and we have yet to see our VA hospitals overwhelmed with mental illness from this war. I have a concern that our Iraqi veterans with mental illness will give up on our VA hospitals, because of the complexity and apathy. We can do better than that. We send them to war to fight for our country and it is our responsibility to take care of them when they return.

It would help to increase the budgets of the VA hospitals, but not before a thorough evaluation of these facilities is conducted. Adding money to facilities that have systemic issues is not going to increase their effectiveness.

When I spoke to Justin on the Sunday before he died, he said, "Dad, I know this is my last chance and I want to get better." He was very positive about what he was going to do when he got out of his program. He had plans for his career and wanted to do something with his life. His step-mom and I were very happy for him and for once in a long time, we had hope that he would be able to lead a happy and healthy life.

Thank you for allowing me to speak to you today.