U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED EIGHTEENTH CONGRESS
364 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

November 19, 2024

The Honorable Denis R. McDonough
Secretary
Department of Veterans Affairs
810 Vermont Ave. NW
Washington, DC 20420

Dear Secretary McDonough:

Our veteran community continues to battle an epidemic caused by the invisible wounds of their service in uniform. As you know, suicide and mental health are both complex issues and as a veteran, combatting veteran suicide is deeply personal for me. It goes without saying that there is no one-size-fits-all approach to preventing suicide, which makes combatting this epidemic incredibly difficult. However, Congress has continued to recognize the uphill battle the Department of Veterans Affairs (VA) faces in reaching veterans who are struggling, which is why we have continually appropriated billions of dollars to the VA's mental health care and services budget. From 2022 to 2025, VA's Budget Request for mental health increased from $13.5 billion to $17.1 billion.[1] Despite consistent budget increases, we lost 6,392 veterans to suicide in 2021 according to the 2023 National Veteran Suicide Prevention Annual Report.[2] This has been relatively unchanged as far back as the 2020 Suicide Report which showed that we lost 6,435 veterans to suicide in 2018.[3] This shows a marginal difference at best, and the number of veterans lost to suicide has remained over 6,000 going as far back as 2018. It is unfathomable that the mental health budget has increased by billions of dollars each fiscal year, yet the suicide rate, tragically, has not budged. We must do better.

Over the past two years, VA's mental health and suicide prevention leadership have come before my committee's Subcommittee on Health on five separate occasions to testify on various issues related to VA's mental health programs and to discuss legislation aimed at addressing those problems. Committee members on both sides of the aisle have repeatedly begged your mental health leadership for change so that we can move the needle. And yet, my committee still hears reports of the Veterans Crisis Line (VCL) not working, veterans being denied community care referrals for mental health support, and

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[1] VA, *U.S. Department of Veterans Affairs FY 2025 Budget Submission* (March 2024), https://department.va.gov/administrations-and-offices/management/budget/

[2] VA, *2023 National Veteran Suicide Prevention Annual Report* (November 2023), https://department.va.gov/suicide-prevention-annual-report/wp-content/uploads/sites/16/2023/11/2023-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf

[3] VA, *2020 National Veteran Suicide Prevention Annual Report* (November 2020), https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf

overdoses continue to be ignored as a suicide statistic, even though medication is still offered as the first option for mental health treatment. This is incredibly concerning.

My committee is not the only party concerned about VA missing the mark when it comes to reducing veteran suicide. As you know, VA's Office of Inspector General (OIG) has published multiple reports that highlight failures at VA that may have directly contributed to veterans dying by suicide. A September 2024 OIG report investigated allegations related to the care of a veteran who died by suicide less than a week after a VA mental health appointment.[4] The OIG substantiated all allegations, including but not limited to, leadership failures to provide guidance, and processing failures related to the care and treatment the veteran received. Another OIG report from July 2024 highlighted a VA clinicians' failure to follow the proper procedures for a veteran with known suicidal ideations.[5] Four days later this veteran died by suicide. These reports demonstrate policy, processing, and accountability failures that should have never happened. Reducing the veteran suicide number has allegedly been a top clinical priority for years. However, under the Biden-Harris administration, it appears that the status quo is the acceptable standard despite billions of dollars at your disposal and landmark legislation over the years to expand the reach of VA's mental health services. The buck stops with leadership – I trust you are well aware of this fact.

My committee takes these failures incredibly seriously, and I need further information to investigate the root cause of the problem. Do you believe that the Office of Mental Health (OMH) and Office of Suicide Prevention (OSP) leaders are capable of carrying out VA's top clinical priority? Why or why not? Please also provide a list of all mental health programs from Fiscal Year (FY) 2021-24. Please also provide performance reviews for all senior executives in OMH & OSP for FY21-24 and provide any bonus amounts received by each individual for each fiscal year.

Please provide, no later than **December 19, 2024**, answers to the questions and your response to my letter, including copies of all responsive documents. When producing documents, please do not alter them in any way, including but not limited to the application of redactions or a watermark. Additionally, digital copies should be provided in a format enabling their printing and copying by the House Committee on Veterans' Affairs. Thank you for your attention to this issue. Please do not hesitate to have your staff contact my staff with questions.

Sincerely,

MIKE BOST
Chairman

Cc: The Honorable Mark Takano, Ranking Member

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[4] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama* (September 2024), https://www.vaoig.gov/reports/hotline-healthcare-inspection/mismanaged-mental-health-care-patient-who-died-suicide-and

[5] VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming* (July 2024), https://www.vaoig.gov/reports/hotline-healthcare-inspection/inadequate-care-patient-who-died-suicide-medical-unit