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117TH CONGRESS
1ST SESSION

H. R. 1123

To direct the Secretary of Veterans Affairs to conduct a review of the deaths of certain veterans who died by suicide, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 18, 2021

Mr. GARBARINO (for himself, Mr. JOYCE of Ohio, Mr. AMODEI, Mr. KATKO, Mr. KILMER, Mrs. RADEWAGEN, Mr. RUSH, and Mr. WELCH) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To direct the Secretary of Veterans Affairs to conduct a review of the deaths of certain veterans who died by suicide, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veteran Suicide Prevention Act''.

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REVIEW OF CERTAIN VETERANS' DEATHS BY SUICIDE.

(a) REVIEW REQUIRED.—Not later than 18 months after the date of the enactment of this Act, the Secretary

of Veterans Affairs shall complete a review of the deaths of all covered veterans who died by suicide during the five-year period preceding the date of the enactment of this Act. Such review shall include—

(1) the total number of veterans who died by suicide during the five-year period preceding the date of the enactment of this Act;

(2) a summary of such veterans that includes the age, gender, and race of such veterans;

(3) a comprehensive list of the medications prescribed to, and found in the systems of, such veterans at the time of their deaths, specifically listing any medications that carried a black box warning, were off-label, psychotropic, or carried warnings that included suicidal ideation;

(4) a summary of medical diagnoses by Department of Veterans Affairs physicians which led to the prescribing of the medications referred to in paragraph (3);

(5) the number of instances in which the veteran who died by suicide was concurrently on multiple medications prescribed by Department of Veterans Affairs physicians;

(6) the percentage of veterans who died by suicide who were not taking any medication prescribed by a Department of Veterans Affairs physician;

(7) the percentage of veterans referred to in paragraph (1) with combat experience or trauma (including, but not limited to military sexual trauma, traumatic brain injury, and post-traumatic stress);

(8) Veteran Health Administration facilities with markedly high prescription and suicide rates of patients being treated at those facilities;

(9) a description of Department of Veterans Affairs policies governing the prescribing of medications referred to in paragraph (3);

(10) any patterns apparent to the Secretary based on the review; and

(11) recommendations for further action that would improve the safety and well-being of veterans.

(b) PUBLIC AVAILABILITY.—Not later than 30 days after the completion of the review required under subsection (a), the Secretary shall—

(1) submit to Congress a report on the results of the review; and

(2) make such report publicly available.

(c) COVERED VETERAN.—In this section:

(1) The term ''covered veteran'' means any veteran who received hospital care or medical services furnished by the Department of Veterans Affairs during the five-year period preceding the death of the veteran.

(2) The term ''black box warning''means a warning displayed within a box in the prescribing information for drugs that have special problems, particularly ones that may lead to death or serious injury.

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