

114TH CONGRESS
2D SESSION

H. R. 4640

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 26, 2016

Mr. JOLLY (for himself, Ms. TITUS, Mr. ABRAHAM, and Ms. GABBARD) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Veteran Suicide Pre-
5 vention Act”.

6 **SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REVIEW OF**
7 **CERTAIN VETERANS’ DEATHS BY SUICIDE.**

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

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

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

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

10 (3) a comprehensive list of the medications pre-
11 scribed to, and found in the systems of, such vet-
12 erans at the time of their deaths, specifically listing
13 any medications that carried a black box warning,
14 were off-label, psychotropic, or carried warnings that
15 included suicidal ideation;

16 (4) a summary of medical diagnoses by Depart-
17 ment of Veterans Affairs physicians which led to the
18 prescribing of the medications referred to in para-
19 graph (3);

20 (5) the number of instances in which the vet-
21 eran who died by suicide was concurrently on mul-
22 tiple medications prescribed by Department of Vet-
23 erans Affairs physicians;

1 (6) the percentage of veterans who died by sui-
2 cide who were not taking any medication prescribed
3 by a Department of Veterans Affairs physician;

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

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

11 (9) a description of Department of Veterans Af-
12 fairs policies governing the prescribing of medica-
13 tions referred to in paragraph (3);

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

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

18 (b) PUBLIC AVAILABILITY.—Not later than 30 days
19 after the completion of the review required under sub-
20 section (a), the Secretary shall—

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

23 (2) make such report publicly available.

24 (c) COVERED VETERAN.—In this section:

1 (1) The term “covered veteran” means any vet-
2 eran who received hospital care or medical services
3 furnished by the Department of Veterans Affairs
4 during the five-year period preceding the death of
5 the veteran.

6 (2) The term “black box warning” means a
7 warning displayed within a box in the prescribing in-
8 formation for drugs that have special problems, par-
9 ticularly ones that may lead to death or serious in-
10 jury.

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