AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

ANSWERING THE CALL: EXAMINING VA'S MENTAL HEALTH POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

WEDNESDAY, APRIL 30, 2025

Serial No. 119–18

Printed for the use of the Committee on Veterans' Affairs

Available via http://govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
61–151 WASHINGTON : 2025

COMMITTEE ON VETERANS' AFFAIRS

MIKE BOST, Illinois, *Chairman*

AUMUA AMATA COLEMAN RADEWAGEN, American Samoa, *Vice-Chairwoman*
JACK BERGMAN, Michigan
NANCY MACE, South Carolina
MARIANNETTE MILLER-MEEKS, Iowa
GREGORY F. MURPHY, North Carolina
DERRICK VAN ORDEN, Wisconsin
MORGAN LUTTRELL, Texas
JUAN CISCOMANI, Arizona
KEITH SELF, Texas
JEN KIGGANS, Virginia
ABE HAMADEH, Arizona
KIMBERLYN KING-HINDS, Northern Mariana Islands
TOM BARRETT, Michigan

MARK TAKANO, California, *Ranking Member*
JULIA BROWNLEY, California
CHRIS PAPPAS, New Hampshire
SHEILA CHERFILUS-MCCORMICK, Florida
MORGAN MCGARVEY, Kentucky
DELIA RAMIREZ, Illinois
NIKKI BUDZINSKI, Illinois
TIMOTHY M. KENNEDY, New York
MAXINE DEXTER, Oregon
HERB CONAWAY, New Jersey
KELLY MORRISON, Minnesota

JON CLARK, *Staff Director*
MATT REEL, *Democratic Staff Director*

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

JEN KIGGANS, Virginia, *Chairwoman*

AUMUA AMATA COLEMAN RADEWAGEN, American Samoa
JUAN CISCOMANI, Arizona
KEITH SELF, Texas

DELIA RAMIREZ, Illinois, *Ranking Member*
TIMOTHY M. KENNEDY, New York
HERB CONAWAY, New Jersey

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

C O N T E N T S

WEDNESDAY, APRIL 30, 2025

ANSWERING THE CALL: EXAMINING VA'S MENTAL HEALTH POLICIES

WEDNESDAY, APRIL 30, 2025

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 360, Cannon House Office Building, Hon. Jen Kiggans [chairwoman of the subcommittee] presiding.

Present: Representatives Kiggans, Ramirez, and Kennedy.

OPENING STATEMENT OF JEN KIGGANS, CHAIRWOMAN

Ms. KIGGANS. Good morning, everyone. The subcommittee will come to order.

I would like to welcome our witnesses, my fellow members, and the audience to this hearing of the Subcommittee on Oversight Investigations. Today we will dig deeper into U.S. Department of Veterans Affairs' (VA) mental health policies to gain insight into the processes and quality of care decisions regarding veterans' mental healthcare. From speaking with veterans in my district, it is clear that we have a lot of ground to cover to fix the mental health crisis in the veteran community.

Of the concerns I hear most from veterans is how long it takes to schedule their appointments for mental health treatments. Delay in mental healthcare in the age of telehealth is well within our ability to address. Veterans deserve timely care.

Despite the VA investing billions into Post-Traumatic Stress Disorder (PTSD) treatment, suicide prevention, and alternative approaches to mental health, we continue to lose too many veterans to suicide. One veteran suicide is too many. In 2022, 6,407 veterans died by suicide. That is 17 veterans a day. Unfortunately, it does not stop there. An additional 20 veterans died by self-injury mortality, which generally means overdose. I have heard horror stories from constituents who have been prescribed pain medication and told to take more when they feel bad and less when they feel better. As a provider, I would not feel comfortable for prescribing two medications that might interact with one another without first consulting a psychiatrist. This is unacceptable.

It is impossible to cover every detail of every case, but we know that we are losing veterans. Despite a seemingly endless amount of resources spent, these numbers have failed to substantially decline. One veteran's suicide, again, is too many.

These men and women volunteer to serve their country in a variety of roles throughout our armed services. They have answered the call to serve. As a veteran and a nurse practitioner, it is alarming that we have allowed VA to fail to move the needle for this long. We must do better. We have tried to throw more money at the problem; the VA's budget has risen 479 percent since 2001. Yet, despite a shrinking veteran population, the veteran suicide rate has remained virtually stagnant. Unfortunately, the VA's own numbers have only shown that they are doing less with more.

This is not a question of spending more taxpayer dollars, but getting veterans what they need when they need it. Making progress means that we must take a closer look into the VA's bureaucracy and improve our oversight of the processes and policies that determine the quality of veteran mental healthcare. Suicide prevention and veteran mental health are bipartisan issues. Losing these veterans impacts red states and blue states.

I hope this hearing will yield results to important questions about VA mental healthcare. How are these policies developed? What steps has the VA taken to adjust this approach? How does the VA use science and data to improve veteran care? Most importantly, how can the VA better serve the veteran?

The answers that we hear today will inform our next steps to address these urgent issues. Veterans should not have to wait for mental healthcare and it is our bipartisan responsibility to ensure the VA has up-to-date policies and is enforcing these policies to ensure no veterans slip through the cracks. Again, this is a bipartisan issue and we cannot let politics stand in the way of making progress.

There was spirited conversation during our last full committee hearing on the VA's workforce reform efforts—that the impact of VA's workforce reform efforts would have on delivering mental healthcare to veterans. The Secretary has addressed this misinformation and, let me reiterate, no mission-critical employees, including those at the Veterans Crisis Line, have been terminated from the VA.

I am committed to ensuring that the VA works for veterans and their caregivers with a functioning, quality workforce. That being said, I look forward to hearing from our witnesses.

I now recognize our Ranking Member Ramirez for her opening comments.

OPENING STATEMENT OF DELIA RAMIREZ, RANKING MEMBER

Ms. RAMIREZ. Thank you, Chair Kiggans.

For many years I worked at a homeless shelter where I saw case of veterans confronting alone, without anyone to turn to, mental health challenges. Imagine, after wearing a uniform and serving our Nation, these veterans were dealing in silence with the pain of PTSD, depression, substance abuse, and the risk of self-harm. I am really glad that today we are having this hearing to truly discuss the necessity of adequate mental health and suicide prevention screening for veterans.

The topic of today's hearing really gets to the crux of why VA and this committee specifically exist. Our responsibility is to ensure that when veterans need help they are connected to the clini-

cians who can provide the care and the services that they need so that no veteran has to confront these challenges alone. That is why we cannot have a complete conversation about mental health and suicide screening at the VA if we are unwilling to also address the cuts to personnel and the resources the agency and the work environment clinicians are currently operating in. We have to look at the entire picture.

You see, the mental health and well-being of veterans does not exist in a vacuum, especially when upwards of 30 percent of the impacted workforce are veterans themselves. The Musk-Trump fueled uncertainty and the chaos being created for veterans and VA staff impact the mental health and the well-being of veterans. We are hearing directly from veterans who are worried about losing their VA care because of the Musk-Trump cuts. We know veterans have lost their jobs across the Federal Government and are now facing the trauma of unemployment due to this administration. Research shows that unemployment and job loss puts individuals at increased risk of suicide.

Let me tell you, being someone that ran a homeless shelter, who saw veterans who were unemployed, who had no housing security, I can attest to this. It is really clear to me that we cannot have a conversation about adequate screening without also discussing adequate staffing across the VA enterprise. We cannot talk about adequate intervention without talking about adequate investment.

Psychiatrists, psychologists, primary care physicians, and medical support assistance have long been on the VA Inspector General's severe occupational staffing shortage list. It is easy to see how shortages of these positions, which directly coordinate and provide mental healthcare to veterans, would affect VA's ability to adequately screen veterans for suicide. We had a talk about the work environment in which clinicians are now forced to provide mental health screenings and treatment.

Since Department of Government Efficiency (DOGE) and Trump's April 15 Return to Office order that left facilities scrambling to find space for physicians, we have heard report after report from providers who are conducting telehealth appointments in compromised conditions, from open spaces to closets to even showers. I can tell you, as someone who served as the executive director of a social service organization that served people experiencing trauma and struggling with suicidal ideation, a shower is not the appropriate place to have these conversations. Providers are worried about the privacy of veterans, about the comfort of the veteran in disclosing their needs, and about having delicate conversations in unfit environments, and they have every single right to be worried. It is unacceptable that clinicians are taking their screenings in a closet.

Sadly, a VA spokesperson dismissed the concerns about veteran privacy as nonsensical, saying that the VA will make accommodations as needed so employees have enough space to work and comply with industry standards for privacy. We are hearing directly from clinicians that those accommodations are just not happening.

Hypocrisy is a word I feel like I am using a lot these days. My colleagues do not act concerned about the mental health of veterans, while ignoring the mental health toll that the Musk-Trump

agenda is taking on them and cheering that agenda on from the halls of Congress.

I will close with this. I believe we have an obligation to ensure that every single veteran access the care they need and they earned. Secretary Collins and President Trump have turned their back on LGBTQ+ veterans by shutting the VA's door to gender-affirming care, which in many cases includes mental healthcare. That, too, is unacceptable.

If we want to talk about threats to veterans' mental health, we have to have an honest conversation about one of the biggest threats, and that is the Trump administration. Through their actions, they are creating the kind of anxiety, the uncertainty, the trauma, and stress that directly and negatively impact veterans' mental health, their well-being, and their care. With that, I look forward to this hearing, to truly forgetting about R and D and putting our veterans first. That also requires the veterans that are part of the workforce that protects our veterans.

With that, Chairwoman, I yield back.

Ms. KIGGANS. Thank you, Ranking Member Ramirez.

I will now recognize our witnesses on our first panel testifying before us today. We have Dr. Wiechers, deputy executive director of the Office of Mental Health of the Veterans Health Administration (VHA), the Department of Veteran Affairs. She is accompanied by Dr. Anthony Stazzone, the chief medical officer of Veterans Integrated Service Network (VISN) 9 at the Veterans Health Administration, Department of Veterans Affairs. We also have Dr. Julie Kroviak, acting assistant inspector general for the Office of Healthcare Inspections of the Office of the Inspector General.

All the witnesses, please stand and raise their right hand.

[Witnesses sworn.]

Ms. KIGGANS. Thank you. You may be seated. Thank you. Let the record reflect that the witnesses answered in the affirmative.

Dr. Wiechers, you are now recognized for 5 minutes to provide VA's testimony.

STATEMENT OF ILSE WIECHERS

Dr. WIECHERS. Good morning, Chairwoman Kiggans, Ranking Member Ramirez, and distinguished members of the subcommittee. I am honored to speak on behalf of the Department of Veterans Affairs about our work in providing high-quality mental healthcare for our veterans. My name is Ilse Wiechers and it has been my honor to serve the past 3 years as the deputy executive director of the Veterans Health Administration Office of Mental Health. Joining me today is Dr. Anthony Stazzone, chief medical officer of the VA MidSouth Healthcare Network.

I have had the privilege of working with and caring for veterans as a practicing board-certified adult and geriatric psychiatrist for the past 15 years. VA's Mission to Care for our veterans drives us to improve daily. Veterans face unique mental health challenges, including higher rates of PTSD, depression, and substance use disorders, all of which significantly elevate their risk of suicide. Currently, 17.6 veterans die by suicide every day, reflecting a grave public health crisis that impacts communities nationwide.

While many veterans are successful and fully integrate back into society, some experience invisible wounds of war. Conditions like PTSD, depression, and substance use disorder, combined with the challenges of life after military service contribute to an elevated risk of suicide. In response, VA has developed a broad continuum of mental health services to ensure veterans receive the help they need. This includes crisis intervention, same-day access for urgent needs, outpatient, residential, and inpatient care across VA medical centers, community-based outpatient clinics, vet centers, the 24/7 Veterans Crisis Line, and a nationwide network of suicide prevention coordinators, or SPCs.

VA's Mental Health Services are designed to be accessible, evidence-based, and recovery-oriented. We emphasize early intervention, continuous support, and seamless integration of mental health into overall healthcare. Most veterans utilizing VA services report positive experiences and satisfaction, appreciating the availability of essential services, the privacy of medical records, ease of access, and the professionalism and courtesy of our VA staff.

In 2018, VA published the National Strategy for Preventing Veteran Suicide, emphasizing a public health approach to suicide prevention. This combines community prevention and clinical intervention actions to directly serve veterans. Our commitment to preventing veteran suicide is integrated throughout all mental health programs and supported by enhanced staff education and suicide prevention.

The Secretary has made preventing veteran suicide a top priority for VA. VA leadership is closely examining all current suicide prevention efforts and we are committed to challenging the status quo in order to find new and better ways of helping veterans. We cannot continue approaches that have failed to produce meaningful improvements despite substantial resource investments. Recent reports by the Office of Inspector General (OIG) have highlighted VA's efficiencies in VA's mental healthcare intake process and adherence to suicide risk identification screening. These findings underscore the need to strengthen initiatives and ensure high-quality care.

VA has implemented a standardized suicide risk screening and assessment process known as the Suicide Risk Identification Strategy, or RISK ID. Completed annually for all veterans receiving VA care, this process includes a primary screening using a standardized questionnaire and a comprehensive suicide risk evaluation for any positive screen. This determines the severity of suicide risk and helps develop a risk mitigation plan. To ensure adherence, VHA issued a memorandum requiring all Veterans Integrated Service Networks to implement RISK ID requirements by April 7, 2025. In Fiscal Year 2024, VA completed over 2.6 suicide risk screenings.

To stay at the forefront of suicide prevention VA continually updates clinical guidelines and training programs. In 2024, VA and U.S. Department of Defense (DOD) released a new Joint Clinical Practice Guideline for the assessment and management of patients at risk for suicide. Additionally, all VHA staff must complete suicide prevention training. VA has also implemented specialty training for SPCs and mental health clinicians on topics like lethal

means safety counseling, ensuring high-quality care for at-risk veterans.

VA is taking decisive action to transform the Department's mental healthcare system for veterans. The path forward requires VA to embrace innovation, accountability, and proven practices across every facet of its operations. Meaningful change requires collaboration within VA and with partners across government, private healthcare, and veteran organizations. This whole of society approach is essential to reach veterans wherever they may be. The oversight from this committee strengthens VA's work and helps ensure our focus remains on what matters most: providing veterans the exceptional care they have earned.

The VA looks forward to continuing to work with this committee and we look forward to answering any questions you may have. Thank you.

[THE PREPARED STATEMENT OF ILSE WIECHERS APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Dr. Wiechers.

Dr. Kroviak, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF JULIE KROVIAK

Dr. KROVIAK. Thank you, Chairwoman Kiggans, Ranking Member Ramirez. I am grateful for this opportunity to discuss the OIG's independent oversight of VA's and mental health services.

The OIG recognizes that meeting the complex needs of veterans requiring mental healthcare comes with extraordinary challenges. The Office of Healthcare Inspections routinely assesses VHA's services and how well they address those challenges. Our clinical teams regularly make recommendations to improve VA's delivery of healthcare through reviews of mental health and suicide prevention programs, inpatient mental health units, reports of harm to patients at individual medical centers, as well as inspections of vet centers. OIG recommendations for corrective action are based on identified deficiencies and noncompliance with VA policies and established standards of care.

As my written statement details, deficiencies can be grouped into three steps stages of suicide risk reduction interventions, with the first focused on screening and assessing veterans' risk. A December 2024 OIG review of VHA's suicide risk compliance found that in Fiscal Year 2023, the annual adherence rate was just 55 percent. Interviews revealed that the reasons for noncompliance included staff feeling uncomfortable with initiating screening and lack of clarity who should be overseeing staff compliance. A tragic example of a failure to properly assess a veteran was documented in an OIG report that found a veteran's crisis line responder did not fully assess a caller's alcohol impairment and access to lethal means. Shortly after the call, the veteran died by suicide.

The second stage of risk reduction is the effective management of acute care needed after a veteran's suicide attempt or ideation. In two separate 2024 hotline reports, our teams found noncompliance with mandates to remove belongings from a patient that could be used in a suicide attempt and with requirements for staff's one-to-one observation for a patient with suicidal ideation. In both in-

stances, the veterans attempted suicide during their hospitalization and, tragically, one died.

Our mental health inspection teams consistently review the environment and care practices of VHA's Acute Inpatient Mental Health Units, repeatedly finding lapses in preparing patients for discharge. Because the highest risk for suicide occurs within the first 30 days after hospitalization, VHA staff should unfailingly carry out activities such as pre-discharge screening, determinations of access to lethal means, and a suicide prevention safety plan to confirm that a hospital discharge is appropriate and safe for each patient.

Third, while the tragedy of a veteran's suicide can overwhelm survivors and healthcare teams, lessons learned can and must support efforts to reduce future suicides. Our work has identified numerous delays and deficiencies in important internal VA reviews after a veteran completes suicide, including root cause analyses, peer reviews, institutional disclosures, and family interviews. Such delays not only impede improvements, but also deprive loved ones of important grief management resources.

The last report in my statement was published just last month on the role of VISN chief mental health officers. Across these 18 regional networks, the chief mental health officers reported they lack clarity about their role and the authority to effectively address staff noncompliance. In effect, VHA's governance structure may contribute to problems with performance and hinder opportunities for processing improvements.

There will never be a single solution to the devastating problem of veteran suicide. Still, we must continue to work toward saving every life. That means not losing sight of what needs to happen today and every day: providing wraparound services that treat known risk factors for suicide, from prevention, such as anxiety and depression management, substance use disorder interventions, PTSD and military sexual trauma treatments, and grief counseling. VHA providers must meet veterans where they are and be ready to effectively intervene during their greatest moments of need. The OIG is committed to conducting oversight to ensure all veterans have access to the high-quality and compassionate care they need and deserve.

Madam Chair, this concludes my statement. I would be happy to take any questions.

[THE PREPARED STATEMENT OF JULIE KROVIAK APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Dr. Kroviak. We will now move to questions and I yield myself for 5 minutes.

I just wanted to start with you. You spoke a little bit, Dr. Kroviak, about staff noncompliance and about the VISN mental health chiefs being kind of frustrated with their ability to understand what their role is. Could you expand on that just a little bit, because I know we have talked about that in different parts of this committee, and what that looks like?

Dr. KROVIAK. Yes, I think there is this poorly defined or lack of clarity in what these critical leaders' roles should be in place of to being a consultative arm. We just repeatedly find that when we are in a facility, if there is an issue brought up, and we go to the VISN

to understand their knowledge of interventions, they either were not aware or felt they could not intervene because that was not in their authority to do so.

Ms. KIGGANS. Would it be helpful to clarify that authority?

Dr. KROVIAK. We think so. We very much think so. The one report on the chief mental health officer is one example. We published other individual hotlines where we really tried to get that message across, that it was concerning that the facility was undergoing such trauma and the VISN either did not know about it or did not effectively intervene or monitor the events that were occurring.

Ms. KIGGANS. The monitoring is there, but just the enforcement of what to do once they identify a problem, what they can—what is the next step they can take?

Dr. KROVIAK. Yes, it becomes unacceptable for this regional source of expertise to just serve in a consultative role, waiting to hear about an issue, and we have repeatedly identified that in the reports.

Ms. KIGGANS. Thank you. Thank you very much for clarifying that. Then we have all heard the saying if you have seen one VA, you have seen one VA. My concern here is that all VA facilities operating off agencywide standardized policies for mental health. How is it that interpretation and adherence to VA's mental health policies varies so much between VISNs and facilities? Either Dr. Wiechers any of you can answer.

Dr. WIECHERS. Thank you for the question. We do have national standards and policies in place for mental health and for suicide prevention. The question of why is there variation, there are several possible causes for that.

One could be that our policy needs to be better clarified and written more clearly. That is something that I take personally to heart and that I am working with my team as we constantly review and update our policies to ensure that we have clear language.

The other could be about ensuring that there is clear training to help educate the field staff and our colleagues at the VISN level about that. We work hard to ensure we have those trainings available and that they are consistent across the system. We work closely, also, with our VISN partners and our facility leaders with open communication. We have regular meetings with our VISN chief mental health officers every week. Then the VISNs, and I will let Dr. Stazzone say more about the communication that they have regularly between facility leadership and VISN leadership.

I think it is a matter of ensuring we have clear policies with standard trainings and clear lines of communication. We are working on all of those things, thanks to the OIG providing us some opportunities in areas where we may have gaps to focus on.

Ms. KIGGANS. Could that clarification include role clarification at the VISN level, what Dr. Kroviak was just talking about?

Dr. WIECHERS. Yes. I am pleased to report that Office of Mental Health has already drafted a functional statement and roles and responsibilities with our partners in the VISN chief mental health officer role. We look forward to having that role clarity for everybody across the system in each of the VISNs very soon.

Ms. KIGGANS. Thank you. Thank you.

Dr. Stazzone, do you have anything to add?

Dr. STAZZONE. No. I appreciate Dr. Wiechers' comments and, as she said, at the VISN level our role is to make sure we have the policies from Office of Mental Health and Office of Suicide Prevention. We meet regularly with them as well as in the VISN we have regular huddles, and also meetings regularly with the facility leadership to make sure those things are going forward.

I think it is important that there is some standardization and understanding authorities across the network. As any healthcare network, you need to have standard processes and policies to follow through and our goal is to make sure those are being followed through to the front lines. Healthcare is a very complex system and trying to make sure we have the right processes in place to follow the policies, to make sure our frontline staff can do the right things and follow through with those is critically important. Communication across the network also up to central office and down all the way to facilities is key. I will speak with VISN 9, we try to do that as much as possible. Our chief medical health officer reports directly to me.

Ms. KIGGANS. I am just curious about the communication flow. I know in my district in Hampton Roads, Virginia, has one of the largest veteran populations and just practicing in primary care there, and I know we have many patients who would receive some level of care at the VA because it entailed great services that they enjoyed: cheap hearing aids, eyeglasses, medications, this type of thing. Then they would come to receive community care from different civilian providers.

One of my biggest frustrations was just trying to get patient notes and documents related to my patients, especially on the mental healthcare side, which I know there is certain privacy issues with mental health. Even from the civilian provider side it was challenging to get notes and an accurate prescribing record, which I thought was perhaps most important, too.

How does the VA work with community providers to make sure that information is shared so providers are making informed decisions about a veteran's especially mental healthcare?

Dr. WIECHERS. Thank you for that question. The office at oversees Community Care works with our third-party administrators in helping manage the network of providers in the community, and working together to get that information back is a key area that we need to focus on and I am sure for the reasons that you have mentioned, because that continuity of care and that information is really valuable for the providers back at VA to understand what is happening in the community.

Ms. KIGGANS. Is there a person that goes behind and is doing that personal follow up, too, with the veteran ensuring that once they have left the office—just talking about continuity of care again, that that pace I feel like is where we lose people a lot of times, especially when we get them in the door. We them seen, we have a plan of care, we start a new medication or have a follow-up visit. Who goes behind and makes sure that, on the compliance side, that that is actually happening. Is there a process in place for that?

Dr. WIECHERS. I will have to take that back so that I can make sure I get the most up-to-date information about it.

Ms. KIGGANS. I have always been a proponent, just on the personal side of it, using home health nurse, especially. I mean, there is a lot of benefit to a visitor, too, in people's homes. We have tried to mandate that or make that—it is hard. We do not have home health providers either, but I just think that piece or what are we doing with that continuity of care piece, because they go home and I mentioned in my opening statements just about veterans who are taking multiple psych meds.

I know you all understand what that interaction piece looks like. It frustrates me when I have surviving family members that will show me bags of medication that they do not know what this is. It was a combination of things that they would, again, take more if they felt worse and less if they felt better. There was some disconnect between when these medications—a lot of disconnect between when these medications were prescribed, how they got to be lumped together, you know. Then it just goes back to the communication flow, which is a source of frustration for me

Again, on the civilian provider side, I think an, you know, electronic health record may be a helpful thing. We will keep working through that. Just that communication piece, that follow-up piece, that continuity and care piece, along with moral clarification and all the other things that I know you all are focused on in talking about, that piece is just important to me personally.

My time has expired. I will yield to my ranking member.

Ms. RAMIREZ. Thank you, Chair. I want to thank you all for being here again. Really appreciate it.

Dr. Wiechers, I want to specially thank you for being here today. Behind me in a moment you will see are the instructions that accompanied a rubric VA supervisors were required to fill out justifying why their employees should not be subject to the agency's planned reduction in force, or what we call the RIF. Supervisors, who are clinicians themselves and who manage employees providing mental healthcare, were obligated to fill out this rubric. As I look at it, having been a manager myself, I find it absurd that the VA could measure mental health providers' value and justification through these very limited scales.

Dr. Wiechers, these instructions require supervisors to provide one to two sentences explaining their special skills, their competencies, and their institutional knowledge for Their positions. How would you fill out this for a mental health provider and the support staff the provider relies on?

Dr. WIECHERS. Thank you for that question. I cannot really speak to a hypothetical. I would have to have an example of a specific individual provider to be able to answer the question. I am just seeing the information that you are providing now in terms of the details. I would respectfully like to take that back and would be happy to take any specific questions you have and report back afterwards.

Ms. RAMIREZ. Thank you for that. Let me just be clear, Dr. Wiechers, this was provided to supervisors already, so this rubric is already available and I am concerned that you would not have seen it prior. Let me ask you this. Do you think one to two sen-

tences fully capture a provider or their support staff importance to the mental health and well-being of veterans?

Dr. WIECHERS. I think that our mental health providers are invaluable resources to our veterans. Obviously the work that they do is complex and is something that is hard to capture in one to two sentences. Nonetheless, I can appreciate the need to have a rubric to make decisions.

Ms. RAMIREZ. Following up on that, the rubric is there. Supervisors have to take time to fill this out. Can you explain to me why supervisors, many of whom are clinicians themselves, were required to take time away from patient care to fill out this rubric?

Let me add a little more. Some providers reported they had to fill this out for over 300 employees, this rubric, and spending some time trying to figure out how in one sentence at most, they could be able to explain the negative service impact of letting that staff person go. I just do not understand.

Tell me, do you think it is a good use of a clinician's time to perform administrative tasks that justify the critical nature of their employees' jobs instead of using their time to provide mental healthcare for veterans?

Dr. WIECHERS. I think putting veterans first is the most important thing that any one of our employees does. Putting the ongoing and sustaining mission and the work that we do is what is most important.

Ms. RAMIREZ. I agree, Dr. Wiechers. We are also here to discuss ways that VA can better screen veterans to ensure that no veteran dies by suicide. I have another follow-up question for you. Will the VA provide gender-affirming care if it saves a veteran from suicide?

Dr. WIECHERS. The Department has made changes to a provision of hormone therapy related to transgender patients, but those who have been receiving that service and continue to, as well as servicemembers who are transitioning into veteran status who are eligible for VHA healthcare. All of our mental health services and preventive health services remain available for all veterans who are eligible for VHA care.

Ms. RAMIREZ. What you are saying, Dr. Wiechers, is that the VA will provide that gender-affirming care if it saves a veteran from suicide?

Dr. WIECHERS. I am saying that the VA is providing services based on the new policy and that mental health services and preventive medical services remain available to all eligible veterans.

Ms. RAMIREZ. Okay. Well, let me pivot for a second here. I know my time is up soon.

Dr. Kroviak, what are the top five clinical severe occupational staffing shortages the Inspector General identified last year?

Dr. KROVIAK. Offhand I do not know the top five, but I do believe the top ones were nurses, physicians, mental health, in particular, psychologists, and psychiatrists.

Ms. RAMIREZ. Got it. Since I only have 15 seconds, Dr. Wiechers, are you aware of the VA barring staff in the field for performing their assigned duties to do veteran outreach within their community? Yes or no?

Dr. WIECHERS. I am not personally aware of that. If you have examples, please share and I would be happy to look at it.

Ms. RAMIREZ. Okay. Just to wrap up, just to put on record, in Chicago, we know that the VA staff are told to no longer go out to the ward offices to do veteran outreach. I guess my last question to you is, do you agree that meeting veterans where they are is a central component to suicide prevention?

Dr. WIECHERS. Yes.

Ms. RAMIREZ. Thank you. With that I yield back.

Ms. KIGGANS. Thank you. We are going to do another round of questions. I just have a couple more since we have a little bit of time.

Dr. Wiechers, could you please explain what policies the VA has reviewed since January to ensure better communication and procedures for servicemembers transitioning to VA care? I know we had a change of administration. We have a new VA Secretary. What improvements have been made to care coordination between the DOD and VA? What do you feel like we should be focused on moving forward?

Dr. WIECHERS. Thank you for that question, ma'am. The VA is working closely with our partners in DOD on transitioning servicemembers. That is work that is been ongoing for some time and continues to this day. I think ensuring seamless transition from servicemember to veteran status is important. In particular, ensuring that we have continuity of mental healthcare, especially for those who may be receiving medications or therapy, treatment as servicemembers, and ensuring that we get them transitioned as smoothly as possible to receiving those services at VA.

Ms. KIGGANS. Is that happening? Is that happening where there is a flawless transition or a seamless transition with charting and records?

Dr. WIECHERS. We are working to ensure that it happens smoothly for everyone. We have lots of folks working together with out colleagues in DOD to help ensure that that is taking place.

Ms. KIGGANS. Okay. Tell us what you need and what we can be helpful with to make that happen. I think that transition piece is critical and challenging in so many ways, but I think with the mental healthcare case we should prioritize that and we owe that to our veterans, especially now.

Can you talk to me, Dr. Kroviak, about just staffing? Staffing. Do you feel like there are issues with staffing shortages? There is a lot of talk, a lot of misinformation, a lot of fear mongering. I do not believe that.

Then, also, could you talk to me a little bit about your use of advanced practice nurses and if you feel like they are being best utilized in the mental health environment?

Dr. KROVIAK. In terms of staffing, you are right. We have not seen the Secretary's plan for what the actual final staffing cuts or decreases in staff will be, but we report annually on clinical staffing shortages. That is a congressionally mandated report. We are doing our work on that now and that will be published probably by the end of the summer. Those are perceptions at each individual facility level as to what the most critical clinical and nonclinical shortages are.

A reminder that it is so important the staff member that meets with the patient, but in that arrangement there are multiple back-

stage staff who are coordinating so many activities to ensure the effectiveness of that meeting between the provider and the patient.

The work we do on our cyclical reviews, hotlines, nationals, we will capture when there are staffing concerns. We might go in for an allegation specific to substandard care and find out that the staff are reporting ineffective staff, too few staff, prolonged vacancies. Our work will continue to ask those questions, and we will absolutely report the findings.

Then your question about nurse practitioners, we have not looked specifically at their use or barriers to using them more so in mental health arena, but we know they are used across the system. With the shortages of providers within VA and without, I cannot imagine that there is not an increased need to encourage their participation in that care.

Ms. KIGGANS. Yes, and they are a great source of, if I might add, of being able to fill those gaps in care. Please make sure we are utilizing all of our advanced practice nurses as well. Hampton VA, which is the VA facility near my district, a lot of challenges we are working through, but when I have had the opportunity to visit and on the mental healthcare side, I think they do a great job and I hear great things about that piece. There are some other pieces we could work to do better, but I am thankful for that and I hope that all VA facilities are prioritizing that care. I know it takes a team. This is not just a provider. That is an important piece and making sure our providers are supported is important, too, when we think about staffing. That is good.

Providing that reassurance, and I know Secretary Collins has done a good job throughout the country really. He has been down to Hampton Roads, but other places as well, just reassuring people that we are focused on staffing. We have picked up the phone, make sure we are focused. We are going to be protective of the actual provider piece, the nurses, the physicians, the allied heart health partners, who touch our patients. Just, again, providing that reassurance piece I think is important.

I wanted to have each of you, if you do not mind, talk about just alternative treatments for mental health. I think that everyone responds differently and we need to meet the veteran where they are at. We have done some discussions in this committee talking about alternative treatments from psychedelics to Electroconvulsive Therapy (ECT) to different—you know, there are a variety of treatments out there.

Can each of you respond just about how you feel that is going in the VA? Is there room for improvement? I feel like we need to do more and probably quicker about, again, meeting the veteran where they are at, what do they respond to? but I am just curious as to your opinions.

Dr. WIECHERS. Thank you for that question. The VA has been growing its use of what we call the somatic treatments. Those are things like ECT, transcranial magnetic stimulation, ketamine infusions, and intranasal S ketamine. Over the last 5 to 7 years we have seen growth and expansion across the system. Could we do more? Yes. We continue to try to expand access to those, both in direct care and also through referral to community providers.

We have, as I know you are aware, we have announced an Request for Application (RFA) for funding of psychedelic research and that is something that continues moving forward at VA. We also have studies ongoing for stellate ganglion block, excuse me, and other kind of emerging therapies as well. I think we are doing a lot in the research space and the innovation space. Then in terms of our existing standards of care for difficult to treat depression or other types of mental health conditions that fail to respond to initial courses of treatment, we have a menu of options available to veterans and we are working on expanding access to those.

Ms. KIGGANS. Good. Thank you.

Dr. STAZZONE. Thank you, Madam Chair. As Dr. Wiechers said, we look at evidence-based therapies to make sure we are doing the right things for the veterans that has been proved effective. There is lots of research in the VA as well. I will say our geriatric research centers also have research into dementia and psychosis as well for mental illness in geriatric populations, which is important.

At this time, treatment-resistant depression, I will speak for VISN 9. We are try to implement three modalities of treatment, ECT, transcranial magnetic stimulation, and ketamine infusion, at all of our sites. All veterans have access to the most up-to-date and evidence-based treatments. I know there is much research going on, as Dr. Wiechers already spoke about, and as those new studies come forward with possibilities, you know, we will adapt those with evidence-based treatment.

Dr. KROVIAK. I will say from an oversight perspective nobody does mental healthcare like VA. They are absolutely pioneers in this field, and we are very encouraged by the previous, ongoing, and forward-looking research that continues. I hate to say it, but we look forward to doing oversight work.

Ms. KIGGANS. Yes, and I appreciate you are just always working to expand the treatment options for veterans and on the geriatric side, too. I mean, I think that is a whole other discussion probably for a whole other committee. I feel like there is not enough focus on that. Our veterans are older adults usually and geriatrics is technically over the age of 65. That is a large, probably, percentage of our veteran population. I know at the Hampton VA, we had one geriatrician on staff and that was not enough and she had some great nurses working with her. Focus on that piece and thank you.

I think we could always have more when we talk about studying dementia as a cognitive impairment. That was my specialty as a geriatric nurse practitioner. But I just in my perfect world, yes, we have a whole other section of the VA that focuses on geriatrics. We talk a lot about mental health and another just personal passion project of mine, but on the geriatric side we do not have advocates for older adults and their specific needs for the patient and for their families and caregivers. We will table that for now, but look forward to future discussions about taking care of our older adults.

With that, I will move to my ranking member if she has any last questions.

Ms. RAMIREZ. Thank you. I just want to follow up.

Dr. Wiechers, as the chair mentioned in her opening, overdoses claim too many veterans' lives. Do you think that Narcan saves lives?

Dr. WIECHERS. Yes.

Ms. RAMIREZ. Will the Trump administration cuts to Narcan funding lead to more overdose deaths, including veteran deaths?

Dr. WIECHERS. I cannot speak to hypotheticals.

Ms. RAMIREZ. You do agree that Narcan saves lives and we should have adequate funding to be able to continue to provide it?

Dr. WIECHERS. I agree that Narcan saves lives and the VA's overdose education and naloxone distribution program has been award-winning and has saved many veteran lives.

Ms. RAMIREZ. All right. Well, let me shift here then for a second to talk more about it. Can you please describe the partnership between the Substance Abuse and Mental Health Service Administration, or what we call SAMHSA, and the VA? Follow up with the second part of it. How does that partnership improve mental health treatment and support services for veterans?

Dr. WIECHERS. What I can speak to is the partnership that I personally have been engaged with colleagues at SAMHSA in as it relates to ongoing work in our development of strategic plans for psychedelic treatments. I believe that our partnership is strong and the connection between our two agencies helps both SAMHSA and our veterans at VA.

Ms. RAMIREZ. Are you concerned that cuts at SAMHSA will affect the VA's ability to provide services to veterans suffering from substance abuse disorder and other mental health challenges?

Dr. WIECHERS. I believe that the VA will continue to provide high-quality access to substance use disorder drug treatments and for mental health treatments for its veterans.

Ms. RAMIREZ. Okay. Let us get a little bit more into that. I want to know how you are going to do that. How will the VA fill in the gaps if SAMHSA is gutted?

Dr. WIECHERS. I will have to wait and see. Again, I cannot provide response to hypotheticals. We will adapt and ensure that all of our veterans continue to have access to Substance Use Disorder (SUD) treatment and mental healthcare.

Ms. RAMIREZ. Yes, but, Dr. Wiechers, I hear you say that you cannot work on hypotheticals. You should be planning. As you are already hearing, there is going to be cuts to particular programming. For me, if we are having real conversations about ensuring that veterans have the resources they need, then you should already be planning on coordinating what you are going to do to fill those gaps. You are telling me that you will be prepared to be able to ensure that veterans continue to get the resource they need. It is hard for me to hear you say you are prepared to ensure that we continue to provide the resources, we have the partnerships we have, but you are not doing any planning.

I think that is part of the challenge that we have seen, particularly in this committee, is that there is no adequate planning or even real strategic consideration when we are talking about letting staff go. We really have to be asking ourselves, when we are making these major decisions and shifts and changes, what will the impact, in fact, be for our veterans and what are we doing in advance to ensure that the veterans that we say that we serve are not impacted by it? I have to say that as you say that, it is really difficult for me because you can keep saying I cannot really plan a rhetor-

ical, but if you are not actually planning for things you already know that are coming, then that is a concern for me, especially as we know how critical the work of this committee is in oversight.

Let me come back to something real quick that I started talking about at the end and, with that, I will yield back to the chair. I mentioned to you that the VA is barring staff in the field from performing their assigned duties to do veteran outreach within their community in a number of locations. We have invited the VA to come to some of the outreach events that we do, particularly around housing, healthcare, and other resources. I submitted a letter March 6, asking why this is happening. You said you were not aware that this was happening. I want to make sure that on the record I know that I submitted a letter over a month ago and I have not received the response. I wonder if, by any chance, do you know that a letter was sent and if you know there is an update on when I can expect a response?

Dr. WIECHERS. Thank you for the question. I will take that back and we will get into it for an answer as to when you can expect your response.

Ms. RAMIREZ. Thank you. Appreciate that.

With that, I yield back to the chair.

Ms. KIGGANS. Thank you. I have no further questions.

Ranking Member Ramirez, do you have any closing remarks?

Oh, I am sorry. Well, we have a new member just joining us, so we will recognize Congressman Kennedy for 5 minutes and then we will close.

Mr. KENNEDY. Thank you very much. Thank you all for being here today, for your service to this country, for your testimony.

Before entering public service, I served as an occupational therapist. My work focused on helping people navigate the challenges of daily life and understanding that health is not just about physical recovery, but it is also about mental and emotional well-being. I saw firsthand how addressing mental health is just as critical as treating physical conditions. Without quality mental healthcare, true healing is incomplete. Our veterans deserve no less, as we know.

I am deeply concerned that VA's and mental health services are not meeting the rising demands of veterans. Because of reckless cuts by this administration, instead of much-needed investment in our bravest, veterans are facing long wait times, workforce shortages, and barriers to accessing a full range of services that they need. If we are truly committed to honoring our veterans' service and sacrifice that they have made, we have to ensure quality, timely mental health support at the gold standard level of care alongside their physical care.

With that, I have a few questions. You know, first and foremost, the VA and this administration are now forcing employees, many of whom were hired as remote workers, to return to office. Dr. Wiechers, was the VA aware of the space constraints for mental health providers before ordering them to work in the office?

Dr. WIECHERS. Thank you for the question, sir. We have a process in place to review at each of the local facilities the space available before any Return to Office orders are submitted to employees

to return. The space available is being considered as we return people to office.

Mr. KENNEDY. Is the agency concerned about the Health Insurance Portability and Accountability Act (HIPAA) violations as providers of reported staff overhearing sessions and the lack of privacy after being placed in congregate settings?

Dr. WIECHERS. All of our facilities and providers are held to the highest legal and ethical standards related to privacy and we have processes in place. Should people be concerned that the space they have available is not suitable for privacy concerns for the care that they are providing, we have processes at each of the facilities that allow other those staff to report those concerns so that they can be addressed and ensure that privacy of our veterans is held sacred, as it should be.

Mr. KENNEDY. Thank you. Dr. Wiechers, on March 4th it was announced that the VA planned to eliminate over 80,000 jobs, which would certainly include mental health providers. Thankfully, that directive is now on hold. Since the VA is already facing a shortage of mental health providers, how does the Department plan provide responsive mental health services in light of these cuts? Were you consulted before the announcement of these cuts?

Dr. WIECHERS. Thank you for the question, sir. There are 30,000 frontline provider and staff positions that are exempt from the hiring freeze and other actions. Included on the list of those 300,000 staff providers are all of our different types of mental health providers. Psychologists, psychiatrists, social workers, marriage and family therapists, Licensed Professional Mental Health Counselor (LPMHCs), peers, all of those folks and our frontline mental health providers are on the exemption list.

Mr. KENNEDY. Is there hiring taking place right now?

Dr. WIECHERS. There is hiring taking place right now. I believe Dr. Stazzone can speak explicitly about VISN 9.

Dr. STAZZONE. Thank you, Dr. Wiechers. Thank you, Congressman. Yes. As Dr. Wiechers said, 300,000 positions were exempted from the hiring freeze. There is ongoing hiring for those positions. In VISN 9 we have a dashboard for workforce management that list the vacancies. We follow through with those and continue recruitments for all the frontline positions that are exempted.

Mr. KENNEDY. While there is hiring that is taking place, are these folks being onboarded?

Dr. STAZZONE. Yes, Congressman.

Mr. KENNEDY. Can you commit to sending this committee data on the number of employees and occupations that have been onboarded since January of this year?

Dr. STAZZONE. Yes, I will take that back Congressman for all employees. I can only speak to VISN 9, but there is a dashboard from workforce management. I believe they can get you those numbers.

Mr. KENNEDY. I think it is vitally important that we have that data. It is one thing to make an argument that there are exemptions while there are tens of thousands of potential cuts and we need to know what those exemptions are, where they are. If there is an argument that there is hiring that is taking place, we need to know if those people are actually being hired and onboarded and put to work rather than just put into a process and not to be

brought onboard. It is very important information. We would appreciate you bringing that to us.

Madam Chair, I yield back.

Ms. KIGGANS. Thank you. Now we will move to our closing.

Ranking Member Ramirez, do you have any closing remarks?

Ms. RAMIREZ. Thank you, Chair. I want to ask as we are wrapping up unanimous consent and to a few of news articles related to veterans' mental health into the record: from Reuters, on democracy, the New York Times, NPR, The Hill, Military.com, and NBC News.

Ms. KIGGANS. So ordered.

Ms. RAMIREZ. Thank you. I would also like to ask for unanimous consent to enter six testimonials from veterans whose mental health is being affected by the cuts to the VA workforce and their ability to receive care.

Ms. KIGGANS. So ordered.

Ms. RAMIREZ. Thank you. I want to end by reminding my colleagues that in order to honor our veterans' service with action we must defend and protect their access to mental health services. That starts by making sure that mental health providers are available.

I look forward to our work and the follow ups we will get from the witnesses today. Thank you.

With that, I yield back.

Ms. KIGGANS. Thank you. For my closing remarks I just want to thank the witnesses for coming in to testify today. We have gained better insight into the VA's mental health policies, the effectiveness of the services they provide to veterans, and how you are working to improve these processes. Thank you very much for clarifying about the mental health providers and partners that are exempt from the cuts and hiring freezes.

We have said this time and time again, straight from the Secretary's mouth, thank you very much for your presence here today and to clarify that. We will continue to clarify that and to remind our veterans that mental healthcare and their health care in general remains a priority. I have personally picked up the phone multiple times to ensure that these positions are not being cut so I can provide some personal validation to them as well. Thank you very much for putting that on the record.

We all know that while the VA has worked hard to provide support for mental health challenges, our veterans continue to struggle. We also know that providers are working hard. I wanted to say a special thank you to them because they are often an underappreciated group; our physicians, our nurses and all of our allied health partners and their staff who work so hard every single day.

We cannot let fearmongering or partisan politics get in the way of achieving results for our veterans. It is one of the reasons I love working in the healthcare space. I feel like it should always be a nonpartisan issue. I think that we should work to hopefully remember that and hopefully we can get there.

The VA must continue to prioritize a quality workforce that can deliver world-class mental health services and meet veterans where they are. We can no longer ask the veterans to navigate the VA's bureaucracy when what they need is help. I know we are all work-

ing hard and have the same objectives here. It is essential that we have our veterans' backs and we reform our approach to improve the policy and services that the VA provides to veterans.

Thank you all so much for taking the time to be here today.

I ask unanimous consent that all members should have 5 legislative days in which to revise and extend their remarks and include any extraneous material.

Hearing no objections, so ordered. This hearing is now adjourned.

[Whereupon, at 11:03 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Ilse Wiechers

Chairwoman Kiggans, Ranking Member Ramirez, and distinguished Members of the Subcommittee. Joining me today is Dr. Anthony Stazzone, Chief Medical Officer of the VA MidSouth Healthcare Network. It is an honor to be here on behalf of VA to discuss the critical work we are doing to ensure our Veterans receive the high-quality mental health care they deserve.

Introduction

Veterans face unique mental health challenges. While many Veterans are very successful and fully integrated back into society, some invisible wounds of war have manifested in conditions like posttraumatic stress disorder (PTSD), depression, and substance use disorders (SUD). These issues, combined with life transitions after military service, contribute to an elevated risk of suicide. In response, VA has developed a broad continuum of mental health services intended to ensure Veterans receive the help they need. This continuum ranges from crisis intervention and screening to same-day access for urgent mental health needs, as well as outpatient, residential, and inpatient care across the country. VA medical centers, community-based outpatient clinics, Vet Centers, the 24/7 Veterans Crisis Line, and a nationwide network of Suicide Prevention Coordinators (SPC) all serve as points of access.

VA's mental health services are designed to be accessible, evidence-based, and recovery-oriented, ensuring that all Veterans receive the mental health support they need, regardless of where they access care. By emphasizing early intervention, continuous support, and the seamless integration of mental health into overall health care, VA is committed to enhancing the well-being and resilience of Veterans nationwide.

Most Veterans who utilize VA health care services report positive experiences and satisfaction with VA mental health care, including the availability of essential services, the strong emphasis on the privacy and confidentiality of medical records, the ease of accessing VA mental health services, the expertise and professionalism of the mental health care staff, and the courtesy and respect demonstrated by the staff toward patients.

In 2018, VA published the National Strategy for Preventing Veteran Suicide [1] which emphasized the need to develop and implement of a public health approach to suicide prevention. The public health approach combines both community prevention and clinical intervention actions that directly serve Veterans. The National Strategy focuses on preventing suicide for all Veterans, as well as selective and indicated strategies for reaching Veterans at higher risk for suicide. VA Suicide Prevention has fueled ongoing work with our partners in the Department of Defense (DoD) to support transitioning Service members. VA's commitment to preventing Veteran suicide is also interwoven throughout all mental health treatment programs and bolstered by enhanced staff educational requirements in suicide prevention.[2]

Let me be clear: the Secretary has made preventing Veteran suicide a top priority for VA. We face a sobering reality that demands acknowledgement: Since 2008, the number of Veterans who died by suicide each year has remained essentially unchanged at roughly 6,500 per year. Yet over that same period, VA spending on suicide prevention has increased by more than 11,000 percent, from $4.4 million per year in 2008 to $522 million per year in 2022. In other words, VA spending on suicide prevention is now more than 100 times what it was in 2008, but we're getting the exact same results. This status quo is unacceptable.

This new Administration and VA leadership are committed to challenging the status quo in order to find new and better ways of helping Veterans. We cannot con-

[1] https://www.mentalhealth.va.gov/suicide__prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf

[2] VHA Directive 1071, Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

tinue approaches that have failed to produce meaningful improvements despite substantial resource investments.

Recent reports by the Office of Inspector General (OIG) have highlighted deficiencies in VA's mental health care intake process and adherence to suicide risk identification screening guidance, among other issues. These findings underscore the urgent need for concerted efforts to address policy adherence and to strengthen our initiatives to provide high-quality health care to our Veterans. Despite these challenges, VA is committed to our mission: promoting, preserving, and restoring Veterans' health and well-being; empowering them to achieve their life goals; and to provide state-of-the-art mental health treatments. We are accelerating efforts to enhance access to care, whether delivered in VA facilities or through VA community care when eligible.

This is not simply an organizational priority; it is VA's sacred obligation to those who served. The Secretary has established this as the standard by which the Department's effectiveness will be measured, and VA leadership will accept nothing less than transformative improvement in suicide prevention and mental health care.

Suicide Risk Identification Strategy (Risk ID)

VA staff play an important role in supporting the Department's top clinical priority to prevent Veteran suicide. VA has implemented a standardized suicide risk screening and assessment process, providing Veterans with a high standard of preventive care. This process, known as the Suicide Risk Identification Strategy, was introduced in May 2018. As a population health effort, Risk ID is completed annually for all Veterans receiving VA care. Risk ID is also completed for Veterans receiving care in a VA emergency department and for Veterans seeking mental health services. Additional suicide screening occurs in certain health care settings, such as during intake at an outpatient mental health visit. Risk ID processes ensure that all VA health care systems are equipped to identify Veterans at risk for suicide and connect them to life-saving resources and interventions. Risk ID consists of a primary screen (using a standardized questionnaire such as the Columbia Suicide Severity Rating Scale), followed by a Comprehensive Suicide Risk Evaluation, a templated clinical assessment, for any patient who screens positive. The goal of the evaluation is to determine the Veteran's severity of suicide risk and collaboratively develop a plan for risk mitigation.

VA is the largest health care system in the United States to implement universal screening for suicide risk, highlighting the Department's commitment to comprehensive suicide prevention. To ensure adherence to the Risk ID screening process, VHA issued a memorandum requiring all Veterans Integrated Service Networks (VISN) to confirm that facilities within each network have established procedures for implementing Risk ID requirements across clinical services. This attestation must align with each facility's standard operating procedures and conform to national policy and guidelines by April 7, 2025.[3] In Fiscal Year (FY) 2024, VA completed over 2.6 million suicide risk screenings.

In addition to broad screening efforts, VA also wants all Veterans and former Service members to know that they can access emergent suicide care, no matter where they are. Under 38 U.S.C. § 1720J, as added by section 201 of the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (P.L. 116–214), any Veteran – whether enrolled in VA or not – and certain former Service members can go to a VA or non-VA facility to access emergent suicide care If you're a Veteran in crisis or concerned about one, contact the Veterans Crisis Line to receive, confidential support 24 hours a day, 7 days a week. You don't have to be enrolled in VA benefits or health care to connect. To reach responders, Dial 988 then Press 1, chat online at VeteransCrisisLine.net/Chat, or text 838255.

Enhanced Training and Clinical Guidance

To stay at the forefront of suicide prevention, VA continually updates its clinical guidelines and training programs to support best practices. In 2024, VA and DoD released a new joint Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide, which compiles evidence-based strategies for evaluation, safety planning, and treatment of suicidal individuals. VA providers are encouraged to familiarize themselves with this critical guidance. Additionally, all VHA health care staff must complete suicide prevention training. In recent years, VA has updated these trainings by, for example, creating improved education for all staff related to the steps to take to save Veterans lives, formerly known as

[3] For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update (VIEWS 12521544)

"Operation S.A.V.E." VA tracks and monitors these courses to ensure training compliance.

Additionally, VA has implemented specialty training for SPCs and mental health clinicians on topics like lethal means safety counseling – such as how to talk with Veterans (and their families) about safely securing firearms or medications during a suicidal crisis. By institutionalizing such training and guidance, VA has worked to standardize the quality of care delivered to at-risk Veterans, no matter which facility they visit.

Another enhancement to our suicide prevention infrastructure is assigning dedicated SPCs across all VA medical facilities. SPCs actively monitor Veterans flagged as high-risk, coordinate follow-up care, facilitate safety planning, and ensure compliance with suicide prevention protocols. Regular contacts from a dedicated suicide prevention team during a high-risk period may reduce the risk of new suicidal behavior over time. During times of personal or community crisis, the SPC program provides a model for addressing risks related to mental health and for recovery enhancement. A 2021 study showed that additional SPC contact reduced the odds, between 4–5 percent, of suicide attempt, suicidal behavior, and reactivation of high-risk status within the next year.[4] Our enhanced safety planning practices now involve comprehensive, individualized safety plans collaboratively developed and documented clearly in electronic health records.

VA and DoD also have written CPGs for Bipolar Disorder, Management of First Episode Psychosis and Schizophrenia, Major Depressive Disorder, PTSD, and SUD. VA encourages mental health care providers to familiarize themselves with these guidelines.

With regard to training staff in recommended therapy dissemination, VHA is a recognized leader in ensuring that staff are trained in VA/DoD CPG-recommended therapies. VHA has done this through the National Evidence-Based Psychotherapy and Psychosocial Interventions (EBP) Provider Training Program, which advances access to VA evidence-based mental health through the provision of high-quality, competency-based provider training in VA/DoD CPG-recommended evidence-based psychotherapies and psychosocial interventions. In Fiscal Year 2024,[5] the National EBP Provider Training Program included 14 training initiatives for depression, PTSD, SUD, insomnia, chronic pain, severe mental illness, and suicide risk management treatments. The program trained 2,781 VA mental health providers in 128 workshops and consultation trainings across the full range of mental health discipline professions and mental health work settings in Fiscal Year 2024. The current VHA workforce has nearly 9,000 providers trained to competency, through the program.

All VHA mental health care staff are also mandated to complete training about Military Sexual Trauma and Prevention and Management of Disruptive Behavior. In recent years, the Office of Mental Health has provided staff with numerous additional trainings, for example, trainings on military cultural competence and trainings on how to treat Veterans with comorbid PTSD and SUD. In Fiscal Year 2024, the Office of Mental Health and Mental Illness Research Education and Clinical Centers provided over 1,000 training sessions to VA staff.

Mental Health Policy and Governance

As a program office, the Office of Mental Health provides policy and operational guidance for delivering mental health services across the continuum of care. The Office of Mental Health also provides ongoing monitoring and makes data available to aid VISNs and facilities in implementing mental health programming in accordance with policy and developing action plans to address non-compliance. VISNs are responsible for ensuring the implementation of such action plans, resolving implementation and compliance challenges in the VA medical facilities within the VISN and providing oversight of VISNs to ensure compliance with mental health directives and their effectiveness. The Office of Mental Health works closely to support such operational implementation efforts and develops and maintains dashboards that provide facilities and VISNs with easily accessible and regularly updated program performance information. Weekly forums between Office of Mental Health leaders and VISN Chief Mental Health Officers offer opportunities for compliance-related discussion and planning, as needed. To further support VISNs and facilities with their implementation efforts, the Office of Mental Health has National Mental Health Quality Improvement and Implementation Consultants, assigned to specific

[4] Doran et al. (2021). Associations between veteran encounters with suicide prevention team and suicide-related outcomes. Suicide & Life-threatening Behavior.

[5] https://www.healthquality.va.gov/guidelines/MH/srb/VADoD-CPG-Suicide-Risk-Full-CPG–2024__Final__508.pdf

VISNs and facilities, who complete scheduled and for-cause site visits and are available to work closely with sites in developing action plans to address non-compliance and ensure those plans are informed by best practices and implementation science.

Conclusion

VA is taking decisive action to transform the department's mental health care system for Veterans. The path forward requires VA to embrace innovation, accountability, and proven practices across every facet of its operations.

Meaningful change requires collaboration, within VA and with partners across government, private healthcare, and Veteran organizations. This whole-of-society approach is essential to reach Veterans wherever they may be. The oversight from the Committee strengthens VA's work and helps ensure our focus remains on what matters most: providing Veterans with the exceptional care they have earned. VA looks forward to continuing to work with this Committee and we look forward to answering any questions you may have.

Prepared Statement of Julie Kroviak

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF JULIE KROVIAK, MD
PRINCIPAL DEPUTY ASSISTANT INSPECTOR GENERAL, IN THE ROLE OF
ACTING ASSISTANT INSPECTOR GENERAL
FOR THE OFFICE OF HEALTHCARE INSPECTIONS, VA OFFICE OF INSPECTOR GENERAL
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS,
HOUSE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
ANSWERING THE CALL: EXAMINING VA'S MENTAL HEALTH POLICIES
APRIL 2, 2025

Chairwoman Kiggans, Ranking Member Ramirez, and Subcommittee members, thank you for the opportunity to discuss the independent oversight conducted by the Office of Inspector General (OIG) of VA's mental health services, programs, and policies. The OIG's Office of Healthcare Inspections routinely reports on the quality of services provided across the Veterans Health Administration (VHA) and on risks to patient safety. OIG personnel regularly assess and make recommendations to improve VA's delivery of health care, including mental health and suicide prevention, through inspections of vet centers, inpatient mental health units, individual medical centers, and healthcare systems' networks.[1] Failure to satisfactorily implement and monitor the corrective actions associated with these recommendations undermines VA's commitment to continuous process improvement, allows identified risks to persist, and undercuts VA's ability to provide timely, high-quality health care.

Because VA leaders have made reducing veteran suicide their highest clinical priority, the OIG has conducted significant oversight work to support that effort. OIG Healthcare Inspections teams frequently encounter dedicated VHA leaders and staff who recognize the urgency of assisting veterans in acute mental health crisis, as well as identifying, screening and coordinating higher level interventions for those who are at higher risk for suicide. Yet despite VHA having robust and comprehensive policies, the OIG has found there are staff who repeatedly apply guidance and mandates inconsistently. In addition, VA leaders do not exercise effective oversight or implement quality assurance programs, thus allowing problems to go undetected or unresolved.

This testimony discusses the OIG's examination of VHA personnel's assessment and care management of veterans from the first opportunity for screening and assessment for suicide risk through interventions and follow-up or ongoing care. From veterans' initial clinical encounter or contact with the Veterans

[1] OIG reports may be found on the website at All Reports, with those related to mental health at this list of reports.

Crisis Line, the OIG has found that VHA staff have not routinely conducted the required screening and risk assessments necessary to ensure patients' safety, nor effectively coordinated treatment and after-care. This finding is based on reviews of how well VHA has adhered to standards and principles for suicide prevention and safe care environments, recovery-oriented treatment, care coordination, and discharge practices. OIG's cyclical inspections of vet centers and inpatient mental health facilities have also identified multiple opportunities for improved operations. As the work discussed in this statement demonstrates, VHA must ensure that its leaders and staff use quality assurance and oversight programs to drive improvement. It must also use critical tools to provide care to veterans and support to loved ones grieving after a suicide. In looking at potential causes for VA deficiencies, this statement concludes with findings from an oversight report released just a few days ago describing the ill-defined roles and responsibilities of Veterans Integrated Service Network (VISN)-level mental health leaders, highlighting an opportunity for VHA to engage leaders to improve the efficiency and quality of mental healthcare delivery.[2]

VHA MUST IMPROVE COMPLIANCE WITH SUICIDE SCREENING AND RISK ASSESSMENT ACTIVITIES

Providing quality mental health care to a veteran who may be in crisis begins with accurate screening and risk assessment. Each interaction must be initiated with an understanding of the immediate risk. It is essential that these risk assessments include reviewing the veteran's access to lethal means, considering other risk factors such as alcohol and substance use, and identifying and including individuals who can offer immediate support to the veteran. Without an accurate assessment, a VHA responder cannot make time-sensitive decisions aimed at stabilizing the crisis and initiating appropriate supportive efforts.

Inadequate Staff Training and Lack of Oversight Contributed to VHA's Suicide Risk Screening and Evaluation Deficiencies

Given the importance of this issue, the OIG conducted a national review evaluating VHA's suicide risk screening and evaluation training, adherence to policies, and oversight procedures.[3] Since May 2018, VHA has relied on a standardized Suicide Risk Identification Strategy (Risk ID) requiring annual screening using the Columbia-Suicide Severity Rating Scale. If a patient screens positive, the provider must complete a comprehensive suicide risk evaluation that includes detailed questions about the patient's suicidal ideation, plan, intent, and behaviors, as well as risk and protective factors. The

---

[2] VA, OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*, March 31, 2025. VISNs are VHA's regional care systems established in 1995 to centralize planning, budgeting, and oversight; align resources; enhance patient access to care; and "better meet local health care needs." https://department.va.gov/integrated-service-networks/, accessed March 19, 2025.

[3] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, December 18, 2024. The OIG findings are based on reviewing metrics at over 130 medical facilities nationwide as well as sending surveys to facility- and VISN-level staff with implementation, training, and monitoring responsibilities for the standardized Suicide Risk Identification Strategy.

provider must then establish a risk-mitigation plan.[4] VHA's required suicide prevention training for care providers does not include Risk ID processes or requirements. Although such training has been developed, it is not mandated and completion is not monitored. The lack of mandated training may have contributed to nonadherence to screening and evaluation, underestimation of suicide risk, and ultimately a failure to facilitate risk mitigation.

Additionally, VHA has not established annual Risk ID performance benchmarks and has conveyed inconsistent expectations to leaders and staff. While VHA requires patients receive annual screening, and any positive screen should have a same-day evaluation, in fiscal year (FY) 2023, annual screening and evaluation compliance was 55 and 82 percent, respectively. Notably, the Combined Risk ID dashboard, which monitors adherence to Risk ID ambulatory care requirements and provides data on performance and trends, does not include facilities using VA's new electronic health record system. VHA recognized the need for additional setting-specific suicide risk screening; however, with the exception of emergency department and urgent care settings, it does not monitor setting-specific Risk ID adherence, such as outpatient mental health treatment, opioid use programs, and sleep and pain clinics.[5]

Further, the OIG found staff faced barriers to completing Risk ID screenings and evaluations, including the following:

1. **Limited engagement of facility clinical staff.** VHA leaders acknowledged the importance of engaging nonmental healthcare staff "to "embed Risk ID into their workflow." One leader suggested those clinical staff may be hesitant to screen patients due to discomfort about what to do when the screening is positive. Additionally, more than half of facility clinical staff the OIG team interviewed perceived Risk ID as the responsibility of suicide prevention program staff.
2. **Lack of facility leaders' support.** Facility staff also spoke about the importance of leaders' support in Risk ID implementation and adherence. Leaders from the then-Office of Mental Health and Suicide Prevention (OMHSP) also acknowledged the importance of engaging VISN and facility leaders in Risk ID implementation, adding a Risk ID evaluation metric to VISN and facility directors' performance plans to communicate expectations and ensure evaluations are completed timely following positive screenings.[6]

---

[4] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., May 23, 2018.

[5] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies.*

[6] OMHSP was reorganized into two offices in April 2024: the Office of Mental Health and the Office of Suicide Prevention. The offices develop and implement mental health and suicide prevention policy, respectively.

3. **Limitations of performance data.** VHA provides an evaluation adherence report, which allows facility staff to view the number of missed screenings within a clinical service, but does not provide patient-identifying information or the name of the provider who did not complete the required screening.
4. **Unclear delineation of responsibilities.** The OMHSP "in conjunction with" the Mental Illness Research, Education, and Clinical Center (MIRECC) have shared responsibility "for monitoring Risk ID implementation and providing feedback to facilities through VISN Chief Mental Health Officers."[7] MIRECC, however, does not have the authority to establish policies or ensure Risk ID implementation. The OIG concluded that the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement.

The OIG made six recommendations to the under secretary for health related to suicide risk and intervention training, suicide screening and evaluation performance benchmarks, setting-specific Risk ID monitoring, effectively addressing barriers to Risk ID nonadherence, nonmental health clinical specialty leaders' awareness of Risk ID requirements, and clear identification of Risk ID monitoring and oversight responsibilities. As of March 31, 2025, all six recommendations are open.[8]

A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions

The OIG recognizes the extreme pressure Veterans Crisis Line (VCL) responders face in meeting the immediate needs of a veteran in acute distress when there is no room for error. The time between contemplation of suicide and an attempt can be minutes, and failing to immediately and accurately assess such risk can be fatal for the veteran. An OIG healthcare inspection following the death by suicide of a veteran in their mid-thirties less than an hour after interacting with a VCL responder revealed (among other issues discussed later in this statement) significant deficiencies in VHA staff training and actions.[9] The patient had prior documented reports of suicidal thoughts and behavior over almost three years and described a plan for suicide involving firearms and hanging themselves from a rafter in the shed in text messages to the responder. The responder documented that the exchange ended without incident. An independent OIG review of the actual text messages found the VCL responder's

[7] MIRECC's mission is to decrease veteran suicide risk through innovative prevention strategies, clinical interventions, and increased information sharing and veteran treatment options. Rocky Mountain MIRECC, https://www.mirecc.va.gov/visn19/aboutus/index.asp, accessed March 17, 2025.

[8] At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 30 calendar days to respond. The OIG began to follow up with VHA for progress updates on the recommendation's implementation in March 2025. Nothing precludes VA from providing interim progress reports.

[9] VA OIG, *A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas*, September 14, 2023.

documentation of the texts inaccurately summarized the exchange and the responder did not offer critical support and interventions to the veteran who was clearly in crisis. Among the findings, the responder did not assess and address risk and consider immediate rescue efforts, failed to understand the veteran's access to identified lethal means and alcohol use, and neglected to access the support of an on-site family member. The specific OIG recommendation related to improving documentation and oversight of staff who provide crisis management services has been closed following the receipt of satisfactory evidence of compliance.

Delays and Deficiencies in Mental Health Care of a Patient

A July 2024 healthcare inspection report found several instances in which a medical center's staff and leaders did not follow VHA policy, resulting in delayed and inadequate mental health care for a patient.[10] The staff did not arrange an evidence-based psychotherapy (EBP) referral for a patient noted to be at high risk for suicide in their record (high-risk flag). The staff did not provide in-person EBP until over a year after the patient's request for mental health care, inconsistent with VHA's requirements.[11] In addition, schedulers also noted a lack of staff to provide EBP over a five-month period, although they did not consistently document attempts to contact the patient as required.[12] A psychiatrist also did not sufficiently address the patient's access to lethal means by not discussing the patient's access to ammunition nor document the patient's comments during a related conversation. Although the OIG did not find that the lack of documentation resulted in a negative outcome, incomplete lethal means discussions may hinder an understanding of a patient's suicide risk and care coordination.

The OIG found that in the 30 days following high-risk flag initiation, staff did not meet with the patient four times as required by VHA.[13] The staff met with the patient twice, and a high-risk case manager unsuccessfully attempted to contact the patient twice. Although a negative outcome was not identified, there was no documentation that the case manager sought help in reaching the patient. Lack of

---

[10] VA OIG, *Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas*, July 31, 2024.

[11] VHA Directive 1160.05; VHA Directive 1230, Outpatient Scheduling Management, July 15, 2016. This directive was in place during the time of the events discussed in the report. It was rescinded and replaced by VHA Directive 1230, Outpatient Scheduling Management, June 1, 2022. Unless otherwise specified, the two directives contain the same or similar language regarding outpatient scheduling requirements.

[12] VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure," updated October 26, 2021. This was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure," updated July 28, 2022. The 2022 standard operating procedure contains the same or similar language regarding minimum scheduling effort requirements.

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to Veterans Integrated Services network (VISN) Directors (10N1-23), VISN CMOs (10N1-23), and VISN Chief Medical Health Officers (10N1-23), October 5, 2021; VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

consultation with a supervisor or suicide prevention coordinator may contribute to insufficient suicide prevention actions in the case of high-risk patients.

The OIG also found the facility did not follow VHA's requirement that staff review or update the patient's safety plan and coping strategies.[14] In the 30 days after the high-risk flag initiation, neither the psychiatrist nor a homeless program social worker reviewed or updated the safety plan with the patient. Further, the homeless program social worker did not assess the patient for suicide risk, as required by facility procedures.[15] An OMHSP leader reported that staff for the homeless program were not expected to review or update the safety plan during high-risk follow-up appointments.

VHA concurred with the OIG's single recommendation to the under secretary for health to clarify requirements for completing suicide risk assessments and safety plan reviews by homeless program staff. The recommendation was closed after VHA implemented a plan requiring training for homeless program field staff on the mandated completion of suicide risk assessments, including a review of safety planning, and the wide dissemination of the training and available resources. The facility director concurred with the five recommendations related to EBP consult management, timely scheduling, and documentation; VA-issued devices; lethal means safety; and high-risk flag follow-up. The OIG will monitor progress on the remaining recommendations until all are closed.

Vet Centers Can Do More to Assess Suicide Risks and Make Safety Plans

Vet centers are important community-based facilities providing psychosocial services to eligible veterans, active duty and reserve service members, National Guard members, and their families. The OIG uses its cyclical Vet Center Inspection Program to ensure that vet center counseling is provided in accordance with VHA policy for safe and effective social and psychological services.[16] Most importantly, the inspections help verify whether vet centers are appropriately identifying and engaging with the most high-risk veterans and collaborating with VHA facilities to ensure that any needed care is provided. Specific focus areas are selected to help provide insight into a client's experience when they seek care or services. Current inspection focus areas include leadership and organizational risks; quality reviews; suicide prevention; consultation, supervision, and training of counselors; and the environment of care. The OIG teams evaluate a vet center's compliance with initiating and coordinating the clinical services required to support veterans deemed to be at high risk for suicide.

These inspections and site visits provide evidence of frequent noncompliance with many required processes, most notably procedures for assessing and documenting a veteran's suicide risk. VHA's Readjustment Counseling Service (RCS) manages vet centers and provides policies to guide the assessment and care management of individuals who are considered at risk for suicide. Vet center

[14] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum; VHA Directive 1166.
[15] Facility Standard Operating Procedure, "Management of High Risk for Suicide Patient Record Flags," March 17, 2022.
[16] All OIG Vet Center Inspection Program reports can be found in this filtered list of reports.

counselors are required to complete a suicide risk assessment for every client at the initial visit and subsequently as indicated. For any client found to be at intermediate to high risk for suicide, counselors must then complete a safety plan, which should identify personalized coping strategies and supportive resources these clients may use to lower their risk of suicidal behavior. OIG teams repeatedly found noncompliance with required procedures documenting suicide risk and a lack of oversight to ensure staff are adequately trained to provide quality services and timely document their work.

Through the inspections, OIG teams have identified three major contributing causes for the weaknesses:

1. **Lack of clear and standardized RCS policies.** The delivery of consistent, high-quality service at vet centers is reliant on clear and consistent policies to guide frontline staff. OIG inspections have found the varying applications of policies are often due to misinterpretation caused by vague, confusing, or conflicting language, or cumbersome processes. For example, RCS staff reported lacking an understanding of the purpose and requirements of the High Risk for Suicide Flag SharePoint site established by RCS to easily identify and anticipate the needs of vet center clients identified as high risk or potentially high risk for suicide by VHA medical facility. The SharePoint site should be used to increase communication with VHA regarding these clients.

2. **Challenges in staffing and workload.** Through interviews and surveys of RCS staff, the OIG gathered consistent reports that noncompetitive salaries and vet center positions with low grade levels on the General Schedule pay scale contribute to vacancies. Vet center and district leaders recognize the challenges but those in acting positions have limited authority to address them. Additionally, leadership teams told OIG staff that it is a challenge to oversee the large number of vet centers in each designated zone.[17] Many of the deficiencies the OIG identified, including missing or insufficient suicide risk assessments, may be improved with more focused zone oversight.

3. **Deficiencies in RCSNet, the vet centers' electronic client record system.** Many areas of noncompliance identified by the OIG's Vet Center Inspection Program were affected by the limitations of RCSNet, the electronic recordkeeping system used by vet center staff. OIG inspection teams observed that RCSNet did not have a function to easily determine when required documentation for specific assessments had been completed. This limitation has made it difficult for RCS leaders to conduct quality oversight and has hampered the OIG's ability to make timely determinations regarding the quality of services and care provided. RCSNet does not allow users to alert care providers to clinical reminders as well as client behavior or suicide flags. Functionality is also insufficient for collaborative or supervisory staff to cosign notes, for limiting system users' permissions that could compromise the integrity of the record, and for viewing scanned records alongside other documentation in a

[17] Each of the five RCS districts consists of two to four zones. Each zone consists of 18 to 26 vet centers.

client's record. RCS staff responses and opinions shared with OIG inspectors related to RCSNet's capabilities were consistently negative.

VHA MUST ENSURE CONSISTENT, HIGH-QUALITY CARE FOR VETERANS REQUIRING INPATIENT MENTAL HEALTH TREATMENT

To ensure high-quality care for veterans at significant risk for suicide, VHA must ensure full compliance with VHA policy for inpatient treatment. The mental health treatment coordinator roles must be clearly defined, including the establishment of written procedures. Mental Health Treatment Coordinator (MHTC) assignments and engagement with mental health unit patients should also be well-defined. There must be full compliance with discharge care coordination requirements as well, including documentation of discharge instructions, coordination with the MHTC, and patient engagement with post-discharge treatment.

Facility Staff Must Closely Follow Policies Requiring Close Observation of Inpatients

The OIG conducted an inspection in response to complaints that facility staff were not following VHA suicide prevention policies within the Overton Brooks VA Medical Center in Shreveport, Louisiana. These lapses related to completing suicide risk screenings and evaluations, using high-risk-for-suicide-patient-record flags, and fully responding to VCL requests. In addition to substantiating those issues, the OIG found concerns with inpatient mental health care treatment at the facility.[18] In one incident, a patient with depression, a substance use disorder, and other medical conditions was admitted to the facility's intensive care unit (ICU) after a suicide attempt. Almost two weeks into the ICU stay, the patient attempted suicide twice more. After these attempts, clinicians reinstated an order for one-to-one observation. For a time, facility staff failed to follow the facility policy that a one-to-one observation staff member have no other responsibilities. In this case, the registered nurse was performing one-to-one duties in addition to other nursing responsibilities for the patient. The OIG made eight recommendations to the VISN and facility directors related to various aspects of the suicide prevention program. The recommendation to the facility regarding one-to-one observation staff assignments in the ICU has been closed following revisions to the policy and facility staff education.[19]

In another incident, the OIG assessed the clinical care of an inpatient who died by suicide at the Sheridan VA Medical Center in Wyoming.[20] The patient was admitted to the facility's inpatient unit, placed on one-to-one observation status for suicidal ideation, started on protocols for treatment of

---

[18] VA OIG, *Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, July 10, 2024.

[19] The OIG made one recommendation to the VISN director related to suicide prevention staff posting and identification of recruitment opportunities and six other recommendations to the facility director related to compliance with suicide prevention and other facility policies.

[20] VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*, July 25, 2024.

alcohol withdrawal symptoms, and had a psychiatry consult initiated. Four days later, the patient was found in the bathroom having died by hanging using a necklace. The OIG found that staff did not follow policy requirements to remove the patient's belongings or reduce environmental risks. This significant failure allowed the veteran to keep items, including the necklace that was used to complete suicide. Additionally, a nurse failed to conduct a warm handoff, as required, to a licensed independent practitioner for the completion of a Comprehensive Suicide Risk Evaluation after a positive suicide risk screening result. The psychiatrist completed a telemental health evaluation of the patient but did not complete the required Comprehensive Suicide Risk Evaluation. On the third day of admission, the psychiatrist did not reassess the patient before changing the patient's one-to-one observation status to every 15-minute checks and did not sign the evaluation note within the required 24-hour time frame, leaving the assessment unavailable to other providers.[21] Critically, the physician on duty on the third day said that had the note been viewable, they would have had a conversation with the psychiatrist to express concern and to convey the opinion that 15-minute checks were not adequate for this veteran. This lapse led to a recommendation, which is still open as not fully implemented, to ensure that suicidal patients are reassessed prior to changing one-to-one observation status orders. The other open recommendation relates to completing evaluations for inpatients who screen positive for suicide risk.

The OIG has closed the remaining two recommendations to the facility director related to completing and authenticating inpatient notes, as well as removing patient belongings and environmental risks. The OIG will follow up on the remaining planned actions until they are completed.

The OIG's Mental Health Inspection Program Identified Issues with VHA's Acute Inpatient Health Care

The OIG established the Mental Health Inspection Program in 2024 to regularly evaluate VHA's continuum of mental healthcare services. The inspection program evaluates acute inpatient health care across six domains: (1) leadership and organizational culture, (2) high-reliability principles, (3) recovery-oriented principles, (4) clinical care coordination, (5) suicide prevention, and (6) safety. Reviews initiated in FY 2024 focused on acute inpatient mental health care at select facilities.

A mental health inspection conducted at the VA Central Western Massachusetts Healthcare System in Leeds found noncompliance with suicide risk screening and evaluation policy.[22] Electronic health record reviews indicated most veterans were involved with interdisciplinary treatment team planning and had documented safety plans. However, some records did not include evidence of timely suicide risk screening. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale within

[21] An unsigned note is not available to other providers. In this case, the psychiatrist told the OIG that the note was not signed within 24 hours due to the need for chart review, dictation, and edits.

[22] VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, March 5, 2025. The other Mental Health Inspection Program publication issued to date is the *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, September 26, 2024.

24 hours before discharge as required, and the safety plans reviewed did not always address ways to make the veteran's environment safer regarding the availability of potential lethal means. Additionally, the OIG found staff completed the "S.A.V.E." and lethal means safety training but not all staff completed the Skills Training for Evaluation and Management of Suicide requirement.[23] As a result, the OIG recommended

- the chief of staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors compliance;
- the chief of staff ensures staff address ways to make veterans' environments safer from potential lethal means in safety plans and monitors compliance; and
- the facility director ensures staff comply with Skills Training for Evaluation and Management of Suicide requirements and monitors compliance.

The facility director concurred with these and the report's additional 13 recommendations and provided acceptable action plans. The OIG will begin the follow-up process in three months, given the report's March 2025 publication.

VHA MUST ADDRESS DEFICIENCIES IN COMPREHENSIVE DISCHARGE PROCESSES

Just as important as the actual inpatient care, VHA providers must ensure that newly discharged veterans are appropriately supported, given their increased risk for suicide. Accordingly, the OIG conducted a review of VHA's inpatient mental health unit suicide risk identification processes, suicide prevention safety plans, MHTC role requirements, and discharge coordination procedures in December 2024.[24] The team examined VHA policies, electronic health records, and conducted interviews of clinicians and patients.

Since 2008, VHA has required that every patient receiving mental health services be assigned a principal mental health provider, now referred to as the MHTC, to support care coordination.[25] Staff must also complete a suicide risk screening within 24 hours before a patient's discharge using the Columbia-Suicide Severity Rating Scale, and work with the patient to establish a suicide prevention safety plan which identifies sources of support and effective coping strategies. The OIG found staff failed to document required suicide risk screening for 27 percent of patients and did not complete safety plans for

[23] VHA identifies the "S.A.V.E." acronym as: signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment.

[24] VA OIG, *Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination*, December 18, 2024.

[25] VHA Handbook 1160.01(1); Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

12 percent of discharged patients. Failure to complete suicide prevention activities may result in an underestimation of patients' risk and a diminished use of life saving resources.

Over 30 percent of facilities lacked an MHTC policy, and separately, mental health unit staff failed to assign an MHTC for nearly 40 percent of patients. Failure to provide written guidance that outlines MHTC procedures may contribute to staff's lack of awareness of responsibilities and result in patients not being assigned an MHTC to offer resources and support during transitions in care. Over half of surveyed patients with an assigned MHTC could not identify that individual and more than 25 percent of MHTCs were uninvolved in discharge care coordination or the transition to outpatient care.

While most patients, regardless of MHTC assignment, attended at least one outpatient mental health appointment within 90 days of discharge, over half of surveyed patients identified self-motivation and 20 percent identified encouragement from a family member or friend as contributing to appointment attendance. The OIG concluded that the MHTC model did not effectively facilitate care coordination and MHTC assignment was not associated with a patient's likelihood of engaging in post-discharge treatment.

The OIG proposed that VHA leaders provide guidance regarding expectations for post-discharge mental health appointment scheduling to promote patient treatment engagement. The issued report had eight recommendations related to suicide risk identification and safety planning. They focused on MHTC written guidance, assignment, and effectiveness, as well as post-discharge mental health appointment scheduling and treatment engagement. All recommendations remain open.

VHA MUST COMPLY WITH REQUIRED POSTVENTION ACTIVITIES AFTER SUICIDES

VHA requires staff to conduct specific reviews and analyses to understand and apply lessons learned after a veteran attempts or completes suicide that can improve the quality and safety of care delivered to future patients. The following sections detail instances of noncompliance with numerous policies regarding root cause analyses, peer reviews, and institutional disclosures to patients' families or representatives. The OIG has also found opportunities for VA to ensure survivors are treated with sensitivity and provided support after the death of a veteran by suicide.

VHA Leaders Must Ensure Facilities Conduct Quality Improvement Programs

Since 2012, VHA has required that staff gather information following all reported patient deaths by suicide to identify contributory factors and to understand the circumstances that had affected the patient[26] A September 2024 OIG healthcare inspection focused on the suicide of a veteran six days after a mental health appointment at the VA Tuscaloosa Healthcare System in Alabama. The resulting report

[26] VHA *Suicide Prevention Program Guide*, November 2020; VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012.

highlighted several deficiencies with the administrative actions taken by facility leaders and staff after they learned the veteran had died by suicide. [27]

Root Cause Analyses

An interdisciplinary team uses a focused review to conduct the root cause analysis, which is meant to identify system issues that contribute to healthcare-related adverse events. Flowing from the analysis are proposed corrective actions to prevent future incidents.[28] According to VHA, after a root cause analysis is conducted, "the organization must then implement an action plan to fortify its systems against vulnerabilities with the potential to impact patients."[29] The root cause analysis' actions and outcomes must be monitored for completion and sustainment, ideally through a reporting system, such as a patient safety committee meeting.[30] The facility director initiated a root cause analysis eight days after facility staff received notification of the patient's death. The OIG found that facility staff did not inform facility leaders, as they should have, about closing an incomplete root cause analysis action item after it was determined to be "not feasible" to complete due to staffing shortages. This lack of communication diminished facility leaders' awareness of staffing barriers to address system vulnerabilities and improve the quality of care. The OIG has closed its recommendation that the facility director evaluate the root cause analysis process based on information presented by the facility.

Peer Review Policies

Peer reviews for quality management are "intended to promote confidential and non-punitive assessments" of clinical care to determine whether there are process improvement opportunities.[31] VHA Peer Review Committees are responsible for holding "formal discussions" regarding a peer review and ensure formal meeting minutes reflect the discussions.[32] In the Tuscaloosa Healthcare System review, the OIG found that the Peer Review Committee failed to address two systems-level issues identified during the process. The lack of committee documentation regarding discussions and tracking actions to resolution may have contributed to gaps in communication and follow-up, and consequently a failure to mitigate identified patient safety risks. The OIG recommended the facility director evaluate the Peer

---

[27] 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 26, 2024. The OIG also substantiated problems with appointment scheduling, supervision of a posttraumatic stress disorder clinic social worker, and medication management.

[28] VHA Handbook 1050.01, National Patient Safety Improvement, March 4, 2011, was rescinded and replaced by VHA Directive 1050.01, VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024. The policies contain similar language related to action items.

[29] VHA National Center for Patient Safety, Guide to Performing a Root Cause Analysis, February 5, 2021, updated in March 2024. The guides contain similar language related to root cause analysis.

[30] VHA National Center for Patient Safety, Guide to Performing a Root Cause Analysis, February 5, 2021.

[31] VHA Directive 1190, Peer Review for Quality Management, November 30, 2023.

[32] VHA Directive 1190.

Review Committee's processes on addressing and identifying system weaknesses in accordance with VHA requirements. The recommendation is now closed in response to information the facility provided.

Institutional Disclosures

An institutional disclosure is a formal process to inform a patient or the patient's personal representative when an adverse event occurred that resulted in the patient's injury or death, including specific information about rights and recourse.[33] A disclosure must be completed regardless of when the adverse event is discovered.[34] The facility's chief of staff in Tuscaloosa did not recall any consideration of an institutional disclosure for the patient.[35] Other leaders told the OIG that an institutional disclosure was not completed because the patient's death did not occur at the facility. Although a patient's death by suicide while receiving care at a facility requires the completion of an institutional disclosure, it is not limited to this circumstance.[36] In this case, a disclosure should have been considered regardless of the location of the patient's death. The OIG concluded that facility leaders may have had an erroneous understanding of institutional disclosure requirements and recommended the director determine if one was warranted. The recommendation was closed after the facility made the disclosure.

This is not the first time the OIG has been concerned that VHA facility leaders have misunderstood institutional disclosure requirements. Given the inconsistent application of the institutional disclosure policy that the OIG observed in various healthcare inspections during FYs 2022 and 2023, the OIG alerted the undersecretary for health in March 2024 to clarify institutional disclosure expectations.[37]

VHA Staff Can Take Actions to Better Interact with Grieving Family Members

Grief reactions to suicide commonly include strong emotions such as guilt, blame, and anger.[38] VHA instructs suicide postvention staff to encourage self-care and coping, provide resources, and offer follow-up support to manage grief over time for families and other loved ones.[39] Additionally, the facility's suicide prevention coordinator is expected to contact the next of kin to inform them about the

---

[33] VHA Directive 1004.08, Disclosure of Adverse Events to Patients, October 31, 2018. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

[34] VHA Directive 1004.08.

[35] 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*.

[36] VHA Directive 1004.08; The Joint Commission, Sentinel Event Policy and Procedures, https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/, accessed May 1, 2024.

[37] VA OIG, Institutional Disclosure Policy Requirements Should Be Clarified, March 13, 2024.

[38] National Action Alliance for Suicide Prevention, Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines, April 2015.

[39] VA, "Recommendations for Postvention – Meeting with Family/Loved Ones," Uniting for Suicide Postvention, accessed April 17, 2024. This site is not publicly accessible.

Behavioral Health Autopsy Family Interview Process and offer the opportunity to participate.[40] The suicide prevention coordinator is required to document the family member's interest in participating in an interview on a Family Interview Tool-Contact form.[41] In one healthcare inspection, the OIG found that the suicide prevention coordinator failed to complete the required contact form after being notified of the patient's death.[42] This failure prevented family members from being contacted for an interview during which information would have been provided on accessing grief support resources. The OIG has closed the recommendation that the VA Tuscaloosa Healthcare System's director ensure compliance with the Behavioral Health Autopsy Family Interview Process standards, including completion of the contact form.[43]

VHA MUST STRUCTURE ITS LEADERSHIP TO ENSURE CONSISTENT OVERSIGHT

In June 2024, the OIG testified that the VISN structure does not ensure accountability and lacks clearly defined leadership roles and standardized responsibilities, which could lead to deficient engagement with facility leaders and inconsistent oversight.[44] Early this week, the OIG highlighted these concerns in a national review of the governance structure and role of the VISN chief mental health officer (CHMO). The OIG concluded that without standardized role definitions and oversight authority, the CMHO's ability to effectively address weaknesses in facility mental health and suicide prevention program performance is limited.[45] The absence of consistent information regarding organizational governance structure and staffing may result in inequities in resources and insufficient oversight of VISN and facility mental health staff services. This may undermine the original purpose of the VISNs, which was to centralize oversight, align resources among facilities, and enhance patients' access to care.

---

[40] VHA Deputy Under Secretary for Healthy for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. The Behavioral Health Autopsy Family Interview Process is a systematic review of relevant behavioral health information about the patient for a period prior to death, including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinicians' notes. VHA, *Suicide Prevention Program Guide*, November 1, 2020. A review and related form must be completed within 30 days of the facility staff's awareness of a patient's death by suicide.

[41] VHA, *Suicide Prevention Program Guide*.

[42] 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*.

[43] There were 13 total recommendations in the Tuscaloosa report. The others related to reviewing the patient's care; boxed warning education; suicide risk screening; appointment scheduling; lethal means safety counseling; PTSD clinic processes; traumatic brain injury evaluation; root cause analyses, peer review, and institutional disclosure processes.

[44] VA OIG, Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections, June 26, 2024.

[45] VA OIG, *Inadequate Governance Structure, and Identification of Chief Medical Health Officers' Responsibility.*

The OIG reviewed VHA written policies related to the oversight of mental health services, VISN organizational charts, and CMHO performance plans and functional statements (position descriptions).[46] The OIG conducted a survey and received responses from 18 CMHOs, their direct supervisors, and 108 of 143 (76 percent) facility mental health leads from across the nation about CMHO responsibilities, communication processes, supervisory structures, and authority. In addition, the OIG reviewed VHA's required "standardized VISN core organizational chart" and supplemental information and found a lack of standardization.

CHMOs reported understanding their oversight responsibilities of outpatient mental health services, mental health residential rehabilitation treatment programs, and primary care mental health integration services. They also confirmed monitoring facility action plans related to compliance and performance deficiencies, but they described a lack of authority as a major barrier to effective oversight, change implementation, and enforcement of noncompliance.

The OIG made five recommendations in March 2025 to the under secretary for health regarding the VISN CMHO. They addressed staffing requirements for mandatory and discretionary positions; standardized VISN core organizational charts to clarity the CMHO position and reporting structure; a functional statement (position description) to reflect responsibilities; a performance plan that aligns with a functional statement; and authority to enhance the governance and the effectiveness of mental health services.

CONCLUSION

Each day, VA staff actively engage in providing high-quality wraparound mental health services to veterans across the country. These services include screening for mental health needs and suicide risk factors, connecting veterans with identified risk factors to higher-level services, managing veterans' acute mental health crises in a variety of therapeutic settings, and supporting families who have lost a loved one to suicide. But there is much more work to be done. Leaders must ensure adherence to VHA policies and consistently implement practices designed to support veterans facing mental health challenges. In a large, decentralized healthcare system, these leaders must have clearly defined standardized roles, responsibilities, and the authority to drive necessary improvements and hold staff accountable.

Every veteran has a unique story of service and sacrifice, from which many carry invisible wounds that make it difficult to reintegrate and fully participate in civilian life. There will never be one solution to a problem as complicated and devastating as veteran suicide, but efforts must continue to better understand and treat those at highest risk. The OIG remains committed, therefore, to conducting

[46] Position descriptions include the major duties, responsibilities, and supervisory relationships of a position. A functional statement is the official description of the primary duties, responsibilities, and supervisory controls assigned by management to a position. For purposes of this testimony, the OIG considers these written descriptions interchangeable. VA Directive 5003, Position Classification and Position Management, August 22, 2022.

impactful, independent oversight that will provide VA with information to improve a wide range of outreach and response efforts, suicide risk identification, acute crisis management, coordinated care and integrated discharge planning, and research that serve veterans, their families, caregivers, and communities.

Madam Chair, this concludes my statement. I would be happy to answer any questions you or other members may have.

STATEMENTS FOR THE RECORD

Prepared Statement of NeuroFlow

NEUROFLOW®

1601 Market St, Suite 1500
Philadelphia, PA 19103
www.neuroflow.com

March 28, 2025

Chairman Mike Bost
House Veterans Affairs Committee
U.S. House of Representatives
Washington, D.C.

Subject: Opportunities to Leverage Technology and Digital Solutions to Improve Veteran Care

Dear Chairman Bost and Members of the House Veteran Affairs Committee,

It is an honor to submit this statement to the committee in advance of the upcoming hearing, drawing on my experiences as a U.S. Army combat veteran, a patient of the Veterans Health Administration, and the CEO and co-founder of NeuroFlow, a VA technology contractor. Our mission is to address the unique challenges veterans face in accessing quality health care by bridging the gap between physical and mental health, ensuring that all veterans receive comprehensive, evidence-based care in an efficient and effective manner.

The purpose of me writing this statement for the record is to accomplish two items. One, I want to ensure the committee is informed of the success the VA has had in collaborating with private companies, specifically with NeuroFlow, and our subsidiary Capital Solution Design, on our products: BHL, BHL Touch, and Onward to innovate and improve access to care. Two, I want to share my perspective on opportunities the VA has to streamline various efforts of innovation, make operations more efficient, and effectively increase access to care, even when additional resources may not be available.

First, our products BHL and BHL Touch have been used for over a decade by the VA to promote analytics and provide measurement-based care. Our work started as a research project at a single VAMC in 2004 to today where BHL Touch has become a foundational clinical tool available in every VAMC enterprise-wide. BHL offers integration with both Millennium Cerner and VistA/CPRS with 70+ available scales/measures to screen Veterans healthcare needs and to track and measure outcomes over the course of treatment. The system has over 17,000 registered VA employee users to assist in care delivery, and millions of Veterans who have come to rely on BHL as a tool for completion of clinical measurement prior to their provider visit. BHL Touch specifically became the primary assessment and survey tool for the VA nationally, capturing over 55% of all depression and anxiety measures within the US Department of Veterans Affairs (VA) in 2023 and 2024, a testament to its efficacy and reach, and the positive impact that can be achieved when the VA collaborates with industry.

Our work extends beyond one contract, and beyond mental health. We firmly believe that mental health and physical health are connected and should be treated as such - just health. Thus, we have invested heavily in the infrastructure and capability to collect data and assessments across the healthcare continuum not limited to behavioral health which is currently live today with our contract work involving clinical reminders and Veteran satisfaction surveys.

Second, I want to state my opinion to highlight the highest value opportunities for VA to streamline various efforts to increase efficiency and optimize resource allocation while improving access to high-quality, data-driven Veteran care. While I'm sure there are several additional areas to improve efficiency, I am able to focus on where my expertise and our experience with our technology lies. These efforts can be summarized in three categories: technological innovation, accountability to quality and connected care, and automation and optimization. Examples of areas ripe for improvement in these categories are as follows:

1. **Technological Innovation:** The VA should consolidate its portfolio of mobile applications that provide evidence-based resources to Veterans into a single delivery platform, which would improve user experience, increase engagement, and be more cost efficient; however, none of the dozens of mobile Veteran apps are connected, nor are they dynamic or reactive in their suggestions, nor do they provide clinical feedback to providers.

   The VA has an opportunity to improve provider workflows and reduce burden by optimizing interoperably, to which several VA systems, home-grown internal VA systems, and third-party companies, do not effectively integrate into EHRs (and provider workflows). Additionally, as clinical care continues to expand its focus to community care providers, it is critical that technology innovation follows this path assisting clinicians in serving veterans at the community level, however, this integration and interoperability across specialities and community care resources does not exist today.

   There are also tremendous opportunities to responsibly use artificial intelligence (AI) across these multiple and robust data sources to identify, measure, triage risk and treatment plans.

2. **Accountability to Quality and Connected Care:** There is a critical need to implement measurement-based care across all care settings and to incorporate additional data sources—such as ecological momentary assessments, claims data, and EHR encounter data—to monitor quality and outcomes. This approach ensures that Veterans receive the right type of care at the right time, with no gaps in service. Additionally, when Veterans are referred to community resources, it is essential to ensure that the quality of that care meets the high standards expected for Veterans.

3. **Automation and Optimization:** It is essential to focus on automating data collection to capture real-time, accurate information that can guide decision-making and improve care coordination for Veterans so that the medical professionals can focus on care, operating at the top of their licensure, rather than concerning themselves with administrative tasks. Leveraging data to identify the next best actions—such as follow-up appointments, referrals,

scheduling, or adjustments in care plans, and recommending care pathways—can help ensure continuity of care, and quality is consistent and measured. By automating the proactive monitoring of these processes and closing any potential gaps, we can enhance the overall quality of care and ensure that Veterans receive timely, effective support tailored to their individual needs.

Finally, as stated before, I am not only a VA partner and contractor, but am also a beneficiary of the VA, and have personally witnessed the personal commitment of the many professionals that work there each day with the goal of providing the best care possible, so to that end thank you to those professionals. Thank you to this committee for your steadfast effort and leadership ensuring that the VA continues to strive to be better each day and to hold them accountable.

I and the companies I represent, NeuroFlow and Capital Solution Design, remain committed to working with the VA and with the House Veterans Affairs Committee to improve the delivery of health services for all Veterans and are available for further discussions or queries regarding this statement and our recommendations.

Cordially,

Christopher Molaro
CEO & Chairman
NeuroFlow, Inc
Capital Solution Design, LLC

Prepared Statement of American Psychological Association Services, Inc.

Chairperson Kiggans, Ranking Member Ramirez, and Distinguished Members of the Committee:

American Psychological Association Services, Inc. (APASI) submits the following statement for the record in advance of the House Veterans Affairs Committee Oversight and Investigations Subcommittee hearing entitled *Answering the Call: Examining VA's Mental Health Policies*. We appreciate the Committee's willingness to examine challenges surrounding the critical delivery of mental health care for our Nation's veterans. Demand for VA mental health care has increased steadily over the past 20 years and continues to outpace other care within the VA. Meeting this demand while maintaining the VA's high level of clinical excellence is a priority.

American Psychological Association and its companion organization APA Services, Inc. (APA/APASI) serve as the Nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as over 173,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science. Psychologists and the profession have a rich history within the VA, serving veterans since World War II. As such, today we would like to address three policy areas important to the delivery of quality mental health care: maintaining clinical excellence and care coordination, protecting veteran privacy and confidentiality, and ensuring adequate mental health provider training and staffing.

Maintaining Clinical Excellence and Care Coordination

APASI is grateful that VA Secretary Collins is making preventing veteran suicide a top priority. Over many years, the VA has made tremendous strides in universal suicide prevention risk assessments and required training for providers of care on topics including but not limited to suicide prevention, lethal means safety, military culture, and military sexual trauma. The demand for mental health care is growing across our entire nation's health care system, also highlighting the unique role and mission within the VA to train much of our Nation's healthcare workforce.

Increased investments in veteran suicide prevention have been impactful, and veteran outcomes are improved when interacting with the VA. The 2024 National Veteran Suicide Prevention Annual Report demonstrates the suicide rates for veterans receiving only VA care are 50 percent lower than even those receiving all their care in the community care program. However, one veteran suicide death is one too many and now is not the time to let our foot off the gas on VA investments in mental health staffing, care coordination, and best practices that could be applied everywhere a veteran in crisis might receive care.

As Congress reviews the VA's internal mental health policies, it is important to highlight that the VA continues to provide veterans with a gold standard of care in mental health treatment. Whether leading the way in post-traumatic stress disorder (PTSD) or requiring access to evidence-based psychotherapy, the VA maintains a high bar [1] and consistently outperforms non-VA care in both quality of care and trust among veterans [2, 3].

Strong internal clinical standards, oversight by the VA Office of Inspector General (VA OIG) and other agencies, and the existence of reporting and compliance mechanisms within the VA all play a role in maintaining exceptional clinical excellence in mental health care. It is worth noting that such high clinical standards and oversight is lacking or nonexistent in VA community care. For example, the mandatory risk assessments and required trainings referenced above are optional in the community. APASI would like to see policies such as adoption of risk assessments and mandatory training applied regardless of site of service for the veteran and agrees with a recent Government Accountability Office report [4] that stronger oversight of community care contracts is necessary to ensure high quality care.

We encourage the Committee to support evidence-based treatments, measurement-based care, and the VA's critical role in care coordination, as each is so important to maintaining the high standards that are at the core of the VA's mental health program. Lessening care coordination and clinical standards does nothing to improve the health of America's veterans. We are concerned, for example, that the recently introduced Veterans' ACCESS Act, H.R. 740, which will allow access to outpatient private treatment without any VA authorization or referral, could adversely impact the quality of care. Care coordination and oversight ensures quality care for

[1] https://www.mentalhealth.va.gov/providers/sud/docs/uniformserviceshandbook1160–01.pdf
[2] https://news.va.gov/press-room/va-outperform-non-va-facilities-cms-ratings/
[3] https://www.va.gov/initiatives/veteran-trust-in-va/
[4] https://www.gao.gov/assets/gao–24–106390.pdf

veterans. We are also concerned that this bill lessens the current VA facility requirement that mental health residential rehabilitation treatment programs (RRTPs) be accredited by both the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission to requiring only one of those accreditations. While improving access to care is critical and community care is a necessary complement to VA direct care, exacting standards for clinical excellence should be applied equally in each setting. Access to "any" care is not necessarily access to "quality" care.

Ensuring Veteran Privacy and Confidentiality

A recent issue of significant concern for us is ensuring veteran privacy and confidentiality when delivering mental health care within the VA. The recent policy change requiring most Federal employees to return to the office, including VA psychologists and other mental health care providers, is significantly impacting the delivery of confidential mental and behavioral health services. Many VA facilities lack sufficient private spaces to accommodate the influx of mental health providers who previously worked remotely. This has resulted in providers being asked to conduct sensitive therapy sessions in open office environments, cubicles, or shared spaces that fail to meet basic HIPAA confidentiality and privacy requirements for the delivery of mental health care services.

The VA has long used telehealth to reach isolated, rural, and disabled veterans in need of mental health services and it further expanded access to telehealth services between 2020–2024 which allowed more mental health care providers to deliver care from private home offices. This enabled the VA to expand to meet a growing demand. Unfortunately, the return-to-office mandate undermines access and confidentiality essential to effective mental health care. This needs to be addressed as plans are put into effect. Without ensuring adequate space to absorb the return of mental health providers, those providers face the difficult choice between violating ethical and legal patient confidentiality requirements or suffering disciplinary action for non-compliance with return-to-office mandates.

In light of these serious concerns regarding the timing and implementation of return-to-office mandates and other policies impacting delivery of mental health services, **we encourage the Committee to consider waivers for all mental health providers that would return to a shared space until veteran privacy and access to care concerns are addressed**. Our concerns currently center on several key issues:

- Ethical and practice standards: Both the APA Ethics Code and VA professional standards require that psychotherapy be conducted in private settings that protect patient confidentiality. In many facilities, the current implementation of return-to-office orders without adequate office space availability appears inconsistent with these requirements.
- Patient confidentiality and trust: A strong therapeutic relationship depends on confidentiality. Veterans dealing with sensitive mental health issues require assurance that their disclosures remain confidential. Conducting therapy in shared spaces fundamentally compromises this trust.
- HIPAA compliance risks: Arrangements in some facilities may violate HIPAA privacy and security requirements if patient information can be overheard in shared spaces. This not only presents individual providers with legal liability and ethics concerns but would also constitute a HIPAA violation by the Veterans Health Administration itself.
- Veteran care impact: These challenges threaten to disrupt ongoing care relationships and may deter veterans from seeking or continuing needed mental health treatment in their preferred setting.
- Workforce retention concerns: Reports indicate that some mental health professionals are considering resignation rather than practicing under conditions they view as unethical and below an acceptable standard of care. This could worsen existing staff shortages in VA mental health services.

Many veterans experience trauma and sensitive mental health conditions. APASI supports long-standing policies that ensure the protection of patient confidentiality and privacy, including adequate physical space within VA facilities to provide private mental health services that prioritize patient needs.

Ensuring Adequate Mental Health Provider Training and Staffing

Finally, APASI continues to be concerned about adequate staffing to serve veterans of today and tomorrow. Psychology is again the number one clinical workforce shortage area within the VA, with 85 of 139 facilities reporting psychology short-

ages [5]. The demand for mental health care continues to increase both within the VA and throughout our Nation's healthcare system. With well over 400,000 new PACT Act Veterans Health Administration (VHA) enrollees, and 754,000 new enrollees overall since August 2022, continued investment into the VA mental health workforce is more important than ever.

The VA provides healthcare training, residencies, and fellowships to more than 120,000 trainees each year in over forty disciplines. Even today, 65 percent of all U.S. psychologists and 70 percent of physicians receive training in the VA. As Congress faces current Administration plans to reduce the size and scope of the VA, we ask that it not lose focus on one of VA's foundational missions dating back nearly 80 years—"To educate for VA and the Nation". Our nation's veterans and every American depends on this critical health care workforce pipeline.

Thank you again for your focus on mental health and the VA policies necessary for quality delivery of care. APASI stands ready to work with the Committee to ensure the best care for veterans.

For more information, contact K. Conwell Smith, APA Deputy Chief for Military and Veteran Policy at csmith@apa.org or (301) 875–8923.

[5] https://www.vaoig.gov/sites/default/files/reports/2024–08/vaoig–24–00803–222.pdf

Documents for the Record Submitted by Delia Ramirez

Submission from Concerned Veteran (3/6/25)

To Whom it may concern I am writing to express my deep concern regarding the Department of Veterans Affairs' decision to lay off tens of thousands of VA workers and the direct impact this will have on the quality of care veterans receive. As a disabled veteran who served 21 years on active duty in the United States Air Force, including five deployments—one of which was to Afghanistan—I have personally relied on the VA for my healthcare. I receive the majority of my care through VA facilities in Shiloh, Illinois, and St. Louis, MO and I am already seeing the consequences of these staffing cuts.

The VA healthcare system is a lifeline for millions of veterans, many of whom, like myself, depend on it for essential medical treatment. Reducing the workforce in such large numbers will inevitably lead to longer wait times, reduced access to specialized care, and an overall decline in the quality of services provided to those who have sacrificed so much for this nation. Veterans should not have to struggle to receive the care they have earned. I urge you to take immediate action to stop these layoffs and ensure that the VA remains fully staffed to meet the needs of those who served. Our country made a promise to its veterans, and we must uphold that promise by protecting and improving the healthcare system we rely on. Thank you for your time and attention to this critical issue. I look forward to your response and to seeing what steps you will take to address this matter.

Sincerely,
[*respondent*]

Submission from Concerned Veteran (3/8/25)

Ranking Member and colleagues, I am very concerned about the proposal to reduce manning at the VA. I have 3 main concerns.

1. The Secretary has said that a portion of the savings will be used to help Veterans. Where is the rest of the savings going? Is the plan to cut millions from Veterans' care and benefits so that savings can be realized in other programs, with a small percentage reinvested in the VA? I use the CBOC in Washington PA. I don't see how that clinic will stay open if the VA loses 17% of its workforce.
2. The 2019 staffing numbers seems completely arbitrary and not based on any analysis. The VBA completed 1 million claims faster than ever - reductions without analysis will not be effective in making the VA more efficient.
3. Centralized decisions - As we have seen with the GSA terminating thousands of leases and then realizing the need to reinstate some, as well as the VA terminating hundreds of contracts then reinstating them because no analysis had been done, it seems like centralized decisions from Washington will have 2nd and 3rd order effects that were not planned for or analyzed when these cuts are made. The original decision that affected the translation contract would have made the processing of claims for thousands of overseas veterans who receive care on the economy impossible. Thankfully it was not cancelled. Healthcare isn't something you get a do-over with like you can GSA leases - you can't come back 3 months after a tumor was missed and tell the Veteran, "Our apologies, we hired more radiologists back on staff now. Sorry about the metastasis."

It is also confusing why VA employees were exempted from the Delayed Resignation Program if the plan was to fire them via reduction in force at a later time. The US government already hurt Vietnam Veterans when they came back, and only started to make amends after Nehmer etc. I urge you to exercise your oversight and power of the purse and make sure that Veterans' benefits and healthcare are not adversely affected by a premature decision to cut an arbitrary number of employees from the VA. NB, I'm a 20 year Army Veteran with 5 deployments, including Syria, Iraq, and Afghanistan.

Submission from Concerned Veteran (3/14/25)

I am a female, United States Navy Veteran concerned with the indiscriminate cuts the current administration is yielding against our VA system. In 1993 I entered a contractual agreement with the American people: I will, at whatever cost, protect our constitutional rights against all enemies foreign and domestic and in return the American citizens will provide any needed care, educational benefits and home loan assistance I may require. Both parties understood the VA would uphold the American people's contractual responsibility for my lifetime no matter the cost nor administration. The unsubstantiated personnel cuts in the VA puts the VA , thereby the American people, in danger of breach of contract. The Veterans Administration requires adequate personnel to assist the 18.1 million Veterans who have proudly and honorably served this country. Failure for the US government to fulfill the American people's promise to our Veterans will be shameful and detrimental. The VA needs to fight as diligently as my 17 year-old self was willing to in order to protect the US Veterans.

Submission from Concerned Veteran (3/15/25)

First, I would like to thank you for representing veterans everywhere. I am currently serving in my 21st year in active duty in the USAF and have directly deployed in support of 6 named conflicts. I am 3rd generation Air Force with combined 75 years of service to this country.

My call to action is twofold, my wife has dedicated the last 11 months serving veterans at the local VA hospital just to be illegally terminated. Why is a department who has historically marketed to preferred hiring of military spouses lying on termination documentation when she has had nothing but outstanding reviews from her supervision? All while being hired under executive order 13832, why is Tracey Therit and secretary Doug Collins not being investigated for falsifying Government documentation? Secondly, I call to action the investigation into the scrubbing of Arlington National cemetery's websites. There is grave concern that history is being erased against Black, Hispanic, and Women veterans via the website. If a sub group is being erased, shouldn't all subgroups be eliminated to prevent bigotry.

Submission from Concerned VA Former Employee (3/17/25)

Dear Members of the Senate House Committee on Veterans Affairs, I hope this email finds you well. My name is [*REDACTED*], and I am writing to express my concerns regarding the planned layoff of 80000 VA employees and how it will affect our veterans' care.

I hope my email is not perceived negatively because I agree that change is needed and costs need to be controlled. I am a registered nurse with 37 years of experience. I worked in the private sector for 30 years before accepting a position at the Iowa City, IA VA in 2016 and transferred to the Harry S Truman VA Columbia, MO in 2017. I met the minimum requirement to retire 01/25 which I did retire. I didn't retire due to the issues presently occurring but the inability to make changes that were in the best interest of our veterans.

I can only speak to what I experienced and witnessed at the Harry S Truman VA. When I transferred to the HSTVA Columbia, MO my position was in the post-anesthesia care unit (PACU) where I possess a strong background in perioperative nursing. I was surprised by the staffing levels and even more surprised that my co-workers thought they were understaffed. I spent a large portion of my career working at two academic hospitals and by those standards, the PACU was overstaffed I can't stress enough that if your committee would consider the following ideas that would cut costs and not cut as many positions. !

1. Use certified medical assistants in all of the clinics. Certified medical assistants can do vital signs, review medications, and request medical records. Currently, HSTVA uses LPN & RNs to do this
2. Use the registered nurses to educate patients to include medications & preparation for surgery etc
3. Is it necessary to pay an RN an associate chief of nursing wages to ($160000 yr) to supervise sterile processing and redesign (Sigma belt). I was with the HSTVA for almost 7 years and I would see an announcement about someone receiving a black belt for a project that was not implemented I was detailed to assist with establishing a pre-op clinic @ HSTVA in 2021. The reason for the need for a pre-op clinic was due to the cancellation of surgical cases and mortality & morbidity rates. An SOP was written and agreed upon but was never truly implemented.

I have examples of the issues please contact me. I'm asking on behalf of our Veterans that if you would redesign the clinical side of the VA hospitals would be a big cost savings.

Submission from Concerned Individual (3/17/25)

Good morning, I am very concerned about the impact on veteran healthcare and benefits with changes/firings made by DOGE since January and future firings. The Secretary of the VA has announced that up to 80,000 workers may be laid off. He also states this will NOT negatively impact healthcare and services for veterans.

However, he does not explain how this will be possible. How can there be fewer workers and services not be impacted, unless we are to believe all 80,000 of these workers did nothing? The veteran who submits a service-related disability claim needs workers to examine the claim and process it through the system. If there are fewer of these workers, how does this impact the timeline? If he says we will only layoff people like clerks and not doctors, who but the doctors now have to do the clerical work the clerks used to do, thus taking time away from their clinical duties?

Why is this huge change happening BEFORE making plans about how to improve processes? These healthcare services are too important to mess around with and hope for the best or "break it and fix later." I would like someone with power (our elected officials) to demand answers about how services will be preserved IN DETAIL. Veterans deserve answers.

With respect,
[*respondent*]

Learn more about LSEG

VA shake-up hits mental health services for US veterans

Reuters
My news
Aa

[1/5] Joey Cortez, a former remote worker who worked for the VA in Washington D.C., poses for a photograph at the North West VA Clinic in San Antonio, Texas, U.S., March 12, 2025. Cortez is one of the... Purchase Licensing Rights Read more

Feedback

Summary

VA layoffs, return-to-office mandates affect some mental health services

Some providers forced to cancel appointments because of ban on remote work

Veterans fear bigger impacts from plan to lay off 80,000 more people

SAN FRANCISCO, March 20 (Reuters) - Joey Cortez, who served 24 years in the U.S. Air Force, had been waiting since August to see a mental health specialist from the Department of Veterans' Affairs, when he experienced a fresh jolt of anxiety.

Cortez was fired last month from his human resources job at the agency - one of about 2,400 employees who lost their jobs at Veterans' Affairs (VA) in the first wave of President Donald Trump's efforts to shrink the federal workforce.

The Reuters Tariff Watch newsletter is your daily guide to the latest global trade and tariff news. Sign up here.

"Once the firings happened and I was terminated, I started having panic attacks to the point where I black out," Cortez, who suffers from post-traumatic stress disorder, told Reuters. The layoff is also making it harder to maintain his sobriety, as a recovering alcoholic.

"Not a day has gone by since I was fired that I haven't thought about picking up a bottle," said Cortez.

After losing his job, Cortez asked the VA to expedite his wait for a therapist and was told there was no record of his request, he said. After a month of calls to the agency, he got an appointment for this August, one year after he started the process. Then the VA offered him an appointment next week because another patient had canceled.

The VA provides health care to 9.31 million U.S. veterans at hundreds of medical centers, clinics and nursing homes across the country.

It also faces complex problems.

"The VA has bloat. There are redundancies. There are places where we have questioned the administration of care and asked, does it need to be the way it is?" Pat Murray, the legislative director for the Veterans of Foreign Wars, which represents Americans who have fought overseas, said in an interview.

The Trump administration plans additional cuts to the VA of more than 80,000 personnel, according to an internal memo obtained by Reuters. The agency has also announced it is phasing out telework.

Reuters spoke to nine current and former VA employees in California, Oregon, Texas and the Washington D.C. area who said the changes were further disrupting some mental health services and fueling anxieties among those who provide and rely on them.

The VA employees - who include six mental health professionals and three people in leadership positions - described cancellations of some in-person and telehealth appointments; confusion over staffing of a crisis hot-line; and professionals conducting telehealth visits in makeshift meeting rooms inside VA buildings.

They spoke on the condition of anonymity, because they were not authorized to speak with the media.

STAFFING SHORTAGES

A former employee at the VA's Office of Inspector General, who is also a veteran, said any future large-scale staffing cuts would likely worsen shortages and impact the quality of care.

"There's no way to take a scalpel and do it appropriately that quickly," he said.

VA spokesperson Peter Kasperowicz told Reuters mental health professionals, such as psychologists and social workers, were not included in February's staffing cuts, and the agency is working to recruit mental health providers and improve wait times.

He did not specify how many support staff for these providers had been affected.

Last week, two federal judges ordered the VA and other federal agencies to reinstate thousands of fired probationary workers. Cortez's pay was reinstated but he was told not to return to work.

The Veterans Health Administration, the branch of the VA that provides healthcare, has experienced severe staffing shortages since 2015, especially among mental health professionals, according to an OIG report last year.

Veterans often benefit from specialized services to treat anxiety, trauma, depression and substance abuse. The proportion of veterans receiving mental health services rose to 31% in 2022 from 20% in 2007, according to the VA. Suicide among veterans is twice the rate of Americans overall.

The VFW's Murray said his organization supports a thorough review of the VA's mental health services, but it needs to be done carefully, "not with a chainsaw."

'THE MOOD IS SO LOW'

In recent years, the agency had encouraged remote work to help expand access to telehealth services and reduce wait times, especially in rural areas where recruiting providers is difficult.

The VA's Kasperowicz said that, while providers will need to return to VA facilities, veterans will be able to access telehealth appointments.

He did not directly address questions about why mental health providers needed to return to the office.

"The VA will make accommodations as needed to ensure employees have enough space to work and will always ensure that Veterans' access to benefits and services remains uninterrupted as employees return to in-person work," Kasperowicz said.

In the last few weeks, demand for services among veterans who are VA employees has also risen, one of the mental health professionals, a social worker, told Reuters. A quarter of VA employees are veterans.

The social worker said he is meeting with two to three VA employees a week who are seeking access to mental health care, citing stress and the fear that they will lose their jobs.

"People are calling out sick. People are ill with stress and worry. The mood is so low."

A mental health supervisor in California described scrambling to cover the caseload of a remote worker who had to cancel appointments with more than a dozen veterans, because she could not access a VA facility.

VA employees in the Washington area and in Oregon said mental health professionals were unsure if they were allowed to answer calls from the VA's crisis hot-line if they were not physically in an office, because they had been instructed not to conduct work outside of a facility.

"People are nervous to be on-call," said a supervisor of mental health providers in the Washington area. "The system is under a lot of duress."

The VA told Reuters that crisis line workers are exempt from the return-to-office policy, and that staff continue to respond quickly to nearly 3,000 calls daily.

Therapists returning to the office are struggling to find private meeting rooms at some VA facilities, according to four of the mental health professionals interviewed by Reuters.

They described medical and mental health professionals converting closets and conference rooms into offices to comply with the mandate to conduct telehealth visits from VA facilities. They expressed concerns that the crowded rooms could violate patient privacy rights.

"We are scrambling to find space," said a provider in California. "Veterans are going without until we can find spaces for these providers."

Reuters was unable to independently verify the accounts of overcrowding. Kasperowicz said the agency's "policy is to bring as many employees back to the office as space permits."

Reporting by Robin Respaut in San Francisco; additional reporting by Julia Harte in New York and Gabriella Borter in D.C.; Editing by Michele Gershberg and Suzanne Goldenberg

Our Standards: The Thomson Reuters Trust Principles.

Suggested Topics:

United States

Purchase Licensing Rights

Read Next

United States
Trump touts economy at Michigan 100-day rally, as Americans grow wary
5:54 AM UTC

Sustainability
Trump's first 100 days target diversity policies, civil rights protections
ago

United States
Trump's approval steady, concerns over economy, immigration rise, Reuters/Ipsos poll finds
April 29, 2025

United States
DOGE staffer advised on cuts to Justice Dept grants, document and source say
April 29, 2025

Trump and DOGE Propel V.A. Mental Health System Into Turmoil

A chaotic restructuring order threatens to degrade services for veterans of wars in Vietnam, Iraq and Afghanistan.

▶ Listen to this article · 10:58 min Learn more

By Ellen Barry, Nicholas Nehamas and Roni Caryn Rabin

Published March 22, 2025 Updated March 24, 2025

Late in February, as the Trump administration ramped up its quest to transform the federal government, a psychiatrist who treats veterans was directed to her new workstation — and was incredulous.

She was required, under a new return-to-office policy, to conduct virtual psychotherapy with her patients from one of 13 cubicles in a large open office space, the kind of setup used for call centers. Other staff might overhear the sessions, or appear on the patient's screen as they passed on their way to the bathroom and break room.

The psychiatrist was stunned. Her patients suffered from disorders like schizophrenia and bipolar disorder. Treating them from her home office, it had taken many months to earn their trust. This new arrangement, she said, violated a core ethical tenet of mental health care: the guarantee of privacy.

When the doctor asked how she was expected to safeguard patient privacy, a supervisor suggested she purchase privacy screens and a white noise machine. "I'm ready to walk away if it comes to it," she wrote to her manager, in a text

message shared with The New York Times. “I get it,” the manager replied. “Many of us are ready to walk away.”

Scenes like this have been unfolding in Veterans Affairs facilities across the country in recent weeks, as therapy and other mental health services have been thrown into turmoil amid the dramatic changes ordered by President Trump and pushed by Elon Musk’s Department of Government Efficiency.

Among the most consequential orders is the requirement that thousands of mental health providers, including many who were hired for fully remote positions, now work full time from federal office space. This is a jarring policy reversal for the V.A., which pioneered the practice of virtual health care two decades ago as a way to reach isolated veterans, long before the pandemic made telehealth the preferred mode of treatment for many Americans.

As the first wave of providers reports to offices where there is simply not enough room to accommodate them, many found no way to ensure patient privacy, health workers said. Some have filed complaints, warning that the arrangement violates ethics regulations and medical privacy laws. At the same time, layoffs of at least 1,900 probationary employees are thinning out already stressed services that assist veterans who are homeless or suicidal.

A demonstration outside a V.A. medical center in Detroit last month. Paul Sancya/Associated Press

In more than three dozen interviews, current and recently terminated mental health workers at the V.A. described a period of rapid, chaotic behind-the-scenes change. Many agreed to speak on the condition of anonymity because they want to continue to serve veterans, and feared retribution from the Trump administration.

Clinicians warn that the changes will degrade mental health treatment at the V.A., which already has severe staffing shortages. Some expect to see a mass exodus of sought-after specialists, like psychiatrists and psychologists. They expect wait times to increase, and veterans to eventually seek treatment outside the agency.

"Psychotherapy is a very private endeavor," said Ira Kedson, the president of AFGE local 310 at the Coatesville V.A. Medical Center in Pennsylvania. "It's supposed to be a safe place, where people can talk about their deepest, darkest

fears and issues." Veterans, he said, trust that what they tell therapists is confidential.

"If they can't trust us to do that, I think that a sizable number of them will withdraw from treatment," he said.

A Veterans Affairs spokesman, Peter Kasperowicz, dismissed the contention that a crowded working environment would compromise patient privacy as "nonsensical," saying that the V.A. "will make accommodations as needed so employees have enough space to work and comply with industry standards for privacy."

"Veterans are now at the center of everything V.A. does," Mr. Kasperowicz added. "Under President Trump, V.A. is no longer a place where the status quo for employees is to simply phone it in from home." Anna Kelly, a White House spokeswoman, said the president's return-to-office order was "ensuring that all Americans benefit from more efficient services, especially our veterans."

The DOGE cuts have already sparked chaos and confusion within the sprawling agency, which provides care to more than nine million veterans. The Trump administration has said it plans to eliminate 80,000 V.A. jobs, and a first round of terminations has halted some research studies and slashed support staff.

Therapy and other mental health services at Veterans Affairs facilities have been thrown into turmoil amid the dramatic changes ordered by President Trump and pushed by Elon Musk's Department of Government Efficiency.
Jamie Kelter Davis for The New York Times

The cuts drive at a sensitive constituency for Mr. Trump, who has campaigned on improving services at the V.A. In Mr. Trump's first term, the agency expanded remote work as a way to reach veterans who are socially isolated and living in rural areas, who are at an elevated risk for suicide. Now those services are likely to be sharply reduced.

"The end of remote work is essentially the same as cutting mental health services," said a clinician at a mental health center hub in Kansas, who spoke on the condition of anonymity. "These remote docs aren't moving and they have other options if they are forced to drive to some office however many miles away every day to see their patient virtually from there."

Veterans, too, are expressing anxiety. Sandra Fenelon, 33, said she had a rocky transition back to civilian life after leaving the Navy in 2022. "I just constantly felt like I am at war," said Ms. Fenelon, who lives in New York and is training to become a pharmacist.

It took a year, working with a V.A. psychologist, until she felt safe enough to begin sharing the troubling things she had seen on deployment, things that, she said, "people on the outside would never understand."

Now, Ms. Fenelon is worried that the tumult at the V.A. will prompt her therapist to leave before she is better. In her session this past week, she burst into tears. "I feel like I'm now forced to be put in a position where I have to start over with someone else," she said in an interview. "How can I relate to a therapist who never worked with veterans?"

'You Deserve Better'

For a suicide prevention coordinator in California, mornings start with referrals from a crisis hotline. On a typical day, she said, she is given a list of 10 callers, but sometimes as many as 20 or 30. The work is so intense that, most days, there is no time for a lunch break or bathroom breaks.

"My job is to build rapport, to figure out what I need to do to keep them alive. I let them know: 'I'm worried about you, I'm going to send someone out to check on you,'" the coordinator said. "I tell them, 'You served this country. You deserve better.'"

The team, which is responsible for covering some 800,000 veterans, was supposed to get three more social workers, but the new positions were canceled as a result of the administration's hiring freeze, the coordinator said.

She said the stress around the staff reductions is intense, and fears it will cause her to miss something critical. "I'm so scared I'll make a mistake," she said. "I'm not sleeping well, and it's hard to stay focused."

Veterans are at sharply higher risk for suicide than the general population; in 2022, the suicide rate was 34.7 per 100,000, compared to 14.2 per 100,000 for the general population. A major factor in this is the availability of firearms, which were used in 73.5 percent of suicide deaths, according to the V.A.

Bilal Torrens had a job helping homeless veterans settle into life indoors. Rachel Woolf for The New York Times

In Denver, Bilal Torrens was just finishing a shift when he was notified by email that he was being terminated.

His job, he said, was helping homeless veterans settle into life indoors after years of living on the street. During those early months, Mr. Torrens said, the men are often overwhelmed by the task of collecting benefits, managing medications, even shopping for groceries; he would sit with his clients while they filled out forms and paid bills.

Are you a federal worker? We want to hear from you.

The Times would like to hear about your experience as a federal worker under the second Trump administration. We may reach out about your submission, but we will not publish any part of your response without contacting you first.

Continue »

The layoffs reduced the support staff at the homeless service center by a third. The burden will now shift onto social workers, who are already staggering under caseloads of dozens of veterans, he said.

"They're not going to have enough time to serve any of the veterans properly, the way that they should be served and cared for," Mr. Torrens said.

Alarms Over Privacy

In Coatesville, Pa., mental health providers have been told they will conduct therapy with veterans from several large office spaces, sitting with their laptops at tables, said Dr. Kedson, who is a psychologist, speaking in his capacity as union president. The spaces are familiar, he said — but they have never before been used for patient care.

"That would sound like you're seeing them from a call center, because you'd be in a room with a bunch of people who are all talking at the same time," Dr. Kedson said. "The veterans who are going to be in that position, I suspect they will feel very much like their privacy is being violated."

So far, only supervisory clinicians have been affected by the return-to-office policy; unionized workers will be expected to report to the office in the coming weeks.

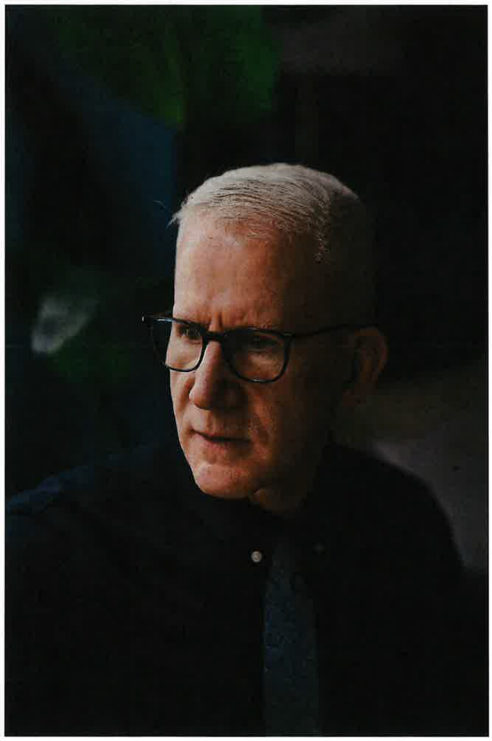
A memorial for veterans who died by suicide in Washington. Stephen Crowley/The New York Times

Dr. Kedson said clinicians have warned that the orders compromise patient privacy, but he has seen little response from the agency's leadership. "They're doing it because these are the marching orders coming out of the current administration," he said. "People are trying to make something that is really untenable work."

Dr. Lynn F. Bufka, head of practice at the American Psychological Association, said the "longstanding presumed practice for the delivery of psychotherapy" requires a private location, like a room with a door and soundproofing outside the room.

She said HIPAA, the health privacy law, allows for "incidental disclosures" of patient information if they cannot be reasonably prevented — a threshold that she said the V.A. risks not meeting. In this case, she said, the privacy risk could be prevented "by simply not requiring psychologists to return to the office until private spaces are available."

Several V.A. mental health clinicians told The Times they were interviewing for new jobs or had submitted their resignations. Their departures risk exacerbating already severe staffing shortages at the V.A., outlined in a report last year from its inspector general's office.



Matthew Hunnicutt, a social worker with nearly 15 years of experience at the V.A., retired last month. Jamie Kelter Davis for The New York Times

"Everybody is afraid, from the top down," said Matthew Hunnicutt, 62, a social worker who retired in late February after nearly 15 years, much of it in supervisory positions, at the Jesse Brown V.A. Medical Center in Chicago.

When staff were ordered to shut down diversity initiatives, Mr. Hunnicutt decided to speed up his retirement, feeling that "everything I had done was just wiped away." He said care at the V.A. had been improved during his time there, with better community outreach, shorter wait times and same-day mental health appointments.

"Just to have it be destroyed like this is extreme," he said.

Alain Delaquérière and Kirsten Noyes contributed research.

Ellen Barry is a reporter covering mental health for The Times.

Nicholas Nehamas is a Washington correspondent for The Times, focusing on the Trump administration and its efforts to transform the federal government.

Roni Caryn Rabin is a Times health reporter focused on maternal and child health, racial and economic disparities in health care, and the influence of money on medicine.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: V.A. Workers See Chaos in Services For Mental Care

Terrorizing our fellow Americans

Russ Vought promised to traumatize Federal workers, and it's happening

FPWELLMAN
MAR 22, 2025

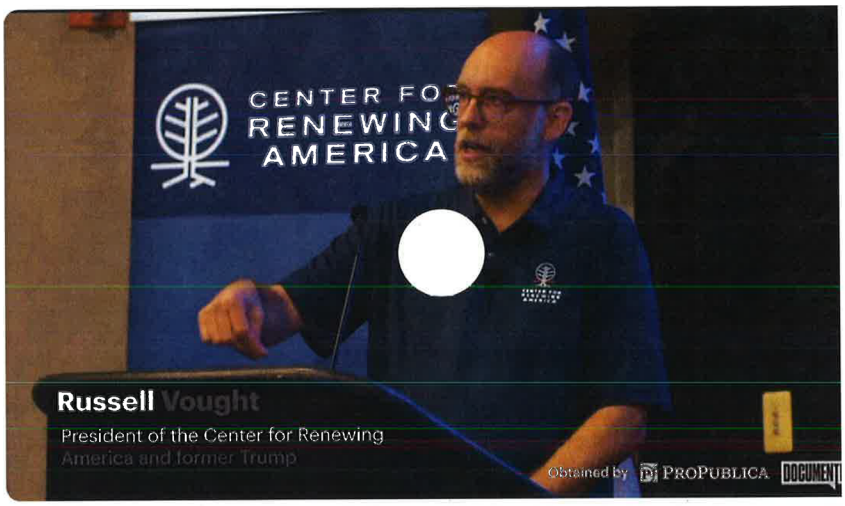
731 81 310 Sha

Don't say you weren't warned

Donald Trump, J.D. Vance, Elon Musk, and Project 2025 promised to do a lot of rea terrible things. True to their word, they are implementing them all while the media watches and tries to make it normal, while Republicans cower in fear, and while Democratic leadership is waiting for his popularity to drop so they can really do so stuff, according to Chuck Schumer.

Our government is being dismantled. We can all see that.

What you might not see is worse. It's the inside terrorist campaign that is purposely and deliberately traumatizing the two million Americans that run our federal government—exactly as promised by the guy the Senate approved 53-47 as the Director of the Office of Management and Budget.



The terrorism campaign is playing out and you are hardly hearing anything about it because it all seems so benign. What is 'traumatizing' about having to work in an office instead of remote? What is the big deal about having to fill out a few forms o your employees performance? What kind of snowflakes can't fill out a little email w five bullets about what they accomplished last week?

Take it all individually and it all sounds so mild and unimportant. Take it as a concerted campaign to force employees to be afraid of writing something that AI w flag as fireable, evaluate people you consider friends knowing that if you fill the for out wrong they will get fired, or spend your days answering new taskings instead of actually doing your job.

Repeat that daily. Over and over. It adds up to trauma, fear, and incapacitation of humans and our entire government

That's what's happening.

What Feds are saying

To paint the picture for you myself, I reached out to friends that are working inside federal government. One is a supervisor in the mental health space of the Departm of Veterans Affairs. The other is a current Federal Bureau of Investigations agent.

Both are military veterans.

I want you to read this all. I have kept their identities anonymous to protect their safety and jobs.

The Veterans Affairs Supervisor

This week my friend who works in mental healthcare for veterans at a VA hospital given a tasking to review all of the people in their section and turn it in the next da

There are over sixty people under their department. I want you to see how insane t set of instructions is for yourself:

SPREADSHEET INSTRUCTIONS:

a. The spreadsheets provided are populated HR Smart data to assist with your analysis your Filled and Vacant positions.
b. VISN/Field/VHACO Program Offices are only being asked to complete E, F, G, AN, AO, AP, AQ, AW, and BK columns which are highlighted green (these cells remove the green when filled).
c. Please complete your entries for every Filled and Vacant positions.
d. Please fill this out to the best of your ability, we understand that the timeframe allowed to address this data call is impactful.
e. Sections highlighted Grey should not be filled.
f. **Please do not change any data that is already filled out.**

Cell Definitions/Instruction:

- Column E: Group Name from Org Chart
  - Description: Please provide the name of this office based on your signed organizational chart.
  - Excel Cell Format:
    - *Open Text*

- Column F: Mission
  - Description: Mission this position is aligned to at the Organizational (Office) Level.

- Please use one of the following Mission areas:
  - Deliver comprehensive medical and hospital services for the medical care and treatment of Veterans. (38 USC 7301)
  - Provide education and training programs for health care personnel to ensure an adequate supply of health personnel to the Nation. (38 USC 7302)
  - Conduct disease and disability research to enhance Veteran care and contribute to medical science. (38 USC 7303)
  - Improve the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters. (38 USC 1785)
- Excel Cell Format:
  - *Open Text, please use one of the 4 missions above.*

- Column G: Function
  - Description: Function of this position aligned to the mission.
  - Excel Cell Format:
    - *Open Text, 1 sentence at most*

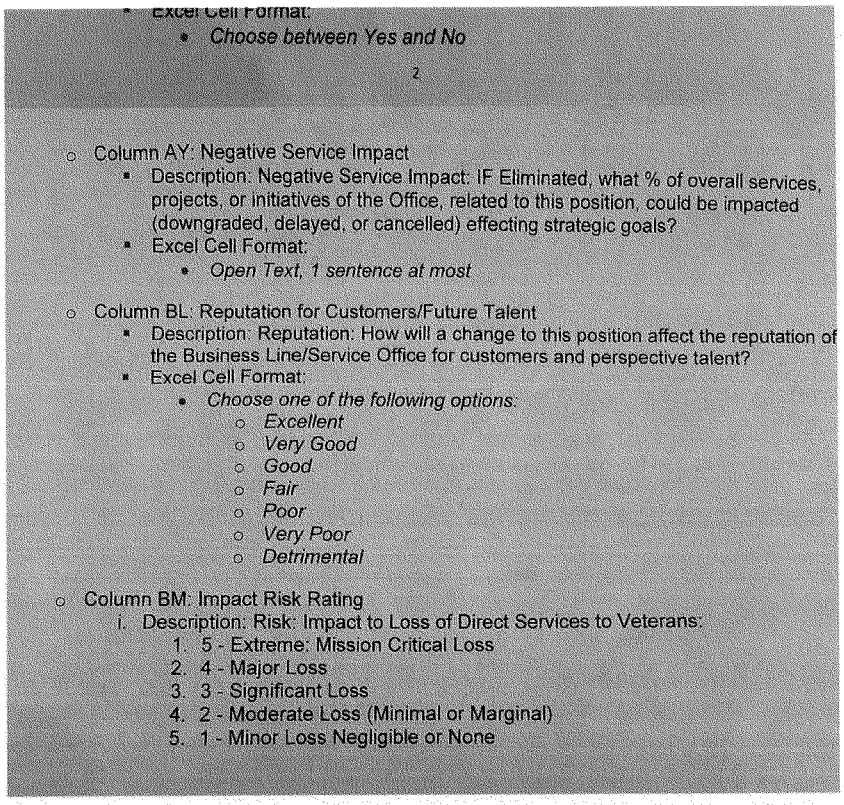
- Column AP: Position Special Skills, Competencies, a/o Institutional Knowledge
  - Description: Position Special Skills: Position special skills, competencies, a/o institutional knowledge to ensure career appointment hires are in the highest need areas.
  - Excel Cell Format:
    - *Open Text, please do not provide more than 1 to 2 sentences to answer this data point.*

- Column AQ: Prioritized Skills, Comp, IK
  - Description: Priority: Related to skills, competencies, and/or institutional knowledge. Please prioritize them by High, Medium, Low need.
  - Excel Cell Format:
    - *Choose between High, Medium, Low*

- Column AR: Streamline
  - Description: Streamline: Could the mission/function of this position be streamlined by eliminating, consolidating, expanding or should it be retained? (consolidating = absorption)
  - Excel Cell Format:
    - *Open Text, 1 sentence at most*

- Column AS: Outcomes (Negative Impact to Veterans)
  - Description: Veteran Impact: If position is eliminated, what (if any) are the direc negative impact(s) to Veterans? Additional justification can be included in part data call.
  - Excel Cell Format:
    - *Open Text, 1 sentence at most*

- Column AT: Contract Impact
  - Description: Contract Impact: If position is eliminated, are there any contracts that would be negatively impacted?
  - Excel Cell Format:



- Excel Cell Format:
  - *Choose between Yes and No*

2

- Column AY: Negative Service Impact
  - Description: Negative Service Impact: IF Eliminated, what % of overall services, projects, or initiatives of the Office, related to this position, could be impacted (downgraded, delayed, or cancelled) effecting strategic goals?
  - Excel Cell Format:
    - *Open Text, 1 sentence at most*
- Column BL: Reputation for Customers/Future Talent
  - Description: Reputation: How will a change to this position affect the reputation of the Business Line/Service Office for customers and perspective talent?
  - Excel Cell Format:
    - *Choose one of the following options:*
      - *Excellent*
      - *Very Good*
      - *Good*
      - *Fair*
      - *Poor*
      - *Very Poor*
      - *Detrimental*
- Column BM: Impact Risk Rating
  - i. Description: Risk: Impact to Loss of Direct Services to Veterans:
    1. 5 - Extreme: Mission Critical Loss
    2. 4 - Major Loss
    3. 3 - Significant Loss
    4. 2 - Moderate Loss (Minimal or Marginal)
    5. 1 - Minor Loss Negligible or None

Yes. 24-hours to complete this on over 60 people.

> My anxiety it through the roof. If I don't get this right, people could lose their jo and vets lose vital services. Yet, I'm being given a day to justify 60+ positions.
>
> It's 9am and I just want to cry. I can't do my job because I'm buried in the bullsh from this admin and the asshole Sec of the VA who gives zero fucks about vetera or VA employees.

> My head is pounding.
>
> I see on this list my colleagues, my friends, fellow veterans. Humans who choose make less, work more hours, and deal with more bureaucracy because they are committed to serving veterans. They do this work because they have a passion fc it. They want me to choose who on this list is less valuable, less critical. I can't. These people have families, lives. They deserve better than one line on a spreadsheet that will likely be reviewed by AI or some DoGE bro who has no ide what we do.
>
> Nearly 300 MH *(mental health)* staff... reviewed line by line. Retain, eliminate, consolidate, expand. A few words to describe the impact of losing this position. Assign a % impact on the mission. What's the potential damage to the reputatior the service line or org. What's the risk? It's so cold. It doesn't capture the work. I doesn't allow for innovation or creativity. It just feels like I'm being made to execute someone else's bad ideas so I will be the bad guy.

On top of that, they have an April 15th deadline to find office space for all of the mental health providers who have been hired over the last four years to work as telehealth therapists. They all have to be in VA facilities and there are not enough private offices for them, as privacy is critical in therapy sessions.

> RTO. Returned to Office that means everyone who is currently teleworking has t return to the office by April 15.
>
> So I am currently scrambling to find offices for mental health providers, which don't exist. This means we are going to have to cancel mental health appointmer for patients because I don't have offices to privately see veterans even by video.
>
> The applies to any staff who is within 50 miles of a VA facility. Which is pretty much everyone. So if I have a staff who lives in Maine but works for *xxxxxx* we ha to find them a place in Maine and they have to return to an office.

> The implications for veteran care are extreme.

When Doug Collins, the Secretary of Veterans Affairs promises that there will be n disruption to veterans healthcare or benefits, you can be assured he is lying throug his teeth. He knows exactly what he is doing.

This last note I received has stuck with me since I read it... "**Does any of this matte**

The FBI Agent

I have another fellow veteran friend who is an agent with the FBI. I asked what's gc on in the agency and how it's impacting their work. The response was lengthy, so I lightly edit it for you.

I want you to think about what you are reading here. This is our nation's top law enforcement agency. Legendary men and women. Multiple movies and television shows about their heroic efforts to defend our country and take down the worst criminals in the world.

This is what they are doing right now.

> - Very limited trust in the current administration, especially following the fork email and dismissal of senior executives.
>
> - Almost no guidance from FBIHQ, specifically the Director and Deputy Directo Director does not hold the daily update briefings from the various divisions. Thi compounds the stress level and many of us of us feel like we're just showing up f paycheck with no idea what direction the organization is heading.
>
> - No official guidance from HQ on how to execute the immigration mission with DHS, so every field office is doing it differently, and in many cases, unsafely. For example, immigration units rely on administrative warrants to pick up undocumented individuals. We have no experience with those and therefore are extremely concerned regarding officer safety, as well as civil rights of subjects.

- Focus on DEIA removal has severely diminished public outreach, especially in civil rights realm. Regular contact with minority groups has dropped significant over confusion over DEIA messaging from HQ.

- LGBT employees have been cautioned about having books and other items in t workspace which could be construed as violating the administration's policy against DEIA. In addition, many members of the community have removed self identification of their sexuality from internal HR databases, as well as removing information regarding same-sex marriages and spouses from the same.

- The reduction in prioritization of civil rights and public corruption and replacement with less complex violent crimes and gangs has added to the frustration and distrust of the administration. There is mistrust and anger follow the pardoning of subjects like the J6ers, and alleged corrupt politicians such as E Adams and Brian Kelsey.

- The poor treatment of ASAC Elvis Chan for his role in communicating with Twitter leading up to and during the 2020 election was a huge blow to morale.

- DOJ's orders to pause investigations into oligarchies, violations of the Foreign Corrupt Practices Act and Foreign Extortion Prevention Act, along with dissolu of the Foreign Influence Task Force and DOJ Public Integrity Section, has led to legitimate concerns regarding the sanctity of future elections, specifically involv foreign malign influence from Russia and China.

Bottom line, many of us are scared when we come to work each day because we have no idea what to expect. We have received almost no guidance from our top leaders. The stress is palpable and whereas political discussions were very limite prior to this administration, they now have become common. Many of my peers myself included - are seeking therapy on a regular basis.

> There is very much an "us versus them" mentality, with "them" being the curren administration. We get more information from the news and social media than v do from HQ. Those of us on the J6 list constantly wait for the other shoe to drop and are extremely concerned for our safety, as well as our families in regards to doxxing and potential violence.
>
> I don't trust the administration to not "accidentally" release the personal information to whomever. Basically, if there wasn't a "deep state" before, they've certainly done their damnedest to create one.

That's the most shocking thing I've read in a long time and almost no one is aware it or reporting on it.

If you have friends in the federal government, check on them, let them vent to you share what they are going through.

If you are an elected representative...do your damn jobs. Do you want veterans to di Do you want crimes to go unpunished? Was this your vision for a "golden age?"

When is enough, enough?

I think it's now. Get in the streets and let them know we are done waiting for our government to be destroyed.

Done.

Author's Note: Thank you for subscribing to On Democracy! Every post is free but your pai upgrade is crucial to helping me continue my work and is deeply appreciated. With your pa subscription we're able to expand our team and bring you more content and breaking news. Your paid subscription supports it all!

If you have tips for me send them to my secure Proton Mail accou
OnDemocracy@pm.me

You can open one for free as well.

On Democracy with FPWellman Substack Community is a reader-supported publication. To receive new posts you can subscribe for free. To support my work and ability to provide this content please become a paid subscriber. **It will be billed as UPEND Collective (UPND-WELL) on your credit card.**

Type your email... Subscribe

731 Likes · 310 Restacks

Previous Next

Discussion about this post

Comments Restacks

Write a comment...

Paul Aaron Roman Mar 22

Liked by FPWellman

Russell Vought is a domestic terrorist

LIKE (53) REPLY

1 reply

Andrew Hazlett Mar 22 *Edited*

Why do you suppose Vought feels such visceral malice toward federal workers? For what is he se revenge? Seems like it is personal for him, not just business. Sure, there are old conservative stereotypes of federal workers as shiftless or meddling, but those don't seem to justify Vought's tooth sadism. What's his beef?

LIKE (27) REPLY

5 replies

79 more comments...

© 2025 FPWellman · Privacy · Terms · Collection notice
Substack is the home for great culture

WAMU 88.5
Morning Edition
MY PLAYLIST

SHOTS - HEALTH NEWS

Trump's back-to-office order will hurt veterans, VA docs and therapists say

MARCH 25, 2025 · 8:04 AM ET

By Katia Riddle

3-Minute Listen PLAYLIST TRANSCRIPT

Your gift isn't just a donation — it's a declaration.

Calls to defund public media are getting louder.

Everyone deserves access to independent, trustworthy journalism. The NPR Network holds the powerful to account and keeps people informed with stories that would otherwise go untold.

Now is the time to join the community of supporters that make this work possible.

Every dollar you give strengthens this essential public service for the road ahead. Can you help?

YES, I'LL DONATE

Telehealth has become common in recent years among medical professionals — especially for mental health therapists — and the VA hired many clinicians on a remote basis. The practice allowed the VA to expand its reach of mental health services into rural areas.

Sponsor Message

SHOTS - HEALTH NEWS

Trump's policies are destabilizing mental health care for veterans, sources say

Now, many say, leadership at the VA has described a working arrangement in which they will still be doing telehealth from open spaces in VA facilities. The VA leaders describe the proposed arrangement like a call center.

"What we've heard is that there's not even enough room for each person to come in one day a week, let alone five," says H, a mental health clinician who asked to be identified only by her initial, for fear of losing her job. "We've been told they're cleaning out closets, they're looking into purchasing headsets."

Veterans' marches to protest Trump's policies took place in state capitols across the country on March 14. This one is in Indianapolis. (Photo by Jeremy Hogan/SOPA Images/LightRocket via Getty Images)
Jeremy Hogan/SOPA Images/LightRocket via Getty Images

H and other mental health providers interviewed for this story say they don't see a way – even with the best headsets available – to provide patient privacy while practicing telehealth from an open space.

In an email response, VA spokesperson Peter Kasperowicz called privacy concerns "nonsensical."

"VA is no longer a place where the status quo for employees is to simply phone it in from home," Kasperowicz writes.

NATIONAL

A VA rescue effort saved 15,000 veterans' homes. Some in Congress want to scrap it

A federal law known as HIPAA, which stands for the Health Insurance Portability and Accountability Act, protects patient privacy, and clinicians say meeting it is the minimum they need to see from the VA. "People need to know that they have privacy and confidentiality, both from a HIPAA standpoint, but in order to do high quality psychotherapy work, both parties need to be fully concentrated and not worried about censoring themselves," says H.

It is not only mental health clinicians who have concerns.

"There's a lot of talk about sexual health," says Paige, a physician at the VA, who asked to be identified by her middle name, for fear of being fired. Paige says there are many different kinds of clinicians throughout the department who regularly need to have delicate conversations with patients.

"Those are not things that any of us wanna talk about, with another person nearby," she says.

Kayla Williams, a senior policy advisor for an organization called VoteVets, says this policy change is not in line with the historic ethos of the agency to take good care of veterans.

"Unfortunately, the emphasis in this current moment does not seem to be on providing that highest quality care, but figuring out ways to cut the size of the department," Williams says.

The VA has cut hundreds of probationary positions – then reversed some decisions – while VA Secretary Doug Collins forecasted tens of thousands more additional jobs would be eliminated. Williams says that between the job cuts and the back-to-office order, VA workers are dispirited.

POLITICS

Pentagon restores webpages of Black veterans, Navajo Code Talkers and others after outcry

"I hear from someone almost every day who tells me that they and their colleagues are crying," says Williams.

VA spokesperson Kasperowicz said in his email response that the organization would make space accommodations in order to ensure veterans' access to care would remain uninterrupted and HIPAA compliant.

Veterans are disproportionately likely to die by suicide, compared to the rest of the population. The VA increased mental health staff by more than 50 percent in recent years, in response to the recognition of a growing need. But data show the estimated wait for a mental health care appointment can still be as long as 45 days.

VA Medical Centers and other health facilities exist across the country, and telehealth has expanded the VA's reach even more. This is the Tibor Rubin Veteran Affairs Medical Center in Long Beach, California pictured in 2019.
Scott Varley/MediaNews Group/Torrance Daily Breeze via Getty Images

Clinicians say the VA's reassurances are little comfort. Some worry they could lose their medical license for providing care in these conditions. They also wonder, if this boundary was crossed, what would be the next one.

H, the mental health professional, says she is concerned the change will lead to more loss of staff — and ultimately compromised care — for veterans. She says she is worried her colleagues will "simply will leave the VA," she says, "because that's not a workable solution."

Have information you want to share about the ongoing changes across the federal government? Katia Riddle is available through encrypted communications on Signal at Katia.75

veterans affairs mental health telehealth hipaa

Calls to defund public media are getting louder.

Whether uncovering local matters, analyzing national affairs or amplifying global issues, we do it for you.

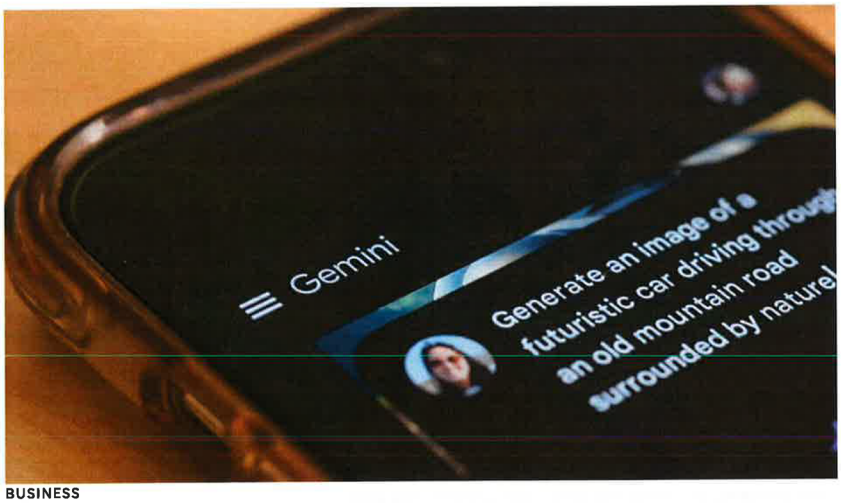
And, we do it with you.

Your voluntary financial support is an essential part of the NPR Network. Every dollar you donate strengthens this public service for the road ahead.

Can you please pitch in?

YES, I'LL DONATE

More Stories From NPR



BUSINESS

Why Google's search engine trial is about AI

OPINION > NATIONAL SECURITY

THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

Cutting veterans' suicide prevention in the name of efficiency is a fatal mistake

BY RUSSELL B. LEMLE, OPINION CONTRIBUTOR - 03/25/25 8:30 AM ET

FOLLOW ON Google News

(AP Photo/David Goldman)

Barbie Rohde holds a photo of her son, Army Sgt. Cody Bowman, at her home Sunday, June 11, 2023, in Flint, Texas. Rohde runs the most active chapter of a nonprofit called Mission 22, focused on ending the scourge of military and veteran suicide. Three-quarters of those who take their own lives use guns. One of them was her 25-year-old son.

Earlier this month, in alignment with directives from President Trump's Department of Government Efficiency, Secretary Doug Collins announced his intention to eliminate over 70,000 positions from the Department of Veterans Affairs. For emphasis, he pointedly added, "So get used to it."

Collins quickly signaled what he plans to cut. During a speech for the American Legion, he criticized the billions spent on suicide prevention efforts, noting that the yearly veteran suicide number — roughly 6,500 — has barely changed. In a follow-up interview, Collins repeated his indictment of VA suicide prevention, and declared that the "programs and operations have serious vulnerabilities for fraud, waste and abuse."

ADVERTISEMENT

Collins has a willing partner in Rep. Mike Bost (R-Ill.), chairman of the House Veterans Affairs Committee. In a recent blistering letter to the VA, Bost wrote, "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."

Bost's and Collins's framing of these topline statistics flagrantly disregards how VA's suicide prevention efforts have effectively and efficiently produced life-saving advances.

by 2 percent.

ADVERTISEMENT

Even accounting for the shrinkage in the veteran population, the VA fared better in addressing suicide risk than the general healthcare system did for civilians.

What about their contentions of overfunding and waste? The Veterans Crisis Line accounts for more than half of the VA's suicide prevention expenses. Since the 24-hour line launched in 2007, staffing has expanded exponentially to meet growing demand. The Crisis Line has initiated more than 351,000 emergency dispatches — 100 per day — each one a potentially life-saving rescue intervention. It has connected over 1.6 million veterans to local VA "suicide prevention coordinators" for follow-up care. The Crisis Line annually handles more than a million calls, texts and chats, with an average wait time of nine seconds.

Most significantly, the last two years have seen a 25 percent reduction in suicide deaths among those who had contacted the Veterans Crisis Line in the last month. How could slashing personnel and slowing these urgent responses possibly be wise?

ADVERTISEMENT

The remainder of the budget provides for suicide prevention coordinators at each of the VA's 170 medical centers, who provide enhanced care for veterans identified as at high risk for suicide. They collaborate with VA providers to monitor suicide risk screening, mental health appointments, follow-ups after missed appointments, safety planning and medical record flagging.

The need for suicide prevention coordinators has grown substantially over the last 17 years, paralleling the doubling of veterans seeking VA mental health care. Their careful attention to veterans using VA services is one plausible explanation for why suicide rates for veterans receiving only VA care are 50 percent lower than for those who exclusively use the government's community care program. As the Congressional Research Service has noted, "Outside the VA, the use of suicide prevention coordinators has not been widely adopted."

Does Collins want to purge the suicide prevention coordinator system that supports veterans during their most vulnerable moments?

CONTENT CONTINUES BELOW SURVEY

What Do You Think?

Loading survey...

With 73 percent of veteran suicides involving firearms, the VA adopted Trump's 2020 roadmap for veteran suicide prevention with a focus on "lethal means safety." The VA

The VA also runs national social media campaigns, distributes lockboxes, consults with firearm retailers and range owners and staffs suicide prevention booths and trainings at major industry events, including the National Shooting Sports Foundation's annual SHOT Show, Business Expo and Leadership Summit. Should these critical priorities be jettisoned, too?

The VA's leveraging of predictive analytics to identify and provide enhanced care to veterans at highest risk for suicide is better than analogous programs. This cutting-edge approach allows the VA to proactively assist susceptible veterans before crises occur — including many without recent suicidal thoughts. Veterans in this program are less likely to discontinue mental health treatment (thereby reducing long-term risk), and have fewer mental health admissions, emergency department visits and suicide attempts.

ADVERTISEMENT

The VA further leads in suicide prevention innovation through its Mission Daybreak grand challenge, which engages thousands of veterans, researchers, technologists, advocates, clinicians and health experts to develop forward-thinking solutions for preventing veteran suicide. Should the VA stop innovating?

Two comprehensive analyses extolled the VA's suicide prevention framework as more robust and methodologically sound than any other. The VA has successfully developed, integrated and standardized multi-level, evidence-based prevention protocols across its entire system — a significant achievement that other healthcare organizations and government agencies have failed to replicate. The VA's approach demonstrates superior

If Collins wants to identify an aspect of veteran suicide prevention with questionable returns, he might consider the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant program for community-based agencies. This program adds $53 million yearly to the budget and has shown no demonstrable impact on reducing suicide risk factors. Yet, paradoxically, this is precisely the aspect of the VA's program that Collins and Bost seem inclined to expand.

ADVERTISEMENT

By any measure, the VA's suicide prevention efforts represent an effective and economical use of taxpayer money, especially given the escalating demand for mental health care and crisis services. Its funding should be increased, not shredded.

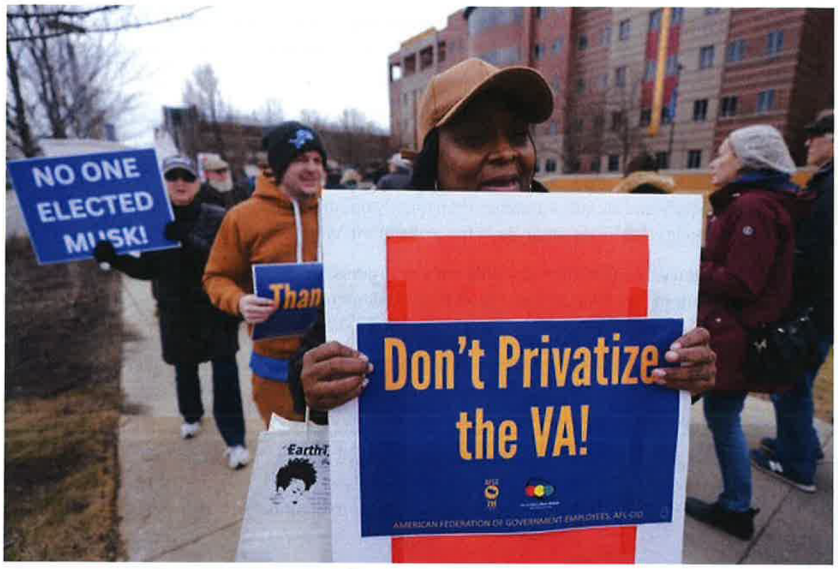
But should the VA suicide prevention budget fall victim to Collins's chainsaw, he should be prepared to answer grieving families and buddies who will ask whether the cost-cutting was worth the lives lost.

Russell B. Lemle, Ph.D. is a senior policy analyst at the Veterans Healthcare Policy Institute.

TAGS DEPARTMENT OF VETERANS AFFAIRS DOGE DOUG COLLINS DOUG COLLINS MENTAL HEALTH MIKE BOST SUICIDE PREVENTION

Copyright 2025 Nexstar Media Inc. All rights reserved. This material may not be published, broadcast, rewritten, or redistributed.

Veterans Fear Trump Administration Plans to Privatize VA Health Care



Protesters walk outside the John D. Dingell Veterans Affairs Medical Center in Detroit, Friday, Feb. 28, 2025. (AP Photo/Paul Sancya)

Military.com | By Jerry Wu

Published March 25, 2025 at 10:42am ET

Over six decades, Mark Foreman has turned to the Department of Veterans Affairs to recover from the consequences of a bullet wound to the hip sustained fighting as a Marine in Vietnam. It took endlessly long, infectious days for him to get out of deep, cavernous mountains after getting shot, three weeks straight of surgeries in Japan, and years of medical care to try to move on from his wound.

Foreman was only 20 when he suffered the injury that would end his military career, and he was discharged after two years of service in 1968. Ever since, the VA has been providing the medical care he needs, as well as helping with the cost of art school that led to a career as a teacher.

"The VA was very supportive of that," said Foreman, who later taught art for 20 years in Milwaukee's public schools. "They knew that it would help me psychologically, emotionally."

Read Next: Businessman John Phelan Gets Senate Approval to Lead Navy

But Foreman is worried. A seismic shift is potentially underway in the way the VA provides medical care and support, accelerated during the first administration of President Donald Trump and potentially ready to expand over the next four years.

"There were so many psychological and physical emotional wounds, and now they've got departments to cover all of it," Foreman said. "But I feel very confident that that's all going to be taken away."

Veterans are increasingly getting care from private medical providers, who are then paid by the VA. It's an effort to create a parallel privatized care system, known by the phrase "community care," that is set to expand further as Congress looks to make it easier for veterans to skip VA facilities.

Before 2014, the Veterans Health Administration mostly operated in government facilities. That system was overloaded at times, such as in the wake of the Vietnam War.

"When I first started working at the VA, it was not a first-class health care system," said Bruce Carruthers, a Vietnam War veteran and a retired VA administrator living in North Carolina. "But later, significant changes started to be made; it became a much more modern health care system."

Between 1995 to 2005, the VA catapulted from 2.5 million to 5.3 million patients, according to the National Library of Medicine. The VA also transformed into a training ground for thousands of health care providers, Carruthers said.

As its patient load grew, so did the stress on the VA, as more and more veterans from the Global War on Terrorism began funneling into the system. Wait times skyrocketed, and old facilities, like the Walter Reed Army Medical Center, faced scandals tied to dilapidated conditions and patient neglect.

That helped lead to the 2014 Choice Act that started the VA on the path toward offering care outside of its own facilities, and was greatly expanded by the VA Mission Act signed by Trump in 2018 that created the community care network.

Today, the demand for private care is rapidly eating into the VA's budget. In fiscal 2023, roughly 40% of all veterans' health care appointments were handled by doctors outside of government facilities, but still funded by taxpayer money, according to VA officials. The agency now serves roughly 9 million patients.

"In the first Trump presidency, we've seen an increasingly larger percentage of our direct care budget spent on outsourced private care," said Mark Smith, an occupational therapist at a VA hospital in San Francisco.

But Smith said the redirection of funds perpetuated the VA's shortfalls, when lawmakers should focus the department's full energy on caring for veterans.

"What happens is the public pays for both," Smith added. "We pay for the public services that we provide at the VA, and then we also pay for the outside care. ... Pretty soon, you don't have the money to maintain your facilities, to keep your staff, to keep the lights on."

The contrast between VA capacity and private care could get much starker if Trump administration plans for VA cuts come to pass. A surge in demand after the passage of the PACT Act made more veterans eligible for VA health care was already stressing the system.

Months before Trump took office, the VA requested a $369.3 billion budget for fiscal 2025, a 9.8% increase from the previous year. That included funding for the agency's health care and benefits branches and the Toxic Exposures Fund, which covers benefits for service members affected by toxic exposures.

But Trump and his top campaign contributor Elon Musk, who has taken on a role seeking to prevent the federal government from spending money approved by Congress and slashing jobs, are looking at shrinking the size of the VA. Most of Musk's efforts are currently tied up in litigation as judges weigh the legality of ignoring civil service protections and rejecting previously signed law directing spending.

A memo released in March indicated that the Department of Veterans Affairs was planning a reorganization that would include cutting more than 80,000 jobs. VA Secretary Doug Collins promised that the layoffs would not impact veterans' care or benefits, though outside observers are skeptical of those claims.

"The average person, of course, doesn't understand it," said Jeff Roy, a U.S. Marine Corps veteran of the Vietnam War. "The veterans, when they're listening, when they're watching these actions and the consequences, they're starting to perk up."

Roy, 76, decided to seek VA care for the first time almost a decade ago in his 60s. After he was discharged from the military, he joined a group calling for the end of the Vietnam War. To him, that also meant boycotting the VA.

He started seeking the VA when he discovered from clinical tests his prostate was showing signs of cancer.

Prostate cancer has been linked to Agent Orange, and the VA presumes that the diagnosis in a veteran is connected to their service and therefore makes them eligible for care.

The VA's own specialized knowledge and services from working with veterans likely made diagnosing his health issues easier, according to Roy. With the VA covering all his treatment,

a hospital in Minnesota, where Roy lives, then performed a lifesaving prostatectomy on him.

He's skeptical that privatized care would have led to such a positive outcome.

"They talk about honoring veterans, supporting veterans and caring about veterans. The incredible term for all of that is that it's a clash of reality," Roy said.

In January, Republican leaders on the Senate and House Veterans' Affairs Committees introduced a bill called the Veterans' Access Act, early drafts of which appeared to make it easier for veterans to access private care without consideration of wait times or VA facility proximity.

A specific section of the bill would direct a three-year pilot program to allow enrolled veterans to access private mental health treatment and substance use services through the community care

network. The program would not require a referral or preauthorization from VA doctors, essentially bypassing the VA, experts said.

"It is changing the VA primarily into an insurance carrier," said Russell Lemle, a senior policy advisor for the Veterans Healthcare Policy Institute, a nonpartisan think tank focused on veterans' health care and benefits.

A spokesperson from the House Veterans Affairs Committee denied that claim and instead said the provision is intended "to allow veterans to access residential rehabilitation treatment programs closer to their homes when VA is either too far away, or not available at all, to bridge the gap that exists in mental health care and rehab access."

Project 2025, a conservative think tank's blueprint for governance that Trump has closely followed since taking office, proposed to completely privatize VA care in the long term, Lemle said.

Carruthers, the former VA administrator, received gallbladder surgery and prostate treatment from the VA because of his years serving in Vietnam. For him, efforts by the Trump administration to cut VA care count as a direct rebuke to veterans.

"To me, 'Thank you for your service' is a meaningless trope if they're not going to support that," he said.

Editor's Note: This story has been updated to correct the area of Bruce Carruthers residence.

-- Jerry Wu covers national security and veterans' affairs in Washington, D.C., for Medill on the Hill. The San Diego native is a sophomore at Northwestern University studying journalism and international studies.

Related: Community Care Is Not VA Care

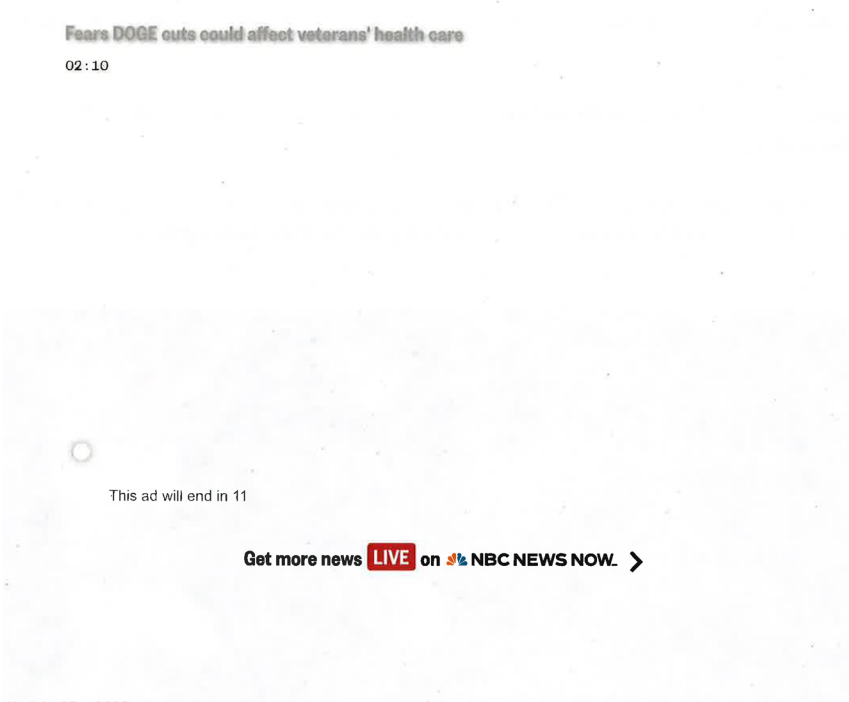
Related Topics: Military Headlines Veterans Department of Veterans Affairs - VA Veterans Health Care

© Copyright 2025 Military.com. All rights reserved. This article may not be republished, rebroadcast, rewritten or otherwise distributed without written permission. To reprint or license this article or any content from Military.com, please submit your request here.

DOGE

She helped veterans in crisis. DOGE cuts eliminated her job.

An office manager at a VA center in Wyoming, where the veteran suicide rate is 50% higher than the national average, was fired last month despite a glowing job review.



March 25, 2025, 6:09 PM EDT

By Laura Strickler, Stephanie Gosk and Lily Becker

CHEYENNE, Wyo. - For years, a small office suite tucked into a nondescript strip mall has provided a lifeline for veterans with mental health issues. It's one of hundreds of tiny centers across the United States designed to act as a refuge for veterans in crisis.

But last month, the office manager, a Marine veteran with a glowing performance review, was fired as part of sweeping cuts across the Department of Veterans Affairs.

The manager, Carla Nelson, was the person who greeted every veteran at the front door. She was the one whose voice they heard when they called in seeking help.

Her termination and the potential for wider cuts have caused concern in the veteran community in Wyoming. Since the terrorist attacks of Sept. 11, 2001, more than 140,000 vets have lost their lives to suicide nationwide, according to the VA, vastly more than the roughly 7,000 U.S. service members who died in the wars in Afghanistan and Iraq. And the veteran suicide rate in Wyoming is 50% higher than the national average, according to the latest VA data.

"We lose too many," said Justin Tripp, a Navy veteran who is now the Wyoming state commander for the VFW.

The issue is personal for Tripp. He said a good friend whom he had served alongside died by suicide recently.

"That transition to civilian life – that's where we lose a lot of people to suicide." Tripp added. "They don't have a good transition. They're not getting help for their mental illness."

— Justin Tripp is the state commander for Wyoming's VFW. NBC News

Roughly 40,000 veterans reside in Wyoming. They and others who live in rural areas tend to have lower incomes than their urban counterparts, and they often struggle to make it to appointments that can be hours away. They also rely on VA services more than those living in urban areas, according to VA data.

The system that serves these veterans is now bracing for much more significant cuts.

Last week, VA departments went through staff, line by line, identifying who was "mission critical" and who could be fired as part of a plan for 80,000 layoffs, according to two current VA sources.

"The real pain is coming," said one VA official who spoke on the condition of anonymity out of fear of retaliation. "If we can't provide the care in these rural communities, there isn't another option, especially for mental health."

In an interview with NBC News, Nelson, the fired office manager, said veterans came from all over the state and beyond to get help for post-traumatic stress disorder and other serious mental health issues.

"We deal with crisis situations," Nelson said. "Some traveled up to an hour to get there, and even some came from Nebraska."

Unlike a VA hospital, small centers like the one where Nelson worked offer an informal setting where veterans can walk in for help. She had been working there since May 2024.

"As a veteran herself, she listens with empathy," read her October 2024 performance review, according to a copy obtained by NBC News. "She is the first person our clients come into contact with."

Her manager also wrote that her customer service with veterans was "always exceptional."

Nelson was at work Feb. 24 when she received an email informing her that she was terminated. "Nobody was pre-warned about any of this," Nelson said. "Nobody knew."

A federal judge has ordered probationary employees like Nelson to be reinstated, but for many the situation remains unclear.

VA press secretary Pete Kasperowicz did not respond to specific questions about Nelson's status.

"VA is complying with the U.S. District Court for the District of Maryland's March 13 temporary restraining order and the U.S. District Court for the Northern District of California's March 13 preliminary injunction related to probationary employees," he said in a statement. "We cannot comment further due to pending litigation."

VA Secretary Doug Collins has sought to reassure those who are worried about how the cuts will impact veterans directly. "We're going to accomplish this without making cuts to healthcare or benefits to veterans and VA beneficiaries," he said in a YouTube post March 5.

Tripp, of the VFW, said he agrees that the VA could benefit from some streamlining. But he believes that terminating someone like Nelson will have consequences for veterans in need of help.

"I would be concerned with positions that are front-line positions that touch veterans every day,:" he said. "I'd want to make sure that somebody's at the front door so if a veteran walked in in a crisis, they would be there to help."

Others in Cheyenne said they were concerned about impending cuts but feared that speaking publicly would make them a target, especially because 70% of the state voted for Donald Trump.

One VA employee, who lives in a Western state and spoke anonymously out of fear of retaliation, said the loss of support staff will impact clinical care because fewer appointments will be made.

While the VA has made great strides in improving telehealth services to assist rural veterans, some are still unable to access them, advocates say.

Chauncey Parker, who runs Great Plains Veterans Service Center in northern Montana, uses a federal grant to pay a network of veterans who drive fellow vets to appointments. He said the VA's expansion into telehealth has helped significantly, but some vets don't have access.

"Some of them don't have the connectivity in the first place," Parker said, "so that in-person visit with their health care provider is about all they have."

If you or someone you know is in crisis, call 988 to reach the Suicide and Crisis Lifeline. You can also call the network, previously known as the National Suicide Prevention Lifeline, at 800-273-8255, text HOME to 741741 or visit SpeakingOfSuicide.com/resources for additional resources.

Laura Strickler and Stephane Gosk reported from Cheyenne and Lily Becker from Washington, D.C.

Laura Strickler
Laura Strickler is a senior investigative producer and reporter for NBC News. She is based in Washington.

Stephanie Gosk
Stephanie Gosk is an NBC News correspondent based in New York City. She contributes to "Nightly News with Lester Holt," "TODAY" and MSNBC.

Lily Becker
Lily Becker is an NBC News intern based in Washington, D.C.

STARS AND STRIPES

VETERANS

Medical staff shortages impeding VA mental health care, advocates tell lawmakers

By LINDA F. HERSEY
STARS AND STRIPES • March 25, 2025

Psychiatrists registered with the Department of Veterans Affairs to provide care in the community often encounter payment delays and scheduling problems, causing them to leave the VA system, according to a former VA clinician now in private practice. (Stars and Stripes)

WASHINGTON — Chronic medical staffing shortages at the Department of Veterans Affairs make it difficult for the most ill patients with mental health conditions to see psychiatrists in a timely manner, according to a former VA clinician now in private practice.

In addition, psychiatrists registered with the VA to provide care in the community often encounter payment delays and scheduling problems, causing them to leave the VA system, said Shankar Yalamanchili, a former VA psychiatrist who now directs River Region Psychiatry Associates, a privately run multistate practice.

Yalamanchili delivered the message to lawmakers Tuesday at a House Veterans' Affairs Committee subpanel on health hearing. He said VA hospitals need the ability to contract directly with private physician groups to fill vacancies so veterans are not underserved or forced to wait months for care.

The Veterans Health Administration is facing medical staffing shortages, according to a VA Office of Inspector General report that found severe personnel shortages in fiscal 2024 impacting clinical and non-clinical jobs. Shortages span nurses, primary care doctors and psychiatrists, among other roles.

Missy Jarrott — mother of Navy veteran Landon Holcomb — told lawmakers that the VA repeatedly canceled and delayed her son's appointments to see a psychiatrist for mood-

stabilizing drugs to treat his depression.

"The system completely failed him," she said.

Holcomb, 39, died from a drug overdose in 2024, after his requests for psychiatric care were denied and then delayed, Jarrott said.

"All Landon asked for was a mental health appointment for medicine management. He raised his hand over and over," she said.

Rep. Mariannette Miller-Meeks, R-Iowa, the subpanel chairwoman, said she does not believe spending more to provide care at the Veterans Health Administration is the answer. In fiscal 2024, Congress provided $121 billion in funding for health services for veterans.

But a severe shortage of doctors was reported by 86% of VA hospitals and clinics in 2024. Though the VA hired more than 300 psychiatrists since 2023, the agency has faced chronic shortages for psychiatrists for several years, reflecting a national shortage. Fewer medical students choose psychiatry as their specialty, according to the American Association of Medical Colleges.

Approximately 40% of veterans require mental health services every year, said Yalamanchili, who urged lawmakers to be more "proactive" in addressing the VA's shortages of medical staff by considering alternative solutions that include hiring doctor groups to fill gaps in care.

Yalamanchili offered insights about shortages and delays in the delivery of care to veterans with psychiatric illnesses. He said private clinicians who register with the VA to accept veterans as patients get frustrated by frequent problems in receiving timely reimbursements for the care that they provide. The VA schedules appointments that veterans have with private clinicians in the community.

Yalamanchili described a "lack of coordination" by the VA that results in appointment cancellations and delays for follow-up visits.

"Private doctors are frustrated and leave the network," he said.

But Rep. Julia Brownley, D-Calif., said "here is a serious lack of oversight" of private doctors in the community, compared with clinicians at the VA.

"We must find a balance between community and VA care," she said.

Michael Urban, an Army veteran and clinical social worker, said he began taking prescribed painkillers after he was injured in an accident during a jump as a paratrooper in the 82nd Airborne Division.

Urban was medically discharged and had to undergo multiple surgeries for his injury. He was placed on a regimen of opioids to dull the pain — "a path all too familiar to many veterans," he said.

In 2004, he began receiving medical care at the Philadelphia VA Medical Center. But Urban said there were long delays for addiction treatment and mental health care.

"I've experienced the challenges of accessing care in the system," he said.

Though there are shorter waits for health care since passage of the Mission Act, which enabled veterans to see community-based clinicians, he said there are sometimes bureaucratic delays in accessing community care.

But Maria Llorente, acting VA undersecretary for the health office of integrated veterans care, said the availability of residential addiction treatment for veterans has grown, as the VA now sends veterans to care in the community when beds at a VA hospital are not available.

Brownley said residential treatment is more costly at private programs, running to $6,000 per day.

Jarrott said her son was booked at Charleston VA Health Care in South Carolina in May 2024 to see a psychiatrist six months after he originally sought mental health care and medication management for his depression.

But Holcomb died from fentanyl poisoning before his scheduled visit, she said. Her son's drug abuse was an attempt to "numb the pain" from mental health problems connected to military service, Jarrott said.

"He was experiencing anxiety, insomnia, restlessness and mood swings. Landon knew that he needed a mood stabilizer," she said. "Help did not come soon enough."

LINDA F. HERSEY

Linda F. Hersey is a veterans reporter based in Washington, D.C. She previously covered the Navy and Marine Corps at Inside Washington Publishers. She also was a government reporter at the Fairbanks Daily News-Miner in Alaska, where she reported on the military, economy and congressional delegation.

Subscribe to Stars and Stripes Just 99¢ a week! SUBSCRIBE

North Korea lashes out at 'Swan of Death' bomber deployment... | Stealth fighters play aggressors in US-South Korea tactical... | ThayerMahan holds christening of unmanned acoustic... | Naval Information Warfare Center provides STEM... | Pepper-sprayed Marines take on non-lethal weapons course...

The New York Times https://www.nytimes.com/2025/03/27/opinion/veterans-mental-health-cuts.html

LETTERS

‘A Gross Dishonor’: Cuts to Veterans’ Mental Health Care

March 27, 2025

More from our inbox:

- Losses in Nature
- A.I. and Humans

A demonstration outside a V.A. medical center in Detroit last month. Paul Sancya/Associated Press

To the Editor:

Re "V.A. Workers See Chaos in Services for Mental Care" (front page, March 24):

I am a Vietnam veteran. I served with the First Cavalry Division as a sanitary inspector and shoe-leather epidemiologist. I spent more than 1,000 hours flying to bases between Saigon and the Cambodian border. We carried the wounded and dead on stretchers to aid stations or graves registration. After returning home in 1971, I went back to school and buried the war.

In 1990, Operation Desert Shield opened up a can of trauma for me and many vets. I could not accept that I, who had not carried a gun, was traumatized by my service. Over the next 30 years I went to family therapy, couples therapy and

individual therapy. But it was only after Covid that I signed up for health care at Veterans Affairs. The trauma therapy there exceeded any I had done before. I believe all the V.A. health services today are nonpareil.

About 6 percent of the nation's population are veterans, and surveys have found that more than half of Americans have a close relative who has served in the military. Yet I do not hear or see my senators nor, with some exceptions, my representatives, objecting publicly and loudly to what President Trump and his appointees are doing to our veterans' services. If they want to be re-elected, they should get some backbone and speak out for the V.A. and all veterans.

This is not a political issue but one affecting the health of the nation. Their deafening silence is a gross dishonor. Let's put some substance behind "thank you for your service."

James C. Wright
Gladwyne, Pa.

To the Editor:

The suicide rate among veterans is staggering — more than double that of the civilian population. How, then, can a Republican administration that pins gun violence on the inaccessibility of mental health care justify what's happening at Veterans Affairs facilities around the country?

With DOGE cutting jobs and driving clinical professionals to quit by fundamentally altering their positions, what's happening is unconscionable. And more lives will be lost as a result.

President Trump should not get to express support for our military and then turn around and pull the rug out from under them. Our veterans — and the mental health work force that treats so many of them — deserve much better.

Sign up for the Opinion Today newsletter Get expert analysis of the news and a guide to the big ideas shaping the world every weekday morning. Get it sent to your inbox.

Thomas E. Templeton
Latham, N.Y.
The writer is a licensed mental health counselor.

To the Editor

The Trump administration's order that Veterans Affairs mental health professionals conduct therapy calls in an open-floor office violates the privacy interests of their patients, and reflects a similar mistake of the Reagan administration's opening policy, which it was forced to reverse.

President Ronald Reagan's first official act after his inauguration in 1981 was to impose a hiring freeze. David Stockman, the director of the Office of Management and Budget, declared the freeze necessary to "control immediately the size and cost of government." Appropriated funds for hiring mental health professionals for Vietnam veteran counseling centers established by Congress were not to be spent. The authority Mr. Stockman relied on to halt the expenditure was the Impoundment Control Act of 1974.

Representative David Bonior, chair of the Vietnam Veterans in Congress Caucus, who sued Mr. Stockman in federal court, was joined by other lawmakers in claiming such funds were not subject to impoundment.

Mr. Stockman, who avoided the draft during the Vietnam War because he was a divinity student, ultimately agreed to the release of funds, thereby securing dismissal of the lawsuit. President Trump, who avoided the draft during the Vietnam War because of alleged bone spurs, should likewise rescind his actions harming emotionally troubled veterans.

Joseph C. Zengerle
Bethesda, Md.
The writer, a disabled Vietnam veteran, was counsel to Mr. Bonior and other plaintiffs in the lawsuit against Mr. Stockman.

To the Editor

I was drafted into the Army in 1967, a 19-year-old boy from Brooklyn, as green as they come. I grew up really fast the next year when I was deployed to Vietnam, and in each and every letter I sent home to my family, I put this on the outside of the envelope in large capital letters: I.A.C.W.B. ("It's a cruel world, baby.")

Though I became cynical in how I viewed the war effort, I made it back in one piece, and I consider myself to this day to be a very lucky man.

What President Trump and Elon Musk are doing to the veterans is an abomination. Mr. Trump has made it clear that he views people risking their lives serving the nation in the military as losers. And now, in a miserable attempt to trim wasteful government fat, he is putting veterans at even greater risk.

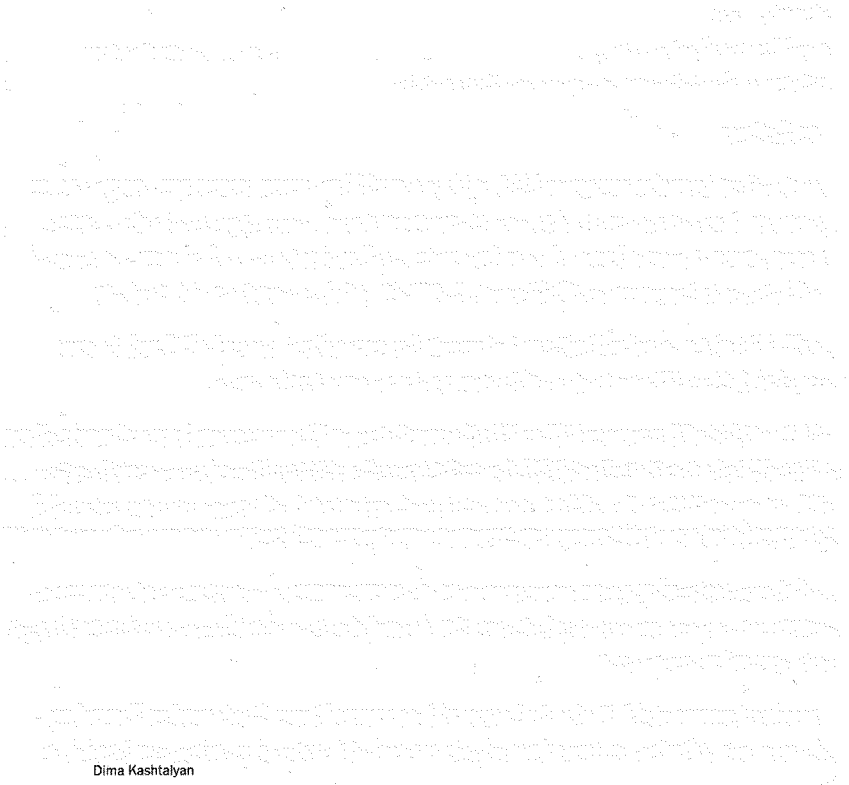
I'm all for eliminating government waste, but why target Veterans Affairs? How about turning your trimming knife to the Pentagon and the bloated defense budget, which grows every year?

If I want to lose weight, I can do it one of two ways: I can limit eating fattening foods and cut calories so that the weight comes off without putting my health at risk.

Or I can cut off my legs.

Len DiSesa
Dresher, Pa.

Losses in Nature



Dima Kashtalyan

To the Editor:

Re "What the Dodo Tells Us, 300 Years After Its Extinction," by Renée Bergland (Opinion guest essay, nytimes.com, March 9):

Dr. Bergland rightly notes that extinction is nothing new. But as the chief scientist at the World Wildlife Fund, I am disturbed by the current rate of nature loss.

Monitored wildlife populations have declined on average by 73 percent in less than 50 years. Life on earth hasn't seen losses this steep since the dinosaurs. Unlike the dinosaurs, however, we have the power to stop and even reverse much of the damage.

Our planet is barreling toward negative tipping points that, if crossed, will have dire consequences for not just nature, but for people as well. That may sound alarmist to some, but the health of even a single species population can have surprising ripple effects and could be the trigger for a more expansive tipping point.

Take the sea otter. As a predator, it keeps ecosystems in balance. When fur traders nearly wiped the species out in the 18th century, sea urchins overwhelmed the kelp forests it called home, hurting fish stocks and reducing coastal protection from storms.

But the sea otter's saga didn't end there. Conservation efforts sparked a remarkable recovery, boosting ecotourism and local economies. In this way, the sea otter is just one of many examples of how thriving communities and a healthy natural world go hand in hand. We flourish, or falter, together.

Rebecca Shaw
San Francisco

A.I. and Humans

To the Editor:

Re "A.I. Will Soon Be Smarter Than Humans. Let's Discuss," by Kevin Roose (The Shift column, Sunday Business, March 16):

I would like to point out that despite all the current fear-mongering, artificial intelligence is not a threat to human beings.

A.I. is an incredible tool when used properly. Its main value is in its predictive abilities. It can sift through huge amounts of data and discern patterns that the human brain, as predisposed to pattern-seeking as it is, cannot.

But A.I. cannot replace human thought. It can never write a work of literature. Yes, it can emulate past authors, but it can do so only in predictive ways. Or random ways.

What it cannot do is create the unexpected. That is something only a gifted author can do. And by "unexpected" I do not mean random. I mean the precise turn of events that creates the most surprise in the reader's mind, and also the sense that what happened was, in fact, precisely what should have been expected.

Only a human mind can do that. So rest assured: A.I. will not replace us.

David Frank DeLuca
Palm Bay, Fla.

A version of this article appears in print on , Section A, Page 25 of the New York edition with the headline: Threats to Veterans' Mental Health Care

She Devoted Her Life to Serving the U.S. Then DOGE Targeted Her.

A veteran who returned from Iraq injured and transformed, Joy Marver is now facing a crisis at home.

By Eli Saslow Photographs by Erin Schaff

Published March 30, 2025 Updated April 2, 2025

It had been six days since Joy Marver was locked out of her office at the U.S. Department of Veterans Affairs, five days since she checked herself into a hospital for emergency psychiatric care, and two days since she sent a letter to her supervisors: "Please, I'm so confused. Can you help me understand?"

Now, she followed her wife into the storage room of their house outside Minneapolis, searching for answers no one would give her. A half-dozen bins held the remnants of 22 years spent in service to the U.S. government — first as a sergeant first class in Iraq, then as a disabled veteran and finally as a V.A. support specialist in logistics. She had devoted her career to a system that had always made sense to her, but now nobody seemed to know whether she had officially been laid off, or for how long, or why.

"Are you sure you never got an email?" asked her wife, Miki Jo Carlson, 49.

"How would I know?" asked Marver, 45. "They deleted my account."

"Maybe it's because you were still probationary?"

"My boss said I was exempt," Marver said. "I was supposed to be essential."

In the last few months, more than 30,000 people across the country were fired by President Trump's new initiative called the Department of Government Efficiency, a historic reduction of the federal work force that has been all the more disruptive because of its chaotic execution. Entire agency divisions have been cut without explanation or mistakenly fired and then rehired, resulting in several lawsuits and mass confusion among civil workers. After a court ruled last week that many of the firings were illegal, the government began reinstating workers, even as the Trump administration appealed the decision and promised more layoffs.

The V.A. alone said it planned to cut about 80,000 more jobs this year — including tens of thousands of veterans — and for Marver the shock of losing her job was eclipsed by the disorientation of being repeatedly dismissed and belittled by the government she served. She had watched on TV as Trump's billionaire adviser Elon Musk took the stage at a political conference wielding a chain saw to the beat of rock music, slicing apart the air with what he called the "chain saw for bureaucracy." She had listened to Trump's aides and allies deride federal employees for being "lazy," "parasitic," "unaccountable" and "essentially wasting" taxpayer money in their "fake jobs."

In Marver's case, that job had meant helping to retrain soldiers for the civilian work force and coordinating veteran burials while earning a salary of $53,000 a year.

"Here's the note I got a little while after I was hired," Marver told Carlson, pulling a form letter from the government. "You represent the best of who we are as Americans," it read. "You could have chosen to do anything with your talents, but you chose public service."

"Kind of boilerplate, but it's nice," Carlson said.

"I would be OK right now with boring and predictable," Marver said, as she tucked the letter back into a file.

Marver served two tours in Iraq.

She dug through the bins, pulling out military awards for “exceptional achievement” and “tactical proficiency,” and pushing aside a large steel hunk of a rocket. It had exploded on her base in Iraq during an attack in 2020, leaving her with a concussion, damaged eyesight and a traumatic brain injury. She’d come home flattened, depressed and ill-equipped to hold a corporate job, but working alongside other veterans at the V.A. had done more to restore her sense of purpose than any of the five medications she was prescribed for post-traumatic stress disorder, panic attacks and anxiety.

She reached into another bin and pulled out an employee of the month certificate and then her last performance evaluation, from October. She read the reviews out loud to Carlson, looking for clues that might hint at a reason for her dismissal. "Joy puts the mission first — team player, responsible, continually displays professionalism. She is a great employee."

She scanned down to her performance rating and saw that her boss had not circled "satisfactory," or "fully successful," or even "excellent," but had instead chosen "outstanding!" — the best possible result.

"I did everything they wanted me to do," Marver said. She flipped over the sheet and read it again, searching for some hidden flaw.

"You're not going to find anything that makes it add up," Carlson said. "This was never about you."

But Marver kept digging through the paperwork, already knowing what came next: a "Fork in the Road" email from Musk offering mass buyouts, a sample letter of resignation provided to all federal employees, and another email demanding that Marver and her colleagues send a list of five things they had accomplished that week. Some of her co-workers had refused to answer in protest, but Marver believed in following orders. She wrote that the Minneapolis V.A. was requiring its remote employees to return to the office, and that she was responsible for preparing the building. She was reviewing floor plans, moving hundreds of chairs and assembling desks in the hallway. Then, on Feb. 14, the first wave of her co-workers had been fired, and she was in charge of collecting their badges. Her managers had reassured her that her job was safe. She was vital to the mission, they said.

She kept digging in the box until she found a few family photographs that she had taken off her desk that last morning, after she couldn't log into her computer. A confused supervisor had suggested she grab her personal items before leaving the building, just in case. Marver had gone back to her truck and texted Carlson, already plagued by the question that had consumed her ever since.

"What just happened?" Marver asked. "It's like being erased out of thin air."

With her wife, Miki Jo Carlson. Marver received a Meritorious Service Medal from the National Guard.

She kept American flags all over the house — raised above the front porch, framed on her bedroom wall, draped over the gun safe and tattooed on her right bicep underneath the word "Loyalty." She had just turned 21 when she enlisted in the National Guard a few months after Sept. 11, 2001, and she had served under Republicans and Democrats for two decades without paying much attention to politics. Her job was to follow orders wherever they led — driving a Humvee that exploded when it hit a roadside bomb in Iraq, scrambling underneath her bed during rocket attacks, defending herself and others with a riot shield in downtown Minneapolis during the violent protests in the aftermath of George Floyd's murder. Her military career spanned three active-duty tours and more than 800 days in war zones, and each year she was graded by her superiors based on a list of Army tenets she understood to be reciprocal: Loyalty. Duty. Respect. Honor. Integrity.

Her final tour had been the most damaging, when she was stationed at Camp Taji outside Baghdad in March 2020 during a series of incoming rocket attacks that killed several soldiers. One day, she heard more than 30 explosions on the base and

started running through clouds of black smoke and into a bunker just as a rocket landed nearby. She felt the shock waves rip through her, clouding her vision and rattling her rib cage. She checked her arms, her shoulders, her legs. Her body remained intact. She stumbled into the middle of the bunker and told her soldiers she was fine, but then she started vomiting, blacking out and slurring her words. A few hours later, she was diagnosed with a concussion and a traumatic brain injury, and doctors had been taking measure of her wounds ever since. She was rated 10 percent disabled for eyesight, 10 percent for hearing loss, 20 percent for back pain, 30 percent for persistent migraines and 70 percent for depression, PTSD, insomnia, anxiety and memory loss.

"I think I'm going to have another panic attack," she said one day, about a week after her firing from the V.A. It was almost 2 p.m., and she was still in her pajamas.

"Have you taken your medicine yet?" Carlson asked.

"I've been trying not to," Marver said.

"Take it," Carlson said. "Kick up the dose. Rockets."

It was the word they used as shorthand for all the accommodations Marver's new life required after she returned from Iraq. Her chronic fatigue and recurring nightmares? Rockets. Her sudden avoidance of crowds? Rockets. They had moved out of a noisy apartment building in downtown Minneapolis and into a suburb south of the city. They bought a house with soundproof walls, a canoe and a view of a lake, but Marver still jolted awake and paced the bedroom at night.

A piece of the rocket from the explosion in Iraq that caused Marver's traumatic brain injury.

Carlson felt as if she were married to a new person, so she had started keeping a handwritten list of all the ways in which Marver was diminished by her last tour. "Memory before Iraq: Great, meticulous." After: "Forgets appointments, leaves lights on, misses entire strips when mowing the grass."

"Personality before Iraq: Does funny dances and makes up silly songs — great social skills." After: "Sense of humor gone and very introverted. Avoids big crowds or new places. She lost her spark. The difference is night and day."

Are you a federal worker? We want to hear from you.

The Times would like to hear about your experience as a federal worker under the second Trump administration. We may reach out about your submission, but we will not publish any part of your response without contacting you first.

Continue »

"Relationship before Iraq: Happy/normal." After: "No intimacy. I am now more of a caretaker than a wife."

Only in the last week had Carlson begun to wonder whether all that caretaking was sustainable on her own. She worked six days a week as a bartender, while Marver found both confidence and community in her job at the V.A. Marver worked alongside other veterans who understood her wounds and forgave her occasional memory lapses. Now she was home alone for much of the day. She mostly stayed in bed, ate microwaved meals and watched the news on TV to see what Trump and Musk were planning next.

Marver wasn't opposed to thoughtful government cuts. During her time in the military, she had complained about the hundreds of billions of dollars spent on new weapons and aircraft that never panned out. She had managed her own tight supply budget of $21 million on her base in Iraq and won praise in her annual reviews for fiscal responsibility and loss prevention.

"There are smart ways to go about this," she told Carlson. "There's plenty to cut. They don't have to go in with a firing squad."

"This isn't helping you," Carlson said. She grabbed the remote and turned off the TV. "You need to eat. Go outside. Get some air. Go for a walk."

"I can't keep piecing myself back together," Marver said.

"Rockets," Carlson said. "We need to ask for some help."

Carlson sometimes felt that Marver was a different person since coming home from Iraq. But working with other veterans helped restore Marver's sense of purpose.

The next afternoon, they drove out of the suburbs and back into Minneapolis to see Marver's psychiatrist at the V.A. The hospital was across the street from the administrative building where Marver used to work, and she pulled up to her old entry gate and tried to look inside. "It's a black box," she said. She was still waiting for an email from human resources with an official reason for her firing. She had tried to ask her co-workers, but some said they were afraid to talk to her over the phone. They worried that their calls were being monitored or that they could be disciplined for sharing information or offering their support.

"I'm getting the same panicky feeling I had that morning," Marver said.

"Relax," Carlson said. "Breathe."

"I couldn't control any of my thoughts," Marver said. She pulled back onto the road, but now her mind was stuck inside the confusion of that last morning at work, when she was locked out of her computer as her colleagues began arriving for work. Her manager said that there had been a mistake, and that he would sort it out. She waited at her desk until another manager came back and said he was sorry, but her name no longer existed in the system. He asked for her badge and walked her outside. She sat in the cab of her truck in the parking lot, staring at the

wheel. She didn't want to go home. She was tired of disappointing Carlson with bad news — tired of being the problem. She started the engine and drove out of the parking lot. She stopped at a traffic light that led onto a bridge.

She knew a half-dozen veterans who had died by suicide, including two of her closest friends in Iraq, and she sat at the red light and considered it for the first time. If she proceeded onto the bridge, if she swung the wheel to the right, if she pressed down on the accelerator and drove over the guardrail. The light turned green. Her hands were shaking. She didn't move. Someone honked from behind, and for a moment it jarred her back. She drove straight over the bridge, parked at the V.A. hospital and followed signs to the psychiatry department.

Now she was arriving there again, for a follow-up appointment. She held Carlson's hand in the waiting room until a psychiatrist came to greet them.

"You might have saved my life that day," Marver told her psychiatrist. "I felt this voice telling me: 'Do it. Just get it over with.' It came on so fast. It scared the shit out of me."

"I'm so glad you had the courage to get help," she told Marver. "How are you doing now?"

"I'm stable, but it's dark," Marver said. "I can't turn off the news. Nothing that's happening makes sense. They keep getting rid of things without even knowing what they're cutting."

During Marver's last deployment in Iraq, Carlson carried a G.I. Jane action figure with her everywhere.

She said she was worried about layoffs affecting the doctors she relied on at the V.A.: the specialist who treated her T.B.I., the neurologist who managed her migraines, the therapist with whom she relived the rocket attacks, and the psychiatrist who rushed out of a meeting to see Marver as soon as she crossed the bridge, consoling and hugging her until she finally stopped shaking.

The V.A. had been scrambling to hire psychiatrists for years to make up for what it called a "severe staffing shortage" as veteran suicide rates rose to epidemic levels. Each V.A. psychiatrist was already responsible for 500 patients, and lately those

patients had begun reporting increased rates of anxiety and stress because many of them were also employed by the federal government.

"Nobody wants to serve this country more than veterans," Marver said. "It's personal for us."

"That's why I love working here," her doctor said.

"I need a purpose," Marver said. "I still want some way to serve."

"Then keep looking."

The interior of the Department of Veterans Affairs hospital, near the V.A. building where Marver worked. Watching the news with her cat, Jinx.

She changed back into her pajamas. She took medication for a migraine. She went back to bed and slept through the afternoon, until Carlson came home from work. "Rockets," Carlson said. "You can't stay like this forever. Get up. Get mad. Get back in the fight."

A former colleague had invited Marver to speak at a town hall in southern Minnesota alongside a few other fired federal workers, and at the last minute, Marver agreed to go. She waited in line for her five-minute slot and then stared out at the crowd of about 100 people, trying to find the right words. "Sorry," she said into the microphone. "This is hard for me." She hadn't spoken in public since she left the military. She scanned the audience for Carlson, who raised her fist in support. "OK," Marver said. "Let's try this." She told the story of her firing, the ensuing confusion and her crisis at the hospital. "Is this how we treat our veterans?" she asked.

The audience clapped as Marver handed the microphone to the next speaker, but on the ride home she could still feel the adrenaline and anger rising into her chest. She stopped on the front porch and reached up for the flag. She smoothed out the fabric and rehung it upside down.

"You're sure about that?" Carlson asked.

"Until this country starts making sense again," Marver said.

The tattoo on Marver's lower right arm reads "Loyalty."

She kept watching the news and checking her email for a reasonable explanation, but every update only left her more confused. More than a week after she was fired, Marver received a "Termination Letter" from human resources: "Your performance has not met the burden to demonstrate further employment," it read.

She received another message a week later: "The V.A. is rescinding the termination," it read. "You will be on administrative leave. You are not to return to duty at this time."

And then, 24 days after she was fired, she got another email with a subject line marked urgent: "Return to Duty Instructions." The message told her to report back to work Monday morning.

"Are you kidding me?" Marver said. She searched for more information online and saw that a federal judge had ordered the government to rehire some probationary employees, ruling that their mass firing was based on "sham" reasoning. The Trump administration had agreed to comply with the order even as it filed an appeal and asked for emergency relief from the Supreme Court.

"Who knows what they'll tell me tomorrow," Marver said, when she showed the email to Carlson.

"Why even go back there again?" Carlson asked.

"Because I can keep helping veterans," Marver said.

She lay awake for most of the night and then got into her car Monday morning. She drove back over the bridge and parked in front of her building. One of her supervisors met her outside and said she would need to spend most of the day "reorienting." The government had to give her back pay for the last 24 days, a new ID badge, new passwords and a new computer monitor.

"All in the name of government efficiency," Marver said.

"Does it feel like déjà vu?" one of her co-workers asked, as he handed her a new ID.

Marver looked at her picture and thought for a moment about the roller coaster of the last month. She had always prided herself on following orders — on adhering to the rules of a system. But now the system was being dismantled, and the orders no longer made sense.

"Actually, no," she said. "This time feels different."

Erin Schaff contributed reporting.

Audio produced by Tally Abecassis.

***A correction was made on April 2, 2025**: An earlier version of this article misstated which employees were included in staffing cuts of probationary employees at the Veterans Administration. No psychiatrists were among those cut.*

When we learn of a mistake, we acknowledge it with a correction. If you spot an error, please let us know at nytnews@nytimes.com. Learn more

Eli Saslow writes in-depth stories about the impact of major national issues on people's lives.

Erin Schaff is a photojournalist for The Times, covering stories across the country.

A version of this article appears in print on , Section A, Page 1 of the New York edition with the headline: Devoted to Serving Her Country, Discarded by Her Government

THE SPOKESMAN-REVIEW
Nation World

They were fired in the name of efficiency based on 'a lie.' Now the VA is paying them not to work

March 23, 2025 | Updated Fri., March 28, 2025 at 2:42 p.m.

1 of 3

By Orion Donovan Smith
orionds@spokesman.com
(202) 853-2524

NORTH CHICAGO, Ill. – The night before Valentine's Day, Ricky Noschese and his wife Laurie left their jobs at a military and veterans hospital and stopped to pick up a heart-shaped chocolate cake to share with their three kids, a family tradition.

As he waited in the car, Noschese's phone lit up with one of the alerts he had set up 10 months earlier, when he started supervising a team of technicians in charge of keeping equipment running at Lovell Federal Health Care Center. In less than a year on the job, he had identified more than $10 million in cost savings and had a long list of ideas to improve operations and complete long-delayed projects.

But when Noschese checked his phone, it wasn't about a problem with the ventilation systems, fire alarms, elevators or emergency generators that he monitored even when he was away from Lovell, which is run jointly by the Defense Department and the Department of Veterans Affairs, his employer.

"This is to provide notification that the Agency is removing you from federal service," the email began. "The Agency finds, based on your performance, that you have not demonstrated that your further employment at the Agency would be in the public interest. For this reason, the Agency informs you that the Agency is removing you from your position with the Agency and the federal civil service effective February 13, 2025."

Puzzled by the generic wording of the email, which was sent by the VA's chief of human resources, Noschese wasn't sure it was real. But when he and Laurie got to work the next morning – he in the hospital's HVAC shop, she as chief of its multiple pharmacies – his boss looked defeated and confirmed that what the email said was true.

Noschese is one of more than 24,000 federal workers, including nearly 1,700 at the VA, who were fired in February after President Donald Trump put billionaire entrepreneur Elon Musk in charge of cutting spending and shrinking the federal workforce as head of the Department of Government Efficiency, or DOGE. This new entity swiftly commandeered the Office of Personnel Management, which functions as the government's HR department, and set about terminating "probationary" workers whose relatively short tenures made them easier to fire.

In Washington state, the VA fired 12 people in Spokane, 14 in the Puget Sound area and six in Walla Walla, according to an internal email obtained by The Spokesman-Review.

In North Chicago, 18 people were fired, according to Lovell employees. Many had received exemplary performance reviews, but they all got the same email saying that, "based on your performance," their work was not "in the public interest."

On March 13, federal judges in California and Maryland ordered the government to immediately rehire the terminated employees. The Trump administration has filed appeals in both cases, but on Monday the VA began notifying its fired workers that they would be placed on administrative leave for an unspecified time, receiving pay but not allowed to work until further notice.

"It is a sad, sad day when our government would fire some good employee and say it was based on performance when they know good and well that's a lie," U.S. District Court Judge William Alsup said in a hearing in San Francisco in February, after unions sued the government over the mass termination.

In a court filing on Tuesday, the VA said all of its fired probationary employees had been reinstated but acknowledged it didn't have contact information for all of them. Emails notifying the affected workers that their termination had been rescinded were sent to addresses to which they no longer had access.

When the news reached them, several of the employees said they still felt apprehensive because they could still be subject to a forthcoming "reduction in force" announced by VA Secretary Doug Collins on March 4 that aims to eliminate at least 70,000 positions.

In response to questions from The Spokesman-Review, VA Press Secretary Pete Kasperowicz said only that the department "is complying with the court's March 13 temporary restraining order" and "cannot comment further due to pending litigation."

Ricky Noschese, an electronic industrial controls mechanic supervisor at the Lovell Federal Health Care Center in North Chicago, Ill., was placed on administrative leave on March 17 after he was terminated along with other probationary employees in February. (Orion Donovan Smith/The Spokesman-Review)

Ricky Noschese, an electronic industrial controls mechanic supervisor at the Lovell Federal Health Care Center in North Chicago, Ill., was placed on

administrative leave on March 17 after he was terminated along with other probationary employees in February. (Orion Donovan Smith/The Spokesman-Review)

With the support of his boss, Noschese wrote a detailed, four-page document to justify his employment. He described how he had helped save taxpayers more than $10 million by using his nearly two decades of experience as an HVAC technician to identify efficiencies and find a cost-effective way to extend the life of the air handling units that circulate air through the 43-building, 1.5 million-square-foot campus. Lovell serves 90,000 patients each year, including veterans, active-duty service members and their dependents, along with the nearly 50,000 recruits who pass through the Navy's only boot camp each year at the adjacent Naval Station Great Lakes.

"Removal of this position, especially the supervisor, will leave the facility at a dangerous deficit," Noschese wrote in the justification memo, noting that half of the positions in his job series already were vacant.

In performance reviews he provided to The Spokesman-Review, Noschese scored "exceptional" in every category, and he received a year-end bonus for "outstanding" performance. Asked about the savings Noschese said he identified, spokespeople at Lovell did not contest his claim and provided the same statement from the VA's national press secretary.

As the head of a 12-person team responsible for ensuring clean water, fire safety and other essentials required to maintain the hospital's accreditation, Noschese and his bosses hoped he would be exempted from the mass firing. But after they sent the justification memo up the chain, they got a curt response: The document was too long. He should sum up his position in no more than three sentences.

Noschese was told that a member of hospital leadership did that, but it made no difference. He had to turn over his badge and go home.

"I'd never loved a job this much," Noschese said in an interview on Monday, before learning that his firing had been put on hold. "Everything that I did, from the moment I stepped into that position to the moment I was forced out."

Noschese said he was drawn to the VA's mission after his wife started working there during pharmacy school. The high school sweethearts grew up on the northern edge of Chicago and got married after she graduated from the University of Illinois, while he learned the HVAC trade.

"The fact that the organization that I had dedicated my entire career to, nearly 15 years at this point, was the same organization that hurt the person I love, that was a really hard thing to swallow," said Laurie Noschese, who had the additional burden of having to reassure the 160 people she supervises that "everything is going to be OK" while they knew her family was one of the first ones affected by the firings.

Ricky Noschese was looking forward to bringing back an apprenticeship program to get veterans into good jobs and replace employees who are nearing retirement. He also thought, he recalled with a rueful laugh, that a government job would be stable.

Having to fill a vacant position is costly and hurts productivity, he said, and firing workers en masse under a false pretense is not only "completely and utterly wrong" but also inefficient.

"You talk about waste," he said. "That's where the waste really, truly comes from."

'It doesn't matter how good I am at my job'

Eleven days after Noschese was fired, Future Zhou sat at her desk at the Seattle VA Medical Center. She felt uneasy.

She had just replied to an email sent by the DOGE-controlled Office of Personnel Management that asked federal workers to justify their jobs with the prompt, "What did you do last week?" In a post on X, the social media platform he owns, Musk warned that "Failure to respond will be taken as a resignation."

Looking for the camaraderie and "battle buddy mentality" she missed from her 11 years in the Army, Zhou left a job at Boeing and started working at the VA in July 2024 as an inventory management specialist. After VA leaders told employees to respond to the email, Zhou explained how she used her supply-chain expertise from the military to make sure the hospital had all the supplies needed to serve the roughly 160,000 veterans enrolled for VA care across Western Washington.

When a coworker called to tell Zhou that another member of her team had been fired, she checked her email and thought she was in the clear. Then the message appeared in her inbox: Because of supposedly inadequate performance, she had been terminated.

Future Zhou, photographed Thursday in Seattle, was an inventory manager for the VA Hospital there when she was fired by the Trump administration. Zhou is currently in the process of getting her job back. (Kevin Clark/Seattle Times)

Of the entire logistics team responsible for keeping the Seattle hospital running, Zhou said in an interview, only the warehouse material handlers had been exempted from the mass firings. She had seen clinics cancel procedures because of delays in getting critical supplies and couldn't believe that VA leaders would make the situation worse by removing relatively low-paid staff in the name of cost savings.

"If we get rid of our supply techs and our logisticians that are ordering these supplies, who's running the hospital?" she said. "You can have all the doctors in the world, but if your doctor doesn't have the tools that they need to take care of you, they cannot take care of you."

Zhou said her team in Seattle already was shorthanded, with half of its eight positions filled, and was authorized to hire two more inventory management specialists before she was fired.

"It's not like they got rid of my position," she said. "They just got rid of me, but the position was still in critical need."

Zhou said that by firing some of the VA's newest hires while pushing older employees to retire early – partly through the "Fork in the Road" email, in which Musk's team essentially offered workers a buyout – the department may not effectively train its next generation of workers. The mass termination, she said, also "left a lot of bad blood" among new employees.

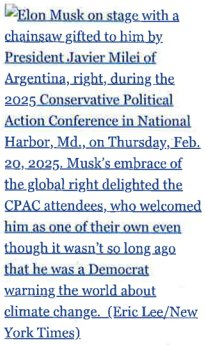
"I'm not as confident coming back into my position," she said. "It doesn't matter how good I am at my job or how hard I work. There's no trust there. There's no loyalty. The federal government doesn't seem to have our back."

Russ Vought, Trump's director of the Office of Management and Budget and a lead author of the policy blueprint known as Project 2025, said in a private speech last year that his goal was to put federal employees "in trauma," as reported by ProPublica and Documented.

"We want the bureaucrats to be traumatically affected," Vought said. "When they wake up in the morning, we want them to not want to go to work because they are increasingly viewed as the villains."

Michael Cecil, a professor at Gonzaga University School of Law, said that while Trump himself may not choose to fire an HVAC expert or a supply-chain specialist, their termination is the downstream effect of his administration's sweeping effort to root out what the president calls a "deep state" of government employees who may get in the way of his agenda.

"The administration is painting with an incredibly broad brush on matters of regulatory policy and federal employees," Cecil said. "That's the real-world implication of pursuing a political agenda in a very broad-stroked way. It impacts people in communities all across the country."



Elon Musk on stage with a chainsaw gifted to him by President Javier Milei of Argentina, right, during the 2025 Conservative Political Action Conference in National Harbor, Md., on Thursday, Feb. 20, 2025. Musk's embrace of the global right delighted the CPAC attendees, who welcomed him as one of their own even though it wasn't so long ago that he was a Democrat warning the world about climate change. (Eric Lee/New York Times)

Elon Musk on stage with a chainsaw gifted to him by President Javier Milei of Argentina, right, during the 2025 Conservative Political Action Conference in National Harbor, Md., on Thursday, Feb. 20, 2025. Musk's embrace of the global right delighted the CPAC attendees, who welcomed him as one of their own even though it wasn't so long ago that he was a Democrat warning the world about climate change. (Eric Lee/New York Times)

Jessica Riedl, an economic policy expert at the Manhattan Institute, said DOGE is engaged in "spending-cut theater" that will have a negligible effect on the nation's budget deficit. By cutting staff at the Internal Revenue Service charged with cracking down on tax evasion, she said, DOGE could actually increase deficits by reducing revenue.

"What DOGE has done has been extraordinarily disruptive to the agencies and people affected," said Riedl, a senior fellow at the conservative think tank and former Republican aide in the Senate. "But the savings are essentially budget dust, in terms of our deficits."

As of Thursday, DOGE claimed to have saved $115 billion, but its "wall of receipts" contains numerous miscalculations and other errors, as reported by the New York Times and other news outlets. Riedl said its actual savings may be as low as $2 billion. By comparison, Musk has lost $122 billion of his personal wealth so far this year, according to the Bloomberg Billionaires Index, largely due to the plunging stock price of Tesla, the automaker he leads.

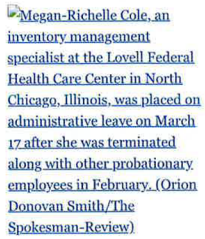
Despite Trump saying in his March 4 address to Congress that the Department of Government Efficiency is "headed by" Musk, the White House has said he doesn't make decisions for DOGE, which isn't technically a federal department.

'Like a family'After Megan-Richelle Cole gave birth to her son in June, she returned to work at Lovell as an inventory management specialist in the pharmacy department, where she managed the supply of medications and ensured that patients didn't receive recalled or expired drugs.

The Army veteran moved back home to the northeast corner of Illinois after she had to leave a similar job at the VA hospital in Charleston, South Carolina, when her doctor's recommendation that she work remotely during her pregnancy conflicted with the hospital's in-person work policy. Although she began working at Lovell in 2010, Cole was considered a probationary employee after returning to work in September.

When she was fired Feb. 24, Cole was in the final stages of buying a house. She suddenly had no income. To make matters worse, the VA didn't provide her with a form required to file for unemployment benefits, and she had to withdraw from the home purchase.

"Everything was going smoothly, like it was supposed to," she said, until the sudden termination left her feeling humiliated and lost. "Nobody knew anything. It was just heartbreaking."



Megan-Richelle Cole, an inventory management specialist at the Lovell Federal Health Care Center in North Chicago, Illinois, was placed on administrative leave on March 17 after she was terminated along with other probationary employees in February. (Orion Donovan Smith/The Spokesman-Review)

Cole's supervisors tried to preserve her job, to no avail. They pointed out that reimbursements that she processed from recalled and expired drugs resulted in more than $775,000 in savings in fiscal year 2024, she said. While her co-workers and bosses in North Chicago were supportive, she said being fired left her feeling "very small" as she walked to her car in disbelief.

Like many VA employees, Cole is a disabled veteran. She sustained a traumatic brain injury, hearing loss and damage to her spine in a car crash when she was stationed in Germany, she said. She wanted to work at the VA both to help her fellow disabled veterans and because she feels more comfortable there, "like a family."

Another disabled veteran fired in North Chicago, Neal Chapman, was looking forward to spending the rest of his career at the VA after nine years in the Army. He was fired seven months after he started working as a carpenter at Lovell.

When he tried to check his email that morning, he found his access already had been terminated, leaving him unable even to read the notification that he had been fired.

Chapman took a pay cut to work at the VA, he said, but he "just wanted to be more involved" and the chance to be around his fellow veterans was invaluable. Two tours in Afghanistan left him with post-traumatic stress disorder and he appreciated not having to explain himself to his coworkers.

"I looked forward to serving the veterans and getting back into it in any way possible," he said. "But then they just kind of dropped the ball on me from out of nowhere."

'Just let me work'

Adam Mulvey just wants to do his job.

After 20 years in the Army – with deployments in Kosovo, Afghanistan and Iraq – he retired at Joint Base Lewis-McChord in 2019. He started working for Washington state's Emergency Management Division, serving as chief of logistics during the COVID-19 pandemic and several major wildfires before his family decided to move to Illinois to be closer to his wife's parents.

Mulvey knew Lovell would be a good place for his family to get their health care, since it serves not only veterans but also the dependents of military retirees, and he was surprised to learn that there was an opening for an emergency manager. After talking with contacts at the American Lake VA near Tacoma, he thought working for the department "sounded like a really good family."

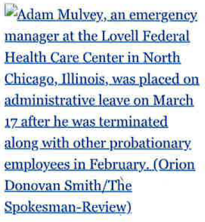
He started the job in March 2024, 11 months before he learned that emergency management jobs were not exempt from the mass termination. He was fired Feb. 13.

Trump administration officials have suggested that the mass termination of probationary employees targeted people who didn't want to work. Speaking to reporters at the White House on March 4, Trump adviser Alina Habba pushed back on criticism of firing veterans, who make up about 30% of the federal workforce.

"We care about veterans tremendously," Habba said. "But at the same time, we have taxpayer dollars – we have a fiscal responsibility to use taxpayer dollars to pay people that actually work. That doesn't mean that we forget our veterans by any means. We are going to care for them in the right way, but perhaps they're not fit to have a job at this moment, or not willing to come to work."

Mulvey said he has enjoyed spending more time with his kids, but after a few days he wanted to be back to work.

"It's painful to not be working and doing that job on a daily basis," he said, adding that he wants his children to see him standing up for all the VA employees who lost their jobs. "They were far too young. In a few years, they won't remember that I wore a uniform, but now they'll see that I'm standing up for a community. I'm standing up for something."



Adam Mulvey, an emergency manager at the Lovell Federal Health Care Center in North Chicago, Illinois, was placed on administrative leave on March 17 after he was terminated along with other probationary employees in February. (Orion Donovan Smith/The Spokesman-Review)

Raphael Garcia mustered out of the Army in April 2024. Spending more than seven years as a combat engineer had taken a toll on his body, and having to wait for the VA to process his disability claim before he could get the health care he needed inspired him to speed up that process for other veterans.

He took a job at the SeaTac office of the Veterans Benefits Administration, the part of the VA that processes claims. He worked to streamline the determination of disability ratings for soldiers who were going through a physical evaluation board to be medically separated from service.

After he was fired, Garcia said, employees from other divisions had to cover his workload, slowing down claims processing for other veterans. When he heard on Tuesday that he would be placed on administrative leave – paid but not allowed to work – he said, "That makes no sense at all. Just let me work. My division is drowning. Let me work."

On Thursday, when he finally received the email notifying him that his firing had been rescinded, Garcia said he felt "a bit uneasy still with all of the uncertainty," and worried that he could be fired again as part of the reduction in force.

"I honestly just want to work again so I can help my division out," he said. "Co-workers and managers keep asking when I'll be back."

'The federal government does not exist to employ people'

In a court filing on Tuesday in response to a federal judge in Maryland, a VA official suggested that the affected employees would remain on administrative leave until the court cases are resolved, because "reinstatement of removed employees to full duty status

would impose substantial burdens on VA, cause significant confusion, and cause turmoil for the terminated employees," especially if an appeals court reverses a district court ruling.

Lisa Marshall Manheim, a professor at the University of Washington School of Law, said the court orders may prompt the Trump administration to revise its approach to firing federal workers. Similar to the government's multiple attempts to ban travelers from Muslim-majority countries from entering the United States during Trump's first term, she said, the administration could rescind its mass termination of probationary employees while looking for a more legally defensible way to accomplish its goal.

While the administration appears to be complying with the court orders, Trump and his allies have escalated attacks against federal judges over the past week. On Tuesday, the president called for a judge who ruled against him to be impeached, drawing a rare rebuke from Chief Justice John Roberts. Musk, in posts on X, has called judges "evil" and claimed that the judiciary branch's blocking of a president's executive orders amounts to "tyranny."

David Super, a professor at Georgetown Law School, said that although there are legal ways to reduce the federal workforce, the Trump administration so far hasn't pursued that path.

"There is a planning process required for RIFs," he said, using shorthand for reductions in force. "If they have, in fact, gone through that and they have found that there are some positions they don't need, then they are in compliance. But my suspicion, because they keep using very large, very round numbers, is that it's the numbers that are driving the process rather than what they actually need. And if that's true, then they're not complying with the law."

Super pointed out that Congress has appropriated enough funds for the VA to support its existing workforce through the end of September. If the Trump administration refuses to use those funds to pay VA employees, that could constitute an illegal "impoundment" and draw a separate legal challenge.

"This administration seems very determined not to comply with federal personnel laws," he said. "And there will likely be further questionable actions and further injunctions before it all gets sorted out."

Meanwhile, the VA is moving ahead with a plan to fire far more employees than it did in February. In a March 4 video message, Secretary Collins said he intends to reduce the workforce to 2019 levels, before Congress passed a major expansion of VA benefits for veterans exposed to burn pits and other sources of toxins.

That would require more than 70,000 layoffs, based on the numbers Collins provided, slashing the workforce by 15% and laying off nearly half of the workers the VA has categorized as nonessential.

"We regret anyone who loses their job," the secretary said. "But the federal government does not exist to employ people. It exists to serve people."

Orion Donovan Smith's work is funded in part by members of the Spokane community via the Community Journalism and Civic Engagement Fund. This story can be republished by other organizations for free under a Creative Commons license. For more information on this, please contact our newspaper's managing editor.

THE SPOKESMAN-REVIEW

Local journalism is essential.

Give directly to The Spokesman-Review's Northwest Passages community forums series -- which helps to offset the costs of several reporter and editor positions at the newspaper -- by using the easy options below. Gifts processed in this system are tax deductible.

Active Person

'I cannot guarantee complete confidentiality,' VA therapists ordered to tell veterans

By Katia Riddle

Published April 11, 2025 at 4:58 PM EDT

Jeremy Hogan/SOPA Images / LightRocket Via Getty Images

Veterans gathered in Indianapolis and in places across the country on March 14 to protest the Trump administration's staff and budget cuts to the Department of Veterans Affairs.

Panic, fear, uncertainty, and anger.

Those are the emotions mental health clinicians who work for the US Department of Veterans Affairs describe as they prepare for the VA's mandatory return-to-office directive. Some are being summoned to offices as soon as Monday, April 14. Representatives from the VA say they are planning to have the back-to-office effort completed by May 5.

For this story, NPR interviewed ten clinicians in VA locations around the country, the ...ajority of whom spoke on condition of anonymity because they were afraid of losi

delays for reporting to an office.

In a memo obtained by NPR, regional leadership at one VA facility offered a script for its therapists to read to patients. "Before we begin our session, I want to inform you that I am currently in a shared office space," reads the script. "While I will do my utmost to maintain your privacy, I cannot guarantee complete confidentiality."

These directives come after the VA indicated it would cut about 80,000 staff in a massive restructuring effort. A widely circulated leaked memo, first obtained by the Associated Press, outlines the effort. In a video addressing the cuts, VA Secretary Doug Collins suggested the agency would eliminate waste and that the "the days of kicking the can down the road are over." He offered reassurance that VA benefits would not be impacted and that the VA "regrets anyone who loses their job."

Telehealth hires

Many VA therapists were hired on a telehealth basis and point out that there simply is not space for them to work at VA facilities. They are anticipating confusion and congestion around issues such as parking, bathroom use and adequate kitchen facilities to reheat their lunches.

But the primary concern for therapists is whether they will be able to deliver quality care to their patients in an environment without confidentiality.

In emails and meetings, VA managers described to VA mental health staff "pod" working environments, where clinicians work with headphones in a call-center like configuration to provide telehealth. In one recording obtained by NPR, a manager in a teleconference meeting acknowledged that it was inevitable therapy sessions would be overheard and exhorted people not to share any confidential information.

Supervisors working from "a shower"

"We won't be able to provide private sessions," says one licensed clinical social worker, who asked to be identified by a middle initial, L., for fear of retaliation. Guaranteed privacy between patient and doctor is a fundamental tenet of quality mental health care, protected by federal law.

Now Playing
Inter B Behavioral Health Platform...

A group of 20 House Democrats signed a letter to VA Secretary Doug Collins vocalizing their outrage on this issue. They describe one scenario in which a social worker supervisor has been ordered to return to work "sharing a 100-foot shower with another supervisor," to provide case management and clinical supervision. "We're sure you can agree," they write, "this sort of arrangement is hardly conducive to delivering the quality of care veterans deserve."

VA response

VA representatives have repeatedly insisted that federal privacy laws will be upheld. In an email response to questions about these issues, VA spokesperson Peter Kasperowicz reiterated an accusation that employees who are sounding alarms are motivated by a desire to "phone it in."

Chip Somodevilla / Getty Images / Getty Images

A person walks into the Department of Veterans Affairs' headquarters a block from the White House on March 6. President Trump and Elon Musk's DOGE effort targets about 80,000 jobs to be cut from the VA.

Kasperowicz wrote that these continuing concerns are "fear mongering from the media," and wrote that "the small number of employees who are desperate to avoid returning to the office will do more to drive away staff and patients than VA's commonsense return-to-office policy ever will."

VA care, he said, would continue uninterrupted and the "VA will ensure that employees ve a workspace that is appropriate for the work they do."

Live Radio - News & Inform...

But therapists say they do not see logistically how this is possible.

L. worried the disclaimers therapists are being encouraged to use at the start of sessions would not withstand legal scrutiny, as consent for information sharing needs to be granted in writing.

"Therapists will either cancel the session themselves," L. says, "and risk being reprimanded, or their patients will cancel."

L. forsees longer waiting times for veterans seeking care as a result and points out that veterans are at disproportionate risk for suicide than those who have not served. Wait times are already bad. Often, he says, his clients "have been waiting months and months – many of them with severe mental health issues, including suicidal thoughts."

Dates changing at the last minute

The VA is one of the biggest providers of mental health care across the US.

In emails shared with NPR, some clinicians were told they would be returning to the office May 5, some were granted exemptions, and some were told to report to work April 14 – though these dates were also subject to change. One document obtained by NPR outlines steps for managers.

"This memo provides a framework to inform a standardized approach to terminating remote and telehealth agreements," it reads.

Many clinicians expressed bewilderment about why certain workers were on the list of mandatory returns and others are not. Others were evaluating the possibility of working from their cars or finding space in a bathroom stall to conduct therapy sessions.

Some workers were asked to participate in rearranging furniture in order to accommodate group seating arrangements. Tasks like "rolling tables to podded rooms as temporary desks," or "rolling away excess furniture," were on a to-do list, obtained by NPR.

"Distress across the board"

Now Playing
Live Radio - News & Inform...

The American Psychological Association issued a statement criticizing the policy and raising concerns about compliance with federal privacy laws.

"Providers are facing difficult choices between violating ethical standards regarding patient confidentiality or facing disciplinary action for non-compliance with return-to-office mandates," reads the statement. It goes on to warn that the policy "could compromise access to care and confidentiality standards that are key to effective mental health treatment."

Under President Biden, the PACT act allocated nearly $800 billion to expand VA care and benefits for veterans exposed to toxins. The current efforts aim to reduce staffing numbers to the levels VA had before this legislation. It is not clear how VA would reduce staff to 2019 levels and still fulfill its legal requirements under the PACT act.

Many clinicians described their recent experience as a kind of emotional warfare, and noted the irony of compromising their own mental health while trying to provide mental health care for others.

"I'm anticipating a good deal of distress across the board," says L. "And that we will generally fail at our mission of treating veterans."

If you or a loved one is in crisis, call, text or chat the 988 Suicide and Crisis Lifeline.

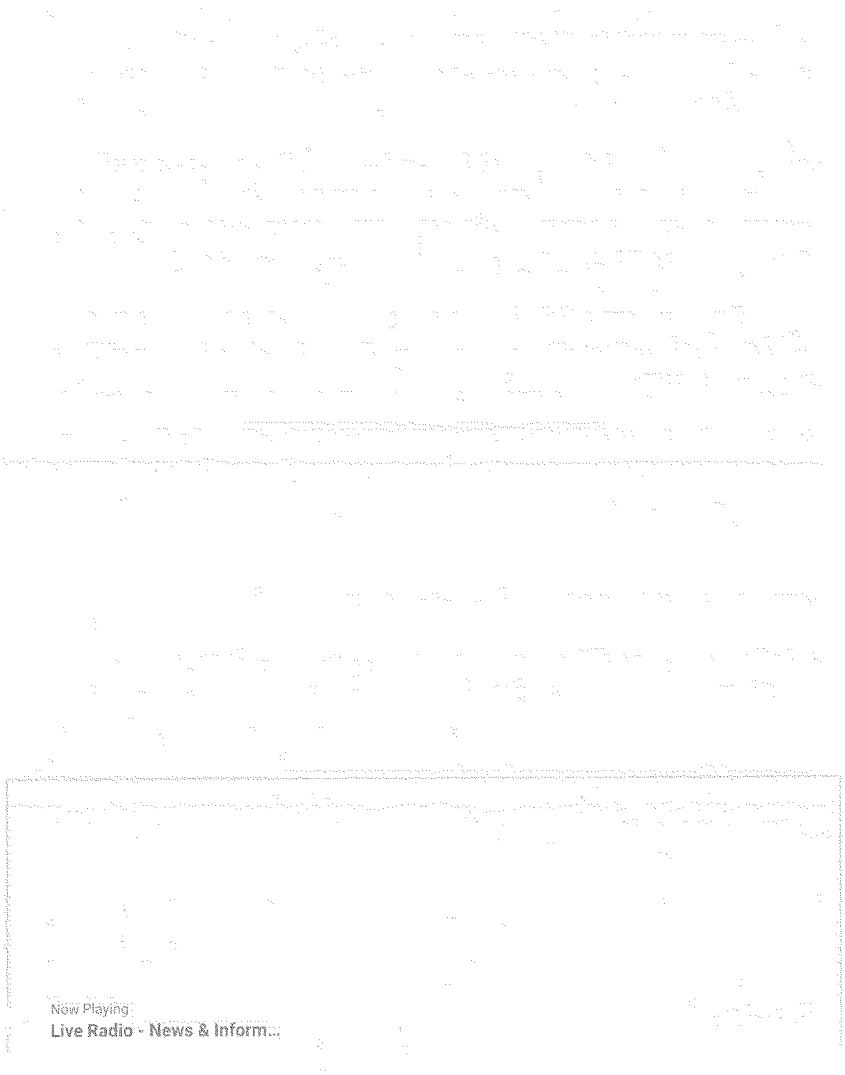
Have information you want to share about the ongoing changes across the federal government? Katia Riddle is available through encrypted communications on Signal at Katia.75

Copyright 2025 NPR

Tags NPR Health NPR Top Stories

tia Riddle
Live Radio - News & Inform...

Katia Riddle is a correspondent at NPR covering mental health. She has reported extensively on the impact of events such as Hurricane Helene, Los Angeles wildfirés and the loneliness epidemic. Prior to her current role, she covered public health including reproductive rights and homelessness. She won a 2024 Gracie Award for a series on reproductive rights.



WAMU 88.5
Listen Now
MY PLAYLIST
npr WAMU 88.5
DONATE

Shots

SHOTS - HEALTH NEWS

VA officials acknowledge the need for privacy for telehealth therapy

APRIL 18, 2025 · 2:00 PM ET

By Katia Riddle

The Department of Veterans Affairs headquarters is a block from the White House in Washington, DC.
Chip Somodevilla/Getty Images

The US Department of Veterans Affairs appears to be backing off a plan to send telehealth therapists back to offices that may lack privacy, according to a memo obtained by NPR.

Addressing widespread concerns over mental health clinicians' ability to conduct confidential sessions, officials from the VA have issued a memo saying that providers must have private workspaces "that foster trusted, confidential, and therapeutic relationships with Veterans," when they return to their offices in the coming weeks.

Sponsor Message

SHOTS - HEALTH NEWS

Trump's back-to-office order will hurt veterans, VA docs and therapists say

The memo is dated April 12, and was issued to regional directors the day after NPR's latest reporting on this issue, which followed other reports and outcry from lawmakers.

After speaking with mental health providers and clinicians all over the country — anonymously, as many fear for their jobs — NPR previously reported that many are afraid they will be unable to provide therapy in private spaces after a mandatory return-to-work order that requires them to report to a VA facility. Many are currently providing telehealth to veterans from home.

The return-to-office order comes after much consternation over an announcement from VA officials and VA Secretary Doug Collins that the agency intends to cut 80,000 jobs. Under President Biden, Congress passed the PACT act, which allocated nearly $800 billion to expand VA care and benefits. The current efforts aim to reduce staffing numbers to the levels before this legislation, though it is not clear how VA would do so and still fulfill its legal requirements under the PACT act.

A script about confidentiality

Prior to the April 12 memo, VA management in one region circulated a script for therapists working in call center-like environments to read to their patients. "I cannot guarantee complete confidentiality," read the document.

SHOTS - HEALTH NEWS

'I cannot guarantee complete confidentiality,' VA therapists ordered to tell veterans

Confidentiality is guaranteed to health care patients through federal law, and the quality of a patient's bond with a provider is one of the key predictors of overall outcomes in clinical therapy.

The April 12 memo stipulates that "spaces used to deliver synchronous telehealth services should offer the same level of privacy and therapeutic environment applicable to an in-person visit in the same space."

Confusion remains

Several clinicians who spoke to NPR about this memo remained perplexed. The memo does not explicitly say therapists would be allowed to continue working from their homes, if private office space is unavailable. But the clinicians said they do not see how they would both meet the privacy requirements and return to work, where many say there is simply not enough space for things like parking and bathroom traffic, let alone adequate private spaces for therapy. Many staff were hired to be telehealth providers working off-site for all or part of the time.

Another document viewed by NPR, which was labeled "pre-decisional," implies clinicians who provide mental health care would be eligible for an exemption to the mandatory return-to-work order. It offers few details, however.

The VA did not respond to a request for comment on what the April 12 memo would mean for employees reporting to overcrowded facilities. For earlier stories, VA spokesperson Peter Kasperowicz has repeatedly said that veterans' care will continue "uninterrupted," through the return to work mandate and insisted that all facilities will be compliant with federal privacy laws. "VA will make accommodations as needed so employees have enough space to work," read a previous statement on the issue.

Some VA employees were required to return to the office on April 14, though others received last minute changes. May 5 is the current date forecasted by the VA to have employees back in person as part of a department wide mandate under the Trump administration and VA Secretary Collins.

A reputation for high quality care

The American Psychological Association has expressed concern for VA therapists who are unable to comply with federal privacy standards. "That's just such a fundamental way that, psychological services and psychotherapy has been conducted," says Lynn Bufka, head of practice for APA. "I think most people feel sort of like, why would we even need to say that so explicitly?"

The VA is seen by many providers as the gold standard of mental health care in the United States, and many are concerned that the return-to-work order and job cuts will lead to attrition from providers or overall degradation of care for veterans.

"From a psychologist's point of view, it's seen as a place of good training and effort to really ensure that care is quality," says Bufka. "Care that is evidence-based, that it is really meeting the needs of a population that was willing to give it everything in order for the rest of us to have the kind of quality of life that we have."

Have information you want to share about the ongoing changes across the federal government? Katia Riddle is available through encrypted communications on Signal at Katia.75

veterans affairs mental health trump

Calls to defund public media are getting louder.

Whether uncovering local matters, analyzing national affairs or amplifying global issues, we do it for you.

And, we do it with you.

Your voluntary financial support is an essential part of the NPR Network. Every dollar you donate strengthens this public service for the road ahead.

Can you please pitch in?

YES, I'LL DONATE