

United States Senate

February 21, 2016

Hon. Robert McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420

Dear Secretary McDonald,

As Chairman of the Appropriations Subcommittee that oversees funding for the U.S. Department of Veterans Affairs (VA), I am writing to call for the firing of Dr. Mary Schohn, Director of Mental Health Operations for the VA's Veterans Health Administration (VHA). The VA Office of Inspector General (VA OIG) and the Government Accountability Office (GAO) have identified patterns of failure and consistent disregard for improvements within VA call centers, and the suicide hotline specifically. As head of the office that oversees the VA's crisis hotline, Dr. Schohn has failed veterans in their darkest hour.

The horrific revelations contained in the recently released VA OIG investigative report, "*Veterans Crisis Line Caller Response and Quality Assurance Concerns*" ([Report No. 14-03540-123](#)), include repeated instances of the VA ignoring veterans' needs for suicide assistance. Specifically, the report, which was based on a review of Veterans Crisis Line (VCL) records from FY 2014 through the first quarter of FY 2015, found that calls to the VCL, which is a component of VA's Suicide Prevention Program, may have been put on hold for 20 minutes or more and often went to a voicemail system no one on the call center staff even knew existed.

The VA's Office of Mental Health Services and Operations, which oversees the VCL program, has been aware of these unacceptable examples of disregard for veterans dating back to at least April 28, 2014. At that time, the Coalition of Veterans Organizations wrote a [letter](#)¹ to then-Secretary Eric Shinseki expressing concern over documented occurrences in which the VCL was "seriously deficient," citing the familiar examples of extended wait times and poorly trained staff.

For several years, media reports have also highlighted problems in the program, all under the direction of Dr. Mary Schohn. A [video](#)² posted online in 2014 shows a veteran who called the hotline on hold for more than 35 minutes.

¹<http://www.coalitionofvets.org/cvo-response-va-crisis-hot-line-problems/>

²<https://www.youtube.com/watch?v=d4jKRWdb8yk>

And again last year, after you had assumed your current role as Secretary, my colleague Senator Bill Nelson (D-Fla.) [wrote](#)³ to you with [concerns](#)⁴ that his constituents were being placed on hold repeatedly when they sought help through the VCL.

Moreover, a November 2014 GAO report, “*VA Health Care: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data*” ([GAO-15-55](#)), found “that VA policies lacked clear direction for how staff at VA facilities should document information about veteran suicides as part of VA’s behavioral health autopsy program (BHAP). The BHAP is a national initiative to collect demographic, clinical, and other information about veterans who have died by suicide and use it to improve the department’s suicide prevention efforts. In a review of a sample of BHAP records from five VA facilities, we found that more than half of the records had incomplete or inaccurate information. The lack of reliable data limits the department’s opportunities to learn from past veteran suicides and ultimately diminishes VA’s efforts to improve its suicide prevention activities.”

Even since May 2010, the VA OIG identified clear problems with VA call centers. The report, “*Veterans Benefits Administration: Audit of National Call Centers and the Inquiry Routing and Information System*” ([Report No. 09-01968-150](#)), identified the Veterans Benefits Administration’s (VBA) eight national call centers and pension call center did not have an adequate process to ensure callers reached a call agent. From the 2010 report:

- During FY 2009, 76 percent of the call attempts reached a public contact representative (call agent). Of the 24 percent who did not reach a call agent, the callers either received a busy signal (blocked call) or hung up while on hold (abandoned call).
- This occurred because: VBA’s telephone system did not route calls to ensure the efficient use of the call agents. VBA did not implement performance standards to hold personnel at call centers accountable for timeliness of responses. Call agents did not have easy access to the information needed to answer callers’ inquiries in a timely manner.
- Timely Access During FY 2009, callers made 7.41 million attempts to contact the eight call centers. Of these attempts, 1.77 million (24 percent) were not completed because the call was either blocked or abandoned. Blocked call rates measure the percentage of attempted calls that received a busy signal.
- In FY 2009, 1.26 million (17 percent) of the 7.41 million call attempts were blocked. Abandoned call rates measure the percentage of calls (calls not blocked) that the caller abandoned before reaching a call agent. In FY 2009, 6.15 million (7.41 million – 1.26 million) calls were connected, but .51 million (8 percent) were abandoned.

³<http://www.militarytimes.com/story/military/benefits/veterans/2015/05/02/veterans-affairs-suicide-hotline-investigation/26649465/>

⁴<http://www.abcactionnews.com/news/local-news/i-team-investigates/i-team-investigation-prompts-sen-nelson-to-demand-answers-from-va>

You've often stated that you are changing the culture at the VA. There can be no higher order within the VA than taking seriously the suicide rates of our service men and women when they return from the battlefield. Use the authority you have to demonstrate that repeated failure at the VA is unacceptable by firing Dr. Schohn, and consider replacing her with someone from the Substance Abuse and Mental Health Services Administration (SAMHSA), a government agency that is using a suicide hotline effectively.

Mark Kirk

A handwritten signature in blue ink that reads "Mark Kirk". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

United States Senator