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# CORRECTING MISMANAGEMENT OF THE VETERANS CRISIS LINE

## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

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JUNE 25, 2025

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# CORRECTING MISMANAGEMENT OF THE VETERANS CRISIS LINE

**WEDNESDAY, JUNE 25, 2025**

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The Committee met, pursuant to notice, at 3:57 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Banks, Sheehy, Blumenthal, Hirono, Hassan, King, and Duckworth.

## OPENING STATEMENT OF HON. JERRY MORAN, CHAIRMAN, U.S. SENATOR FROM KANSAS

Chairman MORAN. The Senate Committee on Veterans' Affairs will come to order. Senator Blumenthal is en route. I'm going to go ahead and make my only statement. We are trying to work our way around votes at 4:15 p.m., so we're going to see if we can figure out a way to make this all work, and make sure we hear the testimony of both panels.

So, good afternoon, and welcome. Nearly two years ago, during another oversight hearing this Committee held, examining the VA's Mental Health and Suicide Prevention efforts. My office received a phone call. That phone call was from a whistleblower reaching out as he listened in real time to VA witnesses answering questions about a tragic veteran suicide and the VA's potential cover-up of serious issues at the Veterans Crisis Line.

The oversight hearing with VA previous leadership left us with more questions than answers, and my office had multiple conversations with this whistleblower. Those meetings led to several other VA employees coming forward to speak with my staff about their firsthand experiences, sharing troubling details about mismanagement at the Veterans Crisis Line. They spoke of policies and practices that may be leaving veterans in critical need of support at an increased risk for harm to self or others.

I would like to thank every individual who bravely stepped forward and contacted our office to share those concerning accounts. I would especially like to thank, express my gratitude to Mr. Brad Combs, a whistleblower, and the Veterans Crisis Line's former lead internal auditor, who placed the original call and who is here with us this afternoon.

Without his sacrifice, his courage to do the right thing for veterans that he and us serve, we would not be in this position today to have this hearing.

After we held multiple meetings and calls with whistleblowers on November 6, 2023, I sent a request to the Comptroller General, Gene Dodaro, to call for a thorough audit of the Veterans Crisis Line. I would like to extend my gratitude to him and his team at the Government Accountability Office, for their thorough and informative work on this matter.

Throughout the past 21 months, my office has worked through hundreds of pages of disclosures, countless hours of interviews, and I am holding this hearing today to release the findings of the GAO investigation, and to hear directly from the initial whistleblower, the program's former lead internal auditor.

It is my intent that this hearing serve to force action. Real change and improvements require transparency and accountability. Based upon information provided by the Office of the Inspector General, it is my understanding that 21 months later, the Veterans Crisis Line still has not completed an internal investigation, nor held anyone accountable, for the inadequate and problematic leader and staff actions before and after a veteran died by suicide.

My expectation is Secretary Collins will hold accountable the individuals, with the department who were responsible for both the mismanagement of the Veterans Crisis Line, and any attempted cover-up of these troubling issues.

The Veterans Crisis Line is a critical tool for veterans at immediate risk of suicide. Members of this Committee, as well as VA leadership, must make certain America's veterans and their family members can depend upon this valuable resource. And I'm going to now pause the hearing in anticipation of the arrival of Senator Blumenthal. Which if things worked as they should, he would appear right now.

[Laughter.]

Senator BLUMENTHAL. And lo and behold.

Chairman MORAN. Senator Blumenthal, thank you for joining us. You were kind enough to allow me to begin. With the critical circumstance with our votes, the interruptions that we will have, I wanted to get started, and I've completed my opening statement. And I now recognize you for yours.

**OPENING STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you to Chairman Moran, as well as to our witnesses on this really critically important topic, which is, as you may gather, bipartisan, and it should be, because the Veterans Crisis Line is a critical resource in our fight to eliminate veteran suicide.

That fight has been ongoing since I came to the United States Senate. One of my very first bills was with Senator John McCain on this topic. It passed the United States Congress, and one of the proudest moments of my life, as the United States Senator, was to go to the White House with John McCain, to the East Room, where President Obama signed our legislation into law, with myself on one side and John McCain on the other.

I don't need to remind any of you that John McCain and President Obama actually ran against each other, but they came together in this cause, and I think we have a similar obligation today.

The Veterans Crisis Line is at the forefront of combating veterans' suicide, as you all know, as trained responders available to any veteran service member or family member, 24 hours a day. This hearing demonstrates that the VA's ability to improve its resource and operation relies on independent bodies like the Inspector General and the Government Accountability Office, as well as, unbreakable protections for whistleblowers, to enable VA employees to sound the alarm on waste, fraud, and abuse.

I want to express my personal regret that VA Inspector General Mike Missal, is not here as a witness. He was fired along with 18 other Inspectors General after performing with huge distinction and honor over different Presidents, Republican and Democratic, and saving taxpayers billions of dollars.

The Trump administration, unfortunately, has also attacked the nonpartisan Government Accountability Office and is working full-time to demoralize and frighten whistleblowers by invalidating collective bargaining agreements, requiring senior leaders to sign NDAs, politicizing independent watchdogs and overhauling hiring requirements to force public servants to declare loyalty to President Trump, not to the Constitution.

These actions, along with a lack of transparency and accountability from this VA and this Administration, make meaningful oversight of VA programs like the Veterans Crisis Line, extremely challenging. The GAO and IG reports that we are discussing today, show that the Veterans Crisis Line needs more resources, more staffing, more investment into technology.

These recommendations demonstrably conflict with the ongoing mismanagement of the department by Secretary Collins and this Administration. There is a practical relevance and importance to the GAO report that we have today that is indisputable.

In the first phase of illegal firings, the Veterans Crisis Line employees, including those who conduct advanced training for responders, were fired without warning. Secretary Collins also fired at least nine staff at one Veterans Crisis Line call center, who were responsible for locating veterans actively in crisis, and coordinating in-person emergency response and coordination with Veterans Crisis Line responders.

Secretary Collins reversed these findings, but not before weeks passed, and the Administration has provided zero answers, none, regarding the Veterans Crisis Line and other suicide prevention efforts that will be impacted by Secretary Collins' goal of terminating an additional 83,000 VA employees in the coming months. That is his plan. We've had testimony about it, but we have no specifics, no facts, especially as concerned the Veterans Crisis Line.

My office, regrettably and tragically, sometimes continues to hear from Veterans Crisis Line and VHA staff, that these reduction-in-force plans have led to significant increases in call volumes to the Veterans Crisis Line, from veterans who fear they're going to be fired.

And the reason is quite simply, that of those 83,000 employees that Secretary Collins is going to fire, a quarter to a third of them are veterans, whose lives are about to be decimated. And so, of course, they're calling the Veterans Crisis Line at a time when it is about to be potentially decimated as well. Secretary Collins ordered in February that all Veterans Crisis Line employees return to office, "return to office" as part of the mandate set by President Trump.

Employees were brought to offices that they never previously occupied. The offices were ill-equipped. They lacked the necessary privacy for calls of this kind of sensitivity. Some Veterans Crisis Line employees simply left. They figured they had no future there, and they lacked the resources to do their jobs in a way they thought necessary.

And then, Secretary Collins reversed the return to office decision for Veterans Crisis Line employees as well. So, I think we can do better. I think we must do better. Veterans Crisis Lines save lives. They literally save lives. And to ping pong these employees is, in my view, disgraceful and a disservice to all our veterans.

Part of the trash and slash strategy that was originated and implemented by the DOGE tech bros, they're still around even though Elon Musk has left, and the effects have been catastrophic for the Veterans Crisis Line. Thank you, Mr. Chairman.

Chairman MORAN. Senator Blumenthal, thank you and I will join you in expressing my gratitude to Inspector General Missal for his efforts during his time as the Inspector General at the Department of Veterans Affairs, and his work to bring information such as this to us for our use in trying to improve the circumstances that veterans face across the country.

Testifying today on our first panel is Mr. Brad Combs, whistleblower and former VCL Lead Internal Auditor, Department of Veterans Affairs, and Ms. Marcia Blane, former VCL Responder, Department of Veterans Affairs. And as I indicated in my opening statement, we're very grateful for your presence here today, and thank you for your willingness to tell us things you think we should know for the benefit of those you have served and I assume will continue to serve. So, Mr. Combs, you're now recognized.

## PANEL I

### STATEMENT OF BRAD COMBS, FORMER LEAD AUDITOR, VETERANS CRISIS LINE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. COMBS. Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to speak with you today. My name is Brad Combs. From 2019 to 2023, I worked as a lead auditor for the Veterans Crisis Line. My work theory gave me a deep insight into its operations.

I was directly involved in the Inspector General's investigation that was discussed with this Committee in the September 2023 hearing. I called this Committee after that hearing because I believed you were being misled. I testify now for all the whistleblowers who had the courage to step forward.

I presented four areas of concern. Number one, Callers with Complex Needs or CWCN. CWCN are callers who display disruptive behaviors such as incessant calling, hate speech or abusive language, but also historically include a small number of misunderstood callers in acute crisis. A small clinical team engages these callers, but due to staffing and demand mismatches, excess demand is re-queued and handled by specially trained responders.

Just before leaving the VA, I received a transferred CWCN call due to a system-controlled gap. This bypasses cues and tracking and risks and indefinite holds and dropped calls, that was a known tactic to avoid returning callers to the call center with no one being the wiser.

The leadership was aware of these issues since 2018, but took no action. Further, in 2022, the cross-functional team that provided oversight of the clinical team's intervention decisions was dissolved and replaced by one reporting to the clinical team, further pushing CWCN into a deep dark hole. As indifference to these callers has continued, several clinicians have left VCL in protest.

Number two, quality assurance. From 2022 into 2023, testing of the reliability for measuring responder adherence to interaction standards, repeatedly showed significant and unacceptable variances. This would include such standards as suicide risk, and lethal means. This would be the equivalent of teachers grading students without fully understanding the subject material themselves. VCL had little actual understanding of how well responders were performing and there was no plan to fix it.

Number three, electronic media management. Chat and text responders are required to handle multiple interactions at a time, when necessary. Responders have continually expressed concerns about this, which has centered on such problems as trying to maintain focus on two interactions while one is at acute risk of self-harm or harming another.

Despite the concerns and accredited recommendations, leadership has made no changes. In fact, when I began to survey for industry standards, the VCL Executive Director ordered me to stop, despite the IG using similar methods in prior reports.

Number four, disclosure of sentinel events. The Suicide Prevention Program Executive Director had known since 2018 of the need to determine when or how to perform a disclosure when something went wrong during or after a VCL interaction. After three years, he still had to be told by his boss to make these disclosures as a result of an Inspector General investigation.

The following year, when the VCL Executive Director learned of VCL's culpability for a veteran suicide that happened one year prior, she did not make a disclosure despite the standard operating procedure she signed now requiring it.

In management's comments to the Inspector General's 2023 report recommendations, even the Veterans Health Administration Under Secretary was clear that he wanted a disclosure completed. But as soon as the report was published, the Suicide Prevention Program Executive Director stopped it from occurring. GAO confirmed that VCL is now back to 2018 on disclosures.

The many Inspectors General investigations have not changed VCL's culture. Managers have exploited accountability gaps, rather

than mitigating against the risks these gaps created, and have been doing this since before my time. The Suicide Prevention Program Executive Director has been leading the VCL since 2017. This is the culture he built.

The VCL Executive Director was moved to the Secretary's office, but months later was still a tasking me through her former boss. Now she works with VHA Under Secretary, even more directly affecting VCL's operations. All of these leaders that made these decisions and took these actions that led us to where we are today, have been kept in roles to still directly affect veterans in the VCL. VCL cannot change or improve until they and their influence are being completely removed.

Thank you for your time and attention. This oral testimony is just the tip of the iceberg, and I thank you for allowing me to also submit written testimony to flesh these items out. I welcome your questions.

[The prepared statement of Mr. Combs appears on page 41 of the Appendix.]

Chairman MORAN. Mr. Combs. Thank you very much. Now, Ms. Blane.

**STATEMENT OF MARCIA BLANE, FORMER RESPONDER, VETERANS CRISIS LINE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Ms. BLANE. Chairman Moran, Ranking Member Blumenthal, and Members of the Veterans' Affairs Committee; thank you for the opportunity to give a voice to Federal employees. I am Marcia Blane, a Licensed Professional Counselor, a Certified Professional Counselor Supervisor, and a Certified Hypnotherapist.

I'm a proud retired employee of the Federal Government where I worked for 28 and a half years, spending 19 years at the Department of Treasury and Internal Revenue Service, and the last nine and a half years at the Veterans Crisis Line at the VA.

As the daughter and mother of Marine combat veterans, watching and living through the impact of post-traumatic stress after combat, my father and my son were greatly impacted. I found it imperative to give back to a community that has given so much of themselves.

When the Atlanta site opened in 2016, future employees were required to have a master's degree in an area of mental health. Our level of education mattered. During our training we were repeatedly told your degrees don't matter. However, for the work that we do to save lives, our degrees certainly mattered. The professionalism we brought to the staff was relevant, because we were trained to deal with crisis differently.

There is a staff of highly trained individuals who are often told, this is not a clinical position, so don't use that skill set. The Veterans Crisis Line is filled with caring professionals who are frequently encouraged to dim their lights and just answer the call. Prioritizing quantity over quality. Responders also faced racially, misogynistic, abusive, and sexually inappropriate interactions with the callers.

I, along with a couple of other responders, worked tirelessly to meet with the leadership staff with the hope of establishing protocols regarding abusive callers. After initially being rebuffed and dismissed by leadership, told that being called the "N" word, repeatedly by callers not in crisis was essentially a "me" problem.

I was later asked to put a team together and offer suggestions to help reduce the impact of racially and sexually charged interactions internally and externally. After our team created robust educational materials and assessments, the process was shut down by those in charge, in the main VCL office. And I was told the leaders are apprehensive to be taught DEI by a responder.

While they coined it DEI, it was actually an effort to educate the masses regarding abusive callers and the impact it has on workers. Unfortunately, this was the continued stance of the leadership at the VCL. Unless you were at the top, any way that you could contribute to making it a better workplace and more effective service for veterans was shunned. Responders continue to face a daily barrage of callers that have been identified as Callers with Complex Needs, CWCNs, who are supposed to be assigned to a team with specialized training to free up the main line.

These callers are aggressive, abusive, disrespectful, and burden the VCL platform. They would intentionally call 30 to 40 times a day, in a hope to interrupt the functioning of the line. They also text and chat about that much. And the outreach volume from CWCNs has only increased in the recent months. Now they are regularly crashing the chat and text platforms, and blocking up the main crisis line for veterans who actually need our help.

We encounter situations where, on one call we have just talked to a person into unloading their firearm that they were planning to use to complete their life, to the next call with an abuser who is calling us every racial epithet they know and suggesting someone sexually assaults us. Can you imagine what those words do to the nervous system of someone who has no recourse, no defense?

The CWCN trained team is constantly understaffed and the calls are still often handled by mainline responders, which again, taxes the broader system, defeating the purpose of the specialized team. The VCL does not have a reprieve from abuse. Attempts to deescalate or redirect can be deemed inappropriate by quality insurance, and you are threatened to be taken off the phone. In those instances, we are reminded that others outside of the VCL, had been hired to become quality monitors and often failed to have the experience of being a crisis responder.

On May 8, 2025, I submitted my final email to the VCL, as it was my last working day before retirement. I shared with leadership that it's important that they gain experience by observing live calls, since most of the leadership has not been a responder. Rules on call handling are being made by people who have not had the experience of talking down a caller or hearing the completion of life and doing all that you can to prevent it.

We are consistently attacked because of the underlying myth that responders aren't working since we are working from home, by individuals who have no direct experience with what we do. People who insist that we need to come into the office full time, meanwhile, the employees working from home statistically have less call

outs, handle more calls, and provide the same quality of service as the reports from the Inspector General show that.

Leaders are trying to manage and supervise when their skills lack ability, insight, and often experience. A recent example of the lack of insight, was the termination earlier in the year of vital VCL employees such as the Social Science Assistants, who are our right hands.

When we are in the throes of a crisis call, they become the investigators to find the locations of callers who won't reveal their locations. They are the voice behind the calls to police departments when rescues are activated. They are the follow up to ensure a veteran or civilian has arrived at a facility. Terminating those employees created a delay in service, reduced employee morale, and made all of us more vulnerable to misses. That's missed opportunities for those with suicidal thoughts.

In closing, the VCL could be a much better place to work if VA utilized the skills and experiences of their employees to create a healthy environment for the employees and those that we serve. There's more to the people working from home for the VCL than what I've shared here. They are professionals that keep individuals who are ready to end their life, to change direction based on hope and the love for what we do. And VA has to do better for them, so they can continue to provide the best possible support for veterans in crisis. Thank you for your time, and I look forward to your questions.

[The prepared statement of Ms. Blane appears on page 49 of the Appendix.]

Chairman MORAN. Thank you, Ms. Blane. Mr. Combs, thank you again for bringing these serious matters to our attention, for working with me and our team and the Government Accountability Office, and for being here today.

I know your motivation is to help improve the circumstances that the Veteran Crisis Line and to protect the well-being of those in need of services. Would you describe for me, for the Committee, the interaction between the veteran caller and the responder that led to the September 23 OIG report?

Mr. COMBS. Yes, sir. If I could really quick—I would like to thank you for listening. It's been really important that you listen and for John and Emily and your staff for everything they did for these past couple years. It was really important.

Chairman MORAN. Thank you.

Mr. COMBS. The interaction that took place, a veteran was in the act of accomplishing a suicide. He contacted the crisis line, via text message. The responder missed multiple cues, multiple cues that the veteran had a belt around his neck, that he was losing consciousness, that he was actually attempting suicide as he was texting her. She reported that the call ended normally. Ten minutes later the veteran was dead, and in fact, died in his garage behind his house, mere feet from his entire family.

Chairman MORAN. My understanding based upon what my staff tells me, that an interaction like that should trigger a root cause analysis. Tell me what that is and tell me if one occurred. Why or why not?

Mr. COMBS. Yes, sir. Root cause analysis within the VA, they use it on a clinical basis, but it's a very common thing that frankly everyone does to get down to what was the root cause of the issue that led to the event. It's used in business as well. A root cause analysis in the VCL's terminology is to identify what the actual root cause of the event was that led to the suicide after VA was last touched, after VA was involved, or VCL was involved, or could be involved in a suicide.

The root cause analysis was not performed in 2021 when we were first informed of the veteran, because we didn't have a transcript and no one was actually all that concerned about it. It was kind of business as usual. But when the IG said they were coming in, we were very concerned about what the IG might identify, so we wanted to dig into what the IG might find out and try to get ahead of the train.

But frankly to be able to put a point on this, the Executive Director determined that a root cause analysis would not be performed in 2021, and in 2022 decided that root cause analysis was appropriate to perform.

Chairman MORAN. My takeaway from your testimony, Mr. Combs, and perhaps you too Ms. Blane, is that there's this culture of turning a blind eye, outright covering up of deficiencies. And what it seems is that it may be really common at the Veterans Crisis Line, and none of this makes sense to me.

I don't think I know people who would not take those circumstances seriously. Whether you're the responder, whether you're the person on the line, or whether you're the that person's supervisor, I don't think I understand how anyone could not see the importance and take every step necessary to protect the life of the caller. What's missing? How does this take place? I wrote down training, attitude, leadership. I don't know what supervision—what's missing here that would cause somebody to do something that seems to me to be so inhumane?

Mr. COMBS. Sir, it is an attitude or a culture of permissiveness. It starts from the top. It's the Executive Director of Suicide Prevention Program that, again, has been running the program as well as the VCL since 2017, who's created the culture of permissiveness and his management team, outside the call center. Because I want to be very clear, call center people are rock stars. But the management team overall, the cultural permissiveness has led to this environment where they chase metrics and not lives.

Chairman MORAN. And what do they benefit by having better metrics? Is there an incentive for better metrics?

Mr. COMBS. Mr. Chairman, I can't answer that because it's completely foreign to me from a service point of view, all I know is to serve.

Chairman MORAN. Senator Blumenthal, I wish he was here. He and I on a different committee, the Senate Committee on Commerce, conducted a long investigation into the sexual abuse of gymnasts in the Olympics. And I remember the Olympian, at least one of them saying what stuck with me from the very beginning is—and it was a series of women who were harmed. And it was, why was there more than one?

And it strikes me as something very similar here about if there's an error, a poor performance, disregard for human life, it happened once, but then it was taken care of. And so, while I would condemn the bad behavior of any employee, I don't understand how it wouldn't be corrected so that it never happened again.

Ms. Blane let me ask you, I also thank you for being here and your courage and explaining and sharing your experience. Describe the VCL leadership. What's the story there?

Ms. BLANE. Thank you so much for that question. I have to start with the fact that I have a lot of leadership experience coming from IRS. So, coming into the VCL, notable things such as no active standard operation procedures were written, there was elevation of positions by clicks, not by experience. There was an ignorance to what was in the union contract, what was right, what was wrong, what was indifferent. And I think that because of a lack of leadership skills, trained individuals on running departments from that manner, trickled down to what was happening at the bottom line with the crisis responder and all of the teams.

When we onboarded in 2016, the management staff were new hires off the street. They had not been Federal employees before. They knew nothing about union contracts. They knew nothing about managerial principles. In fact, I went to the then director and said, listen, I know I'm not in management, but I can guarantee you with all the years that I've been training managers at IRS, I can help get your people on their feet. They said, "no, thank you."

So, at that point, I had to begin looking at how could I be a voice on behalf of the responders and the employees, because I knew that the management staff, their abilities, even in projecting staffing, was not that great, because they just didn't have the experience.

Chairman MORAN. I need to wrap up my questions quickly for the benefit of my colleagues. I want to ask two more and then we'll move on. Are the people you are describing here today, are they still employed at the VA? Has there been any consequences? One or both of you, either of you?

Mr. COMBS. Ms. Chairman, I think Marcia is most—She just left the VCL, so she's probably better situated to answer.

Ms. BLANE. Several of them are still employed. Some have left, but yes, the answer to your question.

Chairman MORAN. And finally, and it kind of fits with what Mr. Combs just said when he deferred to you. So, if you were still an employee at the VA and you were here in front of us, is that something that you would be honored for or something you'd be punished for?

Ms. BLANE. More than likely punished. There is an atmosphere of be quiet, keep your head down or face the consequences.

Chairman MORAN. Strikes me so sadly, because we're dealing with people who served our country, who had no option of keeping their head down.

Ms. BLANE. Correct.

Chairman MORAN. Senator Hassan.

**HON. MARGARET WOOD HASSAN,**
**U.S. SENATOR FROM NEW HAMPSHIRE**

Senator HASSAN. Well, thank you Mr. Chair, and thanks for this very important hearing, and thank you Mr. Combs and Ms. Blane for being here today and for your care for our veterans and your service to our veterans. And Ms. Blane, like you, my dad was a veteran, so I know this is personal for so many of us in this country, as it should be.

Mr. Combs, I also want to just, before I ask you my first question, I want to say thank you for your service, not just to our veterans, but for your service as a veteran yourself. In your written testimony, you discuss the fact that callers to the Veterans Crisis Line with complex needs often exhibit disruptive behavior, but that many of these callers are also in a heightened state, and they're unable to control their emotions because they're in a very vulnerable position.

You also noted that supporting these callers can take a toll on the responders who answer the calls, which is also really understandable. In your experience as the former Lead Auditor at the Veterans Crisis Line, what do you believe are the most important policy changes that can be made to ensure that veterans who have complex needs, get the help that they need while we're also making sure that crisis line workers are supported?

Mr. COMBS. Yes, ma'am. As far as these complex callers, there was a team that was stood up in 2017. This was their purpose. They developed multi-tiered interventions and then also, based on the callers, because these callers are repeated, based on the callers, they provided training or tools to the responders who might encounter them, how to work with each one of these callers, to run it down to mitigate the concerns. That team has been decimated. And the people who stood it up, the clinician who stood it up, have left in protest over the way the callers have been treated.

Senator HASSAN. So, reconstituting that kind of team would be an important first step?

Mr. COMBS. Yes, ma'am.

Senator HASSAN. Okay. Another question for you, Mr. Combs. You've also mentioned that the Veterans Crisis Line had a standard practice of having call responders simultaneously handle multiple chat or text interactions with veterans in crisis. I understand wanting to help as many veterans as possible and trying to reduce wait times, but our veterans also deserve to be given individual attention by crisis line responders. We can and we should accomplish both of those goals.

Our veterans deserve to get prompt support when they reach out to the Veterans Crisis Line, and our responders shouldn't be asked to divide their attention between multiple veterans in crisis at once. So, can you please discuss some of the risks involved with having responders treat multiple veterans at once, and what the crisis line can do to avoid this issue while also ensuring that veterans get prompt help?

Mr. COMBS. Yes, ma'am. As far as the risk, I can talk on a very high level. Marcia is extremely well qualified to answer that question very specifically. But I will tell you, anytime you divert attention from someone who is in crisis, who is an acute risk of actually

committing a suicide or a homicide, you do not want your attention diverted. But I would defer to Marcia for answering that.

Senator HASSAN. And Ms. Blane, please.

Ms. BLANE. Thank you so much for that question. In bringing light to what's happening in the digital media part of what we do at the Veterans Crisis Line. Even as early as yesterday, our responders were still taking two, sometimes three texts or chats from veterans. That puts us in a situation where there are gaps.

Because if you're dealing with someone that's in a crisis and someone, it could be a kid, because we get a lot of children chatting to the Veterans Crisis Line, you are having to divide your attention and something could very well go through the gap and we could miss opportunities.

We need to identify a better way to handle those chats, individualize them so that, one, we don't burn out the responders themselves, and then they're now having to react from anxiety. What did I miss? How did I miss it? And things of that nature.

Senator HASSAN. And when you said, we get a lot of kids, who are the kids? why are they reaching out digitally, texting, chatting?

Ms. BLANE. So, every time an entertainer mentions 988 or chat or text there, we see an abundance of interactions from young people. We see it through the calls when they're on spring break or summer break because they're bored and their parents need to get something for them to do.

And then they also get on the chat, we do have some serious chatters that are that young, that may be feeling some anxiety and things of that nature, but our line is for veterans. And so that taxes our system as well.

Senator HASSAN. Right. Are they ever children of veterans?

Ms. BLANE. No, these are kids that are in the middle of their classroom.

Senator HASSAN. I hear you. Alright. Well, we're waiting for the Ranking Member to return. So, I do have one more question for Mr. Combs. So, I think it is important to acknowledge, like you do in your written testimony, sir, that Veterans Crisis Line and staff are dedicated, hardworking people who want to help veterans and that's been very clear from both of you.

When you have staff who want to do the right thing and who are working under difficult circumstances, it's really important to provide them with the tools and resources necessary to help them do their jobs the best way possible, including effective, consistent feedback and oversight to help them improve.

So based on your experience as an auditor, and Ms. Blane, I'll welcome you to comment as well. Could you please describe some ways in which the crisis line can improve its feedback and quality assurance so that responders can continuously improve and provide veterans with the best care possible.

And I remember that in response to Senator Moran, you said, there's too much chasing of metrics rather than saving lives. But how do we assess what we're doing? How do we tackle the chats that are distracting and disruptive, but how do we get this kind of continuous improvement in this operation?

Mr. COMBS. Yes, ma'am. Continuous improvement at this point, you change the leadership and the top management that has cre-

ated this culture of permissiveness. After that, you need continued oversight. And in Congress, this Committee has done a wonderful job and I do appreciate every bit of what you all have done in bringing this to light and seeing this through with me.

But you need oversight from the auditors, the Inspector General. I'm just going to say the Inspector General community needs to provide continued, repeated, ongoing oversight of the VCL to help them achieve the cultural change they need to achieve, to meet this. The call center is, as Ms. Blane is saying, is not the challenge. It's the managers and leaders outside the call center who are telling them, this is how you're going to do it. We're talking at you, not with you. That's the challenge.

Senator HASSAN. And Ms. Blane, if you have something to add, I'd love to hear it, and then I'll turn it over to Senator King.

Ms. BLANE. Actually, he said it all, it really does need to just have a change in how they present the information and in management.

Senator KING. Can you get closer to your microphone?

Ms. BLANE. Yes, sure. Thank you for that. I absolutely agree with Mr. Combs that there needs to be a change in leadership structure. When we went from serving to productivity, we lost the essence of what needed to be done. That's when the metrics came into play. I shared with them then, having been an analyst at Delta Airlines, you cannot use a productive model in human services. It doesn't work. And that's where the problem has been, is that they tried to create numbers instead of quality.

Senator HASSAN. Well, thank you very much. Thank you both again for being here. And now we have our Ranking Member arrive back. Senator Blumenthal, would you like to go next or would you like Senator King to go ahead?

Senator BLUMENTHAL. I'll yield to Senator King.

Senator KING. That's a rare occurrence around here.

[Laughter.]

Senator BLUMENTHAL. But it should be more common.

**HON. ANGUS S. KING, JR.,**
**U.S. SENATOR FROM MAINE**

Senator KING. I want to follow up on that question, Ms. Blane, about productivity. Were the people in the call centers under pressure to do so many calls a day or not have calls be longer than a certain number of minutes? Describe to me the metrics that were being applied.

Ms. BLANE. Sure. Thank you for that question. So, the metrics that were being applied was the amount of time that you were staying on a call. What a lot of people fail to realize is that veterans that are getting help from the responders at the crisis line, they call back.

For example, even though we're told it's not a clinical role, a lot of us that are licensed, we will literally de-escalate, give them suggestions on home works, walk them through deep breathing. But those things can be easily frowned upon because it takes a call longer to be completed. I am not willing to leave anyone behind that needs my assistance. So, the idea of production didn't work for

me, because human services and human life was more valuable than the numbers.

Senator KING. Well, I fully understand that. I'm amazed that there would be such—the last thing you want to do if you're talking with someone in crisis is to say, I'm sorry, but our time is up. I mean, maybe if you're a cable services call center that's different. I'm surprised that anyone would even think of applying that metric.

Ms. BLANE. Well, we would frequently receive direct messages in TEAMS saying, "hey, I noticed that you've been on this call for a long time. Do you need any help?" Well, what kind of help are you going to help me with if I'm the one de-escalating someone, you can't come in and take over the call. You don't know what's going on within the call. So, you are literally distracting me from completing the call and paying attention to the veteran.

Senator KING. When did this metric system come into place?

Ms. BLANE. In, I believe it was 2018 when we had a director, and then he hired a new person and that person had come from a background in a call center that was more production guided versus being able to be human guided.

Senator KING. Now, I noticed that you left in May, so you went through at least several months of the new Administration at the agency. It's no secret that there were firings, hiring freezes, threats of more firings, reorganization. Did that affect the operation of the call center in terms of people, morale and dedication, people wanting to stay or go? Talk to me about whether the difficulties at the agency level affected the call center.

Ms. BLANE. Thank you so much for that question and bringing the humanism back into it. It absolutely affected the morale. One of the things that happens when you are a crisis responder is you can develop vicarious trauma by listening to the repeated situations that individuals are going through.

However, when you're concerned if you're going to be able to pay your bills, if you're going to be able to keep your healthcare, if you're going to be able to function, that is going to impact your ability to stay focused.

Now, I have to admit, my peers at the Veterans Crisis Line, as Mr. Combs said, are rock stars. They stayed focused. We all came together in TEAMS, and I would say, "hey, here's my phone number if anybody needs me, text me." We had to create situations outside of TEAMS to offer support to each other because it was so overwhelming. Every week, having to write——

Senator KING. The chaos.

Ms. BLANE. The chaos was overwhelming, and it was distracting. Every week you're having to write, what did I do next week or last week letters to send off to an invisible email that you——

Senator KING. That was the famous five things you accomplished.

Ms. BLANE. Yes, the 14 roles.

Senator KING. I sent one of those in myself to Mr. Musk. I never heard back.

Ms. BLANE. Yes, because the mailbox at one point got completely full and nobody was answering it.

Senator KING. Let me ask another question, and this is not about this subject, but what are the issues that are there—there must be a pattern to issues. Are they financial? Are they, you mentioned healthcare. Can you give us a summary of what are the most likely calls are about?

Ms. BLANE. So, most of the calls that we received are usually individuals that have faced levels of trauma from military sexual trauma, remembrance of their time in combat, individuals that may have not gone to combat but may have been on a ship and felt like they were in a sleeping coffin, marital issues. We became notorious for being marriage counselors. Sometimes having to break up arguments over the phone between spouses.

And so, it just varied between that individuals that were homeless or individuals that specifically just felt unseen, unheard, and easily forgotten.

Senator KING. And did you have the capacity to refer them to VA PTSD programs, for example? I mean, in other words, did your duties go beyond listening?

Ms. BLANE. So, the referral processes, the first referral process is to the suicide prevention coordinators. And those individuals are usually housed at the VA medical centers, a social work department that takes those referrals and then tries to disseminate them to the appropriate areas.

Directly referrals, we will send individuals that are facing homelessness, we send them over to the to the national call center for homeless veterans. When it comes to things like needing appointments, I was a little different from what the SOP said. If I have a veteran on the phone and they needed to get through to make an appointment, I'm going to make the call to get them through to make that appointment. The SOP says, transfer them blindly. Let them pick up on that end.

To me, I believe that we needed to be more of a one-stop shop, so that we would not—can you imagine a 90-year-old veteran calling in and the call just keeps circling because he doesn't know what button to push. I'm not going to send them over blindly. And those are some of the things, some of the stressors for our elderly veterans, because everyone was wanting to force them to use a computer, go and navigate a phone system. They can't, it's not a part of their generation. And why would we want to do that? So, I mean——

Senator KING. The most frustrating thing in the world is to be on some kind of call like this, tell your story, and then have somebody say, well, I'll move you over to this other department.

Ms. BLANE. Exactly.

Senator KING. And then you're on hold listening to music. Well, your testimony has been very important and impressive. I hope you can, I'd like to assign some homework. Could you supply to the Committee further thoughts about how this system can be improved, because that's the business we're in here, and both of you have firsthand experience to the extent you can make suggestions about the standard operating procedure or the productivity metrics, those kinds of things, that would be very helpful to us.

Ms. BLANE. Absolutely. Thank you.

Senator KING. Thank you, Ranking Member.

[The information requested begins on page 71 of the Appendix.]

Senator BLUMENTHAL [presiding]. Thanks, Senator King. Senator Banks.

**HON. JIM BANKS,**
**U.S. SENATOR FROM INDIANA**

Senator BANKS. Thank you, Mr. Chairman. Mr. Combs, one of the frequent criticisms I hear about the crisis line is that management often sweeps problems under the rug. And I wonder, is that your experience, what you saw when you were the former auditor?

Mr. COMBS. Thank you for your question, Senator. Yes.

Senator BANKS. Can you expand on that? I mean, why is that not a technical term, but often a description that I hear from people who are criticizing the Veterans Crisis Line and the management?

Mr. COMBS. As far as the——

Senator BANKS. What is that? Sweeping big problems under the rug?

Mr. COMBS. Okay. Well, Senator, a common definition for us to work off of would-be sweeping problems under the rug would be to not address the problem, not learn from it, not resolve it, and not improve from it, but rather ignore the problem, believe it somehow, make it such that it did not occur, and no one's going to find out about it.

Senator BANKS. And you agree that, you know, sort of something that you saw widespread?

Mr. COMBS. Yes, sir. During my time at the VCL, I brought up many challenges that, what we would call in the audit world lack of conformance to regulations, to VA policy, to even statutes. And I was told, well, there's more context to that or it doesn't apply to us or we're VCL and . . . no, we work for the government. We're part of the government. We need to comply with the government rules.

Senator BANKS. What would you say that the Veteran Crisis Line needs to be more effective? Is it technology, better training? What is it going to take to make it work better?

Mr. COMBS. Senator it is about leadership. VCL—I can't talk for right this moment as far as staffing goes. I can't talk right this moment for budgeting. I can't talk about those things. All I can tell you is during my time at the VCL, and I know it's ongoing because I hear and I listen to what this Committee has talked to VCL about and the VA about, as far as the VCL operations. If they needed something, they were getting it.

So, from my perspective, the technology that we lacked, which we did lack technology, was the decisions of leadership. How we staffed the call center when we had people to staff, as the GAO was about to inform you. Chat and text were staffed by historical standards, historical staffing patterns, not by demand, which meant we were going to have to double up because we weren't looking at what was demand going to be for chat and text for this time period.

Instead, you know, we're going to staff it at this level, if it gets overwhelming, double up, triple up if you need to. We don't have a backup. So, make sure you answer the call. It's about leadership and it's about the leadership culture. And as long as we can make problems go away, you are my friend.

Senator BANKS. We heard from crisis line employees who told us that they were regularly texting and web chatting with 2, 3, 4 veterans at the same time. How does that happen?

Mr. COMBS. For the technical aspect of that, you must ask Ms. Blane. I'm not aware of that. I can tell you that within the short little period of time I had to dig into industry standards, that's not the industry standard that I was coming up with. Before I was told to cease my activity by the Executive Director of the VCL. Industry standard is that when you definitely have someone in crisis, you're not handling any more multiple interactions. You're handling that one. You stay focused on that one because that life is at risk.

Now, as far as the technical aspects of how you can handle or how you can end up with multiple interactions, Ms. Blane would have to answer.

Senator BANKS. Ms. Blane, is that an accurate?

Ms. BLANE. It is accurate that there were possibilities to have to handle two, three, and four chats. One, understaffing was an issue at one point when we first came on board, they kept chat and text in New York only. And so, it wasn't spread around and you didn't have enough staffing trained. So, they began the training.

The problem is now the equipment, the software, the platforms that is on that causes crashing and things of that nature. They've beefed up the training for the number of individuals that are going to be doing chat and textbook. As of yesterday, speaking with some current responders, they are still being assigned a minimum of two texts or chats at a time.

Senator BANKS. I've been in Congress for eight and a half years, and we've increased the budget for the Veteran Crisis Line repeatedly. So, is it surprising to you that we would be understaffed and lack training and technology or to Mr. Combs point, is it that really the leadership issue that you're talking about? I mean, I find that shocking.

Ms. BLANE. I think it's a combination of a couple of things. I think it's leadership, and I think that the revolving door of new hires coming in, them not being adequately prepared for abuse from callers, not knowing how to move along. They want to stay, but everybody doesn't have—this'll be funny, my Generation X skin, that we can take tough stuff, right? And keep going. Some of the younger generations, they just cannot handle that level of pressure.

You ask the question about how does it happen when things don't get done, or they're pushed to the side, because they don't want to confront the truth of situations.

You have to confront abuse, because it's burning your people out. It's causing that revolving door. That's a leadership call. You have to want to train and re-train and continuously train.

I came from an environment at IRS where every year, even as Congress is on the floor changing tax laws, we were doing training. There is no up-to-date annual training. You get things in TMS, which is the training block, but it is not the same of going in the classroom and being focused on what changes we need.

The Veterans Crisis Line needs to evolve with what things are going on. We cannot continue to operate from a place, from the ori-

gin vision of what the Veteran Crisis Line is. We've moved into the adult stage, now we need to grow up.

Senator BANKS. Thank you very much. My time has expired.

Senator BLUMENTHAL. Thank you, Senator Banks. I'm going to hold my questions and yield to Senator Duckworth.

**HON. TAMMY DUCKWORTH,**
**U.S. SENATOR FROM ILLINOIS**

Senator DUCKWORTH. Thank you, Mr. Ranking Member. Mr. Combs, during your tenure as lead auditor for the Veterans Crisis Line, was it your experience that responders were the only employees to answer the phones, and could you elaborate on that? Did anybody else answer the Veterans Crisis Line phones other than trained responders?

Mr. COMBS. Thank you for the question, Senator. So trained personnel, yes. Responders that worked every day, all day as responders? No. They did bring in people to work during overtime periods.

Senator DUCKWORTH. So, these were other VA employees?

Mr. COMBS. Other, no, I'm sorry, ma'am. I should clarify. Other VCL employees who had at some point in time gone through responder training and had qualified as a responder and had been approved to work as a responder in times of need, for demand. They could come in when the call was put out, come in and work as responders.

Senator DUCKWORTH. Okay. So, these are folks who had been trained as responders, but maybe are now doing some other job that's not responder training?

Mr. COMBS. Yes, ma'am.

Senator DUCKWORTH. And they were given the opportunity to work overtime to help answer the calls?

Mr. COMBS. Yes, ma'am.

Senator DUCKWORTH. Okay. Did they receive any guidance or training or currency refreshers to assist them in doing that overtime on the hotline? These non-responders, even though they—it's like saying that somebody got the training once upon a time. Now they're off doing something else. Now they, hey, you can pick up a little bit of overtime answering the VCL. Did they get additional training? Did they get the same level of training as the people currently in the responder position?

Mr. COMBS. Well, so again, thank you for the question. The 2023 IG report that, the Inspector General reflects that that practice stopped because of that incident that's described in the report. And in fact, how do I say this—the Deputy Director of the Crisis Clinical Operations, he made the decision that that practice would stop as of that event. And you had to be a full-time responder or work in the call center as that call center team to take a call from any veteran going forward. So that was about February 2022, going forward, you had to be a full-time responder or the supervisor team operation coordinator, assistant deputy director to take a call.

Senator DUCKWORTH. Okay. Thank you. Ms. Blane, can you please confirm whether as recently as May 2025, so just last month, responders were not the only employees to answer the phones?

Ms. BLANE. As of May 2025, it was only responders that were answering the phones.

Senator DUCKWORTH. It was. Okay. Because my understanding is we've got that 160 hours of training, and I think it's really important that people who are answering the phones are the most up-to-date. You had mentioned Ms. Blane earlier that the VCL terminations caused delays in services to veterans. Can you please elaborate? I mean, what guidance did you receive from leadership to mitigate these delays following the wrongful terminations?

Ms. BLANE. With the—thank you so much Senator Duckworth for the question. With the wrongful terminations, we didn't get a lot of communication. That's one of the concerns with the Veterans Crisis Line, is there was not an evolving door on communication. It was pretty much like, here's where it is. Oops, we've changed directions and going from there, just, you know, keep working as normal.

Senator DUCKWORTH. I had a couple people that I knew through my service in the National Guard reach out to myself and some folks within my organization who knew us personally through the Guard who were working the VCL. And some of them received termination notices, and their supervisors didn't even know they just got the email. Did that happen?

Ms. BLANE. That is a failure of leadership. Because that has been the bane of my existence at the Veterans Crisis Line. Again, part of my responsibility at the Department of Treasury, was to train supervisors. And I would often share with them; you all are literally just a grade up with no power. You are getting information at the same time that the responders are. There's no way that you could adequately prepare to funnel information down to us because your leadership fails to trust you with information, in how it's delivered. That is poor leadership.

One of the issues, or one of the things I often say is leaders lead, managers manage. But if you have a leader trying to manage, you've already missed the mark on what you're supposed to be doing.

Senator DUCKWORTH. Thank you. I'm over time. Mr. Chairman.

Senator BLUMENTHAL. Just a few questions. Ms. Blane, I have to tell you, I was really profoundly moved by your testimony, coming from the daughter of a Marine and the mother of a Marine, both combat veterans, both having gone through trauma. You know in your heart how deep and dire the danger can be to somebody going through crisis. But you also know that more is required than just a good heart.

Empathy goes a long way, but professionalism is required. And you are a consummate professional, a Licensed Professional Counselor, Certified Professional Counselor Supervisor, and a Certified Hypnotherapist. You've worked for 28.5 years as a Federal employee, 19 of those years at the Department of Treasury in the Internal Revenue Service. But you pursued your dream, which was to help veterans.

And so, I think your testimony comes from someone who has seen this problem, not only in a personal way, not only in emotional way, but in an analytical way that is very, very important.

And I thought one of the most important observations you made was the effect of terminating the Social Science Assistants.

Now, the temptation is to say, oh, I'm doing it on my own. I can do it all as the crisis line counselor. But these Social Science Assistants who were terminated are important to the work you do. I'd like you to expound a little bit on why that termination was so shortsighted.

Ms. BLANE. The Social Science Assistants are on the same level as 911 operators. They are our eyes, our ears, and our fingers when we are handling a crisis call. We send a message saying, hey, I need to find this person. They are actively suicidal, and all of that information. I can focus on the veteran when I have a Social Science Assistant who is diligently working, tracing calls, working to get locations, full name, date of birth, so I don't have to be bothered in the sense of redirecting my attention. I can stay with this veteran.

When those SSAs were terminated, averagely on the shift after their termination, you're talking 45 to 50 people to two SSAs. My heart broke because I had so many years in criminal investigations at IRS, I know how to do a lot of research, right? But my heart was breaking for them because for every crisis that was coming in, they're juggling so many different calls.

It was a slap in the face of the SSAs and the responders, because you're telling us to give our best, but you take our best from us, our best support, our best voice, our best fingers, and you leave all of us, including that veteran in crisis, in a gap, and possibly harmed.

Senator BLUMENTHAL. And often these SSAs, the Social Science Assistants, help you locate the voice behind the call when they don't want to be located. Because they're about to take their own lives. And this is a desperate act on their part to call you, and you need to find out where they are so you can reach out to them.

Ms. BLANE. Absolutely.

Senator BLUMENTHAL. You remarked in your testimony about how there are a lot of very well-meaning professionals working on the crisis line, who are "frequently encouraged to dim their lights and just answer the call." Could you explain what you meant by that?

Ms. BLANE. Yes. In 2018, I believe that's the correct year. We had a clinical operations person that came into the Veterans Crisis Line with a production model, answer the call, answer the call. In fact, when we began questioning that, his response in one meeting was, if you don't like the way we do things, find another job.

Not taking into consideration the lives that we were changing, which was always a detriment to me, simply because if you don't know what we do, making a blatant statement like that shows that you have ill concern. Trying to operate, and I shared this earlier, trying to operate a production mentality for human services will never be a win. We're not selling products, we're saving lives.

Senator BLUMENTHAL. Yes. I think that's really important. You know, we all have called the lines, you know, like I don't know, for Amazon or whatever, we want to return a product. We're put on hold. It's maddening, but it's not about taking our lives. It's about

sending something back and getting a refund. You have to demonstrate a responsiveness and empathy that is very different.

When we talk about a crisis line, you know, some merchandiser who says, we have great service on our call-in lines, because you don't have to wait for more than 30 minutes or whatever it is. A caller to your line is not going to wait for 30 minutes.

Ms. BLANE. Not at all.

Senator BLUMENTHAL. They need help right away. I just want to ask you one more question. Would you say that employees during the period January to May, you left in May—January there was a new Administration, feel more or less confident in reporting waste or fraud or abuse without fear of retaliation, compared to the previous nine years that you were in the VA?

Ms. BLANE. So honestly, it began in November once the election results came in. People immediately became afraid of just understanding what the previous four years were like with this Administration, and not really having an idea of where we were going.

So, in response to your question, they are less likely to report the fraud and abuse, because as long as we have the ugly umbrella of potential firing, that is going to stop people from fully engaging in sharing the information. We see that every year with those employee survey responses. It never gets a hundred percent of participation.

Senator BLUMENTHAL. I want to thank you and Mr. Combs for your testimony today. It's been extremely important and enlightening, and I want to thank the Chairman, Chairman Moran, for having this hearing which has given us an opportunity to explore the issues that you have raised. It really is I think extraordinarily important that we hear from you and have this hearing. So, I thank the Chairman.

Chairman MORAN [presiding]. Senator Blumenthal, thank you for taking care of the Committee in my absence. I suppose you still need to vote?

Senator BLUMENTHAL. On the second one?

Chairman MORAN. On the second one, it's been called. Okay. Mr. Combs, the whistleblower protections, do they work? Too early to tell?

[Laughter.]

Mr. COMBS. Yes. Thank you, sir. Well, some things you do because it's the right thing to do. You let the chips fall where they may. Within the VA, right before I left, one Deputy Director, he had a direct report hire his wife; Ms. Blane knows who I'm talking about. His wife was hired by his direct report. I received the report to submit to the IG or a hotline complaint. The report—I'm messing this up, sorry.

The report I received was from the Office of Accountability and Whistleblower Protection—in fact, that was the response I saw published regarding the Secretary's response to your letter asking for the GAO to do an audit on the VCL, was that I could have gone to the Office of Accountability and Whistleblower Protection—I had the report that said nepotism did not occur.

The Deputy Director's wife got hired by his direct report to work for the Deputy Director and Office of Accountability and Whistleblower Protection said that did not happen—that's not nepotism.

So, I don't think Office of Accountability and Whistleblower Protection should be trusted, if it still exists, but it should not be trusted. No, whistleblower protections did not work in the VA.

Chairman MORAN. Thank you for your testimony. Not necessarily pleased by the answer, but thank you for your testimony very much. It's my practice and it's certainly, I hope in this case of value. Is there anything either one of you would want to say that you didn't say in your testimony or that we didn't ask questions about that you think we should know?

Ms. BLANE. No, I think all of the questions that were asked and answered gave a better insight to the Veterans Crisis Line from the responders' perspective. So, thank you for today and this opportunity.

Chairman MORAN. You're welcome. Thank you.

Mr. COMBS. Yes, sir. And I know there were multiple whistleblowers that came forward. I really thank you and your staff, John and Emily, again for keeping us anonymous. None of us wanted to be identified. We were protected for two years as this proceeded. I thank you for the ear and for hearing us and going after this, and for John and Emily for doing everything they did for all of us.

Chairman MORAN. Thank you for highlighting the role of John and Emily, and our staff generally, are hugely valuable to us and valuable to veterans in the country. I thank you for your testimony, and will now call to the witness table the second panel.

Testifying today on the second panel is Ms. Alyssa Hundrup, Director Health Care Team, U.S. Government Accountability Office, and Dr. Thomas O'Toole, the Deputy Assistant Under Secretary for Health for Clinical Services, Veterans Health Administration, accompanied by Dr. Christopher Watson, Executive Director, Veterans Crisis Line.

Ms. Hundrup, Doctor, Doctor, thank you for your presence. Ms. Hundrup, we'll start with you, and you're welcome to provide your testimony.

## PANEL II

### STATEMENT OF ALYSSA HUNDRUP, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. HUNDRUP. Thank you. Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, thank you for the opportunity to discuss our work on VA's management of its Veterans Crisis Line or VCL. My testimony covers findings and recommendations we made in a report we are publicly releasing today.

The suicide rate for veterans remains tragically high, with more than 17 veterans losing their lives to suicide every day. The VCL is a vital resource to assist veterans or their loved ones in crisis. The use of the crisis line continues to grow, with customer interactions across call, text, and chat platforms, increasing nearly 40 percent from fiscal years 2021 through 2024.

In total, VCL responded to about 3.8 million interactions over that time and by 2024, it responded to over 2,500 calls every day. The VCL's goal is to answer 95 percent of calls within 20 seconds,

which it has been able to achieve. As of this March, VCL has more than 1000 crisis responders on staff to answer calls.

A subset of responders are trained to work in the Customers With Complex Needs unit. This unit handles callers assigned as having complex needs such as abusive, sexually inappropriate, or high frequency callers.

However, we found problems with how the VCL is managing this unit. Specifically, it made a procedural change so that if there is no responder available in the unit, callers are immediately redirected to the main line. Previously, this redirection occurred after 3 minutes. VCL made this change to reduce wait times for complex callers and reduce the number of abandoned calls.

Yet this change has resulted in many more complex calls being answered by mainline phone responders who have not had complex needs training, and therefore may not be well equipped to handle the interactions. This creates a risk to the quality of service provided to the caller and causes increased stress and burnout for responders.

Therefore, we are recommending that the VCL assess the risk of adverse effects associated with this procedure change. VA agreed with our recommendation stating that it would perform such an assessment by this October. We also identified workload challenges for the VCL's digital services unit for texts and chats.

For example, responders are expected to handle up to two interactions concurrently as demand requires, and we found this has commonly occurred. Text and chat responders are also expected to document their interactions at the same time as they handle live interactions. This is unlike for calls where responders are given time after the call for documentation. Having to do both at the same time can create workload challenges and can distract responders from ongoing interactions, especially if the responder is handling two interactions concurrently. Such challenges can make it difficult to be fully attuned to customer needs, creating a risk to safety and increasing responder burnout.

The VCL has not assessed how these challenges may be affecting the quality of its digital services. So, we are recommending that it do so. VA agreed stating that it would assess its digital services unit by this October.

Finally, we found that the VCL conducts quality assurance reviews, such as using silent monitors to evaluate interactions against a set of standards. The VCL also reviews its involvement in critical incidents such as a related suicide, to identify areas for improvement and provide coaching to responders. An important aspect of addressing critical incidents is also disclosing VCL involvement with certain incidents to customers or their representatives.

However, due to a recent policy change, the VCL now has no procedure for disclosing incidents to customers. The VCL recently withdrew its procedure because it determined the policy applied only to clinical services, whereas the crisis line provides non-clinical services. The lack of disclosure procedures could result in missed opportunities for the VCL to hold itself accountable to customers or their families, in the event that a VCL action or inaction contributed to a customer's harm.

Accordingly, we are recommending that VA establish a procedure for the VCL to identify the types of incidents that warrant disclosure and a process for doing so. VA agreed stating that it would take action to implement it by next January. Doing so will better ensure that VA meets its goal of building trust with stakeholders through transparency and accountability.

This concludes my prepared statement. I'd be happy to answer any questions you may have. Thank you.

[The prepared statement of Ms. Hundrup appears on page 53 of the Appendix.]

Chairman MORAN. Thank you very much. Dr. O'Toole.

**STATEMENT OF DR. THOMAS O'TOOLE, DEPUTY ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS ACCOMPANIED BY DR. CHRISTOPHER WATSON, EXECUTIVE DIRECTOR, VETERANS CRISIS LINE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS**

Dr. O'TOOLE. Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to provide an update on the Department of Veterans Affairs efforts to enhance the Veteran Crisis Line and our continuing commitment to support our veterans in crisis.

My name is Dr. Thomas O'Toole, and I'm the Deputy Assistant Under Secretary for Health for Clinical Services. And joining me today is Dr. Christopher Watson, Executive Director of the Veteran Crisis Line.

VCL continues to encounter a significant and growing demand for its service. In fiscal year 2025, up through this last May, VCL managed nearly 787,000 contacts, including chats and texts. VCL is the only crisis line in the United States that is integrated into a complete healthcare system, offering a direct bridge between immediate crisis intervention and ongoing care. Our dedicated team of crisis responders is trained to provide immediate assistance ensuring that no veterans call for help goes unanswered.

Informed by work of both OIG and GAO, VA is significantly enhanced its capacity to assist veterans in crisis. A September 2023, OIG report identified critical deficiencies within VCL operations and oversight. As of June 25, of this year, VA has implemented and closed 12 of the 14 OIG recommendations, and we are working diligently to close the final two recommendations, by the end of fiscal year 2025.

These actions include: a comprehensive review of staff performance, enhanced training programs, and establishment of more robust oversight mechanisms. Our commitment to these improvements has already bolstered VCL's ability to deliver safer and more effective services. We have reinforced training and guidance for all VCL leaders and staff to ensure full and transparent cooperation with oversight reviews.

Furthermore, we have formalized written standard operating procedures for call escalation, to enhance the consistency and oversight of complex or high-risk calls. One critical area of focus has

been the management of calls from Callers with Complex Needs, or CWCN. We are assessing the outcomes of CWCN calls managed by both mainline crisis responders and CWCN trained crisis responders.

This assessment will inform any necessary adjustments to our procedures and staffing to ensure we provide the highest standard of care. To address concerns about our digital services procedures, we have conducted an in-depth review to analyze crisis responder documentation practices.

We are also enhancing processes to better capture and analyze crisis responder workload. Our goal is to enable crisis responders on digital service platforms to manage the growing volume of texts and chats without compromising service quality. We have implemented a technological solution to mitigate the issue of chats being abandoned due to crisis responder unavailability. This update includes real-time notification to crisis responder supervisors who can reassign chats promptly, ensuring continuous support for veterans.

Recognizing the need for transparency, VA is convening a multidisciplinary work group to establish a standardized process for disclosure procedures. We anticipate the review to be complete in January 2026. The aim is to foster trust and accountability in our services.

In conclusion, VA is committed to preventing veteran suicides and providing critical support in moments of crisis. VA's dedication to implementing OIG and GAO recommendations demonstrates our commitment to continuous improvement in excellence in service delivery.

As we confront an ever-increasing volume of contacts, we remain focused on ensuring that every veteran receives the immediate and effective support they need. So, thank you Chairman Moran, Ranking Member Blumenthal and the Committee for your oversight, guidance, and steadfast commitment to the health and safety of our veterans.

I also want to thank our first panel, the GAO and the OIG for their oversight and input. We need to be doing a better job. We need to be more accountable, and we need to be holding ourselves more accountable. I look forward to your questions and to continued collaboration in our shared mission to support the well-being of our Nation's heroes.

[The prepared statement of Dr. O'Toole appears on page 65 of the Appendix.]

Chairman MORAN. Thank you. Dr. Watson, do you have testimony? You do, Dr. Watson?

Dr. WATSON. No, sir.

[Laughter.]

Chairman MORAN. Well, first of all, Dr. O'Toole, you heard the description of what was described as prevalent or certainly ongoing culture at the Veterans Crisis Line, and you outlined you have these tasks to undertake due to IG and GAO reports, some of which you indicate have been completed, and some which you're still working on. Do you disagree that the culture or the circumstances that were described by the first panel existed?

Dr. O'TOOLE. So, thank you, Senator, and let me just start by saying, you know, I'm deeply disturbed by what I heard. It's unacceptable. I want to thank our first panel for their honesty and for their courage in coming forward with that. We need to be holding ourselves more accountable.

I want to also personally apologize. It's not acceptable that these behaviors and these actions were taking place. So, I have no reasons to dispute it or definitely no interest in disregarding it. This office has been reporting to me among others for about the past six months. And so, I clearly look forward to our opportunity to address these issues most directly.

Chairman MORAN. Do you know the Department of Veterans Affairs well enough to explain to me why those circumstances were there? What you call actions and behavior, and that they were there for a long period of time, but no one seemed to report or change or insist that the behavior changed? Why does it take a GAO report or an Inspector General's report to get someone's attention to do something?

Dr. O'TOOLE. I have been in the VA a long time and unfortunately, you know, we have not always been the best we can be and should be in this regard. I can't speak to the specifics of this. I can't speak to behaviors of individuals of past leadership. I will convey though our commitment to really trying to get this right.

Chairman MORAN. Dr. Watson. I don't know your history and how long you've been at the VA, but do you have an answer to the question of how can this go on? And it continued until some whistleblower decides they've had enough and it needs to be reported.

Dr. WATSON. Similar to Dr. O'Toole, I have been in my role since April 2024. I'm a psychologist. I've been with the VA SSA psychologist since 1993, so I'll be 32 years in September. So, I cannot really explain what has happened prior to my time with the Veterans Crisis Line.

Chairman MORAN. Well sadly, it seems that this circumstance is not limited to the Veterans Crisis Line. This is not the first time we've had reports of this behavior, or the first time we've had a GAO or Inspector General's report. It seems like it's there in a persistent and widespread, but way too far spread circumstance at the VA.

And I don't understand why it is that an entity and organization that's its purpose is to care for those who served our country would have challenges like the Department of Veterans Affairs has. Any opportunity to explain this to me?

Dr. O'TOOLE. I don't have any specific answer to this. I will say, however, that work in the Veterans Crisis Line has got to be one of the most difficult jobs in the VA. Literally, they are trying to save lives hour by hour, 24/7, 365 days. It's a tremendous stress, and we need to be doing a better job of protecting our employees and taking care of our employees because they are the ones who are taking care of our veterans.

Chairman MORAN. What prohibits or prevents the firing, the discharge of an employee in these circumstances? As I understand, they are still working. My experience in so many instances at the Department of Veterans Affairs in which there's been wrongdoing, is that the individual who committed the wrongdoing remains at

the VA, sometimes transferred to a different department, a different hospital. This is not a one-time circumstance in my experience.

Why is it so difficult to discharge an employee for misbehavior?

Dr. O'TOOLE. Well, sir, I mean, you're absolutely right. And looking at the time from this GAO report and OIG report to where we are now, it's very frustrating. Part of the dynamic for the VA is we need to follow a due process for employees who have been accused, and allow the investigatory process to proceed and adhere to the recommendations for what disciplinary action is appropriate. It can be very frustrating, particularly from the outside looking in at that process. But it is a due process that our employees are entitled to.

I will say from a management perspective, if there is an employee that is not performing to the standards that we would expect, our first and foremost goal is to make sure that our veterans are protected from that bad behavior. And oftentimes that requires moving that employee to a different place to work while the investigation is underway. And I just want to point that out within the process, not trying to justify the larger picture.

Chairman MORAN. Did that happen here?

Dr. O'TOOLE. In some instances, yes. I mean, there were 18 employees that were ultimately investigated in this process.

Chairman MORAN. Senator Blumenthal.

Senator BLUMENTHAL [presiding]. [Inaudible.] I'd defer to him if he hasn't.

Senator KING. First, I want to thank Ms. Hundrup for the thorough report. That's really helpful. And I hope that the Committee can pour through it and act on some of those recommendations. My personal aversion is to reports that don't get acted upon, so we're certainly going to try to do that.

One of the issues seems to be, and this is for any of you, responders answering, dealing with multiple contacts at the same time. You're on the phone and you've got a text. I can't understand how that would ever be a good practice. I mean, it just, it's bound to divert your focus from one or the other of the contacts. Ms. Hundrup, is that a problem?

Ms. HUNDRUP. Yes, the concurrent texts and chats, just to build on our concern a little bit, are happening coupled with the documentation requirements. So not only may a responder be required to handle two chats, sometimes up to three concurrently, but they're also required to document that at the same time. Couple that with some uneven algorithms for how responders are assigned the chats and then finally, historical staffing that has not kept up with the demand.

For texts alone, we have seen an 80 percent increase over the four-year period that we looked at——

Senator KING. 80 percent over four years?

Ms. HUNDRUP. For texting. So, I think, maybe just talking about concurrent texts or chats alone, one could understand the VCL's policy, and VCL officials told us that that's industry standard.

When we looked and spoke with SAMHSA, they said that on the 988 lines, there are some call centers that do allow concurrent texting and chatting, however others don't. But I think our concern is that it's not only this concurrent text and chatting, but all of the

other responder tasks combined that are resulting in serious workload challenges.

Senator KING. Are people expected to handle chats and text as well as being on a call?

Ms. HUNDRUP. No. So, they are all separate. If you work a phone line shift, you would be on the phone line strictly. I think we do understand that when a responder is assigned to answer chats or texts, if the phone lines are needing extra staff, they might get shifted over, but then they would shift completely over to the phone lines.

Senator KING. But they still might be dealing with multiple chats and texts at the same time?

Ms. HUNDRUP. Correct.

Senator KING. And that's a challenge, correct?

Ms. HUNDRUP. Correct. Absolutely.

Senator KING. Dr. O'Toole, you've probably heard Ms. Blane's testimony about productivity requirements like the time of calls. That strikes me as not consistent with what we're trying to do here. Nobody's going to stay on one of these calls just for fun. They're on the calls because it's important. Give me some thoughts about the standards that are being applied.

Dr. O'TOOLE. I'd like to defer to Dr. Watson on that, who would know much more about it than I.

Senator KING. Dr. Watson, your thoughts on a time pressure on a person that's on a call.

Dr. WATSON. Yes. Thank you for that question. And that is also a concern. So, what we have with the Veterans Crisis Line is having to strike the best balance that we can to serve and meet the mission of answering as many calls or texts or chats as possible, and making sure that every one of those is at the highest quality. So the feedback——

Senator KING. It strikes me that a time limit of some—if I'm on a call and I get a message that says, you've been on this call too long, I don't understand why that's ever appropriate.

Dr. WATSON. And what is your question for me?

Senator KING. My question is, is that the practice and can't we change it?

Dr. WATSON. We do have some productivity targets that we're being asked to look at, and that is something that we can review and make changes as needed. We do thank the GAO for the recommendations, and we'll definitely follow up on that.

Senator KING. Great. Thank you, Mr. Ranking Member.

Senator BLUMENTHAL. Thanks, Senator King. For whoever can ask it Dr. O'Toole or Dr. Watson, what is the budget request for the Veterans Crisis Line for fiscal year 2026?

Dr. WATSON. It's approximately $312 million.

Senator BLUMENTHAL. $312 million. How does that compare to the current fiscal year 2025?

Dr. WATSON. This year is approximately $306 million.

Senator BLUMENTHAL. 306. So that's really a marginal increase, around $6 million requested increase, correct?

Dr. WATSON. Correct.

Senator BLUMENTHAL. Could you tell me whether the budget documents reflecting that number have been submitted to Congress, as yet?

Dr. WATSON. Thank you for that question, and I do not have the definitive answer of whether that has been submitted and approved, and we can get information for follow up.

Senator BLUMENTHAL. If you would, I'd appreciate it. We've received reports directly to the Committee from VA employees who say that the Veterans Crisis Line is experiencing an increase, in fact, a massive uptick in the outreach volume since the beginning of this year, which happens to coincide with the beginning of the Trump administration. Both overall for 2025 and regularly daily breaking outreach records. Is that report to us in accord with your experience?

Dr. WATSON. Thank you for that question. Yes, we have seen an appreciable increase in our call volume and our chat volume and our text volume.

**VA Response:** The 2026 President's budget requested $312.8 million to support the Veterans Crisis Line (VCL), which represents an increase of 22.2 million (7.7%) above the FY 2025 current estimate.

Senator BLUMENTHAL. Do you have any predictions or early data on why this volume is higher than it has been in recent past? You have a theory or a view as to what the cause is?

Dr. WATSON. Thank you for that question and some initial thoughts about the increase in our volume overall. Some of that is related to multiple customers that call or text or chat multiple times. Some of those callers or customers fall in the customers with complex needs unit. So that accounts for some of the increase.

Some of the increase, I think is certainly a good thing, in that there are more veterans and service members in those that support each group that are wanting to utilize the Veterans Crisis Line.

Senator BLUMENTHAL. I don't have more than a layman's view on this topic, but my working theory would be there's more anxiety and worry and depression than in the past. If the numbers are up, my conclusion would be, there are more mental health challenges. Correct?

Dr. WATSON. That is certainly possible.

Senator BLUMENTHAL. And I would hypothesize that a lot of veterans are really upset about the fact they're going to be fired. Does that make sense?

Dr. WATSON. I understand what you're saying and that's possible as well.

Senator BLUMENTHAL. Okay. I mean, if you're about to lose your job you're likely to be anxious and depressed. Senator King, did you have question?

Senator KING. I just wanted follow up on your question about increasing call volumes, increasing chat. You said 80 percent in the last 4 years. I didn't do the math, but a $6 million increase on a $300 million budget is not a lot. If the demand is, I think your word, Dr. Watson, was appreciably increasing.

I hope that's something that Dr. O'Toole, you can take back, because there are very few, I can't think of any more important func-

tions in the United States Government than this one. And if demand is increasing, we don't want to be putting pressure on people to try to shorten their calls or otherwise meet artificial productivity goals. We want to be sure these calls are responded to.

So, I hope that there might be a hard look at the budget. There ought to be a ratio between calls received and the budget. That's a pretty straightforward proposition. Thank you, Richard.

Senator BLUMENTHAL. I think that's a really important point. And that's where I was going with my questioning. Do you have numbers on the increase in calls?

Dr. WATSON. We do track that information. Please specify more with your question of the period that you are looking for, and we can make sure that we provide that information for you.

Senator BLUMENTHAL. Well, you don't have that information now? The numbers of calls this year compared to last year?

Dr. WATSON. Yes. So, we thank you for that question, Senator. And we receive with our calls between 80 and 90,000 per month.

Senator BLUMENTHAL. 80 to 90,000 now?

Dr. WATSON. Per month. So, each month of the fiscal year, starting in October.

Senator BLUMENTHAL. And what was it for the previous year?

Dr. WATSON. I do not have that information in front of me, but we do track that. I can provide that for you.

Senator BLUMENTHAL. Because that really goes to Senator King's point and the point that I was driving at. I'm going to also hypothesize that the numbers were inadequate last year and are even more inadequate this year in terms of the resources provided to you. Is that a reasonable hypothesis?

Dr. WATSON. I think that's a reasonable hypothesis and we'll be able to check the math to confirm.

**VA Response:** When compared to the baseline levels of demand set when 988 launched, VCL volume has increased across all services. The table below shows the number of calls each year following the implementation of 988, press 1. While the number of calls has increased, our staff has too. We are continuing to hire as needed.

| | 7/1/2022–6/30/2023 | 7/1/2023–6/30/2024 | 7/1/2024–6/30/2025 |
|---|---|---|---|
| Number of Calls | 797,519 | 893,654 | 1,044,461 |
| Percent Year Over Year | N/A | 12.05 | 16.88 |

Senator BLUMENTHAL. I don't mean to be cute about it. Your department or agency saves lives. You save lives.

Dr. WATSON. Yes.

Senator BLUMENTHAL. And I can't think of anything more impactful and the VA does a lot of really impactful and important work, saving lives in surgery, in all kinds of other activities. It's a great agency. It should be preserved, not decimated as the current Administration seems bent on doing.

But I can think of no more important area to provide sufficient resources so you meet the increasing demand, than your agency. So, I hope that you will be a partner in this effort, Dr. Watson, because I know you're committed to the cause and I'm so glad we are having this hearing because it enables us to shine a light on the

importance of adequately resourcing this area of the work that the VA does.

Dr. WATSON. Thank you, Senator, for your support.

Senator BLUMENTHAL. Well, it is support. Senator King.

Senator KING. Just a quick comment. I should have started my questioning by saying, would you please convey our profound appreciation and thanks to the people that are doing this very difficult work, that they're recognized here and we realize how hard it is and that it's challenging and also how important it is.

And I suspect that many of these people are there because of a sense of mission, and please take back our appreciation for what they're doing. We're not trying to be critics; we're just trying to make it work better. And I do want hopefully to take the message back to the people that are on the front lines doing such good work. I just wanted to add that.

Dr. O'TOOLE. Thank you, Senator. And we appreciate that.

Senator BLUMENTHAL. Yes. I'm so glad, again, Senator King. Thank you. Please express our gratitude to these folks because they do a really hard job. There are other people in the VA who have hard jobs, this one is particularly challenging. And I want to go to the question that I asked Ms. Blane about the SSAs.

I'd like to get from you as well, whether there has been an increase or decrease in the number of the Social Science Assistants, because as you've heard, and you know better than I do, but I was struck by how important these personnel are; locating the caller, phoning the police, providing records. It's almost like a nurse in a surgery, providing the scalpel and the this and that. So, if you could provide that information. How many are currently employed, if you know?

Dr. WATSON. Thank you for that question. And again, the support of our staff who do a critical role to serve the mission. I do not have the specific numbers for the SSAs on me at this time. We do track that information and we're able to provide that.

Senator BLUMENTHAL. Yes, if you could get me information about numbers of all your personnel, I would appreciate it.

**VA Response:** Please see below staffing for Social Science Assistants (SSA) staff, Crisis Responders (CRs) and all Veterans Crisis Line (VCL) as of July 10, 2025:

| Position | Current FTEE | FY 24 FTEE | Increase |
|---|---|---|---|
| Crisis Responders | 1,096 | 1,066 | 30 |
| Social Services Assistants | 173 | 154 | 19 |

| Department | Current FTEE |
|---|---|
| Directors Office | 11 |
| Business | 98 |
| Data & Information | 61 |
| Technology & Innovation | 59 |
| Crisis Operations | 1576 |
| Quality, Training & Risk Management | 123 |
| National Care & Peer Support | 92 |
| **Total** | 2020 |

Dr. O'TOOLE. I would just add, and I don't want to speak for Dr. Watson, but we have added, what is it, 187 crisis responders this fiscal year to the Veteran Crisis Line. So, it is a workforce that we are actively recruiting and growing.

Senator BLUMENTHAL. Let me ask you, LGBTQ+ veterans and children of veterans, young people who are LGBTQ+ are you aware of discrimination against them?

Dr. O'TOOLE. No, sir. I'm not.

Senator BLUMENTHAL. It would be against the law, wouldn't it?

Dr. O'TOOLE. Yes, it would.

Senator BLUMENTHAL. And does the VA have policies to prevent responders on the VCL line from discriminating against LGBTQ+ callers?

Dr. O'TOOLE. I will defer to Dr. Watson on that specific question, but the VA by policy cannot, should not, be discriminating against anyone.

Senator BLUMENTHAL. And one last question before we go to Senator Hirono. Do you have policies, Dr. O'Toole, to protect against retaliation for whistleblowers?

Dr. O'TOOLE. We do, and it is something we take very seriously. It is essential and clearly, we have the policies, but if your office or others hear of that occurring, we need to know and investigate and respond aggressively.

Senator BLUMENTHAL. Thank you. I will turn to Senator Hirono if she's ready. Otherwise, I can stall a little while.

**HON. MAZIE K. HIRONO,**
**U.S. SENATOR FROM HAWAII**

Senator HIRONO. I know that we're all committed to providing the services that the veterans need, and there are a lot of changes happening in the VA and the word chaos and confusion I think are apt. But I do have one question for either Dr. O'Toole or Dr. Watson.

My staff spoke with a veteran in Hawaii whose mental health care providers recently left VA. When the veteran asked how he should continue to access mental health care, he and others, they like similar situations, were directed to call the VCL. Can you confirm whether this was a one-off mistake or whether the VA is directing veterans to utilize the VCL for their everyday mental health needs? Either one of you?

Dr. O'TOOLE. Well, I will take a first stab at it and then defer to Dr. Watson. That should not be the approach by any means. And I certainly would hope and expect that it is a one-off. And if your office could follow up with us on that specific veteran, we are more than happy to reach out and make sure that here he——

Senator HIRONO. So, what was supposed to happen?

Dr. O'TOOLE. We should have been able to, and we should by all means, transfer that individual to another mental health provider within the VA system. And if we aren't able to provide care within the VA system, to be able to refer that patient to the community. But it is absolutely unacceptable for any veteran to fall through the cracks.

Senator HIRONO. Do you have something to add?

Dr. WATSON. I concur with Dr. O'Toole. The Veterans Crisis Line is for crisis care of veteran service members, and those that support each group, for the treatment that is needed for mental health, that is to occur either at the facility or healthcare system that's closest to that veteran or service member or in the community as Dr. O'Toole has mentioned.

Senator HIRONO. So, who is this veteran supposed to call to pursue a line of inquiry? This person, this veteran is supposed to get another treatment person to assign to him or her. Is that right? How do we make that happen?

Dr. O'TOOLE. Yes. Obviously, the system did not work for this veteran as it is intended to. And we should have in the context of care for this veteran, without the veteran asking for it, been able to transfer that veteran's care to another mental health provider or make sure we are getting care for that veteran in the community.

And again, we own that we need to address it. So, we are more than happy to follow up with your office to reach out to that veteran to make sure we can fix it.

Senator HIRONO. So, you would like us to provide you with the name of this veteran so someone can contact him with the name of a new treatment person?

Dr. O'TOOLE. Yes, ma'am.

Senator HIRONO. Okay. Has the VCL seen any spikes in outreach following Administration actions that disproportionately impact the veteran community, such as the announcement of probationary firings or RIFs?

Dr. WATSON. Thank you for that question. We do track that information and we have received some increases of course, from the veterans or service members who contact the Veterans Crisis Line. Sometimes they share that information specifically with specific information. Other times they choose not to. But we are looking and tracking that carefully.

Senator HIRONO. So, my understanding of the Veteran Crisis Line is that, veterans call the crisis line with a variety of requests and questions. What kind of training do they—and by the way, how many people do you have nationwide on the crisis line who are taking all these calls?

Dr. WATSON. Are you asking for the specific number of crisis responders?

Senator HIRONO. The people who are taking these calls? How many people does the VA have, manning the crisis lines?

Dr. WATSON. Yes, for the crisis responders, I can give you an exact account. We do track that.

Senator HIRONO. No, gimme ballpark.

Dr. WATSON. I would say, let's say ballpark 1500. We have currently 2,049 employees within the Veterans Crisis Line.

Senator HIRONO. And is that an increase from say, I don't know what is another timeframe when you added more people to——

Dr. WATSON. We had an exponential increase when we moved to 988 press 1 option, in July 2022. So, we had to increase our staffing significantly at that time to manage that change.

Senator HIRONO. Okay. What is a significant increase?

Dr. WATSON. I would have to give you maybe a ballpark, so not an exact number. Because that occurred prior to my time with the

Veterans Crisis Line. I started in April 2024. So, we can get that information for you. I would say we had to increase, I've heard at least by close to a thousand employees to manage that initiative.

**VA Response:** To prepare for 988 Press 1 implementation, VCL added 1,073 new positions in January 2022.

Senator HIRONO. That is very significant. And the reason that you did that was, that what, more veterans were accessing the crisis line?

Dr. WATSON. Correct. We had a 1–800 number prior to July 2022. Then when we connected with our 988 partners, we are press 1, so you call 988 and press 1. So, we need to increase our staff significantly with that change.

Senator HIRONO. So, would you say that the crisis line is one of the first numbers that a veteran might call for information and assistance? It could be the first encounter that a veteran may be having, accessing potential services that the VA provides?

Dr. WATSON. That's a great question and yes, I would. That is our hope as we are an integrated service crisis line for veterans and service members.

Senator HIRONO. So, since we have asked questions about the potential for another 80,000 people from VA being let go, at a time when there are all these needs in terms of providing veterans with services. Is there a plan to eliminate significantly this 1500 people that you have currently on the crisis lines?

Dr. WATSON. That's a great question and no plan that I'm aware of.

Senator HIRONO. I would like a great answer.

[Laughter.]

Dr. WATSON. Yes, no plan that I'm aware of to eliminate our staff.

Senator HIRONO. And what did you say, that as far as, you know, that these people are going to stay there?

Dr. WATSON. As far as I know at this moment, that is correct.

Senator HIRONO. I think if, can you double check that? Because we don't want the first line of encounters for veterans to be among the 80,000 or so that potentially can be cut.

**VA Response:** VCL was granted an exemption from the current federal hiring freeze and has continued to conduct hiring as needed. VA has no plans to reduce the number of VCL staff. Furthermore, on July 7, 2025, VA announced that we are on pace to reduce total VA staff by nearly 30,000 employees by the end of fiscal year 2025, eliminating the need for a large-scale reduction-in-force.

Dr. O'TOOLE. Senator, I would just add to that. So, there are other phone access points for veterans trying to establish care and access care. So, the crisis line is clearly intended for those veterans who are in crisis and who need emergency crisis response. But ending veteran suicides is a priority of this Administration. And, you know, the expectation of that with those positions being exempted for many hiring freezes, through reversal of the return to office provisions for that group. You know, this is a committed group and we

have grown that labor force within the crisis line by 187 individuals for this fiscal year.

Senator HIRONO. I am over my time. Alright. Can I go on? So is there a specific line for suicide situations that people can call?

Dr. O'TOOLE. That would be the Veteran Crisis Line, ma'am.

Senator HIRONO. Okay. That would be the VCL? So then my next question is what kind of training do all your people have in order to deal with these kinds of very critical situations?

Dr. WATSON. Thank you for that question. They have very specific training to help them provide the best support and meet the mission. They often go through many, many hours of training and review. Then they have a precepting program. So, all of these things occur before they're actually allowed on the line to answer a call.

Senator HIRONO. There are some concerns that have been raised about what kind of training your crisis center people have. And so, if you have a description of the kind of training that people have and I don't know what kind of turnover you have, I would imagine that these jobs can be very—it's high pressure. Anyway, can you send me a description of what kind of training your crisis center people get?

Dr. WATSON. Yes. We have very specific training and we can send you that information for follow up.

Senator HIRONO. And what the retention is for your people?

Dr. WATSON. Certainly. Thank you.

Senator HIRONO. Thank you.

**VA Response:** Office of Suicide Prevention (OSP) Veterans Crisis Line (VCL) has an extensive and robust training program providing crisis intervention focus subjects highlighting veteran specific experience including but not limited to modules on Military Culture, Post Traumatic Stress Disorder, Military Sexual Trauma, Engagement, Motivational Interviewing, Lethal Means Safety, Substance Use and Overdose Risk, Risk Assessment, Violence Risk Assessment, Crisis Intervention, and technical application use. All training is tracked through Veterans Affairs' (VA) Talent Management System (TMS). Each module has individual post-test requirements. New Employee Orientation (NEO) training is evaluated through the completion of a pre- and post-test knowledge checks. All trainees are expected to demonstrate competency at the end of classroom period by scoring 80% or higher on the post-test assessment.

The VCL's turnover rate for Fiscal Year 2025 (October 1, 2024, through June 2025) to date is 7.9%.

Senator BLUMENTHAL. Thank you, Senator Hirono. Thank you to our witnesses. And I think there are no further questions. I want to thank members of the audience as well as our witnesses. And please convey to your colleagues, not only at the Veterans Crisis Line, but throughout the VA, our profound thanks for their service.

As harsh as I may have sounded in some of my criticism of the top leadership, I have profound admiration and gratitude for the service of the VA workforce, including present company, because your job is doubly difficult because of the cutbacks that are occurring and the slashing of programs. So, I'm not asking you to comment, but please convey my thanks to your colleagues and with that——

Senator HIRONO. I join in that by the way.

Senator BLUMENTHAL. Thank you, thanks Senator Hirono. And I think by the way, that comment reflects the vast majority of United States Senators, if not everyone.

The hearing record will remain open for five legislative days should any Committee members want to submit additional statements or questions for the record. And I ask our witnesses, both from this panel and the previous one, to respond to any questions that may be submitted in a timely manner.

And with that, the hearing is adjourned.

[Whereupon, at 5:57 p.m., the hearing was adjourned.]

# A P P E N D I X

# Prepared Statements

Brad Combs
Former Veterans Crisis Line Lead Auditor
Written Testimony Before the U.S. Senate Committee on Veterans Affairs
Regarding Mismanagement of the Veterans Crisis Line
June 25, 2025

Chairman Moran, Ranking Member Blumenthal and esteemed members of the Veterans Affairs Committee, thank you for the opportunity to testify today about my experiences while working at the Veterans Crisis Line (VCL) as their Lead Auditor.

I am Brad Combs, a current government auditor and, relevant to this hearing, former VCL Lead Auditor. I have been an auditor for 24 years, with 20 of those years in the federal government. I have led audit teams in the Departments of the Army, Defense, Veterans Affairs (VA) and Health and Human Services, as well as established audit offices in both the Departments of the Army and Veterans Affairs. I am a Certified Public Accountant (CPA) and Certified Fraud Examiner (CFE). Most relevant to this Committee and hearing, from 2019 to August 2023 I was the VCL's Lead Auditor. Finally, I also served as a Supply Officer in the Navy and had multiple operational deployments.

**Role in the Veterans Crisis Line**

As the Lead Auditor in VCL, I reported to the VCL Executive Director (ED). VCL leadership included 3 individuals: the ED, Deputy ED and the Advisor to the Director. Through the bulk of my time at VCL, senior management included 5 Deputy Directors (DD): Crisis Operations; Administrative Operations; National Clinical Care; and Innovations, as well as an Assistant Deputy Director (ADD) for Quality Assurance and Training (QAT). My responsibilities included:

- Performance audits of VCL activities to ensure compliance with standards, policies, directives, regulations, and statutes.
- Quick reviews (within 30 days) of VA Inspector General (IG) hotline complaint referrals to VCL leadership.
- Coordination with IG audit and inspection teams which included:
    - Collecting and/or reviewing evidence.
    - Identifying points of contact for IG for interviews or evidence requests.
    - Authoring management's comments on IG recommendations as well as suggestions of the VHA Undersecretary's general comments to be published in the IG's report.
    - Coordinating and tracking progress to complete recommendations and resolve findings.
- Managing VCL's accreditations both to obtain and, then, to maintain accreditations with:
    - American Association of Suicidology (AAS)
    - Commission on Accreditation of Rehabilitation Facilities (CARF)
    - International Customer Management Institute (ICMI).

Among the audits I completed were:

- Reviewing the accuracy of invoiced call volumes received by the overflow contractor, Lines for Life.
- Examining the Disruptive Behavior Review Team (DBRT) and the Callers with Complex Needs (CWCN) Database.
- Reviewing VCL's handling of IG Hotline complaints that led to IG inspections.
- Examining Responder overtime for frequency and amount.

**Why I am here today to testify**

On September 20, 2023, one month after leaving the VCL, I was encouraged to watch this Committee's hearing regarding the IG's latest report on the VCL, report 22-00507-211, September 14, 2023.[1] I had been intimately involved in that IG examination for obtaining, reviewing, and providing evidence to the IG. I had also crafted management's comments to the recommendations based on input from the managers who would have to accomplish each recommendation.

In aggregate, my truths differed significantly enough from the information presented that I believed those differences should be known. Likewise, I also felt the Veteran being discussed, his brother who had fought so hard for him, his family, and every other impacted Veteran deserved to know what happened. So, not knowing what else to do, I picked up the phone and called this Committee.

Since my first call, I have been talking primarily to two Committee staffers to explain what I knew and saw. Both of these staffers have been ceaselessly diligent in helping me advocate for this cause while protecting my anonymity, and if not for them, and all of the other staffers I have interacted with in the run-up to this hearing, I would not have continued to explain myself or be here today to testify, and GAO likely would not have performed the audit. I thank them both for their service.

I am also aware that I am representing many others who also came forward to share their own truths and thank them for the courage and determination to do what is right regardless of how it could impact them in their job. Because you stepped forward to talk to Congress, this happened. Finally, for all Veterans and those who have Veterans in their lives, this is for all of you, as it should always be.

The topics I heard and, subsequently, further discussed were:

1. Callers with Complex Needs
2. Quality Assurance
3. Electronic media management and staffing
4. VCL Disclosures of sentinel events

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[1] IG report 22-00507-211, *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

**Callers with Complex Needs**

Callers with Complex Needs (CWCN) is a term that defines a wide range of callers that exhibit many different types of disruptive behaviors and, for some, more than one type at the same time. From 2007 to 2017, VCL Responders received calls from such callers, and the interactions had significant negative effects on the Responders. Recovering from those interactions took longer, and Responder burnout began to occur.

In 2017, VCL created a team, the CWCN team, to automatically receive calls from known CWCN as well as have callers believed to be exhibiting disruptive behaviors transferred to them. This worked to decrease the stress such callers could have on the Responders and, per reported metrics, worked incredibly well. The team was led by clinicians who willingly engaged VCL's most difficult and vulnerable Veterans.

VCL also developed a cross-functional Disruptive Behavior Review Team (DBRT). This team determined the selection of interventions to assist in moderating CWCN behaviors and periodically reassessed the appropriateness of the intervention being used on each CWCN. The Veteran Health Administration's (VHA) expert for disruptive behaviors, Lynn Van Male, reviewed and approved VCL's program.

While the overwhelming majority of CWCN are engaging VCL to solely exhibit disruptive behaviors, there are also those callers who are in a heightened emotional state and are unable to control their emotions in that state, as can be expected from someone in crisis. Those that established the team reported helping hundreds of very vulnerable callers transferred to them for exhibiting disruptive behaviors. Through their interactions, and multi-tiered interventions, the CWCN team was able to help the caller regain control of their emotions sufficient to engage and be connected with services to help them. The team also developed supportive tools Responders could use to help in future interactions with the callers.

Shortly before I departed the VCL, I received a transferred call from a known CWCN who had contacted the crisis line. The following day I informed all senior management and VCL leadership of the event. The matter was reviewed for one day. At the end of the review there was no more knowledge of what had occurred than at the start. In fact, over my tenure I had received other transferred calls never understanding they were from the call center.

Knowledgeable former colleagues confirmed that it was known such transfers occurred. Relative to CWCN, a Responder could make a transfer to the CWCN team line circumventing the CWCN queue. Avoiding the queue meant the call would not be re-routed to CWCN trained Responders who took queued CWCN callers when the CWCN team could not. Instead, the caller would sit on hold awaiting a regular CWCN team member to be freed to accept the call. If the CWCN hung up, VCL would be blind for the caller's status.

These colleagues also provided email threads to demonstrate the CWCN issues just described were known as far back as 2018. As I had just performed testing regarding indefinite CWCN holds and records of CWCN calls, I was aware no action had ever been taken. Managers and leaders that were aware but took no action included the heads of Knowledge Management and

Information Management; Director of National Care Coordination; ADD, QAT; DD, Clinical Operations and, later, Business Operations; and all Deputy EDs and EDs for VCL and SPP from 2018 to 2022.

In 2022, the cross-functional DBRT that decided on and oversaw mitigation strategies for CWCN was disbanded. The team was reconstituted as a team of employees subordinate to the CWCN team itself. I strongly advised against this loss of transparency for how VCL treated CWCN. My colleagues, in fact, departed VCL because of the decisions being made regarding these callers. VCL leadership's decisions no longer showed an intent to help these callers but, rather, solely to mitigate the disruption they caused the call center and Responders.

GAO also reports VCL policy has changed for abusive callers. Now, Responders being confronted with what they believe is a disruptive caller should attempt one redirect before hanging up on the caller. While Responders are not to hang up on a caller in which risk of harm to self or others has been identified during the interaction, that also means the caller has to state or confirm that intent before the Responder determined to hang up on them. Forcing Responders to engage with the CWCN in this manner takes VCL back to the beginning to repeat the challenges it faced. Hanging up on a Veteran was once the antithesis of what VCL stood for.

From April to August 2023, I worked alongside a call center expert from the International Customer Management Institute (ICMI) who performed a consultation and accreditation during the period. Relevant to CWCN, VCL evidence produced showed demand was not forecasted for CWCN. Staffing of the few CWCN team members was based on historic staffing patterns, and no model was used for CWCN trained Responders who take CWCN calls when the CWCN team is backed up. This was different than for phone and "chat and text," in which demand was forecasted. Also, while chat and text also used historic staffing patterns, phone was the only modality that used forecasted demand for staffing decisions. ICMI's 2023 accreditation report recommended developing a Workforce Management Playbook for forecasting and scheduling all staffing (phone, chat and text, and CWCN) based on demand.

**Quality Assurance**

Rater reliability is a VCL term that addresses how reliable a rater, a person that rates an interaction, rates the interaction. This can be measured by providing sample interactions to raters and measuring their rating results against a perfectly rated version. The goal is to reduce each rater's variance for interactions to an insignificant level with no variance for critical standards. The ADD, QAT was responsible for this program and held the results.

In 2023, in response to a request from the ICMI accreditor, records for Quality Assurance's silent monitoring program were made available. The period January 2022 to April 2023 were provided. Reliability testing was performed for 8 of the 15 months with extremely significant and unacceptable variances found for critical items such as lethal means safety; suicidal planning and intent; substance use; and violent behavioral risks.

Also significant, from 2022 until 2023, most new call center supervisors were also new to the VCL rather than former Responders. Thus, before accepting their new position, they had no

working knowledge of their Responders' interaction standards and no apprenticeship for testing compliance with them.

Critically, when asked, Quality Assurance had no plan to improve the reliability of these raters. So, as of April 2023, no assurance could be made regarding the reliability of raters, overall. The ultimate effect of this discovery was that VCL had limited actual visibility for how Responders were performing, and there was no plan to improve that visibility. Put simply, the people doing the rating, as a class, did not know enough about what they were rating to credibly grade the Responders' work.

**Electronic media management and staffing**

As of August 2023, simultaneously handling multiple chat or text interactions was VCL's standard practice, and Responders that accepted work in electronic media had to agree to perform multiple interactions to work there. Electronic media Responders were also to maintain concurrent interactions even if one had shown an acute risk of harming themselves or another because they had built rapport with their callers. Changing Responders would require the new one to have to start over to re-establish the rapport and was, therefore, undesirable.

The concern for handling multiple interactions was voiced by electronic media Responders in focus groups I participated in from 2019 to 2023. Challenges cited included maintaining two interactions when one was at acute risk of harming themselves or others, as well as attempting to document a completed interaction into the Medora tracking system while attempting to remain focused and responsive on another ongoing one. Although these concerns were continually presented to VCL Leadership from 2019 to 2023, no changes were made.

The 2023 American Association of Suicidology accreditation report was the first accreditation report during my tenure that recommended all Responders be trained to work all modalities (phone, chat and text) to better back one another up across all of them. As electronic media Responders were already routinely pulled to assist with phones, this was much more about phones now needing to back up electronic media.

As mentioned in the CWCN topic, during the ICMI accreditation it was learned that electronic media was only staffed based on historic staffing patterns despite continually forecasting demand. It was also noteworthy that the head of information management refused to provide staffing utilization reports, or even the variables needed to create them, to the accreditor when asked, and leadership did not intervene. Electronic media had historically been used as a source of extra staffing if phone demand surged. However, because not all phone Responders are trained for electronic media interactions, the reverse is not true. Thus, the only method to accommodate demand surges with electronic media is to require concurrent interactions.

ICMI's recommendation for developing a Workforce Management Playbook for forecasting and scheduling all staffing (phone, chat and text, and CWCN) based on demand was the second time in less than a year that VCL was told to improve the situation for electronic media Responders. Finally, from 2021 to 2023, the VCL call center experienced over a 100% staffing increase while total volumes had only increased, approximately 40%.

Finally, during work incidental to the IG examination leading to IG report 2022-00507-211, I agreed to perform a survey of other crisis centers that conducted electronic media interactions. A list of accredited activities was provided by AAS. As I began reporting results indicating an industry "best practice" might exist for not allowing concurrent interactions; having integrated interaction transcript storage with the chat and text platforms; and performing training specific to written word interactions, I was told to immediately stop the work by my supervisor, the VCL ED. The reasoning was that VCL is a government activity and we have to be careful with whom we performed outreach. The IG had repeatedly performed similar survey work in previous reports on the VCL.

**VCL Disclosures of Sentinel Events**

Per IG report 20-00545-115, April 15, 2021,[2] CARF accredited VCL in early 2018. This was during the current SPP ED's time as VCL Director. The IG noted that CARF identified a VCL deficiency for not having a plan to address critical and sentinel events. In August 2020, VCL leaders reported, to the IG, a plan was in place to develop a standard operating procedure (SOP) and were considering a consult with the National Center for Ethics in Healthcare. As the recommendation and deficiency tracker, I was told by the ADD, QAT and Knowledge Management that a SOP was in development and would be ready before the next CARF accreditation in 2021.

In early 2021, VCL received an accreditation from CARF with the recurring deficiency that VCL needed to develop a plan to address critical and sentinel events. One of those deficiencies was documenting how VCL would handle critical and sentinel events. Soon after, April 15, 2021, the IG issued their report, 20-00545-115. The 2021 accreditation was not mentioned. The IG directed a recommendation on their report to the Office of Mental Health and Suicide Prevention (OMHSP) ED, the supervisor of the SPP ED. This was to determine if VHA disclosure policies apply to the VCL, a non-clinical activity, and establish procedures as appropriate. Both the CARF deficiency and that IG's recommendation were worked jointly.

The OMHSP ED determined that disclosures should occur and VCL developed a policy for critical incidents and a standard operating procedure (SOP) for determining and handling sentinel events up to and including when and how to perform a disclosure.[3] These were published in August 2021. VCL defined a critical incident as any event or situation brought about by the actions or lack of actions, by VCL staff, technical failure, or an established process or process gap that creates a significant risk of substantial or serious harm to the health or safety of a customer. VCL defined a sentinel event as a type of critical incident that includes a suicide and/or homicide death or a suicide and/or homicide behavior with VCL as the last known contact and within 72 hours without VCL dispatching emergency services or requesting Suicide Prevention Coordinator (SPC) outreach. Finally, VCL determined that a disclosure would need to

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[2] IG report 20-00545-115, *Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*, April 15, 2021

[3] VCL-S-ACT-109-2108, *Veterans Crisis Line Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses,* signed August 8, 2021

occur when there was a sentinel event that resulted in, or is reasonably expected to result in, death or serious injury. The SOP also noted that, while disclosures should be initiated as soon as reasonably possible, some sentinel events are only recognized after the associated event, for example, through investigation of a sentinel event, a routine quality review or a look-back. In such instances a disclosure is still required but would be delayed.

Both VCL's critical incident policy and sentinel event SOP were forwarded from VCL, to SPP, to OMHSP, then the VHA Under Secretary, and, finally, to the IG to close their recommendation. No communication was received back directing VCL to modify the documents, hold pending further notice, or otherwise take any action beyond immediate implementation.

The Veteran in IG report 22-00507-211, September 14, 2023, died in January 2021. The suicide occurred very shortly after the interaction ended. VCL was aware of the death within days after it occurred, but unaware of VCL's role in it until the IG provided the text transcript to the SPP ED in February 2022. Made aware of VCL's culpability and with the new SOP for sentinel events in place since August 2021, the VCL ED told the IG she chose not to perform a disclosure because no policy was in place at the time of the Veteran's death.

The VCL ED's signed SOP for sentinel events, provided to SPP, OMHSP, and the VHA Under Secretary, stated that if she became aware of the culpability at a later date, a disclosure should still occur. The ED was in the meeting when the interaction rating results were presented and discussed. VCL even performed two independent ratings of the interaction to ensure reliability. The decision not to perform a disclosure was never discussed in any meeting I attended before the draft report was received.

When IG report 22-00507-211 was published, VHA's response for recommendation 7 included language added by the Undersecretary's office. That was to change the disclosure type from VCL disclosure to institutional disclosure and to add the need to follow VHA Directive 1104.08 for institutional disclosures as well as VCL's own policy. A VCL disclosure is determined by the VCL Executive Director. A VHA institutional disclosure is determined by the facility Risk Manager with notice provided to the Executive Director. Also, while the VCL disclosure would just involve the Deputy Director, Clinical Operations, the institutional disclosure would involve all clinicians and leaders involved in the patient's care. In practical terms, the VCL ED is given wide latitude to disclose or not disclose a VCL disclosure, while an institutional disclosure is presumed to be disclosable. The manager overseeing VCL's responses explained the decision to me in a call so I was aware the Undersecretary's office was also convinced a disclosure needed to occur. Conversely, I had already been told, by those involved in the process, the SPP ED was denying the disclosure.

**Why I left the VA**

Although I had encountered questionable decisions and a general unwillingness to improve and learn from experts before 2022, the events regarding the IG's examination leading to their report, 2022-00507-211, overcame my hope for the management team that continues to run VCL. The decisions I could see that led to that event and the decisions made and actions taken during the IG's examination left me troubled.

My truth is that the Responder who performed the interaction was ill-equipped and ill-prepared to do so and that, if the system worked the way it should have, would not have taken that call. Later in the year, as I was repeatedly involved in decisions for how to respond to oversight activities up to and including Congress, I lost faith in VCL and SPP leadership. In my view, the decisions reflected what was best for their program and individual careers, not us, the Veterans. It was then I determined I had to leave the VCL or I would become part of the problem.

I called this Committee because there was nowhere else to go. The many Inspector General investigations had not improved VCL's culture, it had only polarized leadership against oversight.

The Suicide Prevention Program Executive Director has been leading the VCL since 2017. This is his program. The Assistant Deputy Director for Quality Assurance and Training, the leader who attempted the coverup in the Inspector General's 2023 report, was moved to the Suicide Prevention Program to work on a "special project" while the IG recommendation to investigate her actions remains open 2 years later.

The VCL Executive Director, my former boss, who lied to avoid making a disclosure, was moved to the VA Secretary's office after the Inspector General's 2023 draft report was received for comments but was still sending me tasks and corrections to the IG's draft report, through her former boss. Now she works for the VHA Undersecretary as lead counselor even more directly affecting VCL operations. All these leaders that made the decisions and took the actions that led us to where we are today are being kept in roles to continue to affect and influence the VCL. VCL cannot change or improve until they, and their influence on it, have been permanently removed.

In closing, over my tenure at the VCL, and beyond these leaders just discussed, I met some of the most dedicated, humble, and welcoming staff I could have ever imagined. They work so smart and hard to do what they can to be part of the rescue story of every Veteran that calls. They also accept accountability for their errors and mistakes and learn from them. They deserve managers and leaders that do the same.

Marcia Blane
Former Veterans Crisis Line Responder
Written Testimony Before the U.S. Senate Committee on Veterans Affairs
June 25, 2025

Chairman Moran, Ranking Member Blumenthal, and members of the Veterans Affairs Committee, thank you for the opportunity to give a voice to federal employees. I am Marcia Blane, a Licensed Professional Counselor, a Certified Professional Counselor Supervisor, and a Certified Hypnotherapist. I am the proud retired employee of the Federal Government where I worked for 28.5 years spending 19 years at the Department of Treasury – Internal Revenue Service and the last 9.5 years at the Veterans Crisis Line via the Veteran Administration.

In 2016, I transitioned from the IRS to the VA to pursue my dream and purpose of offering support to Veterans. As the daughter and mother of Marine Combat Veterans watching and living through the impact of post-traumatic stress after combat for my father and son, I found it imperative to give back to a community that has given so much of themselves.

At the IRS, I had the pleasure of rising through the ranks from a clerk to a supervisor who often acted in the role of department manager, facilitator, trainer, and author of many job manuals, and trainer of new leaders. Those years of experience followed me to the VA and upon arrival, I noticed the Department lacked certain levels of structure including Standard Operating Procedures (SOP), guidelines based on the Union Contract, and a leadership staff elevated not based on experience, all of which created unnecessary risk and uncertainties.

When the Atlanta site opened in 2016, future employees were required to have a master's degree in an area of Mental Health. Whether it was a Social Worker, Licensed Professional Counselor, Marriage and Family Therapist, and some Applied Behavior Analysis, the level of education mattered. Prior to Atlanta, you weren't required to have a master's degree to be employed by the Veteran's Crisis Line. In fact, once coming on board our degrees were frowned upon by the staff working in Canandaigua, NY.

The newly hired Responders faced racially, misogynist, abusive, and sexually inappropriate interactions with the callers while facing racially charged interactions with the employees in TEAMS chats. Our complaints about the abuse from our peers led to the separation of chats, but there was no direct consequence against those who initiated the negative interactions. During training, we were repeatedly told "your degrees don't matter." In fact, that had been the perspective given throughout the VA. However, for the work that we do to save lives, our degrees certainly mattered. The professionalism we brought to the staff was relevant because we were trained to deal with crises differently, so there were less incidents of employees telling

Veterans to “go f yourself” or “go kill yourself.” Yes, that actually happened, and we were left appalled when that employee continued to enjoy employment until he retired.

Since 2016, I along with a couple of other Responders worked tirelessly to meet with the leadership staff with the hope of establishing protocols regarding abusive callers. In 2017, during a team meeting attended by the then acting Director, I inquired about the impact of the racially charged calls and the plan to handle these callers and the ability to protect the employees. Her response to the inquiry was, “you all need to find out why it’s so impacting when someone calls you the n word.” Out of frustration, I retorted then we should equally understand that it’s ok for callers to be similarly derogatory to non-Black responders. Without a commitment to make changes, they stormed out of the room, shouting to anyone within ear shot: “Marcia thinks I’m a racist.” I will acknowledge that she tried to rectify her actions and asked me to put a team together and offer suggestions to help reduce the impact of the racially and sexually charged interactions internally and externally.

After working with a team, creating PowerPoints, assessments, and educational information, the process was shut down by those in charge in Canandaigua, NY, the main VCL office, and I was told, “The leaders are apprehensive to be taught DEI by a Responder.” While they coined it DEI, it was actually an effort to educate the masses regarding abusive callers and the impact it has on workers. Unfortunately, this was the continued stance of the leadership at the VCL. Unless you were in Canandaigua, any way that you could contribute to making it a better workplace was shunned.

Even after new leadership was later installed to oversee the operations of the Veterans Crisis Line, we saw a regime disconnected to the actions and experiences of front-line employees. Veterans continue to fall through the gaps as they are connected to burned out Suicide Prevention Coordinators who often end calls if it was known the Veteran was not actively suicidal. The system was and has been broken. You have a staff of highly trained individuals who are often told, “This is not a clinical position so don’t use that skillset.” As a therapist, I understand human behavior and addressing it is contrary treating the VCL like a production line. I utilized my skills to help de-escalate Veterans who were experiencing crises from suicidal ideation and contemplation, to marital problems, to unprocessed trauma. The Veterans Crisis Line is filled with caring professionals who are frequently encouraged to dim their lights and just answer the call.

During the proverbial dimming of the light, we are faced with a barrage of callers that have been identified as Callers with Complexed Needs (CWCN). These callers are aggressive, abusive, disrespectful, and burden the VCL lines. They will intentionally call 30 to 40 times a day in a hope to interrupt the functioning of the line and then go to social media and say things such as “see they don’t answer the call.” We encountered situations where on one call we have just

talked a person into unloading the firearm they were planning to use to complete their life to the next call with an abuser who is calling us every racial epithet they know and joking about you being sexually assaulted.?

In the beginning, the recourse was to redirect the callers three times before disconnecting. Can you imagine what those words do to the nervous system of someone who can't fight back? They have changed the process to redirecting once and terminating the call. Currently, the CWCN-trained team is understaffed, and the calls are being handled more and more by main line Responders, which again taxes the broader system. Several years ago, there was an OIG complaint from those callers that created the CWCN cadre, however the abuse they projected on the employees and the lines overall was not taken into consideration. In the past decade, there have been two individuals charged with abusing federal employees and the line, however there are many more that must face the consequences of the abuse. If these same callers were presenting at a local VAMC they would have been escorted from the premises, a flag placed on their account, and unable to go to the VA without police escort.

The VCL does not have a reprieve from the abuse. If a Responder responds in a manner that Quality Assurance deems inappropriate, you are threatened to be taken off the phone. For example, an abusive Veteran caller consistently called the me "an old Black b****" but continued to mention suicidal ideation. In that instance, the call can't be redirected, and we must pursue a safety plan, assessing for means, and the probability of him acting on the threat of self-harm. In this instance, I responded "young man I'm a part of Generation X and your abuse doesn't cause harm, but I do need to know what you need and the probability of harming yourself." His inability to rattle me caused him to become more aggressive and ending the calling saying, "I'm not going to do anything to myself." The Quality agent saw it as unprofessional and deemed it necessary to be removed from the phones. In those instances, I was reminded that others outside of the VCL had been hired to become Quality Monitors and often failed to have the experience of being a Crisis Responder.

Currently, the CWCN cadre is experiencing increased volumes via digital services resulting in the system crashing frequently. There appears to be a lack of adequate staffing as well as operable bandwidth to handle the volume. Creating a process to restrict incoming calls or text will assist with servicing customers of the VCL.

On May 8, 2025, I submitted my final email to the VCL as it was my last working day before retirement, and I shared with leadership that it is important that they gain experience by observing live calls since most of leadership has not been a Responder. Rules on call handling are being made by people who have not had the experience of talking down a caller or hearing the completion of life and doing all that you can to prevent it. There are not adequate routes of recovery when a Responder experience misses or near misses because of the underlying myth

that “Responders aren’t working since we are working from home” by individuals who have no direct experience with what we do. The employees working from home statistically have less call outs, handle more calls, and provide effective service. One of things that is prevalent is leaders are trying to manage and supervise when their skills lack ability, insight, and often experience. An example of the lack of insight was the recent termination of vital employees, the Social Science Assistants (SSA), who are our ears and fingers when we are in the throes of a crisis call. They become the investigators to find the locations of callers who won’t reveal their locations. They are the voice behind the calls to local police departments when rescues are activated. They are the follow up to ensure a Veteran or civilian has arrived at a facility. Terminating those employees created a delay in service, reducing employee morale, and making all of us vulnerable to misses.

In closing, the VCL could be a much better place to work if VA utilized the skills and experiences of their employees to create a healthy environment for the employees and those that we serve. There is more to the people working from home for the VCL than what I have shared here. They are the professionals that keep individuals who are ready to end their life to change direction based on hope and the love for what they do. And VA has to do better for them so they can continue to provide the best possible support for veterans in crisis.

Thank you for your time and I look forward to your questions.

Marcia Blane

United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, U.S. Senate

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# VETERANS CRISIS LINE

## Actions Needed to Better Ensure Effectiveness of Communications with Veterans

Statement of Alyssa M. Hundrup, Director, Health Care

GAO-25-108411

June 25, 2025

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee:

Thank you for the opportunity to discuss our work on oversight and management of the Department of Veterans Affairs' (VA) Veterans Crisis Line (VCL). My testimony today summarizes our June 2025 report publicly released today entitled *Veterans Crisis Line: Actions Needed to Better Ensure Effectiveness of Communications with Veterans.*[1] As you know, veterans suffer a disproportionately high rate of suicide compared to non-veterans. In 2022, the suicide rate for U.S. veterans was more than twice as high than the rate for nonveterans, and an average of 17.6 veterans died by suicide per day.[2]

Suicide prevention is a top stated priority of the Department of Veterans Affairs.[3] To this end, VA operates the VCL, a 24/7 national toll-free number, online chat, and text messaging service for qualifying individuals.[4] In addition to veterans themselves, the VCL serves veterans' family members and friends. VCL customer interactions (including calls, texts, and chats) have increased nearly 40 percent from fiscal year 2021 through 2024, rising from about 800,000 interactions to about 1.1 million interactions and totaling over 3.8 million interactions over the 4-year period. While texts overall comprised the smallest percentage of VCL interactions, they also experienced the most rapid rate of growth, increasing more than 80 percent, from about 45,000 in fiscal year 2021 to about 82,000 in fiscal year 2024.

[1]See GAO, *Veterans Crisis Line: Actions Needed to Better Ensure Effectiveness of Communications with Veterans*. GAO-25-107182. (Washington, D.C.: June 2, 2025; publicly released: June 25, 2025).

[2]See U.S. Department of Veterans Affairs, Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report*, December 2024.The rate of veteran suicides per day in 2022—the most recent data available—was consistent with recent years: between 2017 and 2021 rates per day ranged from 16.8 in 2020 to 18.6 in 2018.

[3]See U.S. Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan*.

[4]The VA operates the VCL through the 988 Suicide & Crisis Lifeline, which serves anyone in suicidal crisis or emotional distress. The 988 line is administered by the Substance Abuse and Mental Health Services Administration. To reach the VCL, individuals dial 988 and then press 1. Individuals begin a text interaction with the VCL by texting 838255 and can begin a chat interaction through the VCL website.

As of March 2025, all of the more than 1,000 crisis responders employed by the VCL answered phone calls from customers (how the VCL refers to individuals that contact the crisis line). A subset of these responders is also assigned to a "customers with complex needs" (CWCN) unit, which handles complex or high frequency callers on a separate line. Another subset of responders is assigned to the digital services unit, which provides chat and text-based crisis support. In addition to the training all crisis responders receive, CWCN and digital services units' responders are to receive specialized training specific to those units.

The VCL expects its responders to mitigate customers' risk of harm, whether they contact the crisis line by call, text, or chat. Responders are expected to conduct risk assessments to identify suicide or other risk factors, address the crisis presented, and seek supervisory guidance as needed, all to ensure safety for each customer. When there is a risk of imminent harm that responders are not able to mitigate, they are to work with VCL's social service assistants to coordinate an emergency response or welfare check. If the customer agrees, social service assistants may also alert suicide prevention coordinators at the connected veteran's local VA medical center, to facilitate mental health care follow-up after the interaction.

Since 2016, we and the VA Office of Inspector General have raised questions about VCL operations, including call wait times, the provision of crisis services, and oversight and quality assurance.[5] More recently, media reports have described allegations of inadequate staffing and training at the VCL, specifically within the CWCN unit.[6] In our report publicly released today, we describe data on VCL interactions—calls, texts, and chats—for fiscal years 2021 through 2024; examine VCL

[5]See, for example, GAO, *Veterans Crisis Line: Additional Testing, Monitoring, and Information Needed to Ensure Better Quality Service*, GAO-16-373. Washington, D.C.: May 2016.; See also Department of Veterans Affairs' Office of Inspector General, *Veterans Health Administration: Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison*. 20-00545-115. April 15, 2021.; and Department of Veterans Affairs' Office of Inspector General, *Veterans Health Administration: 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*. 22-00507-211. Sept. 14, 2023.

[6]See, for example, "'Complex' Calls to VA Crisis Line Being Handed Off to Understaffed, Undertrained Unit, Whistleblowers Allege," *Military.Com Daily News*, Nov. 15, 2023.

procedures for operating the crisis line; and examine the VCL's monitoring of crisis responders' call, text, and chat interactions.

My testimony today summarizes two key findings from our report. Specifically, my testimony discusses (1) VCL procedures for operating the crisis line and (2) the VCL's monitoring of crisis responders' call, text, and chat interactions.

To conduct our work for the report released publicly today, we reviewed VA and VCL documentation and data and interviewed VCL officials and responders.[7] In addition, we surveyed all VCL crisis responders employed as of May 2024. Our survey included questions on topics including VCL procedures, workload and work environment, and training. We also analyzed monthly VCL data on the results of quality assurance reviews. Additionally, we reviewed VCL documentation for customer interactions to understand how the VCL monitors potential incidents. More detailed information on our objectives, scope, and methodology can be found in the issued report. Our work was performed in accordance with generally accepted government auditing standards.

## VCL Procedures Related to Its Customers with Complex Needs and Digital Service Units May Pose Risks to Customers

In our report, we found that the VCL has procedures in place for managing customer interactions, including call flows that dictate how calls are to be routed to responders, how to document interactions with callers, and procedures for calling back customers who hang up or are disconnected. However, we also found that certain procedures related to handling customers with complex needs and digital services could pose a risk to the quality of service it provides to its customers, and we recommended improvements. Additionally, we identified a technical issue with VCL's chat platform and recommended an improvement that the VCL has since taken action to implement.

**Challenges for customers with complex needs.** We found that a VCL procedural change to immediately redirect callers with complex needs creates risks. The VCL created the CWCN unit in 2017 to manage customers who are abusive, exhibit sexually inappropriate behavior, or make threats of violence toward VCL staff, as well as those who call at a high frequency. In March 2024, the VCL made a change to immediately

[7]See, for example, Department of Veterans Affairs, Veterans Health Administration, *Operations of the Veterans Crisis Line Center,* VHA Directive 1503(2) (Washington, D.C.: May 26, 2020); Veterans Crisis Line, *Standard Operating Procedures for Call Flow*, VCL-S-ACT-216-2308 (August 2023)); and Veterans Crisis Line, *Standard Operating Procedure for Additional Customer Types*, VCL-S-ACT-246-2106 (June 2021).

redirect CWCN callers to an available main phone line responder when a CWCN-trained responder is not available. Specifically, if there is no responder available in the CWCN unit, callers are immediately redirected to a main line responder, a redirection that previously occurred after 180 seconds.[8] VCL officials said they made the change because they had concerns about CWCN wait times. This change has resulted in many more CWCN calls being answered by main phone line responders, and VCL data indicate that CWCN wait times and the number of abandoned CWCN calls have dropped since VCL implemented the procedural change.

However, such main line phone responders may not be best prepared to provide assistance for complex calls. While VCL has established protocols that main phone line responders can follow for interacting with CWCNs, these responders generally lack the specific training received by responders in the CWCN unit. VCL data shows that 84 percent of main phone line responders had not received CWCN unit training as of March 2025, and therefore, main phone line responders may not be well-equipped to handle interactions with CWCN callers. In our survey, main phone line responders indicated that they faced problems interacting with difficult or abusive CWCNs. VCL officials also acknowledged that responders who have not been trained to work in the CWCN unit may struggle and need more recovery time after CWCN interactions.

The VCL does not know the extent of these problems or whether to adjust its procedures because it has not assessed the risks to service quality and customer safety. For example, VCL has not compared the quality of CWCN calls handled by main line phone responders with those handled by CWCN-trained responders. VCL officials acknowledged that such a comparison would help it assess the effects of the shift in CWCN calls to main phone line responders on service for customers and stressors on staff.[9] As a result of its assessment, VCL may find that adjustments to staffing its CWCN unit are needed to ensure there are enough staff working in the unit to maintain service quality for customers and reduce burnout for responders.

[8]Callers will be redirected back to the CWCN if there is also no main phone line availability and a CWCN responder becomes available before a main line responder.

[9]The VCL has a process in place for monitoring the quality of responders' interactions with customers. However, this process does not include comparing the quality of CWCN calls handled by main phone line responders and CWCN responders.

In our report we recommended that the VCL more comprehensively assess the risk of adverse effects associated with its procedure for immediately routing CWCN callers to a main phone line responder if there is no availability in the CWCN unit. VA concurred with this recommendation, stating that it would perform an assessment comparing CWCN calls answered by trained CWCN responders to calls answered by main phone line responders by October 2025.

**Workload challenges for VCL digital services unit.** We found challenges for the VCL digital services unit (text and chat), due to procedure differences from its phone line:

- **Responders are expected to handle up to two interactions concurrently, as demand requires.**[10] Approximately 47 percent of chat responders and 35 percent of text responders who answered our survey for our June 2025 report indicated that they often or always handle two interactions at once. Responders indicated this can distract from each chat or text conversation and increases their feelings of burnout.
- **Responders are expected to document interactions at the same time they handle active interactions.** In interviews, responders noted that for calls, they are given time after the call to document their interactions before taking other calls. Such time is not given for texts and chats, per VCL officials and responders. Having to do both at the same time can create challenges as it distracts responders from ongoing chats and texts, especially if the responder is handling multiple interactions concurrently, according to responders. In November through December 2023, VCL assessed its procedure for text responders to document interactions while they handle active interactions. Based on its assessment, the VCL determined that the procedure did not negatively impact responders or service quality for texts, but they did not assess this procedure for the chat platform.
- **The VCL's chat algorithm unevenly assigns chats among responders.** In our interviews with responders, they noted that the VCL's chat algorithm assigns many chats to certain responders on a

[10]See Veterans Crisis Line, *Standard Operating Procedure for Digital Services Interaction Flow,* VCL-S-ACT-271-2308 (August 2023). According to VCL officials, this procedure is in line with the procedures in place at other crisis lines.

shift and very few chats to others.[11] The VCL updated its algorithm when switching to its new chat platform in August 2024, but responders reported mixed reviews as to whether it has improved chat distribution. The uneven assignment of chats can increase workload and feelings of burnout for responders who are assigned a greater number of chats than their colleagues on the same shift.

VCL does not know how these challenges may be affecting the quality of its digital services, or whether to modify its procedures or staffing levels, because it has not adequately assessed the risks of adverse effects. Additionally, the VCL lacks data on digital services responders' workload, including how much time responders spend actively managing chats or texts during a shift. More comprehensively assessing the risks associated with its digital services procedures would help the VCL understand whether it might be necessary to adjust its procedures to address responder workload challenges and better ensure quality service for customers. It would also help VCL understand whether it might be necessary to adjust how it staffs the digital services unit to maintain appropriate staffing levels based on projected workload.

Accordingly, in our report publicly released today, we recommended that the VCL more comprehensively assess the risk of adverse effects associated with its digital services procedures, making modifications to them and how it staffs the unit, as appropriate. VA concurred with this recommendation, stating that it would assess its digital services procedures by October 2025.

**Technical issue with VCL chat routing process.** The VCL took action to resolve a technical issue we found with the chat platform it had implemented in August 2024. Specifically, chat customers could be redirected between two unavailable responders or the chats could be abandoned, as the system did not automatically change the status of responders who were not available to respond timely to a chat (e.g., responders who were on a break or experiencing internet outages). In our report, we recommended that VCL instruct its chat platform provider to develop a solution to address chats being abandoned after customer

[11]In reviewing VCL data on the number of chats handled by responders from April 2024 through September 2024, we often found a large range in the number of chats handled by responders per day. For example, during the week of April 28, 2024, one responder handled 29 chats on one day while five responders handled one chat each. VCL officials told us that the variation could be the result of factors unrelated to the algorithm, such as some responders getting moved from the chat platform to the main phone line during a shift and others working the whole shift, but they said they have not formally assessed the issue.

redirection to an unavailable responder. In response to our recommendation, VA stated that VHA worked with its chat platform provider to develop and update the process to resolve this issue. To the extent the updated process addresses abandoned chats, this action should meet the intent of our recommendation.

## VCL Monitors Responders' Call, Chat, and Text Interactions Using Data and Quality Assurance Reviews, but Lacks a Procedure for Disclosing Incidents

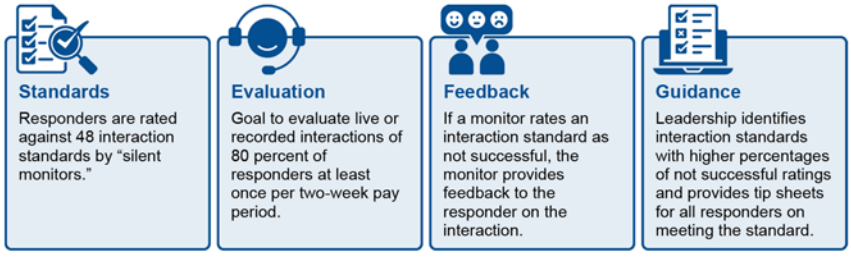
In our report, we found that the VCL uses data and quality assurance reviews to monitor responder call, chat, and text interactions. Separately, the VCL reviews interactions with customers when it learns of a related suicide but lacks a procedure for disclosing such incidents when a VCL action or inaction was a contributing factor.

**Metrics and goals to assess performance.** The VCL monitors incoming call, chat, and text interactions to help assess its performance. For example, the VCL tracks metrics and associated goals related to the number of incoming interactions, the speed at which interactions are answered, and the percentage that are answered or abandoned. For phone calls, the VCL has a service level goal of answering 95 percent of calls within 20 seconds. From fiscal year 2021 through fiscal year 2024, we found the VCL met its goals, answering 98 percent of the approximately 3.1 million calls within 20 seconds.

Additionally, the VCL is in the process of establishing new goals and metrics for chat and text interactions, that it expects to finalize by summer 2025. Based on our review of the VCL's draft policy, the VCL plans to have service level goals of answering 95 percent of chats and 95 percent of texts each within 45 seconds.

**Quality assurance reviews.** We found the VCL regularly conducts quality assurance reviews to monitor responder adherence to customer interaction standards and address deficiencies as needed (see fig. 1).

Figure 1: Overview of Veterans Crisis Line's Quality Assurance Monitoring Process




Source: GAO analysis of Veterans Crisis Line information (text); Gravisio/stock.adobe.com (icons). | GAO-25-108411

According to VCL policy, any interaction (phone, text, or chat) between responders and customers is subject to quality assurance review. The VCL's interaction standards provide specific criteria to which a responder must adhere to be rated as successful. If a responder is rated as not successful on any standard, after the call the silent monitor is to provide feedback to the responder on how to correctly adhere to the standard. If the silent monitor observes that the interaction has an unmitigated risk—such as the absence of attempts by the responder to build trust with the caller—then the silent monitor is expected to reach out to the responder's supervisor for immediate review and resolution.

We found the VCL conducted systematic interventions based on the results of silent monitoring. Specifically, as of June 2023, the VCL started reviewing the monthly results of silent monitoring and began periodically publishing tips—known as "safety moments"— for improving adherence to standards. Safety moments provide additional guidance on how responders should interact with customers to meet the standard. We found that the 10 safety moments issued by the VCL from October 2022 through September 2024 identified interaction standards that had among the highest number of evaluations rated not successful during that period.[12] VCL officials also told us they have taken additional steps to address interaction standards with low responder performance. Such

[12]Our analysis was based on examining monthly VCL quality assurance reviews from October 2022 through September 2024, as well as published safety moments.

steps have included forming workgroups with VCL quality assurance, risk management, and training staff to discuss how to improve responder performance.

**Disclosure of critical incidents.** VCL policy calls for a review when it learns of a suicide or other incident involving a customer following a VCL interaction. Such a review is to examine the VCL's involvement and determine if any VCL shortcoming may have contributed to the incident.[13] If the VCL determines that an action or inaction by VCL staff, technical failure, or VCL process or gap in process created a significant risk of harm to the customer, VCL policy states that the incident should be categorized as a critical incident.[14] Based on the sample of critical incidents we reviewed from October 2022 to March 2024, we found that the VCL has been conducting reviews of incidents and identifying areas for improvement.

The VCL, however, lacks a procedure for determining whether to disclose its involvement in critical incidents to customers or customer representatives. Specifically, according to VCL officials, as of July 2024, the VCL withdrew the section of its policy on critical incidents that addressed disclosure. Previously, VCL's policy was to disclose certain critical incidents when significant action or inaction on the part of VCL staff was a contributing factor to suicides or homicides. VCL's withdrawn policy outlined the procedure for identifying the types of critical incidents that warrant VCL disclosure as well as the subsequent disclosure process. VCL officials explained that, through consultations with other VA offices, VCL determined that the VHA directive that was the basis for the disclosure procedures did not apply to non-clinical services, including the

[13]See U.S. Department of Veterans Affairs, Veterans Health Administration, Veterans Crisis Line, *Policy for Veterans Crisis Line for Managing Critical Incidents and Near Misses* and *Standard Operating Procedure for Reporting and Managing of Critical Incidents and Near Misses*. The VCL maintains incident reports in a centralized information system called the VCL Reporting Hub. According to VCL officials, incidents maintained in the VCL Reporting Hub are divided into four categories: 1) complaints, 2) death by suicide, 3) privacy or release of information, and 4) safety events / near misses. The VCL quality assurance team is responsible for reviewing incidents in the VCL Reporting Hub and taking appropriate actions, as applicable, within 7days of being the incident being reported to the hub.

[14]See Veterans Crisis Line, *Policy for Veterans Crisis Line for Managing Critical Incidents and Near Misses*.

VCL. This is because VCL responders are not considered providers, clinicians, or health care professionals.[15]

Following its decision, VCL officials said they held further consultations with applicable VA offices and learned there is not a VHA policy outlining a disclosure procedure for non-clinical services within VHA. VCL officials further said it was unclear whether VHA planned to develop one. The lack of disclosure procedures could result in missed opportunities for the crisis line to hold itself accountable to customers or their representatives in the event that a VCL action or inaction contributed to a customer's harm. Establishing a disclosure procedure for the VCL would help build trust with customers and other stakeholders and be consistent with a VA strategic goal of building and maintaining trust with stakeholders through transparency and accountability.[16]

In our report we recommended that VA establish a procedure for the VCL, to identify the types of incidents that warrant disclosure to customers or their representatives and to outline a process for disclosing such incidents, or that VA should direct the VCL to develop such a procedure. VA concurred with this recommendation, stating that VHA would convene a workgroup of subject matter experts to discuss disclosure policies for non-clinical VA services. VA provided a target completion date of January 2026 for this recommendation.

Chairman Moran, Ranking Member Blumenthal, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions that you may have.

## GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Alyssa M. Hundrup at HundrupA@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Key contributors to this testimony include Michael Zose (Assistant Director), Catherine Parylo (Analyst-in-Charge), Jim Melton, and Rachel Svoboda. Additional contributors to the prior work on which this testimony is based are listed in our June 2025 report.

[15]Department of Veterans Affairs, *Disclosure of Adverse Events to Patients*, VHA Directive 1004.08 (Washington, D.C.: October 31, 2018).

[16]See Department of Veterans Affairs, *Fiscal Years 2022-28 Strategic Plan*.

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**STATEMENT OF**
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**FOR CLINICAL SERVICES**
**VETERANS HEALTH ADMINISTRATION (VHA)**
**DEPARTMENT OF VETERANS AFFAIRS (VA)**
**BEFORE THE**
**COMMITTEE ON VETERANS' AFFAIRS**
**UNITED STATES SENATE**
**ON**

**"Correcting Mismanagement of the Veterans Crisis Line"**

**June 25, 2025**

Chairman Moran, Ranking Member Blumenthal, and distinguished Members of the Committee, thank you for the opportunity to provide an update on the Department of Veterans Affairs' (VA) efforts to enhance the Veterans Crisis Line (VCL) and our continuing commitment to supporting our Veterans in crisis. My name is Dr. Tom O'Toole, and I currently serve as the Deputy Assistant Under Secretary for Health for Clinical Services. Joining me today is Dr. Christopher Watson, Executive Director, Veterans Crisis Line.

VCL continues to encounter a significant and growing demand for its services. In fiscal year (FY) 2025, through May 18, 2025, VCL managed nearly 787,000 contacts, including over 125,000 chats and texts. Following the launch of 988, calls, chats, and texts to VCL have cumulatively increased by approximately 44%. VCL is the only crisis line in the United States that is integrated into a complete health care system, offering a direct bridge between immediate crisis intervention and ongoing care. VCL connects Veterans directly to local Suicide Prevention staff for support beyond the call. Our dedicated team of Crisis Responders is trained to provide immediate assistance, ensuring that no Veteran's call for help goes unanswered. Informed by work of both the VA Office of Inspector General (OIG) and the Government Accountability Office (GAO), VA has significantly enhanced its capacity to assist Veterans in crisis.

A September 2023 OIG report, "A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and the Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas," identified

critical deficiencies within VCL operations and oversight. As of June 25, 2025, VA has implemented and closed 12 of the 14 OIG recommendations. VA is working diligently to close the final two recommendations before the end of FY 2025. These actions have included a comprehensive review of staff performance, enhanced training programs, and the establishment of more robust oversight mechanisms. Our commitment to these improvements has already bolstered VCL's ability to deliver safer, more effective services.

We have reinforced training and guidance for all VCL leaders and staff to ensure full and transparent cooperation with oversight reviews. Furthermore, we have formalized written standard operating procedures for call escalation to enhance the consistency and oversight of complex or high-risk calls.

One critical area of focus has been the management of calls from callers with complex needs (CWCN). We have begun assessing the outcomes of CWCN calls managed by both main line Crisis Responders and CWCN-trained Crisis Responders. This assessment will inform any necessary adjustments to our procedures and staffing to ensure we provide the highest standard of care for these callers.

To address concerns about our digital services procedures, we have conducted an in-depth review to analyze Crisis Responder documentation practices. Moreover, we are enhancing processes to better capture and analyze Crisis Responder workload. Our goal is to optimize procedures, enabling Crisis Responders on digital services platforms to manage the growing volume of texts and chats without compromising service quality.

Furthermore, we have implemented a technological solution to mitigate the issue of chats being abandoned due to Crisis Responder unavailability. This update includes real-time notifications to Crisis Responder supervisors, who can reassign chats promptly, ensuring continuous support for Veterans.

Recognizing the need for transparency in non-clinical incidents, VA is convening a multidisciplinary workgroup to establish a standardized process for disclosure procedures. The workgroup will review established policies and procedures and identify potential areas for VCL consideration. VA anticipates the review will be complete in January 2026. This initiative aims to foster trust and accountability in our services.

In conclusion, VA is committed to preventing Veteran suicides and providing critical support in moments of crisis. VA's dedication to swiftly implementing OIG and GAO recommendations demonstrates our dedication to continuous improvement and excellence in service delivery. As we confront an ever-increasing volume of contacts, we remain focused on ensuring that every Veteran receives the immediate and effective support they need.

I would be remiss if I did not acknowledge that on May 21, 2025, VA announced the availability of approximately $52.5 million in grants for community-based organizations that provide suicide prevention or emergency clinical services to Veterans at risk of suicide. The Notice of Funding Opportunity assumes that Congress will extend the authority and appropriate funds consistent with section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act (P.L.116-171) as currently written. The reauthorization of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program is critically important. We greatly appreciate the Committee's interest in continuing this program and stand ready to implement the extension of this authority as soon as possible to continue this important work in FY 2026.

Thank you, Chairman Moran, Ranking Member Blumenthal, and the Committee for your oversight, guidance, and steadfast commitment to the health and safety of our Veterans. I look forward to your questions and to continued collaboration in our shared mission to support the well-being of our Nation's heroes.

## Submissions for the Record

## Contents



## Nature of Veterans Crisis Line Operations

The Joshua Omvig Veterans Suicide Prevention Act of 2007, that gave rise to the Veterans Crisis Line, required the Secretary of the Veterans Affairs to provide mental health care on a 24-hour basis to Veterans. Additionally, the "Secretary may provide for a toll-free hotline for veterans to be staffed by appropriately trained mental health personnel and available at all times."

Per the Veteran Health Administration's (VHA) Directive for the establishment of the Veterans Crisis Line (VCL)[1], the center is to be staffed by appropriately trained mental health personnel and is available to Veterans at all times. Additionally, VHA's policy is to provide Veterans, Service members, and their families and friends who are in crisis **or** at risk for suicide with immediate access to suicide prevention and crisis intervention services, including telephone, online chat, and text-based crisis intervention, requests for local emergency dispatch services, as needed, and Requests to VA medical facility SPCs for follow-up and coordination of ongoing Veteran care.

VA indicated, in response to a question submitted by Senator Cassidy as part of the September 20, 2023 hearing, non-clinical (title 5) staff were no longer allowed to perform Responder duties[2]. The reciprocal, then, is that Responder positions are clinical positions trained for providing mental health care. It reasonably follows that VHA's Directive is not misrepresenting VCL's role in providing mental health care for Veterans in crisis OR at risk for suicide. Further supporting this concept, the Deputy Director, Clinical Operations, the Deputy Executive Director, VCL and the Executive Director, VCL must be Psychologists.

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[1] VHA Directive 1503, Operations of the Veterans Crisis Line Center, December 8, 2022

[2] Committee on Veterans' Affairs, United States Senate, Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for our Nation's Veterans, September 20, 2023, Page 80, VA Response to Question 1 for the Record from Senator Bill Cassidy

**Recommendation**: Congress should clarify that the Veterans Crisis Line is a clinical operation and that operational leadership must be mental health clinicians themselves.

## Staffing of the Call Center

Call center staffing for all modalities should be based on forecasted demand. This was recommended by the International Customer Management Institute (ICMI) in 2023 but not realized two years later, as the Government Accountability Office (GAO) reported. VCL's assertion that it lacks the technology to accomplish this is in direct dispute with the ICMI accreditor who explained, in the draft accreditation report I received, the challenge is not the technology, is it having staff competent to use the technology VCL already possesses.

Currently, VCL's contact information system is Avaya. Avaya is well known and industry leading contact information system. It can accomplish demand forecasting and receive input from staff for their utilization throughout their shifts if its capabilities are fully utilized. Within VCL, Avaya is used to receive contact volumes and for phone staff time utilization. VCL does not use it to forecast demand or develop staffing solutions for any of the modalities (phone, chat or text). Demand forecasting and all staffing solutions are developed via locally produced applications that lack documentation to explain their architecture and application and security controls.

Finally, VCL has, historically, used Chat and Text staff to augment phone staffing when unexpected surges occur. This is akin to having a ready reserve force available that can be pulled out when necessary. Since phone metrics are the ones most prominently reported and, until now, concurrent chat and text interactions were never discussed, VCL had no reason to change other than risk to the Veteran. My assertion has remained that an increased risk to the Veteran is one VCL leadership was more than willing to accept as long as it benefitted their phone metrics as those are reported to stakeholders, including Congress.

**Recommendations**:
1. Congress should direct the Secretary of the VA to disallow concurrent interactions for any modality and request the same metrics for all contact types to provide transparency for the use of staff in ensuring all contacts are handled as well as phone contacts have been.

## Callers With Complex Needs

Callers with Complex Needs (CWCN) are callers who display disruptive behaviors such as incessant calling, hate speech, or abusive language but also historically include a small number of misunderstood callers in acute crisis. Originally conceived as an effort to assist these callers while diverting them from call center staff that were quickly burning out from CWCN engagement, the CWCN team readily engaged each caller identified for exhibiting disruptive

behavior. The team worked with each CWCN to learn how to mitigate the behaviors and help the distinct callers work more productively with VCL Responders.

The CWCN team developed multi-tiered interventions as well as guidance for each CWCN thereby preparing Responders for how best to engage these callers and mitigate their worst behaviors. Per research published on the CWCN team's efforts for the period October 2017 to December 2020, the team was a clear success for all the Veteran callers as well as call center staff[3].

Although the approved staffing levels for the CWCN team, at the start of 2023, included:

- 1 GS-13 Supervisor
- 2 GS-12 Supervisors, and
- 12 GS-11 Social Science Specialists (same position description as a call center Responder)

The team functioned, as it could, with 1 GS-13 Supervisor and 1 GS-12 Social Science Specialist with their primary effort consisting of updating reviewed intervention strategies to demonstrate compliance with existing VCL guidance. The ability to engage CWCN were almost non-existent during the work day and truly non-existent during the event and overnight shifts.

In 2021, a new organizational chart was approved with increased staffing for the CWCN team. 6 new staff were to be added to the CWCN team and a Disruptive Behavior Review Team (DBRT) that was disbanded as an oversight body for how VCL was managing CWCN, was to be reconstructed as a team, subordinate to the CWCN team, whose responsibilities were to review and maintain the interventions for the CWCN team. Oversight for whether callers were appropriately labeled as CWCN, whether their interventions were appropriate, and whether they should continue to be identified as CWCN would no longer exist. CWCN and DBRT staff would have every incentive to manage these callers to keep them labeled as CWCN while also avoiding intervention strategies requiring CWCN team direct contact.

Given the above operational situation, it is no wonder, then, that GAO reports Responders are back to handling more and more CWCN callers. They are doing so without the tools the original CWCN team was providing them and, similar to the situation before the CWCN team existed, reporting increased burnout from engaging CWCN. Such situations cause fatigue and errors. Given the stakes VCL cannot accept these risks but MUST mitigate for them.

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[3] Podiogar, M.C.. Carolina, H.S., Lauver, MG, Selig, M.K., Hughes, G.J. (2024). Addressing the Complex Needs of Customers who Contact the Veterans Crisis Line. *Crisis, The Journal of Crisis Intervention and Suicide Prevention,* 45(6), 432-438.

**Recommendations**:
1. Congress should require the Secretary of the VA to report on the clinical outcomes of all VCL contacts in addition to the contact volumes. This moves VCL back to the quasi-clinical activity that was both the intent of Congress and the VHA when VCL began operations.

2. Congress should require the Secretary of the VA to establish a Disruptive Behavior Review Team staffed by personnel independent of the Office of Suicide Prevention, as a whole. Membership should consist of clinicians but should also include Veteran Service Organizations (VSO) represent the Veterans who have the biggest stake in the success of the program.

## Disclosures

In his September 20, 2023 testimony, Matt Miller, the Suicide Prevention Office Executive Director stated he understood the need to rebuild trust with the Veteran population[4]. At the same time, he was denying the Deputy Director, Clinical Operations attempts to move forward with a Disclosure.

The Veterans Health Administration (VHA) Directive on Disclosure of Adverse events[5], explains that VA's core values of integrity, commitment, advocacy, respect and excellence creates an unwavering ethical obligation to disclose the occurrence of harmful adverse events to patients. It explains it is VHA policy to disclose harmful or potentially harmful adverse events to patients in order to maintain trust between the patients and VHA health care professionals.

The VHA Directive provides a permissive culture of Disclosure in which medical facility Directors are to promote an ethical health care environment and culture in which appropriate disclosure of adverse events is routine practice. In fact, the Directive does not provide for decision making for whether to disclose but only for when and how. This is the antithesis of the Suicide Prevention program's culture the current Executive Director of the Suicide Prevention Office was fostered.

**Recommendation**: Congress should require the Secretary of the VA to disclose adverse events resulting from VCL contacts and as currently defined by the VHA Directive on the subject.

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[4] Senate Committee on Veterans' Affairs, Invisible Wounds of War: Improving Mental Health and Suicide Prevention Measures for Our Nation's Veterans, September 20, 2023, Page 24, Response to the Chairman's questions regarding silent monitoring
[5] VHA Directive 1004.08, Disclosure of Adverse Events to Patients, October 31, 2018

## Rater Reliability

A principle focus for a strong quality assurance program is to ensure the reliability of testing it performs. Within such strong programs, a significant amount of time and effort is spent ensuring those who perform the testing are, themselves, performing their testing completely and accurately. Programs for ensuring this reliability are encapsulated in policies, manuals, procedures and desk guides. Reliability testing results are retained and reported upon for improvements.

**Recommendations**:
1. Congress should require the Secretary of the VA to improve the existing quality assurance program to include routine testing of all monitoring staff (silent monitors and call center supervisors) for their consistency in rating interactions.

2. Congress should require the Secretary of the VA to include rater reliability testing results when reporting on silent monitoring metrics and identify improvement strategies where significant variances are discovered.

## Continuous Oversight

To effect real change at the VCL, routine oversight visits performed by Inspectors General is the only reliable method to ensure required changes occur and remain in place so that the intended culture change becomes permanent. Without such continuous oversight, entrenched management has demonstrated the ability to show sufficient superficial effort to end the current level of scrutiny but without substantive changes to the culture. Where recommendations are made, without actual substantive follow-up visits, managers will submit what is necessary to close recommendations without affecting real change. Continuous oversight eliminates these risks.

**Recommendation**: Congress should require bi-annual Inspector General audits of the VCL to ensure expected changes are accomplished and that the VCL does not revert.

Response to Senator King

From Marcia Blane, LPC, CPCS, CHt, Former VCL Responder

Veteran Senate Committee

To Sen. King and Veterans Senate Committee, thank you for allowing me the opportunity to provide additional insight and suggestions Listed below are suggestions to enhance the operations of the Veterans Crisis Line as requested by Senator King.

**Leadership Suggestions**

- Assess current leadership and their experience with handling crisis calls.
- Assess current leadership and their experience with planning, projections, and directing a crisis center.
- Utilize experienced staff members to fill positions versus hiring or promoting individuals groomed by leadership.
- Terminate current executive leadership as they have demonstrated the inability to lead the Suicide Prevention or Veterans Crisis Line with honesty, integrity, and needed leadership skills.

**Crisis Responders: Staffing, Structure, and Wellness**

- Reinstate Hiring Standards: Require leadership hires (Supervisors and above) to shadow frontline staff to ensure understanding of real-time duties, not just SOP adherence.
- Implement Competency-Based Hiring: Use skills-based, scenario-driven interviews to assess role-specific competencies.
- Mandatory Crisis Intervention Training: Ensure all staff, including leadership, are trained in de-escalation and suicide prevention techniques.
- Cultural Competency & Diversity Training: Provide mandatory education on cultural awareness and sensitivity to better serve diverse populations.
- Mental Health First Aid: Equip all staff with practical tools to manage acute mental health situations.
- Accessible Mental Health Support for Staff: Offer confidential, in-house counseling and peer support options for staff.
- Structured Debriefing & Tailored Wellness: Provide post-call debriefs that recognize responders as whole individuals and address the specific emotional toll of crisis work.

- Foster a Compassionate Culture: Extend the same compassion to staff as is expected in Veteran care – empathy, patience, and understanding.
- Collaborative Leadership: Reduce hierarchical management; involve staff in decision and process improvements.
- Monthly Mental Health Time-Off: Allocate protected, non-call time each month to support responder mental wellness.
- Revise CWCN Protocols for Abusive Callers: Develop stricter protocols to restrict continued access by abusive, racist, or sexually inappropriate callers.
- Equity Across all Crisis Sites: Ensure policies, opportunities, and standards are applied consistently at all locations.
- External Wellness Program Options: Offer Staff wellness resources outside of the VCL.
- Transparency for new hires: To reduce the revolving door for new hires post clear tour schedules in job listings to ensure future employees understand the available shifts.
- Establish Annual Training: Crisis Responders should participate in annual training lasting no more than three days to enhance skills, knowledge, and awareness.
- Create a panel to include Responders when reviewing SOP or making changes to ensure the voice of the Responders are included.

**Social Scientist Assistants (SSA)**

- Fair Overtime (OT) Opportunities: Allow SSA staff to work overtime during shortages and to be called in when coverage is needed.
- SSA Scheduling Input: Give SSA supervisors a greater role in schedule creation, ensuring fairness and realistic expectations (e.g., equitable weekends off).
- Adjust SSA Staffing Ratios & Pay Scale: Increase SSA staffing to match call volume and demands. Recommend aligning pay grades to responsibilities:
    - SSA: GS- 7
    - SSA Lead: GS- 8
    - SSA Supervisor: GS- 9
- SSA Policy Development: Include SSA staff in policy development and training when reviewing and changing policies that impact their roles.
- Software Updates and Investigative tools. Enhance research software to afford timely and accurate discovery of a Veteran or person of concern. The research tools have not updated in 10 years.
- Software request from VCL Staff member who is a former Law Enforcement Officer - Great tools such as Open-Source Intelligence (OSINT) TLO (SSA's do not currently

have access to TLO). Currently, VCL operates with very limited investigative tools where information is limited from free websites such as SPOKEO and TRUTHFINDER.

Preceptors/Training

- Training: Preceptors should attend training classes during New Employee Orientation (NEO).
- The Training Staff should be required to spend four hours a month taking calls to maintain their knowledge base.
- Create a hybrid position for Preceptors to include training, phone, and text which will assist with more accurate training and the reduction of new employees being pulled from the call.

**Standard Operation Procedures**

VCL SOP's Contradiction regarding Clinical Position

- Crisis Responders have SOP and are held accountable for asking EOCQ however, if a Responder can determine whether the Caller has a Cognitive Deficit or experiencing Psychosis, this SOP does not apply. This is a SOP, supporting, and allowing Clinical decisions. (Interaction Guidelines NC27, SOP Appendix A for Closing an Interaction).
- Crisis Responders are held accountable for exploring Substance use, indicators for current impairment, assessing the amount used, inquiring about medications that may have been mixed with Substances (C1 Interaction Guidelines). Gathering medical issues, history, discussing past overdoses. All contribute to core functions of having to make a Clinical decision. (Interaction Guidelines NC7B, Page 8 for Standard operating procedure for Call Flow)
- Evaluation of mental status, mood, behavior, speech, making impact on a customer/veteran's outcome.
- Responders must be able to correctly choose Risk Categorization during documentation and make a Clinical judgement based on interaction. This drop-down box is called the "Clinical impressions and Formulation of Suicide Risk". Crisis Responders must be able to choose 1: Low 2: Intermediate and 3: High based on the interaction with customer/veterans' current risk or past risk, including medical history in which a veteran may be flagged as high risk. (Crisis Responder Training Guide Pg 50)

Needs For Improvement, Common Issues Regarding Care, Communication, SOP's and Interactions

Third Party Callers with concerns involving a loved one or veteran that contact VCL for help.

- The current VCL SOP for Crisis Responders delays the process of receiving care, creates unnecessary frustration and anger from Callers which include Family Members of Veterans, Friends, or even Employers.
- These Callers are looking for assistance for someone they care about and will often become irritated at Crisis Responders, hang up or state they would never call again.
- Current VCL SOP has Crisis Responders go in detail to the Third-Party Mental Health and history before even moving on to providing care for the veteran/person of concern (Interaction Guidelines C7, Standard Operating Procedure for Third Party Callers Pg 4).
- Before an interaction can conclude with a Third Party and shift focus, a Crisis Responder must complete the following on the Third-Party Caller: 1) Current thoughts of Suicide. 2 2) Past SI thoughts and if yes; 3) Timeframe 4) Plans 5) Intent. 6) Past Suicide Attempts and if yes 7) Time frame 8) Method. 9) Exploring access to current lethal means 10) Providing lethal means safety counseling 11) Creating a safety plan with Third Party Caller, 12) Providing Third Party Caller resources for themselves.
- Third Party Callers are often not cooperative, blame the VCL for safety risks and become frustrated because the Crisis Responder is perceived to be not providing the assistance for the reason they called. Crisis Responders are unable to avoid this and must complete the full assessment.
- Additionally, Crisis Responders are held accountable and are prohibited to speed up the process by rushing to problem solving, asking multiple questions, rushing the assessment as this contradicts other policies (C1 Interaction Guidelines)

Recommendation: Crisis Responders can still reduce any potential for risks, safety, applying protective measures, limiting liability concerns with Third Party Callers. Crisis Responders can inquire about Current SI only when a Third-Party Caller is attempting to reach out for assistance regarding someone they care about. This creates a quicker process for establishing care, providing emergent assistance and giving all Callers who reach out, a better perception of the VCL taking priority in the person of concern they were initially calling about.

- Substance Use Assessment: Current SOP/Interaction Guidelines are required for Crisis Responders to fully explore Substance use if there is current use in which is volunteered, detected or used the current day. (NC7B Interaction Guidelines, Standard Operating Procedure Call Flow Pg 8)

- During several interactions, even when there is no current SI or safety risk, Responders must complete the additional questions on top of all previous SI questions. Often time, Veterans report they may have consumed one Beer earlier in the day or they may currently be drinking just a couple Beers and watching a Football game. Responders then have to engage in the below questions which often anger, or irritate Callers due to already being safe, not presenting any risks and allowed to drink alcohol socially. This often invites abuse of Responders or disrupts the rapport and trust building process, leaving the Caller at times feeling as if they are being interrogated, hanging up or not cooperating, contributing to the Callers current Crisis.
- Recommendation: **If there is no current SI, safety risks presented or detected**, and the Caller has not volunteered current use of dangerous substances, engaging in high-risk activities, or potential use then this assessment could be avoided.
    - Does the Customer currently have access to substances? If YES, please provide details in the Substance Use Details. *
    - How does the Customer's current use compare to their typical use? *
    - Does the Customer report current physical symptoms as a result of substance use? If YES, please provide details in the Substance Use Details. *
    - How do the physical symptoms compare to the usual effects of Customer's substance use?
    - When Customer started using today, were they thinking about suicide? If NO, please provide details in the Substance Use Details. *
    - Does the Customer have a history of engaging in high-risk behaviors related to substance use?
    - Is the Customer currently withdrawing from substances? If yes, please provide details in the Substance Use Details.

**TEXT/CHAT TRANSFER ISSUES**

Text/ Chat: An encounter with a veteran/customer who contacts VCL through Chat/Text and request transfer to a phone Responder can be at risk due to current SOP guidelines. A responder who takes a transfer from another VCL responder must essentially start the interaction with a fresh perspective encounter, even though the prior interaction was documented and the customer/veteran was identified.

- The customer/veteran now must be put through the entire assessment process again as if it never occurred and relive their trauma by repeating the same experiences with a new VCL responder. This interrupts the trust building process,

safety, causes anger with many customers/veterans who reach out and potentially deter them from reaching out again.

- Due to the frustration of having to go through this again, often times, customers/veterans will just want to avoid repeating this and deny everything or hang up.
- Recommendation: Crisis responders should be allowed to use the veterans/customers prior text/chat interactions before being transferred due to it being documented. Crisis responders can ask the veteran/customer "Has anything changed with your safety since your previous encounter/interaction". This would ease and reduce several veterans/customers anger and frustration at the VCL during crisis moments and increase safety due to them wanting to continue conversation and not hang up.

VCL SOP allows Responders to do this with CWCN callers who are documented high frequent callers and let Responders use previous fresh interactions.

**POTENTIAL SOLUTIONS**

- Changing SOP to better fit Caller's needs, which would avoid unnecessary customer irritation with Responder. Furthermore, it would improve the quality of calls, allowing conversations to flow more naturally. This would also reduce Crisis Responder stress, abuse on the calls, trauma, and anxiety for their performance. Crisis Responders would be able thrive at the position, focus on the Callers needs and be less overwhelmed.
- Several VCL Policies are subjective based as current verbiage is not clear. Silent Monitor encounters can at times be less Policy based, but more perception based, leaving Crisis Responders disciplined at times, adding further stress or affecting retention.
- Allowing Responders more freedom or flexibility to determine whether a Caller is productive, not tie up the line for other Callers who are in Crisis or immediate support. For example, pranks, a Caller who may want to know VCL staff employee personal life, discuss several other topics that may not be related to the call and appear less in need.

**VCL EXPANDED ROLES AND UPDATING OPERATIONS FOR MUCH NEEDED GROWTH**

VCL VETERAN SUPPORT CADRE

- Veterans who work at the VCL can be placed onto a team in order to offer additional support to customers and be transferred. Often, Veterans are frustrated and want to be able to relate to other Veterans. Talking to another Veteran can be therapeutic,

especially for someone who is trained in Mental Health. Again, this would free up Responders to document their call and continue being available for others while a Veteran still gets quality support.

- Prior to being transferred, these customers are deemed fully safe, not under any influence of substances. Due to the interaction being documented, the Veteran supports Cadre should be allowed to continue the interaction, not completing assessments nor crisis needs.
- A simple Peer Support conversation can occur, discussing experiences, offering any helpful information about benefits or resources that have been used etc.

**AI SUPPORT CADRE**

- AI technology with Chat/Text for repetitive, abusive, disturbing conversations. This can still be carefully monitored by a Cadre of Responders. Indicators of risk or any signs of abnormality can be routed to Cadre.
- Gather data and statistics regarding the amount of Chat/Text interactions that result in unproductive interactions, pranks, abuse, or just repeat daily customers that are not in need of support and keeping Responders busy and negatively impacting the platform.
- The data gathered could potentially result in the amount of relief on average that the main line could benefit from.

Pattern Recognition:

- AI can detect repeated contact from the same person (even if anonymous) by analyzing linguistic patterns, timestamps, or metadata (if available). It can flag users who may be abusing the line, trolling, sexually inappropriate messages, or repeated contact without engaging in meaningful dialogue.
- Triage and Routing: Any potential flags or indicators can be routed to assigned Cadre monitoring the Responses.
- AI can assist in triaging conversations, prioritizing users in active crisis versus repeat non-crisis contacts. AI could help route conversations to the appropriate human responder or apply de-escalation protocols.
- Automated Warnings or Responses: For known patterns of abusive behavior, AI might generate automated warning messages or even limit access, depending on the severity and organizational policy.
- Support for Volunteers/Staff: AI can offer real-time coaching or prompts to staff dealing with manipulative or distressing interactions. It can generate summary reports for supervisors about frequent or concerning user behaviors.

- Human-in-the-loop: AI should support, not replace, human decision-making in these sensitive situations.
- Transparency: Inform users in your privacy policy or disclosures if AI is being used to monitor or flag behavior.
- Regular audits: Routinely review flagged conversations to ensure the AI is acting ethically and accurately.
- Regular audits: Routinely review flagged conversations to ensure the AI is acting ethically and accurately.
- Escalation pathways: Provide clear procedures for what happens if a customer is flagged and is routed to assigned Cadre.
- Boundaries with compassion: Having policies that balance protecting Responders while not abandoning users in pain is crucial.

**Staffing Projections**

To assist with potential projections for staffing the exact numbers of Responders on each shift across 24 hours and divided among phone, text, and chat was not provided however after running multiple analysis with an approximate number of employees per shift this appears to be a consistent formula to project staffing needs.

Additionally, there is a concern that leadership needs to enhance the threshold from 10 to 25 Responders to determine if there is a need for overtime opportunities. This would afford the agency to reduce the potential of missed calls.

### Key Variables to Include in the Projection Formula

Let's define the variables first:

- `T = Total number of employees` = 1500
- `P = % of employees handling phone calls`
- `X = % handling text interactions`
- `C = % handling chat interactions`
- `V_avg = Average number of interactions per employee per shift`
- `H = Hours per shift (typically 8 hours)`
- `D = Days in a year` = 365
- `S = Number of shifts per day` (24 ÷ H, e.g., 3 shifts of 8 hrs)
- `AHT = Average Handle Time per interaction (in minutes)`
- `Shrinkage = % of time lost to breaks, training, PTO (typically 25%)`
- **Interaction Capacity Formula**
- This tells you how many **interactions your workforce can handle annually**:
- \text{Total_Interactions} = \left( \frac{T \times (1 - \text{Shrinkage}) \times H \times 60}{AHT} \right) \times D
- ✅ You can break this down by channel:

- \text{Phone_Interactions} = \left( \frac{T \times P \times (1 - \text{Shrinkage}) \times H \times 60}{AHT_{phone}} \right) \times D \text{Text_Interactions} = \left( \frac{T \times X \times (1 - \text{Shrinkage}) \times H \times 60}{AHT_{text}} \right) \times D \text{Chat_Interactions} = \left( \frac{T \times C \times (1 - \text{Shrinkage}) \times H \times 60}{AHT_{chat}} \right) \times D

### Distribution of Employees

Assume a distribution based on demand or historical data. A sample breakdown might be:

- `P = 0.5` (50% handle phone)
- `X = 0.3` (30% handle text)
- `C = 0.2` (20% handle chat)

This means:

- Phone = 750 employees
- Text = 450 employees
- Chat = 300 employees

### Projection Example (Plug-In)

Let's say:

- `H = 8 hours`
- `AHT_phone = 20 min`, `AHT_text = 15 min`, `AHT_chat = 10 min`
- `Shrinkage = 25%`

**Phone Capacity:**

=(750×0.75×8×6020)×365=(270,00020)×365=13,500×365=4,927,500 phone interactions/year= \left( \frac{750 \times 0.75 \times 8 \times 60}{20} \right) \times 365 = \left( \frac{270,000}{20} \right) \times 365 = 13,500 \times 365 = \textbf{4,927,500 phone interactions/year}=(20750×0.75×8×60)×365=(20270,000 )×365=13,500×365=4,927,500 phone interactions/year

Do the same for text and chat.

### Demand Forecast Formula

You can also reverse-calculate staffing needs with:

\text{Required_Staff} = \frac{\text{Expected Annual Volume} \times AHT}{60 \times H \times D \times (1 - \text{Shrinkage})}

Use this to **justify increases or reductions in staff** based on projected demand.

Prepared by Marcia Blane, LPC, CPCS, CHt, with assistance from VCL Responders.