United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

November 19, 2020

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Ave NW
Washington, DC 20420

Dear Secretary Wilkie,

I write to express my concern over troubling findings in the Office of Inspector General's (OIG) recent report, ***Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died***, (Report #18-08642-11). This report highlights how Veterans Crisis Line (VCL) responder missteps, as well as significant VCL management and policy lapses, potentially contributed to a veteran's death.

The VCL provides a key service for responding to veterans in crisis and preventing veteran suicide. However, this OIG report highlighted VCL staff's failure to request an emergency dispatch and adequately respond to a veteran in crisis, as well as underlying staff training and policy issues within the VCL and Department of Veterans Affairs (VA). Less than 12 hours after first contacting the VCL in July 2018, the veteran caller was found dead from an overdose.

This report is particularly disturbing because the veteran spoke to two different VCL responders and reported suicidal ideation, a past suicide attempt, access to lethal means, and intoxication from alcohol and drugs (i.e. prescription and over-the-counter medications). Despite these red flags, neither VCL responder requested an emergency dispatch to check on the veteran and provide any necessary, immediate intervention. Instead, VCL staff conducted safety planning with the veteran and submitted a routine consult to the veteran's local VA suicide prevention coordinator for follow-up.

In reviewing this incident, the OIG team interviewed five crisis line experts. The majority of them – 4 out of 5 – would have called for an emergency dispatch when presented with a similar scenario. The OIG would have also expected a dispatch to be initiated based on the veteran's intoxication, high risk for suicide, and lethal means access. While the manner of death was "best classified as undetermined," a veteran reached out for help and exhibited numerous warning signs, but VCL staff failed to take decisive action that could have potentially saved this veteran's life. This is a heartbreaking outcome for the veteran, their family, and their community.

While the two VCL responders who spoke with this veteran caller made several critical errors – including failing to assess the veteran's use of alcohol or other drugs, failing to evaluate overdose risk, and failing to request an emergency dispatch – there are also critical policy failures at the VCL and VA that could have contributed to this veteran's death. First, the OIG

found that VCL policies, as of July 2018, did not include safety planning for intoxicated callers or overdose risk assessment. While these policies have since been updated, VCL policy still does not address illicit or over-the-counter drug misuse, which was a factor in this veteran's death.

Further, VA needs to review and update Veterans Crisis Line policies and training to ensure responders are educated on lethal means assessment, supervisory consultation, overdose risk, and suicide prevention safety planning. In its review, the OIG found both VCL responders failed to adequately clarify the veteran's access to lethal means and therefore did not appropriately utilize the VCL protocol to reduce the veteran's access to a gun. And, while the first VCL responder reported conducting safety planning with the veteran, the OIG found the responder failed to include key safety plan elements. And, the second VCL responder entirely failed to complete a safety plan with the veteran. At minimum, VA staff must follow Department protocols when assisting veterans in crisis.

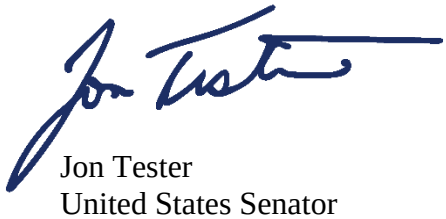
The Department also needs to review policies, training, and quality assurance mechanisms for determining veteran callers' suicide risk. In this incident, the first VCL responder marked the veteran caller as "moderate to low risk" for suicide, and submitted a routine referral to the veteran's local VA suicide prevention coordinator for follow-up. However, the veteran called the VCL on a holiday and VA does not have requirements for suicide prevention coordinators to follow-up with veterans on weekends and holidays, meaning it can be several days before a veteran receives this follow-up outreach.

If the VCL responder had appropriately flagged the veteran, who was under the influence, in possession of lethal means, and expressing suicidal ideation, as high-risk, VA could have deployed more immediate resources to assist this veteran. It is vital that VA ensure call responders are fully trained on how to properly assess suicide risk, and that VA leadership has strong quality assurance mechanisms in place to monitor staff's ability to respond to veterans in crisis.

This OIG report should serve as a call to action for the Department and the VCL. Given the loss of life and gravity of the situation, I ask that VA expedite resolution to the 8 recommendations issued in this report. We must ensure no veteran who reaches out for life-saving assistance falls through the cracks.

I look forward to collaborating with you to ensure that the Veterans Crisis Line and the Department are well-equipped to provide our veterans with access to mental health care and supportive services.

Sincerely,



Jon Tester
United States Senator