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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.