U.S. SENATE COMMITTEE ON
VETERANS' AFFAIRS
★ ★ ★ CHAIRMAN JERRY MORAN ★ ★ ★

VETERANS CRISIS LINE IMPROVEMENT ACT

Strengthening Emergency Response, Follow-Up Care, and Accountability

Since 2023, the Senate Committee on Veterans' Affairs has investigated serious deficiencies at the Department of Veterans Affairs (VA) Veterans Crisis Line (VCL), following whistleblower disclosures and a VA Inspector General report identifying failures surrounding a veteran's death by suicide.[1] At then Ranking Member Moran's request, the Government Accountability Office (GAO) conducted an audit and identified risks involving complex callers, chat and text operations, and critical-incident disclosures. The committee examined those findings at a June 2025 oversight hearing featuring whistleblowers, GAO, and VA.[2] [3]

In February 2025, Chairman Moran requested a second GAO review to examine what happens after veterans contact the VCL. That report, which was released on November 18, 2026, discloses that the VCL handled 1.27 million interactions in FY25 and requested 60,261 emergency dispatches, but local authorities did not dispatch responders in 2,494 cases. VA also closed more than 98% of 196,079 referrals to suicide prevention coordinators within three days, but did not systematically track whether these veterans were reached or obtained care.[4]

The *Veterans Crisis Line Improvement Act* would:

Speed-up emergency response: Requires an up-to-date directory of alternative local crisis-response resources and staffing dispatchers according to actual workload.

Connect veterans to follow-up care: Establishes pathways for same-day VA outreach, including after-hours; the tracking of whether veterans are reached, accept assistance, have care scheduled, and receive services; and the evaluation of improved outreach methods.

Close after-hours safety gaps: Creates a 24/7 process to promptly escalate suspected non-imminent abuse, neglect, or exploitation of a child or vulnerable adult to authorized personnel for assessment and any required reporting.[5]

Increase transparency and oversight: Sets a VCL-specific process for determining when critical incidents warrant disclosure to veterans or their representatives and annual reports to Congress on repeated dispatch nonresponse, referral outcomes, and disclosure decisions.

This legislation is co-led by Sen. Patty Murray (D-Wash.) and is supported by Wounded Warrior Project and The American Legion.

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[1] *A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions*, VA OIG, Report 22-00507-211 (Sept. 14, 2023).
[2] *Veterans Crisis Line: Actions Needed to Better Ensure Effectiveness of Communications with Veterans*, GAO-25-107182 (June 2, 2025).
[3] Senate Committee on Veterans' Affairs, *Correcting Mismanagement of the Veterans Crisis Line*, S. Hrg. 119-108 (June 25, 2025).
[4] *Veterans Crisis Line: Actions Needed to Improve Services Provided After Initial Contact*, GAO-27-108414 (November 18, 2026).
[5] *Review of a Patient's Discharge from the Central Virginia VA Health Care System in Richmond*, VA OIG, Report 25-04450-218 (Aug. 14, 2026).