

**STATEMENT OF
THOMAS O'TOOLE, M.D.
DEPUTY ASSISTANT UNDER SECRETARY FOR HEALTH
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.