United States Government Accountability Office

Testimony

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

For Release on Delivery
Expected at 4:00 p.m. ET
Wednesday, June 25, 2025

VETERANS CRISIS LINE

Actions Needed to Better Ensure Effectiveness of Communications with Veterans

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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

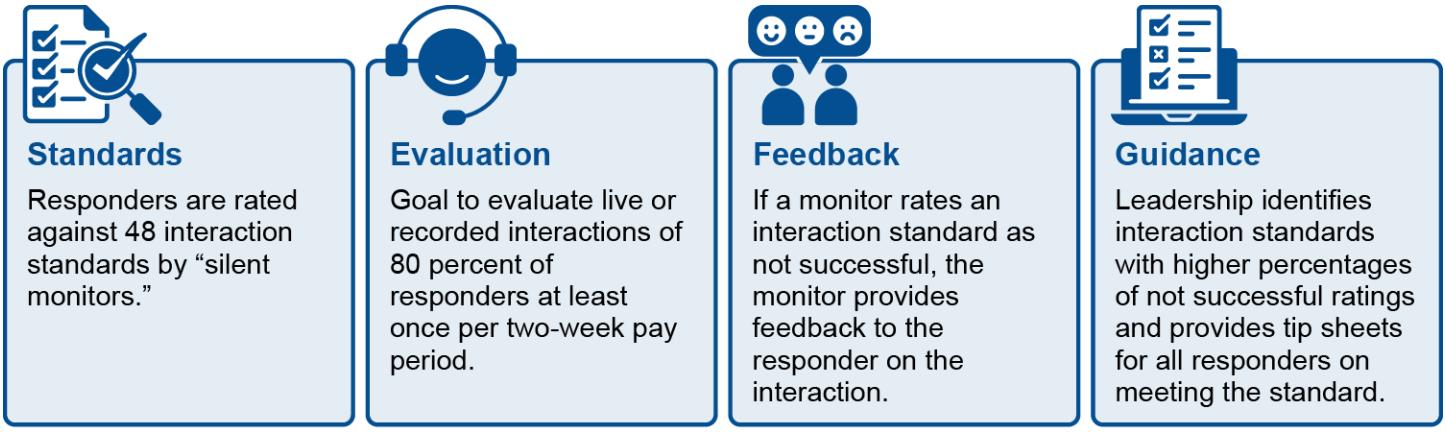
In our report, we found that the VCL uses data and quality assurance reviews to monitor responder call, chat, and text interactions. Separately, the VCL reviews interactions with customers when it learns of a related suicide but lacks a procedure for disclosing such incidents when a VCL action or inaction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