



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Emergency Dispatch and Facility Transport Processes at the Veterans Health Administration's Veterans Crisis Line

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection on June 23, 2025, to evaluate allegations that the Veterans Crisis Line's (VCL's) processes for dispatching emergency services and facility transport plans were inefficient and could negatively affect timeliness and quality of care. The review was also conducted to examine concerns regarding VCL leaders' communication and collaboration with staff. The OIG team conducted virtual interviews from June 30 through September 16, 2025, and continued to request and receive updates through January 21, 2026.

The OIG substantiated that VCL's process for distributing emergency dispatch services and facility transport plans was inefficient as it did not maximize social service assistant (SSA) staff resources, which could potentially affect the quality or timeliness of care received by customers. At the time of the inspection, requests were routed to an SSA team aligned with the VCL crisis responder (responder) rather than to all available SSAs, resulting in uneven workload distribution. The OIG learned that SSA leaders had already identified these inefficiencies and initiated a modernization project in April 2024 with the goal of consolidating SSAs into one team to "enable equitable workload distribution and streamline current processes." Throughout this OIG inspection, SSA leaders were making efforts toward this integration. In January 2026, SSA teams were consolidated into a single team, enabling equitable workload distribution and streamlined processes; as such, the OIG considers this issue resolved.

The OIG substantiated that VCL and SSA leaders did not effectively communicate and collaborate with SSA staff by not responding to staff's questions and concerns regarding workflow processes that could impact customers, acknowledging suggestions for improvement, or engaging them in process improvements directly related to their work.

The OIG identified an additional challenge related to SSA staffing methodology. During interviews SSA supervisors and staff explained SSA processes were further affected by inadequate SSA staffing, which occurs most frequently on weekend and overnight shifts. The OIG identified an opportunity to enhance VCL's methodology for determining SSA staffing levels. VCL leaders base SSA staffing on a fixed ratio of responders to SSAs rather than SSA-specific workload data. Under this model, SSA understaffing occurred on weekends, increasing operational risk.

The OIG made two recommendations to the VCL Executive Director related to evaluating and establishing mechanisms for ongoing, bidirectional communication between leaders and frontline staff and utilizing SSA-specific workload data to inform staffing decisions.

The OIG is aware of VA's transformation in the Veterans Health Administration's management structure. The OIG will monitor implementation and focus its oversight efforts on the

effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Under Secretary for Health concurred with the recommendations and provided acceptable action plans related to implementing a mechanism to facilitate bidirectional communication and analyzing SSA workload data for the consideration of potential staffing adjustments (see appendix A). The OIG will follow up on the planned actions until they are completed.



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Abbreviations

HRO	high reliability organization
OIG	Office of Inspector General
SSA	social service assistant
VCL	Veterans Crisis Line
VHA	Veterans Health Administration



Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on June 23, 2025, to assess allegations that the Veterans Crisis Line's (VCL's) processes related to dispatching emergency services and facilitating transport plans were inefficient and could negatively affect the timely delivery of care. Further, the allegations included concerns about VCL leaders' lack of communication and collaboration with staff. The OIG team conducted virtual interviews from June 30 through September 16, 2025, and continued to request and receive updates through January 21, 2026.

Background

Preventing veteran suicide is the Veterans Health Administration's (VHA's) top clinical priority.¹ In 2007, VHA established the National Veterans Suicide Prevention Hotline, now known as the VCL, in response to the Joshua Omvig Veterans Suicide Prevention Act.² This act mandated VHA provide access to mental health care 24 hours per day.³ The VCL added an online chat feature in 2009 and text messaging in 2011.⁴ Veterans, service members, or concerned family members and friends (customers) access the VCL by telephone, online chat, or text services.⁵ "As of January 2025, VCL has responded to more than 8.4 million calls, 1 million chats, and 447,000 texts."⁶

VCL Staff Roles and Processes

According to VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, during a mental health crisis, customers contact the VCL and interact with a VCL crisis responder (responder).⁷ Responders engage customers through active listening, motivational interviewing, problem-solving, and safety-planning. They also identify suicide risk factors, perform a risk assessment, employ risk mitigation strategies, and partner with the customer to ensure safety and

¹ VHA, "Long-Range Plan FY 2022-2025," n.d.

² Joshua Omvig Veterans Suicide Prevention Act, Pub L. No. 110-110, 121 Stat. 1031, November 5, 2007; VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, May 26, 2020, amended December 8, 2022; VA, "Veterans Crisis Line Fact Sheet," July 2022, accessed May 28, 2025, <https://www.veteranscrisisline.net/media/qnzlds3b/vclfactsheet.png>.

³ VHA Directive 1503(2); VA, "Veterans Crisis Line Fact Sheet."

⁴ VA, "Veterans Crisis Line Fact Sheet."

⁵ VHA Directive 1503(2). VHA's definition for customer also includes civilians who contact the VCL.

⁶ Veterans Crisis Line (VCL) - Effectiveness of VCL Services (fact sheet), December 2024, accessed June 24, 2025, https://www.mentalhealth.va.gov/suicide_prevention/docs/FSTP-Veterans-Crisis-Line-Effectiveness-VCL-Services.pdf.

⁷ VHA Directive 1503(2).

diffuse the crisis.⁸ When a responder assesses a customer's risk of harm to be imminent, the responder may determine the dispatch of emergency services (a welfare check by police) to the customer's location is needed. To do so, responders send an emergency dispatch services request to a social service assistant (SSA), who initiates this process.⁹

VCL guidelines recognize "the SSA [as] one of the most crucial positions at the VCL. They are directly responsible for getting dispatch of emergency services to a location for a caller [customer] in crisis."¹⁰ VHA Directive 1503(2) states that SSAs convey information about the customer to local emergency rescue services, communicate with emergency services throughout the rescue process, and track the status and outcome of the dispatch.¹¹ SSAs communicate with external agencies worldwide and keep the responder informed.¹²

Similarly, when a responder assesses the customer's risk to be acute, or urgent, the responder may collaborate with the customer to develop a facility transport plan.¹³ VCL-S-ACT-219-2308(1), *Standard Operating Procedure for Facility Transport Plans*, defines a facility transport plan as "a crisis intervention plan initiated by the VCL when a Customer requires immediate medical or mental health services and agrees to present to a local medical or mental health facility for treatment."¹⁴ The SSA conducts follow-up with the designated facility staff to ensure the customer arrives and updates the responder accordingly.¹⁵

VCL leaders monitor the percentage of customer contacts that result in emergency dispatch services and facility transport plans to understand customer acuity.¹⁶ According to VCL data provided to the OIG, from October 1, 2024, through September 30, 2025, the VCL facilitated 60,551 emergency dispatch services and 11,450 facility transport plans.

Allegations

In April 2025, the OIG received allegations from a complainant that

⁸ VCL, *Social Science Specialist Training Crisis Responder Participant Guide*, February 2024.

⁹ VHA Directive 1503(2); VCL, *Social Science Specialist Training Crisis Responder Participant Guide*.

¹⁰ VCL, *Social Service Assistant Training Participant Guide*, January 18, 2024.

¹¹ VHA Directive 1503(2); VCL, *Social Service Assistant Training Participant Guide*.

¹² VCL, *Social Science Specialist Training Crisis Responder Participant Guide*; VCL, *Social Service Assistant Training Participant Guide*.

¹³ VHA Directive 1503(2).

¹⁴ VCL, VCL-S-ACT-219-2308(1), "Veterans Crisis Line Standard Operating Procedure for Facility Transport Plan," August 2023.

¹⁵ VHA Directive 1503(2); VCL, *Social Service Assistant Training Participant Guide*.

¹⁶ VHA Directive 1503(2).

- the VCL's process for initiating emergency dispatch services and facility transport plans was inefficient and could negatively affect the quality and timeliness of customers receiving life-saving services, and
- VCL leaders did not effectively communicate and collaborate with SSA staff regarding staff's concerns.

The OIG opened a healthcare inspection to review these allegations. During the inspection, the OIG also identified an opportunity to improve SSA staffing methodology.

Scope and Methodology

The OIG initiated the inspection on June 23, 2025, and conducted virtual interviews from June 30 through September 16, 2025. The OIG continued to correspond with and receive updates from VCL leaders through January 21, 2026.

The OIG interviewed VCL leaders, including the Executive Director and Deputy Executive Director; the crisis operations director, leaders, and supervisors; the director of quality assurance, training, and risk management; the director of data and information management; and the talent management division director.¹⁷ The OIG interviewed SSA leaders and staff, including the SSA division director, SSA section chief, teams operations coordinators, supervisory SSAs, lead SSAs, and 26 SSAs.¹⁸

The OIG reviewed relevant VHA and VCL policies and procedures in effect at the time of the inspection, and VCL organizational charts. The OIG also reviewed staffing methodology, VCL call volume and SSA workload data, and SSA modernization project documents including charters, meeting minutes, and email communications.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

¹⁷ For this report, the OIG refers to the VCL's Executive Director, Deputy Executive Director, and division directors (such as crisis operations and data and information management) as VCL leaders.

¹⁸ The OIG uses the term SSA leaders when referring to leaders within the SSA chain of command; these include the SSA division director and section chief. The OIG uses the term SSA division director to refer to the division director over workflow and air traffic controllers, in addition to SSAs.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

Inspection Results

1. Distribution of Emergency Dispatch Service and Facility Transport Plan Requests

The OIG substantiated VCL's process for distributing emergency dispatch service and facility transport plan requests was inefficient as it did not maximize SSA staff resources, which could potentially affect the quality or timeliness of customers receiving care. Specifically, when the inspection began on June 23, 2025, the OIG found that requests for emergency dispatch services and facility transport plan assistance were not distributed to all available SSAs but rather to the SSA team aligned with the responder.

When the OIG asked about VCL processes, VCL and SSA leaders and staff explained that when a customer contacts the VCL, the contact is routed to all available responders. The first available responder accepts the contact and engages the customer. However, when a responder assesses the customer's risk of harm to be imminent, the responder sends a request for emergency dispatch service or facility transport plan assistance only to the SSA team aligned with the responder, regardless of the SSA team's workload, rather than to all available SSAs.

Consequently, at any given time, one SSA team may manage many emergency dispatch service and facility transport plan requests while another may manage a few. While SSA leaders and staff shared concerns related to managing multiple emergency dispatch service and facility transport plan requests and described informal processes used to mitigate potential delays, neither were aware of any adverse events or delays in customers receiving emergency services.

VCL and SSA leaders explained that this distribution process was developed when responders and SSAs were physically located in one of three VCL locations (Canandaigua, Atlanta, and Topeka). However, the rationale for site-based teams became obsolete in early 2020 when all responders and SSAs began working remotely.

The OIG learned that SSA leaders initiated an "SSA team modernization" project in April 2024, with the goal of consolidating SSAs into one team to "enable equitable workload distribution and streamline current processes." Although efforts to integrate SSA staff into one team were underway during this inspection, as of December 2025, SSA staff remained segregated into teams. In response to a December OIG inquiry, the SSA section chief reported the integration of SSA staff into one team was anticipated to occur in January 2026. On January 21, 2026, the SSA

section chief confirmed the implementation of one SSA team occurred on January 11, 2026; as such, the OIG considers this issue resolved and did not make a recommendation.

2. VCL Leaders' Communication and Collaboration

The OIG substantiated that VCL and SSA leaders did not effectively communicate and collaborate with SSA supervisors and staff by not responding to staff's questions and concerns regarding workflow processes that could affect customers, acknowledging suggestions for improvement, or engaging them in process improvements directly related to their work. As a result, the OIG found an overall sense of disempowerment among SSA supervisors and staff and a shared belief that their opinions were not valued, undermining the tenets of a high reliability organization (HRO).

One of the foundational pillars of an HRO delineates that in a culture of safety "... front line staff members routinely report ... unsafe conditions because they trust that leaders want to know," and leaders openly communicate meaningful improvements to staff.¹⁹ Similarly, the HRO value, *duty to speak up*, states "everyone has a Duty to Speak Up when they see a safety issue, and leaders have a duty to listen and respond to the concerns that staff members raise."²⁰

During interviews, SSA staff reported there were avenues to share concerns with SSA supervisors; however, SSA staff questioned whether concerns were escalated to VCL leaders as they did not receive feedback, concerns were not addressed, and related changes were not made. Although SSA staff felt that SSA supervisors generally understood and agreed with the concerns brought forward, they felt the supervisors were powerless to influence change. This sentiment was echoed by SSA supervisors during OIG interviews. Supervisory SSAs reported communicating feedback and concerns through the supervisory chain but felt the concerns are not "taken seriously," or get lost.

The OIG learned these concerns were not new. Between August 2024 and June 2025, 29 roundtable meetings with SSA supervisors were held to obtain feedback on what was, and was not, working well. An SSA leader reported distributing a summary of the meetings to SSA staff in August 2025. The meeting summary delineated supervisor requests, including increased leadership transparency; bidirectional communication that flows between staff and leaders, adding the "why" when communicating changes to staff to help them understand the basis for decisions; including frontline staff in workgroups; and increased inclusion, collaboration, and shared decision-making.

During interviews, VCL and SSA leaders did not identify an established pathway for bidirectional communication. In addition, VCL and SSA leaders expressed appreciation for the

¹⁹ VA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024.

²⁰ VA, "Deference to Expertise: HRO Principle" (fact sheet), January 2024.

OIG's attention to the complexity and importance of the SSA position and shared that the SSA role has historically been underrecognized as they operate behind the scenes and do not directly interact with customers.

3. SSA Staffing Methodology

The OIG identified an additional challenge related to SSA staffing methodology. During interviews, SSA supervisors and staff explained SSA processes were further affected by inadequate SSA staffing, which occurs most frequently on weekend and overnight shifts. In an effort to better understand SSA staffing methodology, the OIG spoke with VCL and SSA leaders who reported that SSA staffing is not based directly on SSA workload data. The VCL's director of data and information management shared that, rather than SSA workload, they use a predetermined ratio of responders to SSAs, based on responder workload (measured in call volume to the VCL).

The OIG found that this approach to determining the staffing ratio does not account for the volume and complexity of the requests being managed by SSAs. For example, responder workload tends to decrease on weekends; however, SSA workload, measured in the number of emergency dispatch services and facility transport plans, decreases to a lesser extent on weekends and would result in SSA understaffing using a ratio model.²¹ The OIG determined it may be beneficial for VCL leaders to use SSA-specific workload data rather than a ratio of responder staffing levels for predicting SSA workload.

Conclusion

The OIG substantiated VCL's process for distributing emergency dispatch service and facility transport plan requests was inefficient as it did not maximize SSA staff resources and could potentially affect the quality or timeliness of care received by customers. The OIG learned SSA leaders recognized the distribution process was inefficient and, in April 2024, began developing a plan to equitably distribute SSA workload. On January 11, 2026, SSAs were consolidated into one team enabling equitable workload distribution across all available SSAs. The OIG determined that while the allegation was substantiated, VHA had already identified the issue and was working on a solution during this inspection.

The OIG substantiated that VCL and SSA leaders did not effectively communicate and collaborate with SSA supervisors and staff by not responding to staff's questions and concerns regarding workflow processes that could affect customers, acknowledging suggestions for improvement, or engaging them in process improvements directly related to their work. As a

²¹ The OIG performed statistical modelling to assess the relationship between responder and SSA workload. The modelling suggested that responder workload accounted for about 27 percent of the variation in the SSA workload.

result, the OIG found an overall sense of disempowerment among SSA supervisors and staff and a shared belief that their opinions were not valued, undermining the tenets of an HRO.

The OIG identified an opportunity to improve the SSA staffing methodology. During interviews SSA supervisors and staff explained SSA processes were further affected by inadequate SSA staffing, which occurs most frequently on weekend and overnight shifts. SSA staffing decisions were based on a fixed responder-to-SSA ratio rather than SSA-specific workload data. The OIG analysis of responder and SSA workload data found that under VCL's current responder-to-SSA ratio model, SSA understaffing would occur on weekends.

The OIG made two recommendations to the VCL Executive Director related to evaluating and establishing mechanisms for ongoing, bidirectional communication between leaders and frontline staff and utilizing SSA-specific workload data to inform staffing decisions.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–2

1. The Veterans Crisis Line Executive Director takes action to evaluate and implement mechanisms that facilitate ongoing, bidirectional communication between Veterans Crisis Line frontline staff and leaders to ensure staff have an avenue to express concerns, share feedback, and receive timely, relevant responses.
2. The Veterans Crisis Line Executive Director considers using social service assistant-specific workload data to determine social service assistant staffing levels rather than a fixed ratio of responders to social service assistants.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 7, 2026

From: Office of the Under Secretary for Health (10)

Subj: VA Office of Inspector General (OIG) Healthcare Inspection—Review of Emergency Dispatch and Facility Transport Processes at the Veterans Health Administration's Veterans Crisis Line

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Review of Emergency Dispatch and Facility Transport Processes at the Veterans Health Administration's Veterans Crisis Line. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.
2. VHA is committed to continually improving our processes and tools to serve Veterans in crisis. Thank you for highlighting this important area of focus.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

John J. Bartrum, JD, MBA

[OIG comment: The OIG received the above memorandum from VHA on May 7, 2026.]

Office of the Under Secretary for Health Response

Recommendation 1

The Veterans Crisis Line Executive Director takes action to evaluate and implement mechanisms that facilitate ongoing, bidirectional communication between Veterans Crisis Line frontline staff and leaders to ensure staff have an avenue to express concerns, share feedback, and receive timely, relevant responses.

Concur

Nonconcur

Target date for completion: October 2026

Under Secretary for Health Comments

The Office of Suicide Prevention (OSP) Veterans Crisis Line (VCL) is taking action to evaluate and implement mechanisms that facilitate ongoing, bidirectional communication between VCL frontline staff and leaders. To substantiate completion of this recommendation, OSP will provide a summary of evaluations and implemented mechanisms that ensure frontline staff have an avenue to express concerns, share feedback, and receive timely, relevant responses.

Recommendation 2

The Veterans Crisis Line Executive Director considers using social service assistant-specific workload data to determine social service assistant staffing levels rather than a fixed ratio of responders to social service assistants.

Concur

Nonconcur

Target date for completion: December 2026

Under Secretary for Health Comments

OSP will consider using social service assistant (SSA)-specific workload data to determine SSA staffing levels rather than a fixed ratio of responders to SSAs. To substantiate completion of this recommendation, OSP will provide a feasibility analysis and plan to capture and measure SSA workload data and evaluate potential staffing level adjustments based on the feasibility analysis.

OIG Contact and Staff Acknowledgments

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