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VA Office of Inspector General Releases Evaluation of the Veterans Crisis Line
Veterans Crisis Line Faces Administrative and Staff Training Challenges

WASHINGTON – The VA Office of Inspector General (OIG) issued its health care inspection, *Evaluation of the Veterans Health Administration Veterans Crisis Line*, reporting deficiencies in multiple areas of VA’s administration of its Veterans Crisis Line (VCL). While the OIG was impressed with the dedication of VCL staff answering calls and assisting veterans, it found that VA’s VCL management team faced significant obstacles providing suicide prevention and crisis intervention services to veterans, service members, and their families. The VCL’s biggest challenges include meeting the operational and business demands of responding to over 500,000 calls per year, and training staff to assess and respond to the needs of individual contacts with veterans and family members under stressful, time-sensitive conditions.

“Veterans are at a disproportionately high risk for suicide compared to the rate of U.S. civilian adults,” said Michael J. Missal, Inspector General, U.S. Department of Veterans Affairs, Office of Inspector General. “The VCL is a critical effort to reduce veteran suicide for those who call in crisis. Therefore, it is imperative that VA take further steps to increase the effectiveness of VCL operations. We made 16 recommendations to VA to improve crisis intervention services for veterans in distress. It is a mission shared by all of us: VA, the OIG, and the public, to get this right.”

Among other weaknesses, the OIG identified the failure to respond adequately to a veteran in multiple calls identified in a complaint received by the OIG. The failure to respond adequately to the veteran’s urgent needs resulted in missed opportunities to provide crisis intervention services.

The OIG’s VCL inspection also identified internal quality assurance deficiencies, including that there was not an adequate process to collect, analyze and effectively review relevant quality management data in order to make changes and improve outcomes for callers. As a result, we made recommendations to improve VCL’s internal auditing and quality assurance processes so that VCL staff can recognize and effectively implement improved services to callers.

The OIG’s VCL inspection further found deficiencies in the governance and oversight of VCL operations. In February 2016, VCL was realigned to the Veterans’ Health Administration’s
Office of Member Services, a business operations group with expertise in call center operations. VA leadership stated at the time that Member Services and the Office of Mental Health Operations, its clinical oversight group with expertise in suicide prevention, would work together closely to manage VCL services. We found substantial differences at the highest levels between the two groups that resulted in decisions with insufficient clinical input to VCL operations.

In February 2016, the OIG issued *Healthcare Inspection–Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua*. In this inspection, OIG made seven recommendations. While the Veterans Health Administration agreed with all recommendations, as of the publication of this new report, all seven remain open. Failure to implement our previous recommendations impairs the VCL’s ability to increase the quality of crisis intervention services to veterans seeking help.

The VA OIG conducts oversight of VA and its programs and operations, providing independent and objective reporting to the VA Secretary and the Congress for the purpose of preventing and detecting fraud and abuse, and bringing about positive change in the integrity, efficiency, and effectiveness of VA. To report potential criminal activity, fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at vaoighotline@va.gov or www.va.gov/oig/hotline/default.asp.

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