US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

National Review of Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings

National Review	24-00560-29	January 13, 2026

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) initiated a national review to evaluate the Veterans Health Administration's (VHA's) adherence to suicide risk and intervention training, use of suicide risk identification processes in audiology settings, and implementation of progressive tinnitus management (PTM) from October 1, 2023, through September 30, 2024.

Audiology is a critical healthcare access point for many patients, as one of the only VHA clinical services that does not require a direct referral from a medical professional.[1] All enrolled patients are eligible for comprehensive VHA audiology diagnostic evaluations.[2] Audiology staff completed an average of approximately 447,000 new patient appointments each year from fiscal years (FYs) 2021 through 2024.[3]

Tinnitus, the perception of ringing or noises in the absence of external sound, is the most prevalent service-connected disability for veterans.[4] Veterans diagnosed with tinnitus are more likely to be diagnosed with mental health or behavioral disorders, including post-traumatic stress, depression, anxiety, and substance use.[5] The association between tinnitus and mental health

[1] "Rehabilitation and Prosthetic Services," VHA Audiology Services, accessed May 12, 2025, https://www.rehab.va.gov/audiology/index.asp.

[2] "Audiology Services Fact Sheet," VHA Rehabilitation and Prosthetic Services, accessed June 17, 2024, https://www.rehab.va.gov/PROSTHETICS/factsheet/Audiology-FactSheet.pdf#.

[3] "Rehabilitation and Prosthetic Services (RPS) Dashboard," VHA Support Service Center, accessed August 13, 2024, https://app.powerbigov.us/groups/me/apps/875a7ae0-f7ce-46a4-bab8-c2fb60804ee0/reports/42f60993-376f-4fe1-aaae-3cd51fca49d7/ReportSection4502d0718503e5db8542. (This website is not publicly accessible.); A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023. "VA Finance Terms and Definitions," VA/VHA Employee Health Promotion Disease Prevention Guidebook, July 2011, accessed July 23, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

[4] Tinnitus may be a symptom of hearing loss; "Tinnitus," U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Deafness and Other Communication Disorders, accessed October 6, 2025, https://www.nidcd.nih.gov/health/tinnitus; VA, *Veterans Benefits Administration Annual Benefits Report Fiscal Year 2024*, accessed May 19, 2025, https://www.benefits.va.gov/REPORTS/abr/docs/2024-abr.pdf.

[5] Kathleen F. Carlson et al., "Health Care Utilization and Mental Health Diagnoses Among Veterans With Tinnitus," *American Journal of Audiology* 28, no. 1S, (April 2019): 181–190, https://doi.org/10.1044/2018_AJA-TTR17-18-0042.

conditions suggests a need for a coordinated patient-centered approach between audiology and mental health services to identify and manage co-occurring conditions.[6]

In 2017, VHA developed training for clinical healthcare providers on how to discuss and evaluate suicide risk and engage patients in treatment when necessary. VHA also updated generalized training for nonclinical employees on how to support veterans in crisis.[7] Since 2020, VHA has required clinicians in outpatient care settings, including audiology services, to complete an annual suicide risk screening with all patients when the screening is due.[8]

Additionally, the VA/DoD Clinical Practice Guideline for Tinnitus, although not required, emphasizes coordination between audiologists and mental health providers to address patient behavioral and mental health needs using the evidence-based PTM protocol.[9] PTM consists of five levels that provide increasingly intensive clinical services, aimed at minimizing the impact of tinnitus on patients' lives.[10] Screening for mental health treatment needs may occur in Level 2 and collaboration with mental health clinicians to ensure appropriate individualized mental health intervention occurs in Levels 3, 4, and 5.[11]

---

[6] Kathleen F. Carlson et al., "Health Care Utilization and Mental Health Diagnoses Among Veterans With Tinnitus"; Kasra Ziai et al., "Tinnitus Patients Suffering from Anxiety and Depression: A Review," *The International Tinnitus Journal* 21, no. 1 (June 2017): 68–73, https://www.tinnitusjournal.com/articles/tinnitus-patients-suffering-from-anxiety-and-depression-a-review.html; Austin Prewitt et al., "Mental Health Symptoms Among Veteran VA Users by Tinnitus Severity: A Population-based Survey," *Military Medicine* 186, January/February Supplement 2021 (January 25, 2021): 167–175, https://doi.org/10.1093/milmed/usaa288; Caroline J. Schmidt et al., "Need for Mental Health Providers in Progressive Tinnitus Management: A Gap in Clinical Care," *Federal Practitioner*, May 2017, accessed July 5, 2024, https://cdn.mdedge.com/files/s3fs-public/fedprac/0517fp_mental_health.pdf.

[7] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training,* December 22, 2017, rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training,* May 11, 2022, amended June 21, 2022. The directives contain similar language related to required clinical and nonclinical employee training requirements.

[8] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., November 13, 2020; Assistant Under Secretary for Health Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., January 7, 2025.

[9] "VA/DoD Clinical Practice Guideline for Tinnitus," VA/DoD, accessed July 31, 2024, https://www.healthquality.va.gov/guidelines/CD/tinnitus/VADOD-CPG-Tinnitus-Full-CPG-2024_Final_508.pdf.

[10] National Center for Rehabilitative Auditory Research, "Overview of PTM," chap.3 in *Progressive Tinnitus Management: Clinical Handbook for Audiologists,* accessed April 24, 2025, https://www.ncrar.research.va.gov/Documents/ClinicalHandbookAndSupplements.asp.

[11] National Center for Rehabilitative Auditory Research, "Overview of PTM," chap. 3.

Review Results

The OIG determined that Office of Suicide Prevention (OSP) leaders did not recognize audiologists as clinical staff, which contributed to audiologists' completion of suicide risk and intervention training intended for nonclinical rather than clinical employees. VHA requires nonclinical staff to complete Signs, Ask, Validate, Encourage and Expedite (VA S.A.V.E.) training and clinical staff to complete Skills Training for Evaluation and Management of Suicide (STEMS) training within 90 days of entering their positions and annually thereafter.[12] VHA-identified audiology points of contact (audiology contacts) from 132 of 140 facilities provided suicide risk and intervention training records. The OIG found that most nonclinical staff completed the correct training. However, most clinical staff did not complete the correct training and reported a lack of awareness of training requirements as the most common barrier to completion.

During an interview, when asked about suicide risk and intervention training policy and guidance, an OSP Education and Training leader stated, "audiologist [*sic*] are not included in the definition of healthcare providers, so they are expected to complete [VA] S.A.V.E." Six days later, in a written response to an OIG request, an OSP Policy Development leader stated that suicide risk and intervention training policy was being revised to include audiologists as healthcare providers. However, in a subsequent unsolicited email, the OSP Policy Development leader acknowledged that audiologists are considered health care providers "as defined within the current directive."

The OIG would expect that OSP leaders specifically identify clinical staff required to complete STEMS training and ensure accurate training assignment. Given OSP leaders' inaccurate training expectations for audiologists, the OIG is concerned that other clinical staff may not be assigned the required STEMS training. Clinical staff not being accurately assigned STEMS training could result in missed opportunities to identify suicide risk and provide suicide prevention services to mitigate risk. Additionally, this training may decrease clinicians' discomfort with completing suicide risk screening.

The OIG found that in FYs 2023 and 2024, audiology service staff's national adherence to annual suicide risk screening was 22 and 39 percent, respectively. In FYs 2023 and 2024, adherence to annual suicide risk screening in audiology services varied significantly across facilities but did not exceed 39 percent. The OIG also found that audiology staff did not complete any suicide risk screenings in 15 of 135 facilities over both years, accounting for

[12] The acronym "S.A.V.E" summarizes the steps to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment, and expedite getting help. "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis," VA, accessed June 24, 2025, https://www.mentalhealth.va.gov/suicide_prevention/docs/VA_SAVE_Training.pdf; VHA defines clinical staff as licensed independent practitioners, advanced practice providers, registered nurses, and case managers. VHA Directive 1071(1).

24,000 missed screenings.[13] Additionally, approximately 29,000 patients at these 15 facilities only received VHA care within the audiology service, raising concern that some of these patients may not have received a suicide risk screening at any time during either FY.

An Office of Audiology and Speech Pathology Services leader reported that audiologists receive limited training in suicide risk screening and were initially uncomfortable completing the screening. The leader also reported a perception that adherence improves with increased education but noted the Office of Audiology and Speech Pathology Services had not consulted with OSP as of May 2025.

Considering that audiologists provide clinical services to a significant number of patients who do not receive any other VHA health care, deficiencies in suicide risk screening may result in not identifying patients at risk for suicide and missed opportunities for risk mitigation. The OIG would expect a collaborative partnership between the Office of Audiology and Speech Pathology Services and OSP to support greater adherence to the suicide risk screening requirement for this vulnerable population.

The OIG found that while most facilities offer the highest level of progressive tinnitus management, most facility policy documents do not define PTM mental health integration processes, and Audiology and Speech Pathology Service and OSP leaders do not provide oversight of PTM implementation. The OIG requested and reviewed PTM implementation status information from 127 VHA audiology contacts. The majority reported having implemented PTM, with most offering Level 5–Individualized Support. Audiology contacts identified limited scheduling availability and lack of collaboration, administrative time, and co-location with mental health services as the most common barriers to PTM implementation.

Of the 91 facilities that submitted policy guidance documents, only 1 facility provided a standard operating procedure related to PTM. Additionally, the National Director, Audiology and Speech Pathology Service was unaware of prior collaboration and reported not collaborating with the Office of Mental Health since assuming the role in November 2023. Further, the director stated that mental health integration to support PTM implementation is a "local-driven decision."

Inadequate oversight of mental health integration may limit VHA's ability to evaluate and address barriers to PTM implementation, which may result in missed opportunities to identify co-occurring mental health treatment needs and provide mental health services. Given the widespread use of PTM across VHA and inclusion of PTM in the clinical practice guideline, the OIG would expect collaboration between Audiology and Speech Pathology Service and the

[13] The OIG found that although approximately 25,000 patients had screenings due at the time of an audiology visit, another clinical service completed screenings for 1,000 patients to fulfill the requirement.

Office of Mental Health to support implementation and oversight of the critical mental health integration component of PTM.[14]

The OIG made five recommendations to the Under Secretary for Health related to delineating oversight responsibility for suicide risk training in audiology services; clarifying suicide risk and intervention training requirements for audiologists; ensuring accuracy of training assignments; and evaluating oversight of and barriers to mental health integration in audiology services, as well as the definition of healthcare provider for purposes of suicide risk and intervention training.[15]

VA Comments and OIG Response

The Acting Under Secretary for Health concurred with the recommendations and provided action plans that included implementation of a directive that will contain suicide risk and intervention training requirements, define healthcare provider, and outline oversight responsibilities (see appendix C). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
In the role of Acting Assistant Inspector General,
for Healthcare Inspections

[14] "VA/DoD Clinical Practice Guideline for Tinnitus."

[15] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Contents

Abbreviations

FY	fiscal year
OIG	Office of Inspector General
OSP	Office of Suicide Prevention
PTM	progressive tinnitus management
S.A.V.E.	Signs, Ask, Validate, Encourage and Expedite
STEMS	Skills Training for Evaluation and Management of Suicide
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a national review to evaluate Veterans Health Administration's (VHA's) mental health integration within audiology settings, including suicide risk and intervention training, suicide risk identification processes, and tinnitus management from October 1, 2023, through September 30, 2024.

Background

Audiology is a critical healthcare access point for many patients, as one of the only VHA clinical services that does not require a direct referral from a medical professional.[1] All enrolled patients are eligible for comprehensive audiology clinical services—including diagnostic evaluations—and VHA is the largest employer of audiologists in the United States, with audiology services available at more than 650 VHA sites of care.[2]

Veterans receive audiology care through VHA Rehabilitation and Prosthetic Services, which provides "medical rehabilitation, prosthetic and sensory aids services" through a wide range of disciplines that also includes physical therapy, occupational therapy, chiropractic care, and more.[3] Audiology staff completed an average of approximately 447,000 new patient appointments each year from fiscal years (FYs) 2021 through 2024.[4] Within Rehabilitation and Prosthetic Services, audiology staff completed the most new patient appointments annually compared to other service areas (see figure 1).[5]

---

[1] "Rehabilitation and Prosthetic Services," VHA Audiology Services, accessed May 12, 2025, https://www.rehab.va.gov/audiology/index.asp.

[2] "Rehabilitation and Prosthetic Services," VHA Audiology Services; Audiologists, required by VA to maintain state licensure, "are trained to identify, diagnose, treat, and monitor" auditory (hearing) disorders. "Audiology Services Fact Sheet," VHA Rehabilitation and Prosthetic Services, accessed June 17, 2024, https://www.rehab.va.gov/PROSTHETICS/factsheet/Audiology-FactSheet.pdf#. "Rehabilitation and Prosthetics Services: VHA Audiology," VA, accessed May 12, 2025, https://www.rehab.va.gov/audiology/.

[3] "Rehabilitation and Prosthetic Services," VA, accessed July 1, 2025, https://vaww.rehab.va.gov/. (This site is not publicly accessible.); "Rehabilitation and Prosthetics Services," VA, accessed May 19, 2025, https://www.rehab.va.gov/index.asp.

[4] "Rehabilitation and Prosthetic Services (RPS) Dashboard," VHA Support Service Center, accessed August 13, 2024, and May 20, 2025, https://app.powerbigov.us/groups/me/apps/875a7ae0-f7ce-46a4-bab8-c2fb60804ee0/reports/42f60993-376f-4fe1-aaae-3cd51fca49d7/ReportSection4502d0718503e5db8542. (This site is not publicly accessible.); A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2023 began on October 1, 2022, and ended on September 30, 2023. VA, "VA Finance Terms and Definitions," in *VA/VHA Employee Health Promotion Disease Prevention Guidebook*, July 2011, accessed July 23, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

[5] VHA Rehabilitation and Prosthetic Services includes "programs for medical rehabilitation, prosthetic and sensory aids services that promote the health, independence and quality of life for Veterans with disabilities." "Rehabilitation and Prosthetic Services," VA.

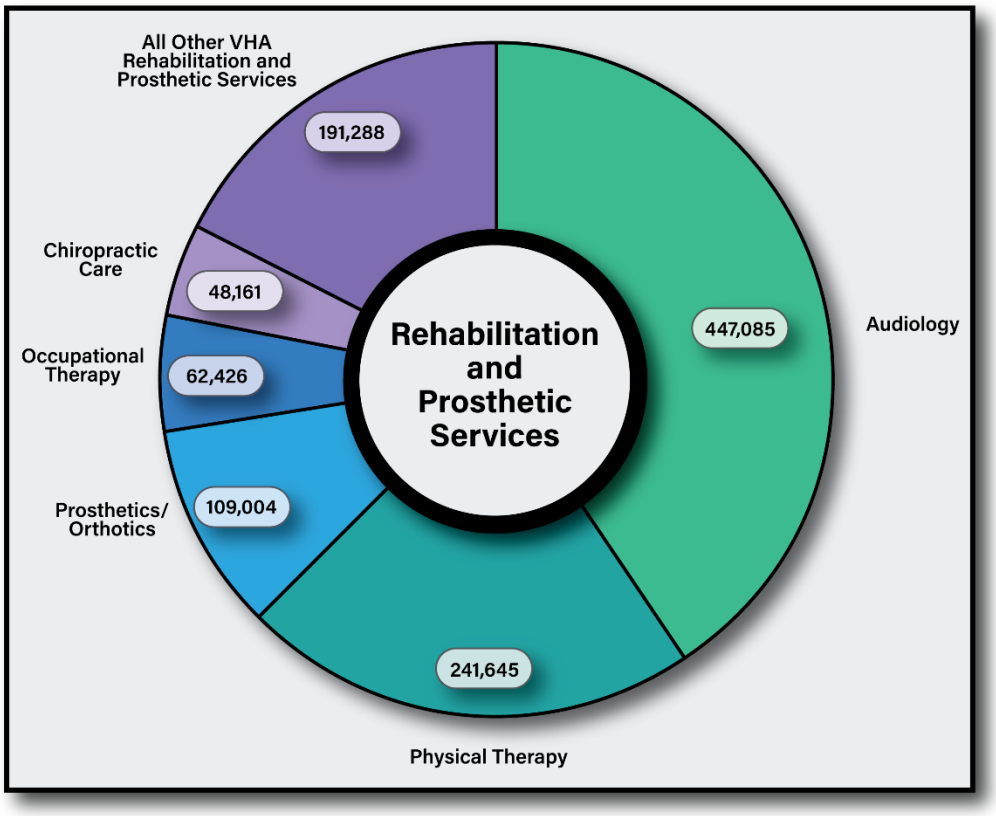

Figure 1. *Average number of new patient appointments, FYs 2021 through 2024.*
Source: OIG analysis of VHA new appointment data.

The large number of annual audiology appointments may reflect veterans' need for services to treat tinnitus, the perception of ringing or other noises in the ear or head in the absence of external sound.[6] Veterans are more likely than the general population to develop tinnitus, the most prevalent service-connected disability, with over three million receiving VA disability compensation for the condition as of September 2024.[7]

The correlation between tinnitus and mental health conditions is well established.[8] Veterans diagnosed with tinnitus are more likely than those without tinnitus to be diagnosed with mental health or behavioral disorders, including post-traumatic stress, depression, anxiety, and substance

[6] Tinnitus may be a symptom of hearing loss; "Tinnitus," US Department of Health and Human Services, National Institutes of Health, National Institute on Deafness and Other Communication Disorders, accessed October 6, 2025, https://www.nidcd.nih.gov/health/tinnitus; "Progressive Tinnitus Management," VA Office of Research and Development, accessed July 21, 2025, https://www.research.va.gov/research.

[7] "Progressive Tinnitus Management," VA Office of Research and Development; VA, *Veterans Benefits Administration Annual Benefits Report Fiscal Year 2024*, accessed May 19, 2025, https://www.benefits.va.gov/REPORTS/abr/docs/2024-abr.pdf.

[8] Kasra Ziai et al., "Tinnitus Patients Suffering from Anxiety and Depression: A Review," *The International Tinnitus Journal* 21, no. 1 (June 2017): 68–73, https://www.tinnitusjournal.com/articles/tinnitus-patients-suffering-from-anxiety-and-depression-a-review.html.

use.[9] Further, increased severity of tinnitus appears associated with increased likelihood of reported depression and anxiety.[10]

The association between tinnitus and mental health conditions suggests a need for a coordinated patient-centered approach between audiology and mental health services to identify and manage co-occurring conditions.[11] In FY 2024, among the 324,701 patients who received audiology services for tinnitus, approximately 43 percent (139,424) had a documented mental health diagnosis. Sixty-seven percent (217,561) of patients who received audiology services for tinnitus did not have a VHA mental health visit during the same year. Given the volume of patients accessing audiology services and the association of tinnitus and mental health conditions, audiologists may be in a unique position to identify mental health concerns and refer patients for specialty care.[12]

In 2017, VHA developed training for clinical healthcare providers on how to discuss and evaluate suicide risk and engage patients in treatment when necessary. VHA also updated generalized training for nonclinical employees on how to support veterans in crisis.[13] Since 2020, VHA has required clinicians in outpatient care settings, including audiology services, to complete an annual suicide risk screening with all patients when the screening is due.[14]

Additionally, in 2005, VHA created progressive tinnitus management (PTM) to provide a hierarchical and interdisciplinary approach to the management of tinnitus, which included

---

[9] Kathleen F. Carlson et al., "Health Care Utilization and Mental Health Diagnoses Among Veterans With Tinnitus," *American Journal of Audiology* 28, no. 1S, (April 2019): 181–190, https://doi.org/10.1044/2018_AJA-TTR17-18-0042.

[10] Austin Prewitt et al., "Mental Health Symptoms Among Veteran VA Users by Tinnitus Severity: A Population-based Survey," *Military Medicine* 186, January/February Supplement 2021 (January 25, 2021): 167–175, https://doi.org/10.1093/milmed/usaa288.

[11] Kathleen F. Carlson et al., "Health Care Utilization and Mental Health Diagnoses Among Veterans With Tinnitus,"; Caroline J. Schmidt, et al., "Need for Mental Health Providers in Progressive Tinnitus Management: A Gap in Clinical Care," *Federal Practitioner* (May 2017), https://cdn.mdedge.com/files/s3fs-public/fedprac/0517fp_mental_health.pdf; Austin Prewitt et al., "Mental Health Symptoms Among Veteran VA Users by Tinnitus Severity: A Population-based Survey."

[12] Rebecca J. Bennett et al., "Perspectives on Mental Health Screening in the Audiology Setting: A Focus Group Study Involving Clinical and Nonclinical Staff," *American Journal of Audiology* 30, no. 4, (December 2021): 980–993, https://doi.org/10.1044/2021_AJA-21-00048.

[13] VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training,* December 22, 2017, rescinded and replaced by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022. The directives contain similar language related to required clinical and nonclinical employee training requirements.

[14] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., November 13, 2020; Assistant Under Secretary for Health Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) et al., January 7, 2025.

guidance for audiologists on screening for anxiety, depression, post-traumatic stress, and sleep disorders.[15] PTM consists of five levels that provide increasingly intensive clinical services aimed at minimizing the impact of tinnitus on patients' lives.[16] Screening for mental health treatment needs may occur in Level 2 and collaboration with mental health or primary care clinicians to ensure appropriate individualized mental health intervention occurs in Levels 3, 4, and 5 (see figure 2).[17]

VHA policy requires that veterans are provided access to integrated, specialized, evidence-based audiology services and the clinical practice guideline to engage in shared decision making with patients to make treatment decisions.[18] The National Director, Office of Audiology and Speech Pathology Services told the OIG that VHA does not require facilities to implement PTM but it "is one of the best evidence-based practices out there."

[15] Progressive Tinnitus Management is "a stepped-care program that involves coordinated care between Audiology and Behavioral Health." "Progressive Tinnitus Management," National Center for Rehabilitative Auditory Research, accessed August 13, 2025, https://www.ncrar.research.va.gov/ClinicianResources/IndexPTM.asp; National Center for Rehabilitative Auditory Research, *Progressive Tinnitus Management: Clinical Handbook for Audiologists*, accessed July 31, 2024, https://www.ncrar.research.va.gov/Documents/ClinicalHandbookAndSupplements.asp;"Hearing Loss," VA Office of Research and Development, accessed September 27, 2022, https://www.research.va.gov/topics/hearing.cfm#research4; Tara L. Zaugg et al., "Factors Affecting the Implementation of Evidence-based Progressive Tinnitus Management in Department of Veterans Affairs Medical Centers," *PLoS ONE* 15, no. 12 (December 28, 2020), https://doi.org/10.1371/journal.pone.0242007.

[16] National Center for Rehabilitative Auditory Research, "Overview of PTM," chap.3 in *Progressive Tinnitus Management: Clinical Handbook for Audiologists,* accessed April 24, 2025, https://www.ncrar.research.va.gov/Documents/ClinicalHandbookAndSupplements.asp.

[17] National Center for Rehabilitative Auditory Research, "Overview of PTM," chap. 3.

[18] VHA Directive 1170.02(1), *VHA Audiology and Speech Pathology Services*, December 9, 2020, amended July 19, 2022; "VA/DoD Clinical Practice Guideline for Tinnitus," VA/DoD, accessed July 31, 2024, https://www.healthquality.va.gov/guidelines/CD/tinnitus/VADOD-CPG-Tinnitus-Full-CPG-2024_Final_508.pdf.

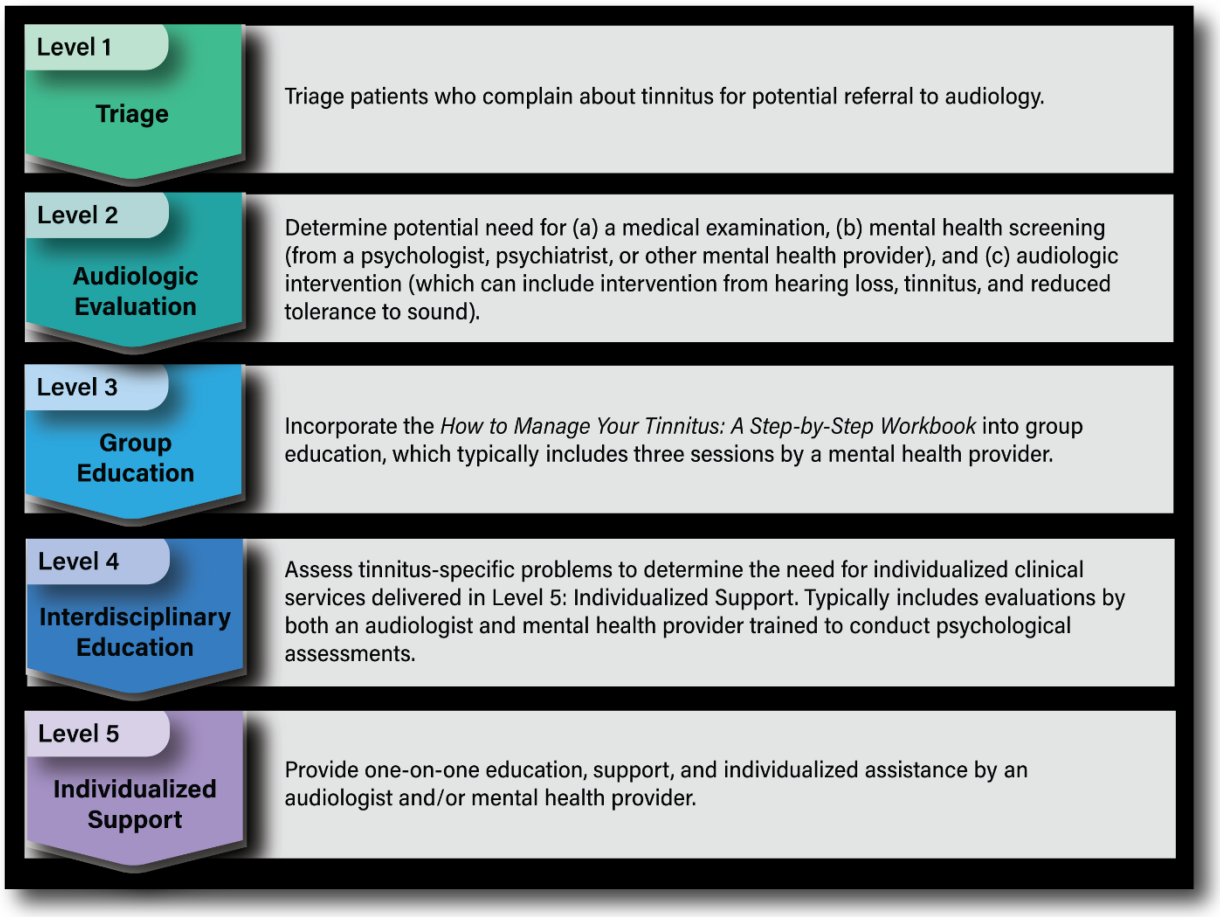

Figure 2. *PTM levels and objectives.*
Source: National Center for Rehabilitative Auditory Research, Progressive Tinnitus Management: Clinical Handbook for Audiologists, 2010.

Several studies have evaluated VHA PTM implementation and identified variability in mental health integration and barriers to implementation.[19] Overall, these studies suggest a need for increased acknowledgment of tinnitus and mental health comorbidities, and increased coordination of care between audiology and mental health.

Prior OIG Reports

In a December 2024 national review evaluating adherence to required annual suicide risk screening across clinical settings, the OIG found that VHA lacked a clear strategy to ensure non-

[19] Caroline J. Schmidt et al., "Need for Mental Health Providers in Progressive Tinnitus Management: A Gap in Clinical Care"; Tara L. Zaugg et al., "Factors Affecting the Implementation of Evidence-based Progressive Tinnitus Management in Department of Veterans Affairs Medical Centers"; Amy Boudin-George et al., "Understanding Tinnitus Clinical Care in the Veterans Health Administration and Department of Defense: Overview of Survey Results," *American Journal of Audiology* 33, no. 4 (December 2024): 1184–1201, https://doi.org/10.1044/2024_AJA-24-00060.

mental health leaders and staff understood and followed suicide risk screening and evaluation requirements. The OIG recommended the Under Secretary for Health ensure non-mental health clinical specialty leaders are aware of and adherent to the suicide risk identification screening requirements.[20] The OIG closed the recommendation in October 2025.

Scope and Methodology

The OIG initiated this national review in November 2024 to evaluate VHA's adherence to suicide risk and intervention training, use of suicide risk identification processes in audiology settings, and implementation of PTM. The OIG team reviewed relevant VHA national documents, policies, memorandums, and audiology accreditation and scope of practice standards.

The OIG requested documents related to mental health screening, suicide risk training and screening, and PTM implementation from VHA-identified audiology points of contact (audiology contacts) at 140 VHA facilities that deliver audiology services.

The OIG also requested facility policies, standard operating procedures, and memorandums of understanding in effect from October 1, 2023, through September 30, 2024. These documents relate to the screening and evaluation of mental health and substance use symptoms, integrated dual diagnosis treatment, coordination of care for mental health and substance use conditions, and suicide prevention for patients receiving audiology services. Of the 140 document requests distributed, the OIG received 108 (77 percent) complete responses, 26 (19 percent) partially complete responses, and no responses from 6 (4 percent) of audiology contacts (see appendix A).

The OIG interviewed Audiology and Speech Pathology Service and Office of Suicide Prevention (OSP) Program Office leaders.

The OIG compiled and analyzed VHA data from all unique patients who received audiology services in FYs 2023 and 2024.[21] Among those unique patients, the OIG determined the number of patients who (1) received treatment for tinnitus, (2) had a co-occurring mental health diagnosis, (3) did not engage in VHA mental health treatment, and (4) did not receive care in any other VHA service.[22] Additionally, the OIG obtained FYs 2023 and 2024 audiology suicide risk screening adherence data from OSP for 135 of 140 facilities.[23]

---

[20] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, Report No. 23-02939-13, December 18, 2024.

[21] The OIG defined patients as receiving audiology services if the patient attended a visit that was coded consistent with audiology services, either as the primary or secondary service. The OIG did not independently verify VHA data for accuracy or completeness.

[22] The OIG defined treatment for tinnitus through a patient's primary or secondary diagnosis of tinnitus. Mental health diagnosis was determined through and active mental health diagnosis in the patient's electronic health record problem list at the time of the audiology visit. The OIG defined engagement in mental health treatment as a visit, during the same year as the audiology visit, with a primary or secondary mental health code.

[23] VHA data excluded 5 facilities due to implementation of a new electronic health record system.

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).

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 within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Implementation of Required Suicide Risk and Intervention Training

VHA implemented mandatory suicide risk and intervention training to "ensure that VHA employees have adequate training to recognize the signs of suicide risk, understand proper protocols for responding to suicide crisis and understand best practices for suicide prevention among Veterans."[24] Specifically, all nonclinical staff are required to complete Signs, Ask, Validate, Encourage and Expedite (VA S.A.V.E.) training and all clinical staff must complete Skills Training for Evaluation and Management of Suicide (STEMS) within 90 days of entering their positions and annually thereafter.[25] VHA requires medical center directors to ensure VHA healthcare providers are assigned and complete the mandatory training.[26]

Audiology contacts from 132 of 140 facilities provided suicide risk and intervention training records.[27] The OIG found that while most nonclinical staff completed the required VA S.A.V.E. training, most clinical staff did not complete the required STEMS training (see figure 3). Further,

[24] VHA Directive 1071(1).

[25] The acronym "S.A.V.E" summarizes the steps to take in recognizing and responding to a veteran in suicidal crisis: signs of suicidal thinking, ask questions, validate the person's experience, encourage treatment, and expedite getting help. "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis," VA, accessed June 24, 2025, https://www.mentalhealth.va.gov/suicide_prevention/docs/VA_SAVE_Training.pdf; VHA defines clinical staff as licensed independent practitioners, advanced practice providers, registered nurses, and case managers. VHA Directive 1071(1).

[26] VHA Directive 1071(1).

[27] The OIG excluded two facilities from analysis that partially completed the document request but did not provide audiology staff names or positions.

the majority of clinical staff who completed the required STEMS training did so after the OIG requested training completion documents.[28]

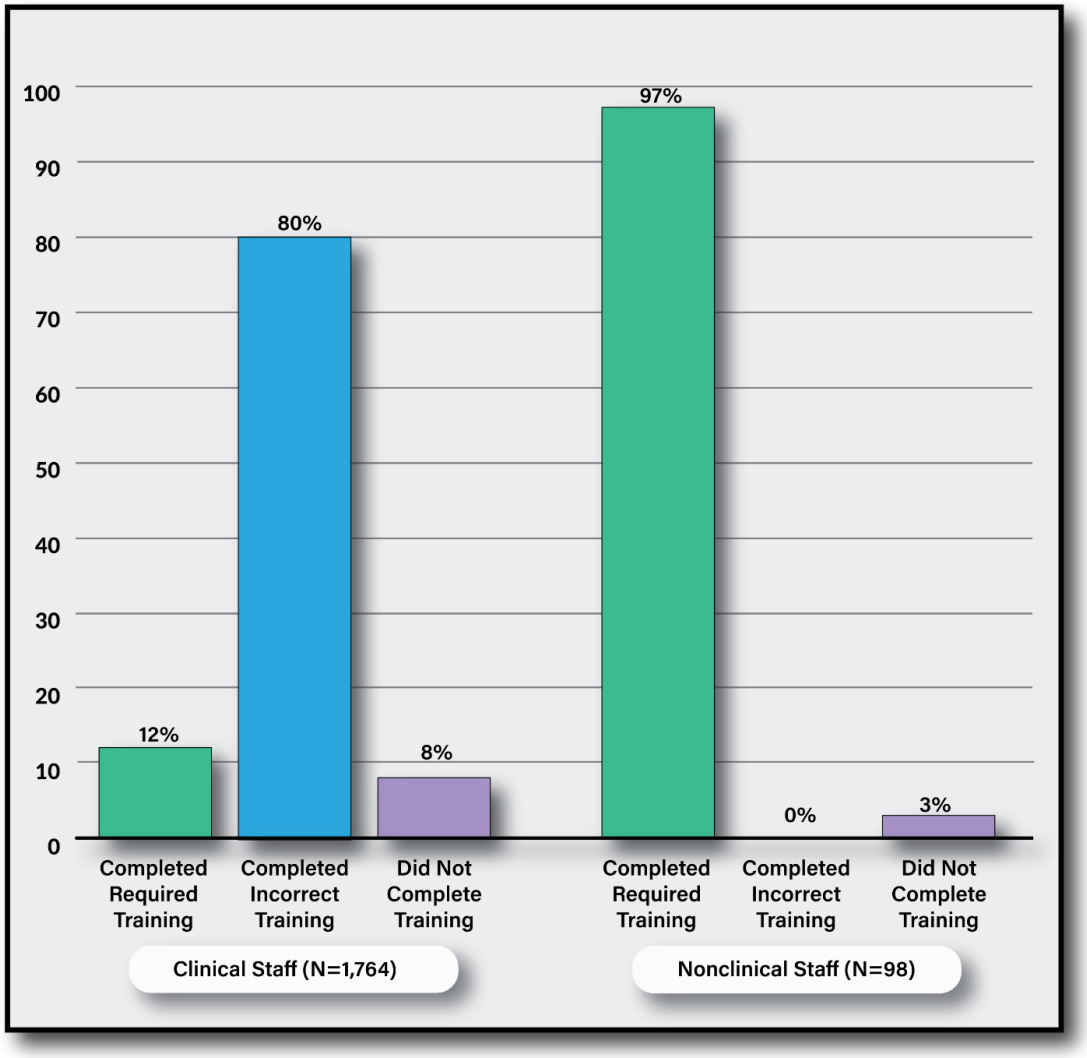

Figure 3. *Designation of reported audiology positions as clinical or nonclinical and suicide risk and intervention training completed by audiology staff.*
Source: OIG analysis of facility document request responses.
Note: Audiology contacts did not provide training completion records for 143 clinical and 3 nonclinical audiology staff. These individuals are reflected in the "Did Not Complete Training" category.

[28] Of the 209 audiology clinical staff who completed STEMS training, 186 (89 percent) completed the training after the OIG requested audiology staff training records on November 18, 2024.

Of 120 audiology contacts, half reported lack of awareness of training requirements as a barrier to suicide risk and intervention training completion.[29] Audiology contacts indicated that audiologists were assigned nonclinical training in VHA's Talent Management System (see figure 4).[30]

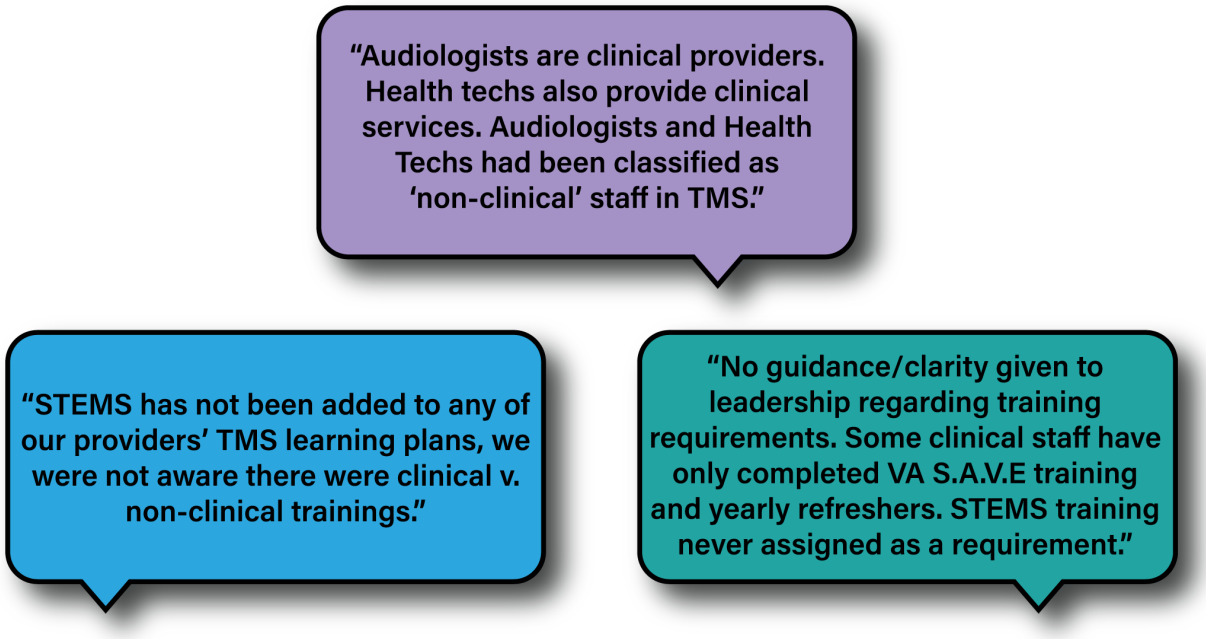

Figure 4. *Audiologist comments related to awareness of training requirements.*
Source: OIG analysis of audiology contact document request responses.

The National Director, Audiology and Speech Pathology Service told the OIG that OSP is responsible for suicide risk and intervention training guidance. In a March 25, 2025, interview with the OIG, an OSP Education and Training leader stated, "audiologist [*sic*] are not included in the definition of healthcare providers, so they are expected to complete [VA] S.A.V.E." On March 31, 2025, in a written response to an OIG request, an OSP Policy Development leader stated that suicide risk and intervention training policy was being revised to include audiologists as healthcare providers. On April 11, 2025, in an unsolicited email to the OIG, the OSP Policy Development leader wrote,

> While Audiologist [*sic*] are not assigned STEMS training at the national level, Audiologists are considered VHA health care providers as defined within the

[29] The OIG excluded 7 facilities from analysis that partially completed the document request but did not provide a response to whether lack of awareness of training requirements was a barrier.

[30] Talent Management System (TMS) is a "web-based enterprise application for managing education and training records within the VA workforce. It serves as the main access point to training opportunities within the Department, as well as from external sources …. As the VA's system of record for education and training, TMS … provides training certification and compliance tracking for all VA staff and it supports multiple internal and external reporting requirements." VA, *Talent Management System 2.0 Assessing VA Central Office*, March 6, 2024.

current directive. For the purposes of Suicide Risk and Intervention Training expectations, it is the responsibility of the VA medical facility Director to ensure all VHA health care providers are assigned STEMS.

The OIG found that nonclinical audiology staff completed the VA S.A.V.E. training. However, the OIG determined that OSP leaders' did not recognize audiologists as clinical staff, which contributed to audiologists' completion of VA S.A.V.E. training rather than STEMS training. The OIG expects OSP leaders to specifically identify clinical staff required to complete STEMS training and medical center directors to ensure accurate training assignment. Given OSP leaders' inaccurate training expectations for audiologists, the OIG is concerned that other clinical staff may not be assigned the required STEMS training. Clinical staff not being accurately assigned STEMS training could result in missed opportunities to identify suicide risk and provide suicide prevention services to mitigate risk. Completion of this training may decrease clinicians' discomfort recognizing and responding to suicide risk and warning signs.

2. Suicide Risk Screening in Audiology Settings

Among individuals who died by suicide, an estimated 92 percent received healthcare services, mostly in medical specialty and primary care settings, in the year prior to death. Approximately half of those individuals did not have a mental health diagnosis.[31] Therefore, it is critical for clinicians across healthcare settings to screen patients for suicide risk.[32]

VHA requires clinicians to complete an annual suicide risk screening with all patients in outpatient care settings, including audiology services, at the first appointment when the screening is due.[33]

---

[31] Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention,* 2021; Brian K. Ahmedani et al., "Variation in Patterns of Health Care Before Suicide: A Population Case-control Study," *Preventive Medicine*, no. 127 (2019): https://doi.org/10.1016/j.ypmed.2019.105796.

[32] Department of Health and Human Services, *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) [et al.], November 23, 2022.

[33] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) [et al.], November 23, 2022; This memo was updated by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to Veterans Integrated Service Network Directors (10N1-23), January 7, 2025;"Office of Suicide Prevention Suicide Risk Identification (Risk ID) Strategy Frequently Asked Questions (FAQ)," VA, accessed August 5, 2024. This website was removed as of August 20, 2025. https://dvagov.sharepoint.com/sites/ECH/srsa/_layouts/15/viewer.aspx?sourcedoc={208aba8f-415d-467e-87e5-a4999fce1441}. (This site is not publicly accessible.)

In FYs 2023 and 2024, 269,078 patients received only audiology services at VHA facilities. As the sole VHA clinical contacts for these patients, audiologists are in a unique position to identify individuals at risk for suicide.[34] Although screening adherence within audiology service improved from FYs 2023 to 2024, audiology staff screened fewer than 40 percent of patients who were due (see figure 5).

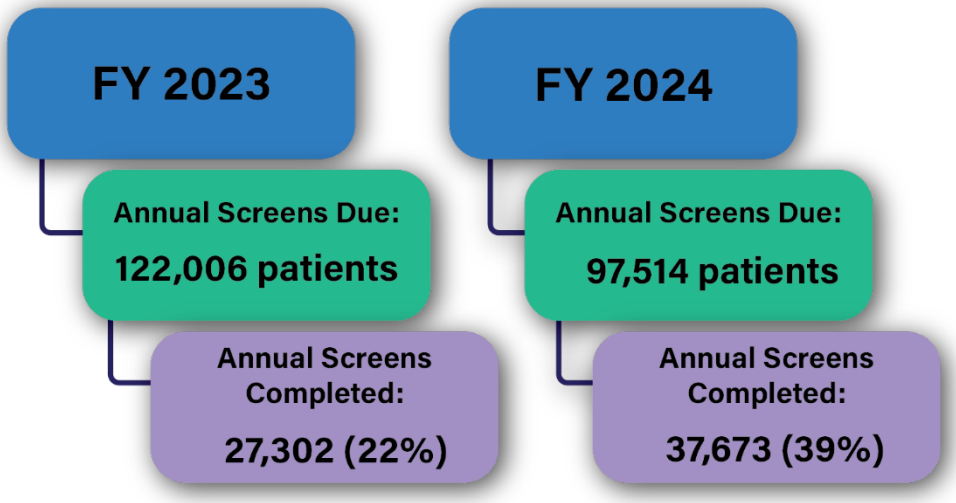

Figure 5. *FYs 2023 and 2024 data on the number of patients with an annual suicide risk screening due at an audiology appointment and number of suicide risk screenings completed in audiology service.*
Source: OIG analysis of clinical encounter and Risk ID data.

Nationally, the OIG found that audiology service staff's adherence to annual screening was 22 and 39 percent in FYs 2023 and 2024, respectively.[35] Adherence to annual suicide risk screening varied significantly across facilities.

The OIG found that in FYs 2023 and 2024, audiology staff at 15 facilities did not complete any screenings. During the same period, the 15 facilities accounted for about 24,000 suicide risk screenings that were not completed when due.[36] Approximately 29,000 patients at these facilities only received VHA care within the audiology service; the OIG is concerned that some may not have received an annual screening during either FY (see figure 6).

[34] Through review of audiology stop code data, the OIG identified 269,078 patients for whom audiology was their only VHA clinical point of contact.

[35] During the time frame of this review, VHA reported using an appointment-based performance metric that evaluated suicide risk screening on the same day as a clinical encounter in which the screening was due until July 2025, when a population-level performance metric was implemented to evaluate the percentage of VHA patients, at any VHA facility, with a completed suicide risk screening in the past year.

[36] The OIG found that although approximately 25,000 patients had screenings due at the time of an audiology visit, another clinical service completed screenings for 1,000 patients to fulfill the requirement.

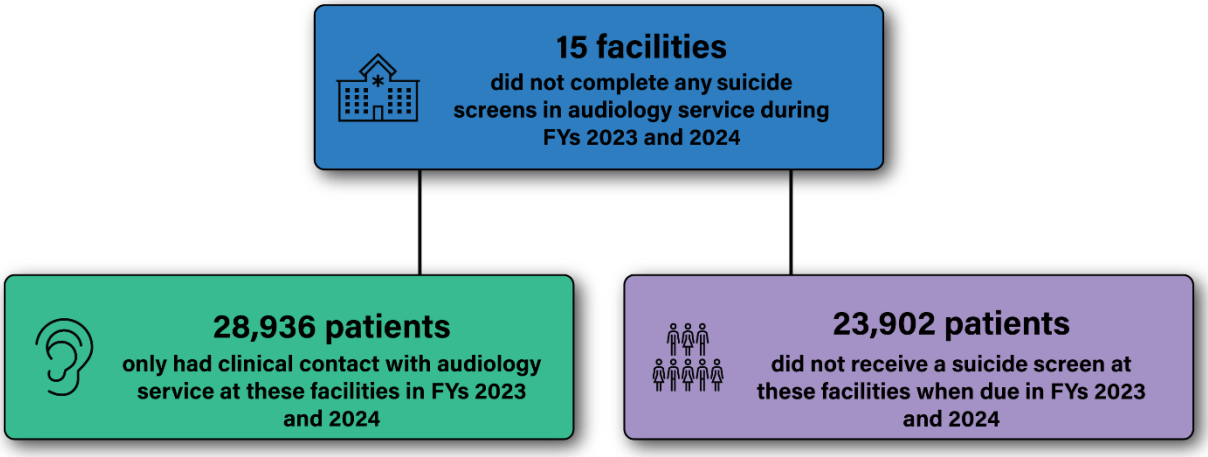

Figure 6. *Audiology screening adherence in FYs 2023 and 2024.*
Source: OIG analysis of clinical encounter and Risk ID data.
Note: The OIG is unable to determine how many of the patients who did not receive a suicide screening also only had clinical contact with audiology services.

VHA requires suicide risk screening across clinical services to ensure "that the entire healthcare system" is equipped to identify patients at risk for suicide and connect those patients to "life-saving resources and interventions."[37] In interviews with the OIG, OSP leaders confirmed that suicide risk screening is required in audiology service. An Office of Audiology and Speech Pathology Services leader reported not monitoring suicide risk screening adherence and stated that OSP holds this responsibility. The Office of Audiology and Speech Pathology Services leader stated that audiologists receive limited training in suicide risk screening and were initially uncomfortable completing the screening. The leader also reported a perception that adherence improves with increased education but noted the Office of Audiology and Speech Pathology Services had not consulted with OSP as of May 2025.

The OIG would expect a collaborative partnership between the Office of Audiology and Speech Pathology Services and OSP to support greater adherence to the suicide risk screening requirement for this vulnerable population. Considering audiologists provide clinical services to a significant number of patients who do not receive any other VHA health care, deficiencies in

[37] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) [et al.], November 23, 2022. This memorandum was replaced by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum to VISN Directors (10N1-23), January 7, 2025. Both memorandums contain similar language about ensuring the entire healthcare system is equipped to identify patients at risk for suicide and provide life-saving resources.

suicide risk screening may result in not identifying patients at risk for suicide and missed opportunities for risk mitigation.

3. PTM Implementation and Oversight

The VA/DoD Clinical Practice Guideline for Tinnitus (clinical practice guideline) provides evidence-based recommendations for effectively managing tinnitus.[38] The clinical practice guideline, although not required, focuses on widely used and accessible tinnitus assessment and management strategies and is suitable for most audiology settings.[39]

The clinical practice guideline also emphasizes coordination between audiologists and mental health providers to address patient behavioral and mental health needs using evidence-based protocols such as PTM.[40] The OIG received PTM implementation status information from 127 VHA audiology contacts. The majority reported having implemented PTM, with most offering Level 5–Individualized Support (see figure 7).

Highest Level of PTM Implemented	Number of Facilities (N=112)	Percent of Facilities
Level 1-Triage	1	1%
Level 2-Audiologic Evaluation	20	18%
Level 3-Group Education	12	11%
Level 4-Interdisciplinary Evaluation	5	4%
Level 5-Individualized Support	74	66%

Figure 7. *Highest level of PTM implemented among facilities that reported PTM implementation.*
Source: OIG analysis of VHA facility document request responses.
Note: The OIG excluded 15 facilities that reported not having implemented PTM.

Audiology contacts identified limited scheduling availability and lack of collaboration, administrative time, and co-location with mental health services as the most common barriers to PTM implementation; each was reported by approximately a third of respondents. Of the 91

[38] "VA/DoD Clinical Practice Guideline for Tinnitus," VA/DoD, accessed July 31, 2024, https://www.healthquality.va.gov/guidelines/CD/tinnitus/VADOD-CPG-Tinnitus-Full-CPG-2024_Final_508.pdf.
[39] "VA/DoD Clinical Practice Guideline for Tinnitus," VA/DoD.
[40] "VA/DoD Clinical Practice Guideline for Tinnitus," VA/DoD.

facilities that submitted policy guidance documents, just 1 facility provided a standard operating procedure related to PTM.[41]

The National Director, Audiology and Speech Pathology Service explained to the OIG, "the expectation is that if you're providing PTM just like anything else, you need to have the resources in place for referral … It is vital, for PTM to be successful, to have some sort of mental health integration." However, the National Director, Audiology and Speech Pathology Service was unaware of prior collaboration and reported not collaborating with the Office of Mental Health since assuming the role in November 2023. Further, the Director stated that mental health integration to support PTM implementation is a "local-driven decision."

The OIG determined that while most facilities offer the highest level of PTM, most facility policy documents do not define PTM processes related to mental health integration. In the absence of policies or facility documentation, OIG is unable to determine the level of mental health integration for PTM. Further, neither Audiology and Speech Pathology Service nor OSP leaders reported providing oversight of PTM implementation.

PTM is used widely across VHA and included in the clinical practice guideline. Therefore, the OIG would expect collaboration and clear delineation of responsibilities between Audiology and Speech Pathology Service and the Office of Mental Health to support the critical mental health integration component of PTM. Inadequate oversight of mental health integration may limit VHA's ability to evaluate and address barriers to PTM implementation, which may result in missed opportunities to identify co-occurring mental health treatment needs and provide mental health services.

Conclusion

OSP leaders' not recognizing audiologists as clinical staff contributed to audiologists' completion of VA S.A.V.E. training rather than STEMS training. Given OSP leaders' inaccurate training expectations for audiologists, the OIG is concerned that clinical staff in other VHA services may not be assigned or receive STEMS training, limiting their ability to assess patients for suicide risk and engage them in treatment.

Audiology staff screened fewer than 40 percent of patients who were due for a suicide risk screening. The OIG would expect a collaborative partnership between the Office of Audiology and Speech Pathology Services and OSP to support greater adherence to the suicide risk screening requirement in audiology settings.

[41] The OIG received and reviewed 146 documents consisting of directives, memorandums, policies, standard operating procedures, and clinical practice guidance and excluded facility announcements, emails, informal instructional documents, and external accrediting standards. VA Eastern Kansas Healthcare System staff provided the OIG with a PTM standard operating procedure.

Although most facilities offer the highest level of PTM, most facility policy documents do not define PTM processes related to mental health integration. Audiology and Speech Pathology Service and OSP leaders do not provide oversight of PTM implementation.

Given the widespread use of PTM across VHA and inclusion of PTM in the clinical practice guideline, the OIG would expect collaboration between Audiology and Speech Pathology Services and the Office of Mental Health to support implementation and oversight of the critical mental health integration component of PTM. Inadequate oversight of mental health integration may limit VHA's ability to evaluate and address barriers to PTM implementation, which may result in missed opportunities to identify co-occurring mental health treatment needs and provide mental health services.

The OIG made five recommendations to the Under Secretary for Health.[42]

Recommendations 1–5

1. The Under Secretary for Health clarifies the requirements for suicide risk and intervention training for audiologists and delineates responsibility for ensuring training is completed as required.
2. The Under Secretary for Health evaluates the definition of healthcare provider for the purposes of suicide risk and intervention training.
3. The Under Secretary for Health evaluates the accuracy of suicide risk and intervention training assignment, consistent with Veterans Health Administration policy, for all healthcare providers.
4. The Under Secretary for Health ensures audiology staff complete suicide risk identification screening as required.
5. The Under Secretary for Health evaluates oversight of and barriers to mental health integration in audiology services and takes action as appropriate.

[42] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Document Request

Table A.1. VHA Facilities that Did Not Respond to the OIG Document Request

System Name	Location
VA New Mexico Healthcare System	Albuquerque, New Mexico
VA Fayetteville Coastal Healthcare System	Fayetteville, North Carolina
VA Hampton Healthcare System	Hampton, Virginia
Texas Valley Coastal Bend VA Health Care System	Harlingen, Texas
Robley Rex VA Medical Center	Louisville, Kentucky
Northern Arizona VA Health Care System	Prescott, Arizona

Source: OIG document request analysis.

Appendix B: Suicide Risk Screening Adherence FYs 2023 and 2024

Table B.1. VHA Facilities Without Completed Suicide Risk Screenings in Audiology FY 2023

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
VISN 1: VA New England Healthcare System	6510	1889	185	32%
402 VA Maine Healthcare System	865	590	51	74%
405 VA White River Junction Healthcare System	780	172	22	25%
518 VA Bedford Healthcare System	552	119	14	24%
523 VA Boston Healthcare System	1135	0	21	2%
608 VA Manchester Healthcare System	620	327	12	55%
631 VA Central Western Massachusetts Healthcare System	818	302	18	39%
650 VA Providence Health Care System	803	379	11	49%
689 VA Connecticut Healthcare System	937	0	36	4%
VISN 2: New York/New Jersey VA Health Care Network	5663	3359	227	63%
526 VA Bronx Healthcare System	195	8	39	24%
528A8 VA Albany Healthcare System	539	64	14	14%
528A7 VA Syracuse Healthcare System	601	544	10	92%
528A6 VA Finger Lakes Healthcare System	747	281	26	41%
528 VA Western New York Healthcare System	356	192	19	59%
561 VA New Jersey Healthcare System	792	517	23	68%
620 VA Hudson Valley Healthcare System	805	700	18	89%
630 VA NY Harbor Healthcare System	596	241	52	49%
632 VA Northport Healthcare System	1032	812	26	81%
VISN 4: VA Healthcare	6007	1360	271	27%
460 VA Wilmington Healthcare System	474	54	10	14%
503 VA Altoona Healthcare System	285	67	30	34%
529 VA Butler Healthcare System	267	150	13	61%
542 VA Coatesville Healthcare System	522	104	16	23%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
562 VA Erie Healthcare System	417	86	22	26%
595 VA Lebanon Healthcare System	915	460	30	54%
642 VA Philadelphia Healthcare System	1361	1	45	3%
646 VA Pittsburgh Healthcare System	1316	333	69	31%
693 VA Wilkes-Barre Healthcare System	450	105	36	31%
VISN 5: VA Capitol Health Care Network	4357	615	141	17%
512 VA Maryland Health Care System	940	0	31	3%
517 VA Beckley Healthcare System	305	149	9	52%
540 VA Clarksburg Healthcare System	358	135	18	43%
581 Hershel “Woody” Williams VA Medical Center	496	250	16	54%
613 Martinsburg VA Medical Center	451	80	28	24%
688 VA Washington DC Healthcare System	1807	1	39	2%
VISN 6: VA Mid-Atlantic Health Care Network	7862	718	240	12%
558 Durham VA Health Care System	1834	5	54	3%
565 VA Fayetteville Coastal Healthcare System	1602	0	31	2%
590 VA Hampton Healthcare System	1443	0	34	2%
637 VA Asheville Health Care System	559	94	24	21%
652 Central Virginia VA Health Care System	595	52	22	12%
658 VA Salem Healthcare System	640	0	25	4%
659 Salisbury VA Health Care System	1189	567	50	52%
VISN 7: VA Southeast Network	9013	1039	275	15%
508 VA Atlanta Healthcare System	2297	737	26	33%
509 VA Augusta Health Care System	980	0	62	6%
521 Birmingham VA Health Care System	1888	0	79	4%
534 Ralph H. Johnson VA Health Care System	943	0	13	1%
544 Columbia VA Health Care System	716	43	13	8%
557 VA Dublin Healthcare System	410	135	14	36%
619 VA Central Alabama Health Care System	1626	119	17	8%
679 VA Tuscaloosa Healthcare System	153	5	51	37%
VISN 8: VA Sunshine Healthcare Network	9328	2850	292	34%
516 Bay Pines VA Healthcare System	1468	9	113	8%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
546 Miami VA Healthcare System	771	196	25	29%
548 West Palm Beach VA Healthcare System	1319	453	16	36%
573 VA North Florida/South Georgia Veterans Health System	1822	965	20	54%
672 VA Caribbean Healthcare System	310	27	29	18%
673 VA Tampa Healthcare System	1536	457	13	31%
675 VA Orlando Healthcare System	2102	743	76	39%
VISN 9: VA MidSouth Healthcare Network	4768	1141	87	26%
596 Lexington VA Healthcare System	688	131	29	23%
603 VA Louisville Healthcare System	626	206	7	34%
614 VA Memphis Healthcare System	395	317	6	82%
621 VA Mountain Home Healthcare System	1045	8	13	2%
626 VA Tennessee Valley Healthcare System	2014	479	32	25%
VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan	8137	2964	451	42%
506 VA Ann Arbor Healthcare System	830	307	37	41%
515 VA Battle Creek Healthcare System	652	484	31	79%
538 VA Chillicothe Healthcare System	191	103	2	55%
539 VA Cincinnati Healthcare System	929	56	20	8%
541 VA Northeast Ohio Healthcare System	1229	156	32	15%
552 VA Dayton Healthcare System	1177	443	31	40%
553 VA Detroit Healthcare System	618	352	20	60%
583 VA Indiana Healthcare System	879	613	22	72%
610 VA Northern Indiana Healthcare System	910	300	246	60%
655 VA Saginaw Healthcare System	722	150	10	22%
VISN 12: VA Great Lakes Health Care System	5931	688	241	16%
537 VA Chicago Healthcare System	309	101	10	36%
550 VA Iliana Healthcare System	364	0	15	4%
556 Lovell Federal Healthcare System	1053	227	56	27%
578 VA Hines Healthcare System	1040	0	33	3%
585 VA Iron Mountain Healthcare System	180	0	8	4%
607 William S. Middleton Memorial Veterans Hospital and Clinics	702	143	12	22%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
676 Tomah VA Health Care System	559	217	53	48%
695 VA Milwaukee Healthcare System	1724	0	54	3%
VISN 15: VA Heartland Network	3728	682	172	23%
589 VA Kansas City Healthcare System	785	384	15	51%
657 VA St. Louis Healthcare System	600	0	7	1%
589A4 VA Columbia Missouri Healthcare System	674	0	50	7%
589A5 VA Eastern Kansas Healthcare System	614	119	20	23%
589A7 VA Wichita Healthcare System	261	175	10	71%
657A4 VA Poplar Bluff Health Care System	278	3	9	4%
657A5 VA Marion Healthcare System	516	1	61	12%
VISN 16: South Central VA Health Care Network	7596	1477	176	22%
502 VA Alexandria Healthcare System	416	12	8	5%
520 VA Gulf Coast Healthcare System	3237	817	52	27%
564 Veterans Health Care System of the Ozarks	839	323	31	42%
580 VA Houston Healthcare System	879	0	28	3%
586 VA Jackson Healthcare System	327	0	9	3%
598 Central Arkansas Veterans Healthcare System	489	325	20	71%
629 VA Southeast Louisiana Healthcare System	773	0	17	2%
667 VA Shreveport Healthcare System	636	0	11	2%
VISN 17: VA Heart of Texas Healthcare Network	5770	282	114	7%
504 VA Amarillo Healthcare System	290	95	20	40%
519 VA West Texas Healthcare System	164	93	1	57%
549 VA North Texas Health Care System	2169	0	55	3%
671 South Texas Veterans Health Care System	1861	1	15	1%
674 VA Central Texas Healthcare System	923	0	17	2%
740 VA Texas Valley Coastal Bend Healthcare System	349	93	6	28%
756 VA El Paso Healthcare System	14	0	0	0%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
VISN 19: VA Rocky Mountain Network	7922	215	279	6%
436 Montana VA Healthcare System	220	0	0	0%
442 Cheyenne VA Health Care System	735	0	19	3%
554 VA Eastern Colorado Health Care System	3150	40	125	5%
575 VA Western Colorado Healthcare System	270	15	14	11%
623 Eastern Oklahoma VA Health Care System	549	0	26	5%
635 VA Oklahoma City Healthcare System	987	0	17	2%
660 VA Salt Lake City Healthcare System	1900	160	70	12%
666 Sheridan VA Health Care System	111	0	8	7%
VISN 20: VA Northwest Health Network	5600	2546	271	50%
463 Alaska VA Healthcare System	477	5	201	43%
531 VA Boise Healthcare System	535	0	24	4%
648 VA Portland Health Care System	1942	1172	27	62%
663 VA Puget Sound Health Care System	2646	1369	19	52%
VISN 21: VA Sierra Pacific Network	7398	1727	370	28%
358 Manila VA Outpatient Clinic	451	0	235	52%
459 VA Pacific Islands Health Care System	452	113	7	27%
570 VA Central California Health Care System	421	223	9	55%
593 VA Southern Nevada Healthcare System	577	227	2	40%
612 VA Northern California Health Care System	2666	637	31	25%
640 VA Palo Alto Health Care System	1622	353	72	26%
654 VA Sierra Nevada Health Care System	299	168	2	57%
662 San Francisco VA Health Care System	910	6	12	2%
VISN 22: VA Desert Pacific Healthcare Network	10973	2450	129	24%
501 VA New Mexico Healthcare System	651	31	20	8%
600 VA Long Beach Healthcare System	1021	839	12	83%
605 VA Loma Linda Healthcare System	1979	1570	5	80%
644 VA Phoenix Health Care System	2528	2	34	1%
649 Northern Arizona VA Health Care System	202	0	5	2%
664 VA San Diego Healthcare System	1568	0	22	1%
678 Southern Arizona VA Health Care System	1613	8	15	1%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
691 VA Greater Los Angeles Healthcare System	1411	0	16	1%
VISN 23: VA Midwest Health Care Network	4885	1300	412	35%
437 Fargo VA Health Care System	261	25	21	18%
438 VA Sioux Falls Health Care System	507	0	53	10%
568 VA Black Hills Health Care System	298	10	17	9%
618 Minneapolis VA Health Care System	1799	567	90	37%
636A8 VA Iowa City Healthcare System	416	0	16	4%
636A6 VA Central Iowa Health Care System	609	379	3	63%
636 VA Nebraska-Western Iowa Health Care System	282	8	3	4%
656 St. Cloud VA Health Care System	713	311	209	73%

Source: OIG analysis of Risk ID data.
Note: The OIG excluded five sites that implemented the new electronic health record system because data were not available.

Table B.2. VHA Facilities Without Completed Suicide Risk Screenings in Audiology FY 2024

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
VISN 1: VA New England Healthcare System	5341	2661	178	53%
402 VA Maine Healthcare System	785	559	54	78%
405 VA White River Junction Healthcare System	472	177	32	44%
518 VA Bedford Healthcare System	484	234	11	51%
523 VA Boston Healthcare System	818	177	24	25%
608 VA Manchester Healthcare System	627	450	18	75%
631 VA Central Western Massachusetts Healthcare System	714	436	6	62%
650 VA Providence Health Care System	732	431	4	59%
689 VA Connecticut Healthcare System	709	197	29	32%
VISN 2: New York/New Jersey VA Health Care Network	4425	3340	192	80%
526 VA Bronx Healthcare System	179	7	39	26%
528A8 VA Albany Healthcare System	335	167	9	53%
528A7 VA Syracuse Healthcare System	564	545	12	99%
528A6 VA Finger Lakes Healthcare System	513	432	29	90%
528 VA Western New York Healthcare System	287	201	13	75%
561 VA New Jersey Healthcare System	673	551	11	84%
620 VA Hudson Valley Healthcare System	632	543	23	90%
630 VA NY Harbor Healthcare System	398	184	27	53%
632 VA Northport Healthcare System	844	710	29	88%
VISN 4: VA Healthcare	4777	2625	210	59%
460 VA Wilmington Healthcare System	494	412	5	84%
503 VA Altoona Healthcare System	242	173	25	82%
529 VA Butler Healthcare System	162	128	8	84%
542 VA Coatesville Healthcare System	344	212	12	65%
562 VA Erie Healthcare System	319	63	8	22%
595 VA Lebanon Healthcare System	896	547	26	64%
642 VA Philadelphia Healthcare System	960	431	61	51%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
646 VA Pittsburgh Healthcare System	883	458	48	57%
693 VA Wilkes-Barre Healthcare System	477	201	17	46%
VISN 5: VA Capitol Health Care Network	3843	1007	159	30%
512 VA Maryland Health Care System	798	133	54	23%
517 VA Beckley Healthcare System	173	155	1	90%
540 VA Clarksburg Healthcare System	214	172	14	87%
581 Hershel “Woody” Williams VA Medical Center	362	228	13	67%
613 Martinsburg VA Medical Center	372	261	22	76%
688 VA Washington DC Healthcare System	1924	58	55	6%
VISN 6: VA Mid-Atlantic Health Care Network	6047	1538	199	29%
558 Durham VA Health Care System	1444	546	61	42%
565 VA Fayetteville Coastal Healthcare System	1345	0	26	2%
590 VA Hampton Healthcare System	1103	192	22	19%
637 VA Asheville Health Care System	307	91	13	34%
652 Central Virginia VA Health Care System	522	131	18	29%
658 VA Salem Healthcare System	444	41	20	14%
659 Salisbury VA Health Care System	882	537	39	65%
VISN 7: VA Southeast Network	7665	1080	224	17%
508 VA Atlanta Healthcare System	2023	751	9	38%
509 VA Augusta Health Care System	807	0	32	4%
521 Birmingham VA Health Care System	1641	0	73	4%
534 Ralph H. Johnson VA Health Care System	747	0	17	2%
544 Columbia VA Health Care System	788	40	15	7%
557 VA Dublin Healthcare System	352	118	12	37%
619 VA Central Alabama Health Care System	1236	168	15	15%
679 VA Tuscaloosa Healthcare System	71	3	51	76%
VISN 8: VA Sunshine Healthcare Network	7449	3447	313	50%
516 Bay Pines VA Healthcare System	890	0	141	16%
546 Miami VA Healthcare System	666	236	42	42%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
548 West Palm Beach VA Healthcare System	908	567	19	65%
573 VA North Florida/South Georgia Veterans Health System	1502	1004	18	68%
672 VA Caribbean Healthcare System	303	54	32	28%
673 VA Tampa Healthcare System	1136	437	15	40%
675 VA Orlando Healthcare System	2044	1149	46	58%
VISN 9: VA MidSouth Healthcare Network	3913	1856	88	50%
596 Lexington VA Healthcare System	472	176	33	44%
603 VA Louisville Healthcare System	571	252	3	45%
614 VA Memphis Healthcare System	412	287	5	71%
621 VA Mountain Home Healthcare System	828	51	12	8%
626 VA Tennessee Valley Healthcare System	1630	1090	35	69%
VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan	6301	4042	330	69%
506 VA Ann Arbor Healthcare System	640	438	65	79%
515 VA Battle Creek Healthcare System	618	451	34	78%
538 VA Chillicothe Healthcare System	108	73	7	74%
539 VA Cincinnati Healthcare System	700	381	16	57%
541 VA Northeast Ohio Healthcare System	1199	706	38	62%
552 VA Dayton Healthcare System	712	479	27	71%
553 VA Detroit Healthcare System	429	310	16	76%
583 VA Indiana Healthcare System	683	512	21	78%
610 VA Northern Indiana Healthcare System	688	427	98	76%
655 VA Saginaw Healthcare System	524	265	8	52%
VISN 12: VA Great Lakes Health Care System	3563	1746	153	53%
537 VA Chicago Healthcare System	203	122	9	65%
550 VA Iliana Healthcare System	255	64	9	29%
556 Lovell Federal Healthcare System	191	150	6	82%
578 VA Hines Healthcare System	653	247	25	42%
585 VA Iron Mountain Healthcare System	127	56	8	50%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
607 William S. Middleton Memorial Veterans Hospital and Clinics	430	307	11	74%
676 Tomah VA Health Care System	508	394	34	84%
695 VA Milwaukee Healthcare System	1196	406	51	38%
VISN 15: VA Heartland Network	3153	966	144	35%
589 VA Kansas City Healthcare System	606	446	15	76%
657 VA St. Louis Healthcare System	680	0	7	1%
589A4 VA Columbia Missouri Healthcare System	576	5	55	10%
589A5 VA Eastern Kansas Healthcare System	540	356	21	70%
589A7 VA Wichita Healthcare System	210	97	14	53%
657A4 VA Poplar Bluff Health Care System	257	0	10	4%
657A5 VA Marion Healthcare System	284	62	22	30%
VISN 16: South Central VA Health Care Network	5488	2390	167	47%
502 VA Alexandria Healthcare System	325	4	15	6%
520 VA Gulf Coast Healthcare System	1948	1527	42	81%
564 Veterans Health Care System of the Ozarks	707	328	30	51%
580 VA Houston Healthcare System	872	61	34	11%
586 VA Jackson Healthcare System	318	70	13	26%
598 Central Arkansas Veterans Healthcare System	419	320	10	79%
629 VA Southeast Louisiana Healthcare System	381	0	9	2%
667 VA Shreveport Healthcare System	518	80	14	18%
VISN 17: VA Heart of Texas Healthcare Network	4860	586	111	14%
504 VA Amarillo Healthcare System	190	118	11	68%
519 VA West Texas Healthcare System	162	156	0	96%
549 VA North Texas Health Care System	1864	0	67	4%
671 South Texas Veterans Health Care System	1513	273	10	19%
674 VA Central Texas Healthcare System	1004	0	21	2%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
740 VA Texas Valley Coastal Bend Healthcare System	126	39	2	33%
756 VA El Paso Healthcare System	1	0	0	0%
VISN 19: VA Rocky Mountain Network	5848	2225	580	48%
436 Montana VA Healthcare System	101	31	1	32%
442 Cheyenne VA Health Care System	611	247	15	43%
554 VA Eastern Colorado Health Care System	2295	565	456	44%
575 VA Western Colorado Healthcare System	267	62	16	29%
623 Eastern Oklahoma VA Health Care System	344	144	24	49%
635 VA Oklahoma City Healthcare System	802	145	25	21%
660 VA Salt Lake City Healthcare System	1306	994	37	79%
666 Sheridan VA Health Care System	122	37	6	35%
VISN 20: VA Northwest Health Network	4883	1460	124	32%
463 Alaska VA Healthcare System	374	0	82	22%
531 VA Boise Healthcare System	314	0	13	4%
648 VA Portland Health Care System	1753	849	14	49%
663 VA Puget Sound Health Care System	2442	611	15	26%
VISN 21: VA Sierra Pacific Network	5567	2642	589	58%
358 Manila VA Outpatient Clinic	452	0	221	49%
459 VA Pacific Islands Health Care System	496	411	6	84%
570 VA Central California Health Care System	361	213	11	62%
593 VA Southern Nevada Healthcare System	550	389	7	72%
612 VA Northern California Health Care System	1835	1201	25	67%
640 VA Palo Alto Health Care System	947	96	292	41%
654 VA Sierra Nevada Health Care System	223	200	1	90%
662 San Francisco VA Health Care System	703	132	26	22%
VISN 22: VA Desert Pacific Healthcare Network	9270	2656	165	30%
501 VA New Mexico Healthcare System	453	307	5	69%

System Name	Total Due	Completed in Audiology	Completed in Another Service Area	Adherence
600 VA Long Beach Healthcare System	972	769	32	82%
605 VA Loma Linda Healthcare System	1618	1106	13	69%
644 VA Phoenix Health Care System	2310	2	44	2%
649 Northern Arizona VA Health Care System	145	0	6	4%
664 VA San Diego Healthcare System	1216	0	16	1%
678 Southern Arizona VA Health Care System	1350	25	10	3%
691 VA Greater Los Angeles Healthcare System	1206	447	39	40%
VISN 23: VA Midwest Health Care Network	4285	1406	346	41%
437 Fargo VA Health Care System	240	136	13	62%
438 VA Sioux Falls Health Care System	466	0	44	9%
568 VA Black Hills Health Care System	219	15	12	12%
618 Minneapolis VA Health Care System	1909	634	102	39%
636A8 VA Iowa City Healthcare System	485	0	36	7%
636A6 VA Central Iowa Health Care System	369	305	3	83%
636 VA Nebraska-Western Iowa Health Care System	71	10	7	24%
656 St. Cloud VA Health Care System	526	306	129	83%

Source: OIG analysis of Risk ID data.

Note: The OIG excluded five sites that implemented the new electronic health record system because data were not available.

Table B.3. VHA Facilities with No Suicide Screenings Completed in Audiology Settings in FYs 2023 and 2024

System Name	Location
358 Manila VA Outpatient Clinic	Pasay City, PH
438 VA Sioux Falls Health Care System	Sioux Falls, SD
509 VA Augusta Health Care System	Augusta, GA
521 Birmingham VA Health Care System	Birmingham, AL
531 VA Boise Healthcare System	Boise, ID
534 Ralph H. Johnson VA Health Care System	Charleston, SC
549 VA North Texas Health Care System	Dallas, TX
565 VA Fayetteville Coastal Healthcare System	Fayetteville, NC
629 VA Southeast Louisiana Healthcare System	New Orleans, LA
636A8 VA Iowa City Healthcare System	Iowa City, IA
649 Northern Arizona VA Health Care System	Prescott, AZ
657 VA St. Louis Healthcare System	St. Louis, MO
664 VA San Diego Healthcare System	San Diego, CA
674 VA Central Texas Healthcare System	Temple, TX
756 VA El Paso Healthcare System	El Paso, TX

Source: OIG analysis of Risk ID data.

Appendix C: Office of the Under Secretary for Health Response

Department of Veterans Affairs Memorandum

Date: October 22, 2025

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

Subj: Office of Inspector General (OIG) Report — National Review of Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings

To: Director, Mental Health National Reviews, Office of Healthcare Inspections (54MHP2)

1. Thank you for the opportunity to review and comment on OIG's draft report on Inadequate Mental Health Integration and Suicide Risk Identification in Audiology Clinic Settings.
2. The Veterans Health Administration (VHA) greatly values the OIG's assistance in ensuring that all stakeholders are unified in supporting VHA's vision of providing all Veterans with access to the highest quality care. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.
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:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on October 22, 2025.]

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health clarifies the requirements for suicide risk and intervention training for audiologists and delineates responsibility for ensuring training is completed as required.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. VHA agrees to clarify the requirements for suicide risk and intervention training for audiologists and delineates the responsibility for ensuring training is completed as required. VHA is in the process of publishing a Department of Veterans Affairs (VA) enterprise-wide directive, Mandatory Suicide Prevention Training, that will replace VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022. The pending VA directive will reflect the requirements for suicide risk and intervention training for health care professionals (which includes audiologists) and expands oversight compliance for mandatory trainings.

VHA Audiology and Speech Pathology program office will provide guidance to field audiologists through the electronic communication clarifying that audiologists are considered health care professionals as defined in VHA Directive 1071(1).

Recommendation 2

The Under Secretary for Health evaluates the definition of healthcare provider for the purposes of suicide risk and intervention training.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. VHA concurs with this recommendation and has completed this action. During the course of this Healthcare Inspection, VHA met with subject matter experts and the Office of General Counsel to evaluate the definition of health care professional for the purposes of suicide

risk and intervention training. In the forthcoming VA Directive, Mandatory Suicide Prevention Training, the definition has been updated.

Recommendation 3

The Under Secretary for Health evaluates the accuracy of suicide risk and intervention training assignment, consistent with Veterans Health Administration policy, for all healthcare providers.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. VHA agrees to evaluate the accuracy of suicide risk and intervention training assignment, consistent with the forthcoming VA Directive, Mandatory Suicide Prevention training. VHA will update assignment profiles within the Talent Management System to align with the forthcoming VA Directive, Mandatory Suicide Prevention Training.

Recommendation 4

The Under Secretary for Health ensures audiology staff complete suicide risk identification screening as required.

_X_ Concur

____Nonconcur

Target date for completion: July 2025

Under Secretary for Health Comments

Concur. In January 2025, VHA Memorandum 2025-01-03, Suicide Risk Screening and Evaluation Requirements and Implementation Update delineated that facilities must have processes for regularly monitoring compliance of risk identification implementation within respective standard operating procedures (SOP). In July 2025, VHA changed how they track suicide risk screenings. Instead of checking each individual visit (eCSSRS1), they now look at whether Veterans have been screened at any VHA facility in the past year (suiscreen1). This new method measures the percentage of Veterans who have had a suicide risk screening annually. The focus has shifted from checking each visit to ensuring the entire system is accountable. VHA is now using a system-wide approach to make sure all Veterans are screened for suicide risk regularly. VHA requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 5

The Under Secretary for Health evaluates oversight of and barriers to mental health integration in audiology services and takes action as appropriate.

_X_ Concur

____Nonconcur

Target date for completion: March 2026

Under Secretary for Health Comments

Concur. Audiology and Mental Health will engage in active collaboration to support the needs of Veterans being seen in Audiology service.

VHA Audiology and Speech Pathology will engage VHA Office of Mental Health (OMH) to evaluate oversight of and barriers in the meaningful integration of mental health services into audiology to support integrated and collaborative care. Depending on the findings, VHA Audiology and Speech Pathology will collaborate with OMH to determine if action is needed and take action as appropriate.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Sami Cave, MA, Director Amber Singh, PhD, Director Marsha Alishahi, LCSW Christine Micek, MSN, RN Rebecca Smith, LCSW Robert Yang, MD, MHA
Other Contributors	Kevin Arnhold, FACHE Alicia Castillo-Flores, MBA, MPH Darryl Joe, JD Natalie Qualls, LCSW Larry Ross, MS Natalie Sadow, MBA Caitlin Sweany-Mendez, MPH April Terenzi, BA, BS Ashley Wilson Tammra Wood, LCSW-S

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.vaoig.gov.