US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin

Mental Health Inspection	25-00731-115	May 19, 2026

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Executive Summary

The mission of the VA Office of Inspector General (OIG) Mental Health Inspection Program is to evaluate VA's continuum of mental healthcare services. On July 7, 2025, the OIG announced an inspection to address the mental health care delivered in the acute mental health inpatient unit (inpatient unit) at the Clement J. Zablocki VA Medical Center (facility). The facility is part of the VA Milwaukee Healthcare System in Wisconsin. The OIG conducted inspection activities from July 7 through 30, 2025, and completed the on-site portion of the inspection from July 22 through 24, 2025. At the conclusion of the on-site visit, the OIG team provided the Facility Executive Director with preliminary findings and observations from the inspection.

The OIG evaluated acute inpatient mental health care across five domains. The OIG assessed processes in each of the domains and identified successes and challenges that affected the provision of the quality of care provided on the inpatient unit. Seven recommendations were issued to facility leaders.

The OIG is aware of VA's transformation in the Veterans Health Administration's (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.

For background information on each domain, see appendix A.[1] For information on the OIG's data collection methods, see appendix B.

Domain	OIG Summary
Leadership and Organizational Culture	The OIG looked at reporting channels, committee structures, staffing practices, and oversight and monitoring provided by leaders. The OIG observed that the facility had a unique organizational structure, including two Co-Division Managers who functioned as the chiefs of mental health, two inpatient mental health co-program managers, and a consultative and non-supervisory Associate Chief of Staff for Mental Health. The OIG found that the Mental Health Executive Council did not include veteran representation required under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[2]

[1] The underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[2] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

Domain	OIG Summary
Recovery-Oriented Principles	To assess the inpatient unit's integration of recovery-oriented principles, the OIG examined aspects of leadership, treatment planning, therapeutic and interdisciplinary programming, and the care environment.
Clinical Care Coordination	To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, interdisciplinary treatment planning, medication management, and discharge planning. Staff did not document veterans' legal commitment statuses as detailed in VHA's policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)."[3] Staff also did not document medication risks and benefits discussions, as required by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[4] Additionally, most discharge instructions were not written in easy-to-understand language and did not include the reason for prescribed medications.
Suicide Prevention	To evaluate suicide prevention activities on the inpatient unit, the OIG reviewed compliance with required suicide risk screening and evaluation, safety planning, and training. The OIG found that not all staff completed the VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) training required by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*.[5]

[3] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the health record review period. Unless otherwise noted, all versions contain similar language related to documentation of voluntary or involuntary legal status.

[4] VHA Directive 1160.01; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended May 1, 2024.

[5] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022.

Domain	OIG Summary
Safety	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. While the facility recorded Mental Health Environment of Care Checklist inspection attendance, the suicide prevention coordinator did not attend consistently. During the on-site inspection, the OIG identified a ligature risk in the telephone booth that the chief engineer resolved the same day. Some inpatient unit staff did not complete the annual training required under VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[6]

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with recommendations 1–7 and the Facility Director provided action plans (see appendix E). Based on the information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the identified actions to ensure that they have been implemented and sustained.

The Facility Director reported that mental health staff began using the correct admission screening note and reviewing documentation of veterans' legal status. Facility leaders committed to ensuring documentation of informed consent discussions and discharge instructions are written with easy-to-understand language. Additionally, the Facility Director reported plans to ensure staff complete suicide prevention and safety training and attend mental health environment of care inspections, as required.

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Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[6] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017. This directive was rescinded and replaced by VHA Directive 1167, November 4, 2024. The policies contain similar language related to the design of the inpatient unit and staff training requirements.

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Abbreviations

OIG	Office of Inspector General
STEMS	Skills Training for Evaluation and Management of Suicide
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The mission of the VA Office of Inspector General (OIG) is to conduct independent oversight of VA. The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care through 1,380 healthcare facilities to over nine million enrolled veterans.[1] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On July 7, 2025, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the Clement J. Zablocki VA Medical Center (facility), part of the VA Milwaukee Healthcare System in Wisconsin. The OIG conducted inspection activities from July 7 through 30, 2025, and completed the on-site portion of the inspection from July 22 through 24, 2025.[2] At the conclusion of the on-site visit, the OIG team provided the Facility Executive Director with preliminary findings and observations from the inspection.

VHA's "mental health services are organized across a continuum of care" and "in a team-based, interprofessional, patient-centered, recovery-oriented structure" (see figure 1).[3] Under VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, VHA healthcare system leaders are expected to ensure all veterans who are eligible for care have access to recovery-oriented inpatient, residential, and outpatient mental health programs.[4]

All VHA healthcare systems must provide evaluation, diagnosis, and treatment for the full spectrum of mental health conditions. Required services include psychological and neuropsychological evaluation, evidence-based individual and group psychotherapy, pharmacotherapy, peer support, and vocational rehabilitation counseling.[5]

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[1] "Mission, Vision, Values," OIG, accessed August 11, 2025, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed August 11, 2025, https://www.va.gov/health/aboutvha.asp. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[2] For the purposes of this report, the OIG defines the term "healthcare system" as a parent facility and its associated medical centers, outpatient clinics, and other related VA services or programs.

[3] VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.

[4] VHA Directive 1160.01. In this report, the OIG refers to veterans instead of patients to support recovery-oriented language.

[5] VHA Directive 1160.01. If a healthcare system does not provide required services, those services must be offered through another VA facility or program.

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01 and VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, August 13, 2019, amended to VHA Directive 1163(1) on March 7, 2025. This directive was rescinded and replaced with VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services, on August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.

According to VHA 1160.06, *Inpatient Mental Health Services*, inpatient mental health services are considered the most intensive level of mental health care used to treat veterans safely and effectively during periods of acute mental distress.[6] In fiscal year 2024, VHA healthcare systems delivered inpatient mental health care for 64,298 veteran stays.[7]

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[6] VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023, amended to VHA Directive 1160.06(1), December 27, 2024. Unless otherwise specified, the amended directive contains similar language related to inpatient mental health unit requirements.

[7] VHA identifies a "patient stay" as a distinct instance of a veteran staying on a specific unit for a defined time frame. "ADT Using NUMA," VHA Support Service Center, accessed April 30, 2024, http://vharamp.vssc.med.va.gov/VSSCSearch/Pages/results.aspx?k=ADT%20using%20NUMA. (This site is not publicly accessible.); The fiscal year for the federal government is a 12-month period from October 1 through September 30 and is identified by the calendar year in which it concludes. 49 C.F.R. § 1511.3 (2003).

To evaluate the quality of inpatient mental health care at the facility, the OIG assessed specific processes across five domains: leadership and organizational culture, recovery-oriented principles, clinical care coordination, suicide prevention, and safety. For background information and related requirements, refer to appendix A. For information on the OIG's data collection methods, see appendix B.

About the VA Milwaukee Healthcare System

VA Milwaukee Healthcare System, part of Veterans Integrated Service Network (VISN) 12, provides acute inpatient mental health care at the facility and operates five community-based outpatient clinics in Green Bay, Appleton, Cleveland, Union Grove, and Oconomowoc, Wisconsin.

In fiscal year 2024, VA Milwaukee Healthcare System provided health care to 58,744 veterans, with 16,593 receiving outpatient mental health care. The acute inpatient mental health unit (inpatient unit) maintained an average daily census of 16, with staff caring for 621 veterans. Staff submitted two consults for inpatient mental health care in the community. At the time of this inspection, the inpatient unit had 34 authorized beds.[8]

[8] "Corporate Data Warehouse (CDW)," VA Health Systems Research, accessed April 8, 2020, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm; "VHA Support Service Center Capital Assets (VSSC)," VA, accessed July 18, 2025, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm/about_data.

Leadership and Organizational Culture

"Leaders usually impose structure, systems, and processes [on an organization], which, if successful, become shared parts of the culture. And once processes have become taken for granted, they become the elements of the culture that may be the hardest to change."[9] Healthcare system leaders can nurture a positive, safety-oriented culture by building effective reporting and communication structures, incorporating stakeholder feedback, and supporting continuous performance improvement.[10]

The OIG reviewed the facility's leadership structure, inpatient unit staffing practices, and VISN oversight. The OIG evaluated how these elements support inpatient unit operations, compliance with requirements, and delivery of quality care.

Leadership Structure

At the time of the OIG's inspection, the facility's executive leadership team consisted of the Executive Director, Associate Director, Assistant Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Chief of Staff for Clinical Affairs. The Chief of Staff supervised the Co-Division Managers, Mental Health (Co-Division Managers), who served as the facility's mental health leads and oversaw all mental health programs as required under VHA Directive 1160.01.[11]

The OIG observed the facility had a unique mental health organizational structure that included the two Co-Division Managers, who functioned as the chiefs of mental health, and two inpatient mental health co-program managers (co-program managers). Additionally, facility staff reported having a consultative and non-supervisory Associate Chief of Staff for Mental Health. Leaders highlighted the perceived benefits of this organizational structure, including shared responsibilities, improved workload management, increased staffing coverage, and collaboration for more efficient decision-making. Mental health leaders also reported staff communicated inpatient unit needs and concerns through huddles, leadership rounding on the unit, team meetings, and direct engagement with supervisors.[12] Additionally, VISN and facility leaders reported the Associate Chief of Staff for Mental Health was an academic liaison to a psychiatry residency program, an arrangement that supported staff recruitment.

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[9] Edgar H. Schein, *Organizational Culture and Leadership*, *4th Edition, 2010*, accessed June 25, 2024, https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

[10] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024.

[11] VHA Directive 1160.01.

[12] A huddle is a brief meeting that includes "appropriate discipline-specific team members to communicate information about the patient care work for a specified period of time." VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

VHA Directive 1160.01 requires healthcare systems to establish a mental health executive council to ensure quality mental health care is delivered and includes treatment that is responsive to veteran preferences.[13] The facility Mental Health Executive Council was co-chaired by the Co-Division Managers.[14] The council included the suicide prevention program manager, local recovery coordinator, and inpatient unit staff, but did not meet the requirement for veteran representation.[15] The Co-Division Managers reported veterans were not included on the council due to a concern about discussing certain operational topics in their presence and the belief that other councils at the facility provided sufficient veteran representation. In response to the OIG's finding, facility leaders included veteran representation on the council.

Inpatient Unit Staffing

The inpatient mental health co-program managers oversaw inpatient unit operations, such as group programming, and supervised direct care staff.[16] One co-program manager served as the inpatient mental health nurse manager. The other co-program manager supervised psychology, psychiatry, and social work staff. (For information on current staffing levels, see appendix C.)

Facility leaders told the OIG about difficulty hiring social work staff on the inpatient unit due to budgetary restrictions and recruitment challenges. However, facility leaders stated these staffing challenges had not affected veteran safety in the prior year.

Mental health leaders described addressing staffing challenges by recruiting from professional training programs, assigning staff to multiple programs, and requesting coverage from facility staff as needed. Facility leaders also reported using recruitment and retention tools such as an education debt reduction program, competitive salary restructuring for psychiatry, and flexible work schedule options.

Recommendation

1. The Facility Executive Director ensures the Mental Health Executive Council includes veteran representation.

For a detailed action plan, see appendix E.

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[13] VHA Directive 1160.01.

[14] VHA Directive 1160.01. VHA requires mental health leads or designees to serve as chairs of healthcare systems' mental health executive councils. The facility refers to its mental health executive council as the Mental Health Leadership and Management Operations Committee.

[15] VHA Directive 1160.01. The OIG reviewed meeting minutes from fiscal year 2024.

[16] VHA Directive 1160.06; VHA Directive 1160.06(1).

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[17] When a veteran understands the risks and benefits of treatment options and the provider understands the veteran's preferences and values, the veteran is empowered to make decisions and meet treatment goals.[18]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the healthcare system's integration of recovery-oriented principles, as required, on the inpatient unit.[19]

Leadership

VHA Directive 1160.06 expects the program manager to "coordinate and promote consistent, sustained, high quality therapeutic programming" on the inpatient unit.[20] At the time of the inspection, the two co-program managers jointly oversaw inpatient unit operations, coordinated inpatient unit group programming, and gathered feedback from veterans (discussed further in Inpatient Unit Staffing, above).

Local recovery coordinators are key mental health leaders within VA healthcare systems, with nonclinical duties focused on integrating recovery-oriented practices across all mental health services.[21] At the time of inspection, the facility met VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services* requirements for a full-time local recovery coordinator.[22]

[17] "Recovery and Recovery Support," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[18] "Shared Decision-Making in Mental Health Care," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed May 12, 2022, https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4371.pdf.

[19] VHA Directive 1160.06; VHA Directive 1160.06(1).

[20] VHA Directive 1160.06; VHA Directive 1160.06(1). According to VHA Directive 1160.06, the inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services. The amended directive contains similar language related to program manager responsibilities. Directive 1160.06 defines the role of the inpatient mental health program manager as a leadership position that can be filled by the "full range of core mental health disciplines." The amended directive does not include this specification but notes the position title may vary based on "the discipline selected."

[21] VHA Directive 1163(1), *Psychosocial Rehabilitation and Recovery Services*, March 7, 2025, was rescinded and replaced with VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025. For the purpose of this inspection, the directives contain the same or similar language related to psychosocial rehabilitation and recovery services.

[22] VHA Directive 1163(1), March 7, 2025; VHA Directive 1163, August 14, 2025; "Local Recovery Coordinators – Home," VA Central Office, accessed November 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/LRC. (This site is not publicly accessible.)

The facility also had a standard operating procedure (SOP) for education, staff training, and recovery-oriented care on the inpatient unit, consistent with VHA Directive 1160.06.[23] The local recovery coordinator reported leading facility-wide recovery transformation efforts through staff training and collaboration with inpatient leaders on the development of recovery-oriented programming.

Facility leaders provided the OIG with their local plan for continued transformation to recovery-oriented mental health services, as required by VHA Directive 1163(1).[24]

Facility leaders identified processes to solicit input from veterans who had used mental health services through veteran councils and informal interactions with staff, and planned to release a new patient experience survey.[25] Leaders reported implementing suggestions for the inpatient unit, such as computer kiosks for veteran use (discussed further in the Physical Environment section below).

Recovery-Oriented Programming

Inpatient leaders reported that nurses introduced recovery-oriented principles to veterans at admission and reinforced them during hospitalization using a handbook and daily programming.[26] This aligns with VHA SOP 1160.06.3, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06."[27] Inpatient unit staff provided comprehensive recovery-oriented, interdisciplinary programming on weekdays and on weekends, as required by VHA Directive 1160.06.[28] The OIG observed consistent staff-veteran engagement and unit leaders described daily treatment team meetings, which included the veteran, to set individualized goals and coordinate outpatient care for continuity.

[23] VHA Directive 1160.06; VHA Directive 1160.06(1).

[24] VHA Directive 1163(1); VHA Directive 1163; Milwaukee VAMC, "Mental Health Recovery Oriented System of Care Implementation Strategic Plan," July 8, 2025.

[25] VHA Directive 1160.01; The Joint Commission, *Standards Manual e-dition*, PI.04.01.01, August 2024. "The hospital uses improvement tools or methodologies to improve its performance."

[26] VHA Office of Mental Health and Suicide Prevention, SOP 1160.06.3, "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06," September 29, 2023.

[27] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.3.

[28] VHA Directive 1160.06; VHA Directive 1160.06(1).

Physical Environment

Figure 2. *Sunroom in the common area and computer kiosks available for veteran use (top row), and a mural painted by a veteran with the signature removed for privacy (bottom row).*
Source: Photos of the facility's inpatient unit taken by OIG staff from July 22 through 24, 2025.

The OIG found the inpatient unit supported a recovery-oriented environment with features like natural light, warm paint colors, clean furniture, and murals by veterans on interior and sally port walls, as outlined in the *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.[29] Additionally, veterans had access to a sunroom in the absence of available outdoor space. One day room contained four kiosks allowing veterans to access online banking, legal services, education assistance, housing assistance, and health education (see figure 2 for relevant images). In addition to the physical environment, the OIG observed staff consistently engaged with veterans in hallways, day rooms, and group rooms, reflecting recovery-oriented care.

The co-program managers reported staff escorted clinically stable, longer-term patients to the hospital library as part of individualized care. However, mental health leaders acknowledged the absence of written guidance to safely escort veterans for off-unit breaks but indicated potential plans to address it in an existing facility policy.

[29] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021; VHA Directive 1160.06; VHA Directive 1160.06(1).

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective" treatment.[30] For veterans with "complex health and social needs, care coordination is crucial for improving access to [services], clinical outcomes, [and] care experiences."[31] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a less-intensive level of care.[32]

The OIG evaluated the quality of clinical care coordination for veterans receiving inpatient mental health treatment and assessed access to services, local procedures for involuntary treatment, interdisciplinary team treatment planning, medication management, and discharge planning.

Access to Care

Successful coordination of mental health care requires well-defined screening and admissions processes that ensure veterans are evaluated and receive clinically appropriate treatment.[33] The OIG found facility leaders established required standard operating procedures for the inpatient unit admission processes including admission and exclusion criteria, and interfacility transfers, per VHA SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[34]

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[30] "Care Coordination," Agency for Healthcare Research and Quality, accessed April 30, 2024, https://www.ahrq.gov/ncepcr/care/coordination.html.

[31] Denise M. Hynes et al., "Understanding Care Coordination for Veterans with Complex Care Needs: Protocol of a Multiple-Methods Study to Build Evidence for an Effectiveness and Implementation Study," *Frontiers in Health Services* 3 (August 15, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[32] VHA Directive 1160.06; VHA Directive 1160.06(1).

[33] VHA Directive 1160.01; VHA Directive 1160.06; VHA Directive 1160.06(1).

[34] VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, was rescinded and replaced by SOP 1160.06.2 on December 19, 2024. Unless otherwise specified, the updated SOP contains similar language related to inpatient mental health unit requirement. The SOP clarified the requirement to include procedures and processes for facility staff responsible for admission of veterans to the inpatient mental health units.

Involuntary Hospitalization and Treatment

An involuntary hospitalization is the "legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital."[35]

Standards and procedures for civil commitment are provided by state law and vary by state.[36] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[37]

Per VHA Directive 1160.06, the facility policy outlined the processes for involuntary hospitalization admissions; the OIG found these processes to be in alignment with Wisconsin state laws.[38] Mental health leaders provided a tool used by social work staff for monitoring and tracking veterans' legal (voluntary or involuntary) commitment statuses.

VHA's policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)" states that a registered nurse must conduct and record a review of documents required for admission, including voluntary or involuntary legal commitment status, prior to a veteran's arrival on the inpatient unit.[39] The OIG found that 84 percent of electronic health records had the required admission screen documenting veterans' legal commitment statuses.[40] Mental health leaders reported being unsure why the admission screen documentation was not consistently completed and stated they would complete a review of this issue. When veteran's legal status is not documented, staff may not have enough information to make accurate treatment-based decisions.

Treatment Planning

In alignment with VHA Directive 1160.01 requirements, the facility's standard operating procedure outlined the inpatient unit treatment planning process, including recovery-oriented

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[35] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed July 27, 2023, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[36] "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[37] VHA Directive 1160.01.

[38] VHA Directive 1160.06; Milwaukee VAMC Memorandum 006S-33, "Protective Placement, Guardianship, Emergency Detention, and Treatment Directors Affidavit," February 2019.

[39] VHA Office of Nursing Services VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (SOP), revised April 5, 2023, November 2, 2023, and September 10, 2024. All three versions were in effect during the health record review period. Unless otherwise noted, all versions contain similar language related to documentation of voluntary or involuntary legal status.

[40] The OIG used 90 percent as the expected level of compliance for health record reviews. VHA Office of Nursing Services, VHA-ONS-NUR-22-01.

elements such as veterans' involvement in setting individualized goals.[41] Mental health leaders described processes to oversee the quality of treatment planning documentation through periodic auditing and peer reviews. Mental health leaders explained that the interdisciplinary treatment team met five days a week with each veteran to work collaboratively on the veteran's stated goals.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requires an informed consent discussion between prescribers and veterans on the risks and benefits of medication treatment.[42] The OIG found that half of the reviewed health records did not have documentation of informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment. A Co-Division Manager reported believing these discussions occurred but acknowledged prescribers did not consistently document them. When providers and veterans do not consistently discuss the risks and benefits of medication use, veterans may be deprived of the ability to make informed decisions.

Discharge Planning

The OIG found facility leaders established written guidance on coordination of care processes for veterans transitioning from inpatient care, per VHA Directive 1160.01.[43] The guidance outlined processes for outpatient follow-up appointments and discharge coordination that involved the veteran, the interdisciplinary treatment team, and relevant outpatient providers.[44]

All reviewed health records included documentation that the veteran was offered a copy of discharge instructions.[45] Additionally, all reviewed records included a discharge summary.

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[41] VHA Directive 1160.01; Milwaukee VAMC, "Standard Operating Procedure (SOP): Instructions and Standards for Completing Mental Health Suite Recovery Plans," March 2014, revised January 8, 2016, and June 25, 2019.

[42] VHA Handbook 1004.01(5), *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009, amended September 17, 2021; VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, December 12, 2023, amended January 12, 2024, February 22, 2024, and May 1, 2024. All versions were in effect during the health record review period and, unless otherwise noted, contain similar language related to medication risks and benefits discussion.

[43] VHA Directive 1160.01; Milwaukee VAMC, "Discharges: Planned and Unplanned from Mental Health Acute Inpatient and Residential Beds," January 2024.

[44] Milwaukee VAMC, "Discharges: Planned and Unplanned from Mental Health Acute Inpatient and Residential Beds," January 2024.

[45] VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.1*, November 29, 2022; VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023. The policies contain similar language related to discharge summary requirements; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Office of Mental Health, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

While all health records included a medication list in discharge instructions, most did not provide the reason for prescribing the medications (see figure 3), which is required by VHA Directive 1345, *Medication Reconciliation*.[46] Providing the reason a medication is prescribed supports veterans' participation in their care and is consistent with recovery-oriented principles.

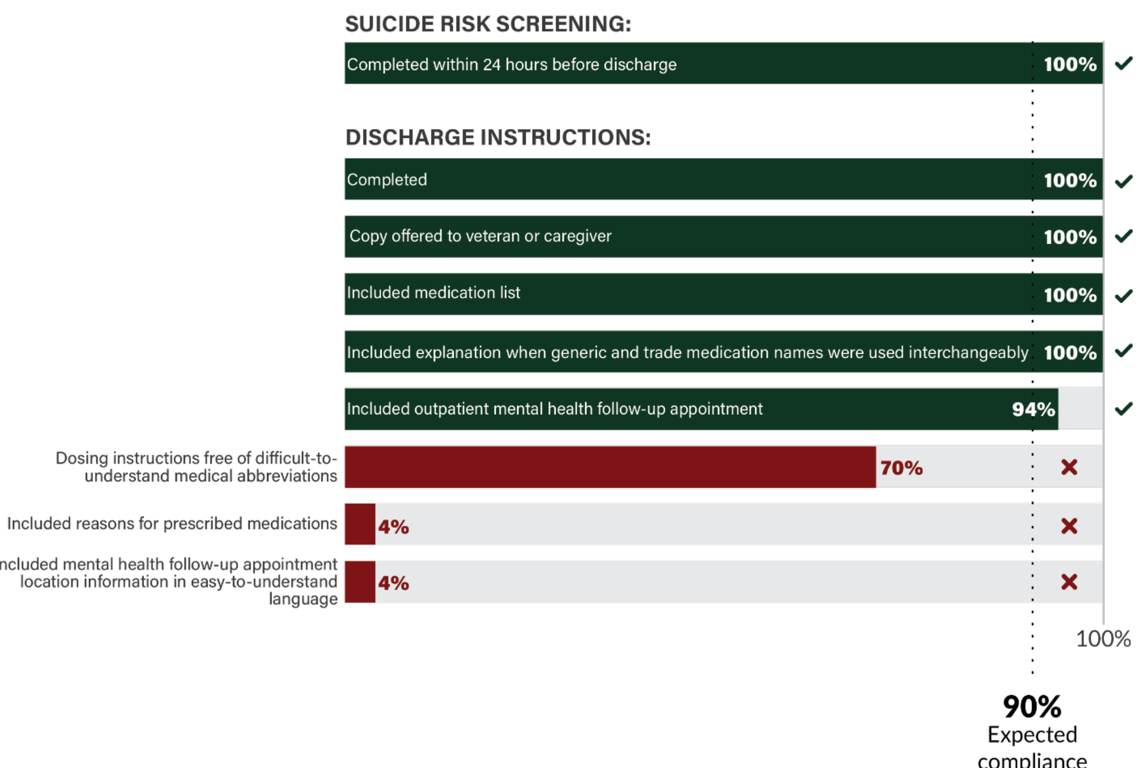

Figure 3. *Discharge-related screening and documentation.*
Source: OIG review of 50 inpatient unit electronic health records.

Most discharge instructions included the outpatient mental health follow-up appointment information required under VHA's *Health Record Documentation Program Guide*. However, the majority used abbreviations and acronyms for appointment locations that could confuse veterans and caregivers (see figure 4).[47] Inpatient unit leaders acknowledged they were aware of national guidance that clinic naming conventions should be understandable by veterans and were actively working on corrections. Lack of clarity in discharge instructions may create barriers for veterans to attend follow-up appointments and receive timely mental health care.

[46] VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

[47] VHA, *Health Record Documentation Program Guide Version 1.2*; VHA, *Health Record Documentation Program Guide Version 1.3*; VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023.

```
Future Appointments Populated
12/18/2023 10:15  MKE PH MH OP 43 DC PDE
12/18/2023 11:00  GLAD WH ACUPUNCTURE
```

Figure 4. *Example from discharge instructions with difficult-to-understand appointment information outlined in red.*
Note: Per facility staff, MKE refers to Milwaukee, PH refers to phone, MH refers to mental health, OP refers to outpatient, 43 refers to building 43, DC refers to discharge, PDE refers to post-discharge engagement, GLAD refers to the Gladstone community based outpatient clinic, and WH refers to whole health.
Source: OIG review of veterans' electronic health records.

Additionally, many reviewed health records had discharge instructions with medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 5).[48] Accurate and easy-to-understand discharge instructions could prevent medication errors at home following hospitalization. (See figure 3 for relevant health record findings.)

```
DEXTRAN 70/GLYCERIN/HYPROMELLOS SOLN,OPH
  Give:  1 DROP OU TID PRN
DULOXETINE CAP,EC
  Give:  30MG PO Q12H
FERROUS SULFATE TAB
  Give:  325MG PO BID
```

Figure 5. *Example of discharge instructions, including medical abbreviations (outlined in red), provided to a veteran.*
Source: OIG review of veterans' electronic health records.
Note: The medical abbreviations OU, TID, PRN, PO, Q, and BID are used to describe how medications should be taken.

Recommendations

2. The Facility Executive Director ensures staff complete the mental health nursing admission screen note, with veterans' legal status, for admissions to the inpatient mental health unit and develops a plan to monitor for sustained compliance.
3. The Chief of Staff ensures documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance.

[48] VHA Health Information Management Program Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023.

4. The Chief of Staff ensures veterans’ discharge instructions are written in easy-to-understand language and include the purpose of each medication.

For detailed action plans, see appendix E.

Suicide Prevention

The underlying causes of death by suicide can be complex and multifactorial. Preventing suicide may require coordinated systems, services, and resources to effectively support at-risk veterans.[49]

VA is dedicated to preventing suicide and defines prevention as "participating in activities that are implemented prior to the onset of suicidal events and are designed to reduce the potential for suicidal events."[50] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[51]

To evaluate suicide prevention activity on the inpatient unit, the OIG assessed compliance with required suicide risk screening and evaluation, safety planning, and training.

Suicide Risk Screening and Evaluation

VHA's suicide risk identification strategy requires staff to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening) for all veterans within 24 hours prior to discharge from inpatient mental health units.[52] The OIG found inpatient unit clinical staff completed the suicide risk screening within the required time frame in all reviewed electronic health records (see figure 3).[53] Completion of suicide risk screening at discharge can provide a more clear understanding of the veteran's readiness for discharge.

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[49] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*, 2018.

[50] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

[51] VA, *National Strategy for Preventing Veteran Suicide 2018–2028*.

[52] *Department of Veterans Affairs* (*VA*) *Suicide Risk Identification Strategy, Minimum Requirements by Setting*, updated May 10, 2023; 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 Services Network (VISN) Director (10N1-23), et al., November 23, 2022.

[53] VA, *Department of Veterans Affairs* (*VA*) *Suicide Risk Identification Strategy, Minimum Requirements by Setting*; 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 Services Network (VISN) Director (10N1-23), et al., November 23, 2022, was replaced by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025. While VHA requires staff to complete suicide risk screenings within 24 hours before discharge, the OIG also considered screenings compliant if completed on the day of discharge; The OIG used 90 percent as the expected level of compliance for health record reviews.

Safety Planning

94% of records reviewed had suicide prevention safety plans completed or reviewed prior to discharge. Of those:

100%	Used appropriate note title
91%	Addressed ways to make the veteran's environment safer from other potentially lethal means beyond access to firearms and opioids
97%	Offered veterans or caregivers a copy of the safety plan

Figure 6. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

Staff used the nationally standardized note titles for all completed or reviewed suicide prevention safety plans, per VHA policy "For Action: Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes."[54] Most of the reviewed safety plans addressed ways to make the environment safer from potentially lethal means beyond firearms and opioids as specified in the *VA Safety Planning Intervention Manual* (see figure 6).[55] Identifying potential lethal means in the veteran's environment may reduce the risk of self-harm. Additionally, the OIG found staff provided a copy of the safety plan to most veterans or caregivers at discharge, as required.[56]

Training

Skills Training for Evaluation and Management of Suicide (STEMS) and VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) assist clinicians and nonclinical staff, respectively, in identifying the warning signs of suicide risk and appropriate interventions.[57]

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[54] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., August 17, 2022, was replaced by "For Action: Update to Use of National Standardized Suicide Prevention Safety Plan Progress Notes," memorandum on November 18, 2024. Unless otherwise specified, the updated memo contains similar language related to documentation of suicide prevention safety plans requirement.

[55] VA, *VA Safety Planning Intervention Manual*, February 23, 2022.

[56] VA, *VA Safety Planning Intervention Manual*.

[57] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), September 2023.

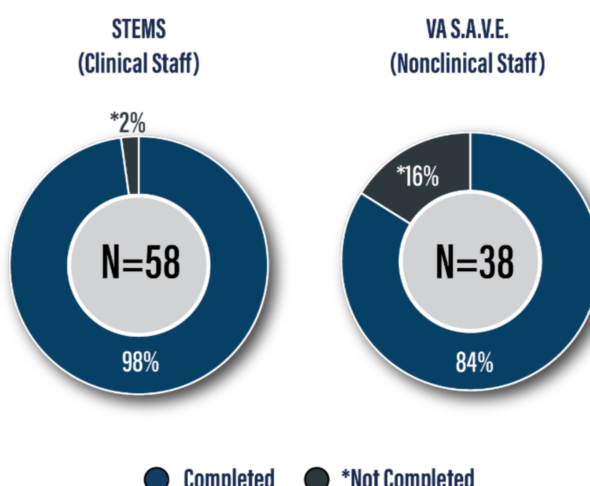

Figure 7. *Inpatient unit staff completion of mandatory suicide prevention training.*
Source: OIG document review of clinical and nonclinical staff training certificates.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings during the time frame of July 7, 2024, through July 6, 2025.

Most clinical staff completed required STEMS training. However, some nonclinical staff did not complete the VA S.A.V.E. training required by VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training* (see figure 7).[58] When staff do not complete required S.A.V.E training, they may not be able to identify suicide risk factors and may lack awareness of resources and interventions to enhance veterans' safety.

Recommendation

5. The Facility Executive Director ensures staff complete VA S.A.V.E. training and develops a plan to monitor for sustained compliance.

For a detailed action plan, see appendix E.

[58] VHA Directive 1071(1); Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23) et al., June 9, 2022.

Safety

The primary goal of inpatient mental health care is to stabilize veterans experiencing acute distress through the provision of a safe and secure therapeutic environment.[59] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[60]

To assess the inpatient mental health environment, the OIG evaluated aspects of compliance with ongoing assessment of suicide hazards and completion of mandatory staff training.

Mental Health Environment of Care

The interdisciplinary safety inspection team, comprised of both mental health and other facility staff, is responsible for conducting environment of care inspections as stated in VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[61] The National Center for Patient Safety continually updates the Mental Health Environment of Care Checklist "based on reports from the field of hazards or adverse events encountered at the local level."[62] Interdisciplinary safety inspection team members are required to use this comprehensive checklist of over 150 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[63]

The facility's established Interdisciplinary Safety Inspection Team met quarterly and completed the required biannual environment of care inspections of the unit. Facility staff recorded mental health environment of care inspection attendance. However, the inspection team lead reported that despite staff reminders, the suicide prevention coordinator did not consistently attend inspections. When team members do not attend inspections, environmental hazards may go unrecognized and unabated.

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[59] VHA Directive 1160.06; VHA Directive 1160.06(1).

[60] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017. This directive was rescinded and replaced by VHA Directive 1167, November 4, 2024. The policies contain similar language related to the design of the inpatient unit and staff training requirements.

[61] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[62] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, accessed June 5, 2025, https://www.patientsafety.va.gov/features/Mental_Health_Environment_of_Care_Checklist.asp.

[63] VHA Directive 1167, May 12, 2017. The Mental Health Environment of Care Checklist "consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff workstations."

In a physical inspection of the unit, the OIG observed adherence to all OIG randomized safety elements.[64] However, the OIG identified a ligature risk in the telephone booth; the chief engineer reported that staff resolved this issue the same day.

Training

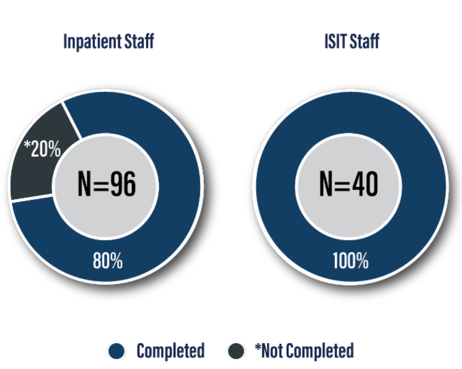

Figure 8. *Mental Health Environment of Care Checklist training completion, July 7, 2024, through July 6, 2025.*
Source: OIG document review of staff training certificates.
Note: Inpatient staff included all staff and volunteers who provide services on the inpatient unit.

VHA Directive 1167 requires staff to be trained on environmental hazards and oriented to the "content and proper use" of the Mental Health Environment of Care Checklist.[65]

All Interdisciplinary Safety Inspection Team members completed the required annual training; however, some inpatient unit staff, including volunteers who performed work on the inpatient unit, did not complete the training (see figure 8).[66] Facility and unit leaders were unaware that all staff who performed work on the unit had to complete the training.[67] Completing annual training on environmental hazards and VHA safety requirements may reduce safety risks for veterans and staff on the inpatient unit.[68]

Recommendations

6. The Facility Executive Director ensures Interdisciplinary Safety Inspection Team members participate in Mental Health Environment of Care Checklist inspections and develops a plan to monitor for sustained compliance.
7. The Facility Executive Director ensures all required individuals complete Mental Health Environment of Care Checklist annual training and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix E.

[64] "Mental Health Environment of Care Checklist." The OIG reviewed the inpatient unit for randomized safety elements such as anchor free doors, ligature free window coverings, and secured under-sink storage.

[65] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

[66] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, updated Dec 2022.

[67] Staff who performed work on the unit included those such as group facilitators or volunteers.

[68] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety; VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024.

Conclusion

To assist facility leaders in impactful quality of care improvements, the OIG conducted a review to evaluate acute inpatient mental health care provided at the facility.

The OIG observed a recovery-oriented and veteran-centric environment through staff engagement with veterans on the unit, a well-lit sunroom, and kiosks for veterans to access online banking, legal services, and housing assistance. Facility leaders had a plan for continued transformation to recovery-oriented services, and interdisciplinary programming was available to veterans seven days a week. However, mental health leaders did not have written guidance to ensure staff and veterans' safety during off-unit activities. Additionally, facility leaders did not include veteran representation on the facility Mental Health Executive Council.

Facility policy included guidelines for involuntary hospitalization and had processes to oversee compliance with state laws. However, staff did not complete required documentation of legal (voluntary or involuntary) commitment status or informed consent discussions between prescribers and veterans on the risks and benefits of medication treatment.

All reviewed electronic health records had a completed suicide risk screening within 24 hours prior to veterans' discharge from the inpatient unit. Most staff completed or reviewed suicide prevention safety plans and documented offering a copy to veterans or their caregivers.

When veterans were discharged from inpatient hospitalization, staff typically provided instructions that were difficult to understand and did not have important details for appointment follow-up and medication management.

Staff did not consistently complete Mental Health Environment of Care Checklist or VA S.A.V.E. trainings. Although staff conducted environment of care inspections at the required frequency, the OIG found that not all required Interdisciplinary Safety Inspection Team members attended inspections.

The OIG issued seven recommendations to the Facility Director and Chief of Staff. Based on information provided by facility leaders, the OIG closed recommendation 1. For the remaining open recommendations, the OIG will follow up on the identified actions to ensure that they have been implemented and sustained.

The Facility Director reported ensuring completion of required nursing admission screening. Facility leaders also described plans to ensure that informed consent discussions are documented and veteran discharge instructions are easy to understand. Additionally, the Facility Director committed to ensuring staff complete suicide prevention and safety training and attend safety inspections as required.

These recommendations may improve the quality and delivery of veteran-centered, recovery-oriented care on the inpatient mental health unit and beyond. Additionally, the OIG hopes the successful practices highlighted in this report will be used by other VHA facility leaders to improve their inpatient mental health unit operations.

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.

Appendix A: Background

Inpatient Mental Health Services

VHA offers acute inpatient mental health services as a “high-intensity” treatment option for veterans experiencing “acute and severe emotional or behavioral symptoms” that pose a safety risk or result in compromised mental function. When a healthcare provider determines that inpatient mental health care is appropriate, the veteran should be immediately admitted ensuring safety and stabilization.[69]

VHA Directive 1160.06 requires inpatient unit staff use a veteran-centered, “evidence-based, recovery-oriented approach” that incorporates evaluation and monitoring, interdisciplinary treatment, discharge planning, sufficient staffing, privacy, and dignity.[70] To evaluate the quality of recovery-oriented care provided at the healthcare system, the OIG assessed compliance with VHA requirements in the five domains described below.

Leadership and Organizational Culture

Organizational structure plays a critical role in the quality of healthcare delivery. Elements such as formal reporting channels, committee structures, and staffing practices should support inpatient unit operations and align with care delivery needs.[71]

According to VHA’s requirements, the healthcare system director is responsible for overseeing inpatient mental health services. The chief of staff, in collaboration with the associate director of patient care services, should ensure that inpatient units have sufficient staffing to form interdisciplinary teams, ensure veterans’ access to mental health care, and fully implement program requirements.[72]

Each VHA healthcare system must have a dedicated chief mental health lead with overall responsibility for mental health service operations, including mental health services that may be aligned under a different department. The mental health lead may also be referred to as the mental health service line director, chief of mental health, or other comparable title. According to VHA Directive 1160.01, the mental health lead or designee serves as the chair of the healthcare system’s mental health executive council, which ensures staff provide high-quality care and are

[69] VHA Directive 1160.06; VHA Directive 1160.06(1).

[70] VHA Directive 1160.06; VHA Directive 1160.06(1).

[71] VA, *Leader’s Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024, https://dvagov.sharepoint.com/sites/vhahrojourney/Shared%20Documents/Forms/HRO%20Assessment%20and%20Planning%20Resources.aspx?id=%2Fsites%2Fvhahrojourney%2FShared%20Documents%2FHRO%20Leaders%20Guide%20to%20Foundational%20HRO%20Practices%2Epdf&parent=%2Fsites%2Fvhahrojourney%2FShared%20Documents. (This website is not publicly accessible.)

[72] VHA Directive 1160.06; VHA Directive 1160.06(1).

responsive to veterans' preferences.[73] Each council must include "at least one Veteran, and ideally one who is receiving mental health services" and not employed at the local healthcare system. The mental health executive council should meet quarterly and "record minutes that are accessible to all mental health clinical staff."[74] The healthcare system mental health lead must assign an inpatient mental health program manager "to coordinate and promote consistent, sustained, high quality therapeutic programming" in the inpatient unit setting.[75]

The VISN director is responsible for ensuring that inpatient mental health services "are accessible without delay to all eligible Veterans in the VISN" and that the programs offered on the inpatient unit are compliant "with relevant state laws governing inpatient mental health care, hospital accreditation regulations, and VISN and facility level procedures."[76] VHA requires the appointment of a full-time VISN chief mental health officer to "ensure transparency of decision making and to promote communication between the field and central office."[77]

Recovery-Oriented Principles

The President's *New Freedom Commission on Mental Health* report outlined a vision for the delivery of recovery-oriented mental health care.[78] The Substance Abuse and Mental Health Services Administration "defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential."[79]

To support veterans' recovery, VHA Directive 1163 requires healthcare systems to have a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[80] Additionally, VHA requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish a standard operating

[73] VHA Directive 1160.01.

[74] VHA Directive 1160.01.

[75] VHA Directive 1160.06; VHA Directive 1160.06(1).

[76] VHA Directive 1160.06; VHA Directive 1160.06(1).

[77] "Mental Health Required Staff Listing," VA Office of Mental Health, accessed February 8, 2023, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MH_Staffing_Req.aspx. (This site is not publicly accessible.)

[78] "Achieving the Promise: Transforming Mental Health Care in America," President's New Freedom Commission on Mental Health, accessed September 15, 2025, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport.htm; "President's New Freedom Commission on MH: Report to the President: Inside Cover," Mental Health Commission, accessed June 11, 2024, https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/InsideCover.htm.

[79] "Recovery and Recovery Support," US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, accessed September 19, 2022, https://www.samhsa.gov/find-help/recovery.

[80] VHA Directive 1163(1).

procedure that includes processes for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[81]

VHA requires adherence to principles of veteran-centered, recovery-oriented mental health care and ongoing evaluation of services provided on the inpatient unit.[82] VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care, and therefore, provides design guidelines for healthcare systems to create a hopeful and healing environment while maintaining safety.[83] For VA medical facilities with a Mental Health Environment of Care Checklist-compliant secure outdoor space, daily programming should include dedicated time for veterans to be outdoors.[84]

Clinical Care Coordination

Care coordination poses a major challenge to healthcare safety for chronically ill individuals who receive services from multiple providers in a variety of settings.[85] VHA requires inpatient units to have an interdisciplinary treatment team composed of individuals who are responsible for the veteran's care. An interdisciplinary approach is critical to ensure comprehensive, coordinated, and holistic care.[86]

VHA SOP 1160.06.2 recommends healthcare systems to have standard operating procedures outlining admission processes, and VHA Directive 1160.06 requires systems to provide access to mental health treatment for veterans who are either voluntarily or involuntarily held on an inpatient unit.[87] When treatment is not available within the healthcare system, staff may transfer the veteran to another VHA or non-VHA system for inpatient mental health care.[88]

The federal government lacks civil commitment laws; therefore, VHA healthcare system leaders are required to have clear guidelines that align with state and local laws for civil commitment.[89] Staff must be aware of the veteran's legal status (voluntary or involuntary admission) to

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[81] VHA Directive 1160.06; VHA Directive 1160.06(1).

[82] VHA Directive 1160.06; VHA Directive 1160.06(1); VHA Directive 1163(1); VHA Directive 1160.01.

[83] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*

[84] VHA Directive 1160.06; VHA Directive 1160.06(1). For VA medical facilities with a Mental Health Environment of Care Checklist-compliant outdoor space, "designated time for Veterans to be outdoors should be incorporated into the daily programming as permitted by staffing, individual Veteran interest, safety observation level of the Veteran, weather and as determined by the patient's [Interdisciplinary Treatment Team], clinical condition, and any other relevant contingency factors."

[85] The Joint Commission, *Standards Manual e-dition,* PC.02.02.01, August 2024. "The hospital coordinates the patient's care, treatment, and services based on the patient's needs."

[86] VHA Directive 1160.06; VHA Directive 1160.06(1).

[87] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; VHA Directive 1160.06; VHA Directive 1160.06(1).

[88] VHA Directive 1160.06; VHA Directive 1160.06(1).

[89] VHA Directive 1160.06; VHA Directive 1160.06(1).

safeguard against potential civil rights violations, including illegal detainment in a locked inpatient unit.[90]

The interdisciplinary treatment team must ensure the recovery-oriented treatment plan includes the veteran's personally identified goals and is completed in collaboration with the veteran. The interdisciplinary treatment team must also ensure outpatient mental health care is coordinated with the veteran prior to discharge, including follow-up appointment information.[91]

VHA requires that veterans receive a copy of the written discharge plan and a copy of the safety plan, as applicable, at discharge.[92] The written discharge plan must include the provider's name if available, as well as follow-up appointment information.[93]

Suicide Prevention

According to the *2024 National Veteran Suicide Prevention Annual Report*, "suicide was the 12th-leading cause of death for Veterans in 2022," and the second-leading cause of death among veterans under age 45.[94] Suicide risk is elevated after a suicide attempt including the period following discharge from an inpatient psychiatric setting.[95] Therefore, there is a critical need for suicide risk assessment prior to discharge from inpatient mental health care, as well as linkage to follow-up mental health care.[96]

Inpatient unit clinical staff are to complete the Columbia-Suicide Severity Rating Scale (suicide risk screening), a risk assessment tool, for veterans within 24 hours prior to discharge, as required by VA's suicide risk identification strategy.[97] According to VHA's memorandum "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," a positive suicide risk screening then requires the "timely completion of the Comprehensive

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[90] VHA Office of Nursing Services, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care Standard Operating Procedure (SOP)," revised April 5, 2023.

[91] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[92] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[93] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[94] VA Office of Suicide Prevention, *2024 National Veteran Suicide Prevention Annual Report*, December 2024.

[95] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[96] Deputy Under Secretary for Health for Operations and Management, "Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up," memorandum to Network Directors (10N1-23) et al., June 12, 2017.

[97] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Minimum Requirements by Setting," updated May 10, 2023.

Suicide Risk Evaluation."[98] Staff may complete the risk evaluation in lieu of the suicide risk screening prior to discharge.[99]

When veterans are determined to be at risk for suicide, providers are expected to engage them in safety planning.[100] Safety planning is an intervention in which "patients are given tools that enable them to resist or decrease suicidal urges for brief periods of time" and "involves eliminating or limiting access to any potential lethal means in the environment."[101]

In 2018, VA published its 10-year strategic plan for preventing veteran suicide, which outlines the objective of reducing access to lethal means. The document discusses provider education for veterans on safe storage and access to firearms, as well as "storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons."[102] The *VA Safety Planning Intervention Manual*, a guide to help VHA providers develop safety plans with veterans, further emphasizes identification of access to potentially lethal means such as firearms, opioids, medications, ropes, and household toxins.[103]

According to VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," all patients in a VHA inpatient mental health setting "must be offered the opportunity to create or update a Safety Plan as part of the discharge plan. This should be documented in the patient's medical record."[104]

VHA Directive 1071(1) requires healthcare providers complete Skills Training for Evaluation and Management of Suicide and nonclinical staff complete VA S.A.V.E. (signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment) training annually.[105] In June 2022, VHA issued a memorandum indicating a target of at least 95 percent completion for mandatory suicide prevention trainings.[106]

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[98] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum.

[99] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy: Frequently Asked Questions (FAQ)," updated December 13, 2022.

[100] VA, VA Safety Planning Intervention Manual.

[101] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, (2012): 256-264.

[102] VA, *National Strategy for Preventing Veteran Suicide 2018-2028*.

[103] VA, *VA Safety Planning Intervention Manual*.

[104] VHA, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[105] VHA Directive 1071(1).

[106] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Suicide Prevention Fiscal Year (FY) 2022 Funding Commitment Notification."

Safety

In VHA healthcare systems, inpatient mental health units must be designed to ensure veteran safety while still integrating recovery-oriented principles into the environment.[107] Interdisciplinary safety inspection team members and all inpatient unit staff are responsible for ensuring a safe environment.[108] Additionally, an inspection team is required to assess the inpatient unit twice annually for suicide hazards using the Mental Health Environment of Care Checklist and the patient safety manager or other designated mental health staff track corrective actions taken for identified environmental risks. The Mental Health Environment of Care Checklist is "designed to help identify and abate suicide hazards on mental health units and other areas treating Veterans at high acute risk for suicide. It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion/physical restraint rooms, and staff work stations."[109]

An interdisciplinary safety inspection team is a mandatory subcommittee of the healthcare systems environment of care committee, with team membership documented as part of the inspection rounds summary. According to VHA Directive 1167, the inspection team should include an inpatient mental health unit program director and inpatient unit nurse manager, the suicide prevention coordinator, a patient safety manager, a representative from engineering/facilities management, and an "additional clinical staff from any discipline or work area."[110]

[107] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to the incorporate recovery and ensure safety on the inpatient unit.

[108] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to all staff members' responsibility to ensure safety on the inpatient unit.

[109] VHA Directive 1167, May 12, 2017; VHA Directive 1167, November 4, 2024. The policies contain similar language related to an interdisciplinary safety inspection team and use of the Mental Health Environment of Care Checklist; VHA Directive 1160.06.

[110] VHA Directive 1167, November 4, 2024.

Appendix B: Methodology

The Mental Health Inspection Program focuses on the quality of care provided by VHA's inpatient mental health services.[111] The OIG randomly selected the VHA healthcare systems included in fiscal year 2025 reviews from all systems with inpatient mental health beds.[112]

The OIG conducted a virtual and on-site review at the facility from July 7 through 30, 2025, including an on-site inspection from July 22 through 24, 2025. The OIG did not receive any complaints beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient unit, documents, and electronic health records. Additionally, the OIG conducted a physical inspection of the inpatient unit and interviewed key staff and leaders.

The OIG reviewed select staff's certificates for annual completion of STEMS, VA S.A.V.E, and Mental Health Environment of Care Checklist trainings.[113] Staff were excluded from analysis of STEMS and VA S.A.V.E trainings if identified as being employed in their position less than 90 days. Except for a 95 percent threshold for mandatory suicide prevention training completion, the OIG used 90 percent as the expected level of compliance for record review.

The OIG's analysis relied on inspector identification of salient information based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* The OIG did not analyze compliance with individual healthcare system policies.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA leaders complete corrective actions. Leaders' responses to the report recommendations appear in appendix D and appendix E.

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 issues.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[114] The OIG reviews available evidence within a specified

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[111] The OIG conducts cyclic reviews of select areas of focus within VHA's continuum of mental health care.

[112] The OIG identified healthcare systems with inpatient mental health beds using the Monthly Program Cost Report (MPCR) code of 1310 (High Intensity General Psychiatric Inpatient Unit). For fiscal year 2025, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal year 2024. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[113] VHA Directive 1071(1); VHA Directive 1167.

[114] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

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.

Electronic Health Record Review

The OIG reviewed 50 randomly selected electronic health records of veterans discharged from an acute inpatient mental health stay of more than 48 hours at the facility from October 1, 2023, through September 30, 2024.[115] The OIG identified the health record sample from a list of all individuals with a Monthly Program Cost Report discharge code of 1310 (High Intensity General Psychiatric Inpatient Unit) and excluded all other records. For veterans with multiple admissions during the review period, the OIG included the veteran's first admission only. The OIG used 90 percent as the expected level of compliance for record review.

OIG Inspection of the Physical Environment

The OIG inspected selected areas of the inpatient unit to evaluate if the facility provided a therapeutic, recovery-oriented environment and maintained veteran safety.[116] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as natural lighting, artwork, and calming paint colors. The OIG also observed the unit for general cleanliness and veteran access to secure outdoor space.[117] Further, the OIG's physical inspection of areas in the inpatient unit focused on additional selected safety elements specific to this facility.

The OIG reviewed the mental health environment of care data documented in Patient Safety Assessment Tool for inspections completed in fiscal years 2024 and 2025, and assessed corrective actions taken for deficiencies unresolved for more than six months.

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[115] The OIG identified the health record sample from a list of all individuals with a Monthly Program Cost Report discharge code of 1310 (High Intensity General Psychiatric Inpatient Unit) and excluded all other records. For veterans with multiple admissions during the review period, the OIG included the veteran's first admission only.

[116] VHA Directive 1160.06. A unit is an "area in a medical facility and especially a hospital that is specially staffed and equipped to provide a particular type of care." *Merriam-Webster.com Dictionary*, "unit," accessed August 10, 2022, https://www.merriam-webster.com/dictionary/unit.

[117] VHA Directive 1160.06; VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

Appendix C: Inpatient Unit Staffing

The OIG examined the facility's inpatient unit staffing, which also reflected an interdisciplinary team approach.

Table C1. Inpatient Unit Staffing

Discipline	FTEE	Percent Dedicated Per FTEE
Assistant Nurse Manager*	2	100
Chaplain	1	33
Dietitian‡	2	5–50
Emergency Department Mental Health Team§	5	20
Medical Support Assistant	4	30–100
Music Therapist	1	80
Nurse‖	34	33–100
Nursing Assistant	15	100
Occupational Therapist	2	100
Peer Support Specialist	1	8
Pharmacist	4	25
Program Manager#	2	100
Psychiatrist	6	10–100
Psychologist	2	8–50
Social Worker	3	25–100
Volunteer	3	100

Source: OIG review of the facility's mental health inpatient unit staffing spreadsheet and interviews (July 2025).

Note: FTEE indicates full-time equivalent employee. Table does not include staff whose percent dedicated per FTEE is less than five.

One assistant nurse manager is detailed to the position while another staff member is on military leave. FTEE does not include staff on military leave.

‡*Includes one dietitian and one dietetic technician.*

§*Includes interdisciplinary team that provides coverage to the inpatient unit after regular working hours, on weekends/holidays, and as needed.*

‖*Includes 33 staff nurses and one educator. One staff nurse is on military leave and not included in FTEE.*

#*Includes one nurse and one psychologist who serve as co-program managers.*

Appendix D: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 1, 2026

From: Network Director, Veterans Integrated Service Network (VISN) 12 (10N12)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin

To: Director, Office of Healthcare Inspections (54MH00)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report, Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin.

2. I concur with the findings and recommendations identified by the OIG, and the corrective action plans submitted by the facility.

3. I would like to thank the OIG inspection team for their review of the VA Milwaukee Healthcare System.

(*Original signed by:*)

Daniel S. Zomchek, Ph.D.
Network Director, VISN 12

[OIG comment: The OIG received the above memorandum from VHA on April 2, 2026.]

Appendix E: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 31, 2026

From: Director, Department of Veterans Affairs (VA) Milwaukee Healthcare System (695)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin

To: Director, Department of Veterans Affairs (VA) Great Lakes Health Care System (10N12)

1. We appreciate the opportunity to review and comment on the OIG Mental Health Inspection of the VA Milwaukee Healthcare System in Wisconsin. I have reviewed the documentation and concur with the recommendations and will take corrective action.

2. I have reviewed the documentation and concur with the response as submitted.

3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

James McLain, FACH
Executive Director

[OIG comment: The OIG received the above memorandum from VHA on April 2, 2026.]

Healthcare System Director Responses

Recommendation 1

The Facility Executive Director ensures the Mental Health Executive Council includes veteran representation.

__X _Concur

_____Nonconcur

Target date for completion: Request Closure

Director's Comments

Mental Health (MH) Division Manager will ensure the Mental Health Executive Leadership Operations Meeting includes Veteran attendance at the quarterly meeting effective September 1, 2025.

The MH Division Manager will report on the attendance of a veteran at the quarterly meeting to the Quality Management Oversite Committee (QMOC). Compliance will be monitored quarterly with a target of 90% for two consecutive quarters. The QMOC is Co-Chaired with the Facility Executive Director and the Chief of Quality and meets every other month.

OIG's Comments

The OIG closed the recommendation as leaders completed improvement actions before publication of the report.

Recommendation 2

The Facility Executive Director ensures staff complete the mental health nursing admission screen note, with veterans' legal status, for admissions to the inpatient mental health unit and develops a plan to monitor for sustained compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

In March 2025, the Mental Health Nursing Leadership observed that the Veterans Affairs Approved Enterprise Standard (VAAES) Acute Inpatient Nursing (NSG) Admission Screen was incorrectly being used for a number of Veterans admitted to the Acute Mental Health Inpatient Unit (AMHU) resulting in missing Veteran legal information. The AMHU educator sent an email with screenshots of the correct document mental health nursing screening note to inpatient

unit nursing staff identifying the issue and the expected corrections. Compliance has been demonstrated for May (91%), June (100%), and July (100%).

In July 2025, during the OIG review, nursing leadership conducted a review of current medical records for completion of the legal status. Legal status auditing has been 90–100% since August 2025.

Documentation using the mental health nursing screening note, including veteran's legal status, for admissions to the inpatient mental health unit will be monitored as follows:

The AMHU Educator will conduct an audit of monthly inpatient unit discharges for documentation of Veteran legal status.

The MH Division Managers will report the results of the documentation of the Veteran legal status audit to the QMOC. Compliance will be monitored monthly with a target of 90% for six consecutive months. The QMOC is Co-Chaired with the Executive Director and the Chief of Quality and meets every other month.

Recommendation 3

The Chief of Staff ensures documentation of discussions between the prescriber and veteran on the risks and benefits of newly prescribed medications prior to administration and develops a plan to monitor for sustained compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

In October 2025, the AMHU Program Manager and the Clinical Applications Coordinator (CAC) team revised the Mental Health Acute Discharge Progress Note template to include documentation of the risks and benefits of newly prescribed medication discussed with the Veteran. Provider education on the template revision and expectation for completion was completed by November 5, 2025.

Ongoing compliance will be measured through monthly monitoring by the Mental Health Quality Analyst via chart review. The Mental Health Quality Analyst will audit the presence of a documented discussion between the prescriber and the Veteran on the risks and benefits of newly prescribed medications in the electronic health record, with the goal of attaining six months of 90% compliance

The audit will be reported to the Mental Health Leadership. The MH Division Manager will report monthly to the Medical Executive Committee (MEC), which is chaired by the Chief of Staff. The Facility Executive Director attends the MEC.

Recommendation 4

The Chief of Staff ensures veterans' discharge instructions are written in easy-to-understand language and include the purpose of each medication.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The AMHU Program Manager collaborated with the Clinical Applications Coordinator (CAC) team to update the Future Clinic Visits discharge instructions for patient friendly clinic names and to update any clinic name that falls outside this naming convention.

AMHU providers are required to enter discharge medication orders without medical or pharmacy abbreviations and to include the purpose of each medication. Pharmacy and the CAC team modified the discharge instructions, "Medication Grid for Patient", to identify the medication indication for VA medications and to remove abbreviations. Pharmacists and /or a unit nurse will do the final report review and meet with the Veteran to provide the instructions at time of discharge.

The Mental Health Quality Analyst will complete monthly audits of discharge instructions to assess documentation of medication purpose, medication orders written in easy-to-understand language and without medical or pharmacy abbreviations with a compliance rate of 90% or greater for six consecutive months.

The audit will be reported to the Mental Health Leadership. The MH Division Manager reports monthly to the Medical Executive Committee (MEC), which is chaired by the Chief of Staff. The Facility Executive Director attends the MEC.

Recommendation 5

The Facility Executive Director ensures staff complete VA S.A.V.E. training and develops a plan to monitor for sustained compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The Facility Executive Director will ensure S.A.V.E. training requirements are met consistently. MH leadership will collaborate with ancillary service managers to ensure S.A.V.E training is assigned to applicable AMHU ancillary staff. Ancillary service managers are responsible for

their AMHU ancillary staff S.A.V.E. training completion within 365 days of last completion. The Designated Learning Officer (DLO), or designee, will generate a monthly report within VA Talent Management System (TMS) detailing staff S.A.V.E. training completions. Quality Management will audit this report for training evidence of compliance and provide feedback to ancillary leadership.

Compliance will be monitored monthly with a target of 95% for six consecutive months. Overall training compliance will be reported quarterly to the MH Division Managers who will report results to the Quality Management Oversight Committee (QMOC). The QMOC is Co-Chaired with the Facility Executive Director and the Chief of Quality.

Recommendation 6

The Facility Executive Director ensures Interdisciplinary Safety Inspection Team members participate in Mental Health Environment of Care Checklist inspections and develops a plan to monitor for sustained compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director’s Comments

The Lead for the Mental Health Environment of Care Checklist (MHEOCC) will ensure core members of the MHEOCC team attend quarterly meetings and inspections. Each core member has two alternates to call upon as needed. Attendance audits for September and December 2025 have been 100%.

The MH Division Manager will report the MHEOCC core member attendance result to the QMOC. Compliance will be monitored quarterly with a target of 90% for two consecutive quarters. The QMOC is Co-Chaired by the Executive Director and the Chief of Quality and meets every other month.

Recommendation 7

The Facility Executive Director ensures all required individuals complete Mental Health Environment of Care Checklist annual training and develops a plan to monitor for sustained compliance.

__X _Concur

_____Nonconcur

Target date for completion: July 2026

Director's Comments

The Facility Executive Director will ensure all MHEOCC training requirements are met consistently. MH leadership will collaborate with ancillary service managers to ensure MHEOCC training is assigned to applicable AMHU ancillary staff annually. Ancillary service managers are responsible for their AMHU ancillary staff MHEOCC training to be completed within 365 days of last completion. The DLO or designee will generate a monthly report within VA Talent Management System detailing staff MHEOCC training completions. Quality Management will review this report for evidence of compliance with training.

Compliance will be monitored monthly with a target of 90% for six consecutive months. Overall training compliance will be reported quarterly by the MHEOCC Lead to the MH Division Managers who will report results to the QMOC. The QMOC is Co-Chaired by the Executive Director and the Chief of Quality and meets every other month.

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