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ACTING ASSISTANT INSPECTOR GENERAL
FOR THE OFFICE OF HEALTHCARE INSPECTIONS, VA OFFICE OF INSPECTOR GENERAL
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS,
HOUSE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
ANSWERING THE CALL: EXAMINING VA'S MENTAL HEALTH POLICIES
APRIL 2, 2025

Chairwoman Kiggans, Ranking Member Ramirez, and Subcommittee members, thank you for the opportunity to discuss the independent oversight conducted by the Office of Inspector General (OIG) of VA's mental health services, programs, and policies. The OIG's Office of Healthcare Inspections routinely reports on the quality of services provided across the Veterans Health Administration (VHA) and on risks to patient safety. OIG personnel regularly assess and make recommendations to improve VA's delivery of health care, including mental health and suicide prevention, through inspections of vet centers, inpatient mental health units, individual medical centers, and healthcare systems' networks.[1] Failure to satisfactorily implement and monitor the corrective actions associated with these recommendations undermines VA's commitment to continuous process improvement, allows identified risks to persist, and undercuts VA's ability to provide timely, high-quality health care.

Because VA leaders have made reducing veteran suicide their highest clinical priority, the OIG has conducted significant oversight work to support that effort. OIG Healthcare Inspections teams frequently encounter dedicated VHA leaders and staff who recognize the urgency of assisting veterans in acute mental health crisis, as well as identifying, screening and coordinating higher level interventions for those who are at higher risk for suicide. Yet despite VHA having robust and comprehensive policies, the OIG has found there are staff who repeatedly apply guidance and mandates inconsistently. In addition, VA leaders do not exercise effective oversight or implement quality assurance programs, thus allowing problems to go undetected or unresolved.

This testimony discusses the OIG's examination of VHA personnel's assessment and care management of veterans from the first opportunity for screening and assessment for suicide risk through interventions and follow-up or ongoing care. From veterans' initial clinical encounter or contact with the Veterans

[1] OIG reports may be found on the website at All Reports, with those related to mental health at this list of reports.

Crisis Line, the OIG has found that VHA staff have not routinely conducted the required screening and risk assessments necessary to ensure patients' safety, nor effectively coordinated treatment and after-care. This finding is based on reviews of how well VHA has adhered to standards and principles for suicide prevention and safe care environments, recovery-oriented treatment, care coordination, and discharge practices. OIG's cyclical inspections of vet centers and inpatient mental health facilities have also identified multiple opportunities for improved operations. As the work discussed in this statement demonstrates, VHA must ensure that its leaders and staff use quality assurance and oversight programs to drive improvement. It must also use critical tools to provide care to veterans and support to loved ones grieving after a suicide. In looking at potential causes for VA deficiencies, this statement concludes with findings from an oversight report released just a few days ago describing the ill-defined roles and responsibilities of Veterans Integrated Service Network (VISN)-level mental health leaders, highlighting an opportunity for VHA to engage leaders to improve the efficiency and quality of mental healthcare delivery.[2]

VHA MUST IMPROVE COMPLIANCE WITH SUICIDE SCREENING AND RISK ASSESSMENT ACTIVITIES

Providing quality mental health care to a veteran who may be in crisis begins with accurate screening and risk assessment. Each interaction must be initiated with an understanding of the immediate risk. It is essential that these risk assessments include reviewing the veteran's access to lethal means, considering other risk factors such as alcohol and substance use, and identifying and including individuals who can offer immediate support to the veteran. Without an accurate assessment, a VHA responder cannot make time-sensitive decisions aimed at stabilizing the crisis and initiating appropriate supportive efforts.

Inadequate Staff Training and Lack of Oversight Contributed to VHA's Suicide Risk Screening and Evaluation Deficiencies

Given the importance of this issue, the OIG conducted a national review evaluating VHA's suicide risk screening and evaluation training, adherence to policies, and oversight procedures.[3] Since May 2018, VHA has relied on a standardized Suicide Risk Identification Strategy (Risk ID) requiring annual screening using the Columbia-Suicide Severity Rating Scale. If a patient screens positive, the provider must complete a comprehensive suicide risk evaluation that includes detailed questions about the patient's suicidal ideation, plan, intent, and behaviors, as well as risk and protective factors. The

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[2] VA, OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*, March 31, 2025. VISNs are VHA's regional care systems established in 1995 to centralize planning, budgeting, and oversight; align resources; enhance patient access to care; and "better meet local health care needs." https://department.va.gov/integrated-service-networks/, accessed March 19, 2025.

[3] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies*, December 18, 2024. The OIG findings are based on reviewing metrics at over 130 medical facilities nationwide as well as sending surveys to facility- and VISN-level staff with implementation, training, and monitoring responsibilities for the standardized Suicide Risk Identification Strategy.

provider must then establish a risk-mitigation plan.[4] VHA's required suicide prevention training for care providers does not include Risk ID processes or requirements. Although such training has been developed, it is not mandated and completion is not monitored. The lack of mandated training may have contributed to nonadherence to screening and evaluation, underestimation of suicide risk, and ultimately a failure to facilitate risk mitigation.

Additionally, VHA has not established annual Risk ID performance benchmarks and has conveyed inconsistent expectations to leaders and staff. While VHA requires patients receive annual screening, and any positive screen should have a same-day evaluation, in fiscal year (FY) 2023, annual screening and evaluation compliance was 55 and 82 percent, respectively. Notably, the Combined Risk ID dashboard, which monitors adherence to Risk ID ambulatory care requirements and provides data on performance and trends, does not include facilities using VA's new electronic health record system. VHA recognized the need for additional setting-specific suicide risk screening; however, with the exception of emergency department and urgent care settings, it does not monitor setting-specific Risk ID adherence, such as outpatient mental health treatment, opioid use programs, and sleep and pain clinics.[5]

Further, the OIG found staff faced barriers to completing Risk ID screenings and evaluations, including the following:

1. **Limited engagement of facility clinical staff.** VHA leaders acknowledged the importance of engaging nonmental healthcare staff "to "embed Risk ID into their workflow." One leader suggested those clinical staff may be hesitant to screen patients due to discomfort about what to do when the screening is positive. Additionally, more than half of facility clinical staff the OIG team interviewed perceived Risk ID as the responsibility of suicide prevention program staff.
2. **Lack of facility leaders' support.** Facility staff also spoke about the importance of leaders' support in Risk ID implementation and adherence. Leaders from the then-Office of Mental Health and Suicide Prevention (OMHSP) also acknowledged the importance of engaging VISN and facility leaders in Risk ID implementation, adding a Risk ID evaluation metric to VISN and facility directors' performance plans to communicate expectations and ensure evaluations are completed timely following positive screenings.[6]

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[4] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to Veterans Integrated Service Network Directors (10N1-23) et al., May 23, 2018.

[5] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to the Veterans Health Administration's Suicide Risk Screening and Evaluation Deficiencies.*

[6] OMHSP was reorganized into two offices in April 2024: the Office of Mental Health and the Office of Suicide Prevention. The offices develop and implement mental health and suicide prevention policy, respectively.

3. **Limitations of performance data.** VHA provides an evaluation adherence report, which allows facility staff to view the number of missed screenings within a clinical service, but does not provide patient-identifying information or the name of the provider who did not complete the required screening.
4. **Unclear delineation of responsibilities.** The OMHSP "in conjunction with" the Mental Illness Research, Education, and Clinical Center (MIRECC) have shared responsibility "for monitoring Risk ID implementation and providing feedback to facilities through VISN Chief Mental Health Officers."[7] MIRECC, however, does not have the authority to establish policies or ensure Risk ID implementation. The OIG concluded that the shared responsibility for addressing Risk ID deficiencies has contributed to a lack of clarity related to accountability for Risk ID adherence monitoring and performance improvement.

The OIG made six recommendations to the under secretary for health related to suicide risk and intervention training, suicide screening and evaluation performance benchmarks, setting-specific Risk ID monitoring, effectively addressing barriers to Risk ID nonadherence, nonmental health clinical specialty leaders' awareness of Risk ID requirements, and clear identification of Risk ID monitoring and oversight responsibilities. As of March 31, 2025, all six recommendations are open.[8]

A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions

The OIG recognizes the extreme pressure Veterans Crisis Line (VCL) responders face in meeting the immediate needs of a veteran in acute distress when there is no room for error. The time between contemplation of suicide and an attempt can be minutes, and failing to immediately and accurately assess such risk can be fatal for the veteran. An OIG healthcare inspection following the death by suicide of a veteran in their mid-thirties less than an hour after interacting with a VCL responder revealed (among other issues discussed later in this statement) significant deficiencies in VHA staff training and actions.[9] The patient had prior documented reports of suicidal thoughts and behavior over almost three years and described a plan for suicide involving firearms and hanging themselves from a rafter in the shed in text messages to the responder. The responder documented that the exchange ended without incident. An independent OIG review of the actual text messages found the VCL responder's

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[7] MIRECC's mission is to decrease veteran suicide risk through innovative prevention strategies, clinical interventions, and increased information sharing and veteran treatment options. Rocky Mountain MIRECC, https://www.mirecc.va.gov/visn19/aboutus/index.asp, accessed March 17, 2025.

[8] At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 30 calendar days to respond. The OIG began to follow up with VHA for progress updates on the recommendation's implementation in March 2025. Nothing precludes VA from providing interim progress reports.

[9] VA OIG, *A Patient's Suicide Following Veterans Crisis Line Mismanagement and Deficient Follow-Up Actions by the Veterans Crisis Line and Audie L. Murphy Memorial Veterans Hospital in San Antonio, Texas*, September 14, 2023.

documentation of the texts inaccurately summarized the exchange and the responder did not offer critical support and interventions to the veteran who was clearly in crisis. Among the findings, the responder did not assess and address risk and consider immediate rescue efforts, failed to understand the veteran's access to identified lethal means and alcohol use, and neglected to access the support of an on-site family member. The specific OIG recommendation related to improving documentation and oversight of staff who provide crisis management services has been closed following the receipt of satisfactory evidence of compliance.

Delays and Deficiencies in Mental Health Care of a Patient

A July 2024 healthcare inspection report found several instances in which a medical center's staff and leaders did not follow VHA policy, resulting in delayed and inadequate mental health care for a patient.[10] The staff did not arrange an evidence-based psychotherapy (EBP) referral for a patient noted to be at high risk for suicide in their record (high-risk flag). The staff did not provide in-person EBP until over a year after the patient's request for mental health care, inconsistent with VHA's requirements.[11] In addition, schedulers also noted a lack of staff to provide EBP over a five-month period, although they did not consistently document attempts to contact the patient as required.[12] A psychiatrist also did not sufficiently address the patient's access to lethal means by not discussing the patient's access to ammunition nor document the patient's comments during a related conversation. Although the OIG did not find that the lack of documentation resulted in a negative outcome, incomplete lethal means discussions may hinder an understanding of a patient's suicide risk and care coordination.

The OIG found that in the 30 days following high-risk flag initiation, staff did not meet with the patient four times as required by VHA.[13] The staff met with the patient twice, and a high-risk case manager unsuccessfully attempted to contact the patient twice. Although a negative outcome was not identified, there was no documentation that the case manager sought help in reaching the patient. Lack of

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[10] VA OIG, *Delays and Deficiencies in the Mental Health Care of a Patient at the Michael E. DeBakey VA Medical Center in Houston, Texas*, July 31, 2024.

[11] VHA Directive 1160.05; VHA Directive 1230, Outpatient Scheduling Management, July 15, 2016. This directive was in place during the time of the events discussed in the report. It was rescinded and replaced by VHA Directive 1230, Outpatient Scheduling Management, June 1, 2022. Unless otherwise specified, the two directives contain the same or similar language regarding outpatient scheduling requirements.

[12] VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure," updated October 26, 2021. This was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure," updated July 28, 2022. The 2022 standard operating procedure contains the same or similar language regarding minimum scheduling effort requirements.

[13] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to Veterans Integrated Services network (VISN) Directors (10N1-23), VISN CMOs (10N1-23), and VISN Chief Medical Health Officers (10N1-23), October 5, 2021; VHA Directive 1166, *Patient Record Flags*, November 6, 2023.

consultation with a supervisor or suicide prevention coordinator may contribute to insufficient suicide prevention actions in the case of high-risk patients.

The OIG also found the facility did not follow VHA's requirement that staff review or update the patient's safety plan and coping strategies.[14] In the 30 days after the high-risk flag initiation, neither the psychiatrist nor a homeless program social worker reviewed or updated the safety plan with the patient. Further, the homeless program social worker did not assess the patient for suicide risk, as required by facility procedures.[15] An OMHSP leader reported that staff for the homeless program were not expected to review or update the safety plan during high-risk follow-up appointments.

VHA concurred with the OIG's single recommendation to the under secretary for health to clarify requirements for completing suicide risk assessments and safety plan reviews by homeless program staff. The recommendation was closed after VHA implemented a plan requiring training for homeless program field staff on the mandated completion of suicide risk assessments, including a review of safety planning, and the wide dissemination of the training and available resources. The facility director concurred with the five recommendations related to EBP consult management, timely scheduling, and documentation; VA-issued devices; lethal means safety; and high-risk flag follow-up. The OIG will monitor progress on the remaining recommendations until all are closed.

Vet Centers Can Do More to Assess Suicide Risks and Make Safety Plans

Vet centers are important community-based facilities providing psychosocial services to eligible veterans, active duty and reserve service members, National Guard members, and their families. The OIG uses its cyclical Vet Center Inspection Program to ensure that vet center counseling is provided in accordance with VHA policy for safe and effective social and psychological services.[16] Most importantly, the inspections help verify whether vet centers are appropriately identifying and engaging with the most high-risk veterans and collaborating with VHA facilities to ensure that any needed care is provided. Specific focus areas are selected to help provide insight into a client's experience when they seek care or services. Current inspection focus areas include leadership and organizational risks; quality reviews; suicide prevention; consultation, supervision, and training of counselors; and the environment of care. The OIG teams evaluate a vet center's compliance with initiating and coordinating the clinical services required to support veterans deemed to be at high risk for suicide.

These inspections and site visits provide evidence of frequent noncompliance with many required processes, most notably procedures for assessing and documenting a veteran's suicide risk. VHA's Readjustment Counseling Service (RCS) manages vet centers and provides policies to guide the assessment and care management of individuals who are considered at risk for suicide. Vet center

[14] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memorandum; VHA Directive 1166.

[15] Facility Standard Operating Procedure, "Management of High Risk for Suicide Patient Record Flags," March 17, 2022.

[16] All OIG Vet Center Inspection Program reports can be found in this filtered list of reports.

counselors are required to complete a suicide risk assessment for every client at the initial visit and subsequently as indicated. For any client found to be at intermediate to high risk for suicide, counselors must then complete a safety plan, which should identify personalized coping strategies and supportive resources these clients may use to lower their risk of suicidal behavior. OIG teams repeatedly found noncompliance with required procedures documenting suicide risk and a lack of oversight to ensure staff are adequately trained to provide quality services and timely document their work.

Through the inspections, OIG teams have identified three major contributing causes for the weaknesses:

1. **Lack of clear and standardized RCS policies.** The delivery of consistent, high-quality service at vet centers is reliant on clear and consistent policies to guide frontline staff. OIG inspections have found the varying applications of policies are often due to misinterpretation caused by vague, confusing, or conflicting language, or cumbersome processes. For example, RCS staff reported lacking an understanding of the purpose and requirements of the High Risk for Suicide Flag SharePoint site established by RCS to easily identify and anticipate the needs of vet center clients identified as high risk or potentially high risk for suicide by VHA medical facility. The SharePoint site should be used to increase communication with VHA regarding these clients.

2. **Challenges in staffing and workload.** Through interviews and surveys of RCS staff, the OIG gathered consistent reports that noncompetitive salaries and vet center positions with low grade levels on the General Schedule pay scale contribute to vacancies. Vet center and district leaders recognize the challenges but those in acting positions have limited authority to address them. Additionally, leadership teams told OIG staff that it is a challenge to oversee the large number of vet centers in each designated zone.[17] Many of the deficiencies the OIG identified, including missing or insufficient suicide risk assessments, may be improved with more focused zone oversight.
3. **Deficiencies in RCSNet, the vet centers' electronic client record system.** Many areas of noncompliance identified by the OIG's Vet Center Inspection Program were affected by the limitations of RCSNet, the electronic recordkeeping system used by vet center staff. OIG inspection teams observed that RCSNet did not have a function to easily determine when required documentation for specific assessments had been completed. This limitation has made it difficult for RCS leaders to conduct quality oversight and has hampered the OIG's ability to make timely determinations regarding the quality of services and care provided. RCSNet does not allow users to alert care providers to clinical reminders as well as client behavior or suicide flags. Functionality is also insufficient for collaborative or supervisory staff to cosign notes, for limiting system users' permissions that could compromise the integrity of the record, and for viewing scanned records alongside other documentation in a

[17] Each of the five RCS districts consists of two to four zones. Each zone consists of 18 to 26 vet centers.

client's record. RCS staff responses and opinions shared with OIG inspectors related to RCSNet's capabilities were consistently negative.

VHA MUST ENSURE CONSISTENT, HIGH-QUALITY CARE FOR VETERANS REQUIRING INPATIENT MENTAL HEALTH TREATMENT

To ensure high-quality care for veterans at significant risk for suicide, VHA must ensure full compliance with VHA policy for inpatient treatment. The mental health treatment coordinator roles must be clearly defined, including the establishment of written procedures. Mental Health Treatment Coordinator (MHTC) assignments and engagement with mental health unit patients should also be well-defined. There must be full compliance with discharge care coordination requirements as well, including documentation of discharge instructions, coordination with the MHTC, and patient engagement with post-discharge treatment.

Facility Staff Must Closely Follow Policies Requiring Close Observation of Inpatients

The OIG conducted an inspection in response to complaints that facility staff were not following VHA suicide prevention policies within the Overton Brooks VA Medical Center in Shreveport, Louisiana. These lapses related to completing suicide risk screenings and evaluations, using high-risk-for-suicide-patient-record flags, and fully responding to VCL requests. In addition to substantiating those issues, the OIG found concerns with inpatient mental health care treatment at the facility.[18] In one incident, a patient with depression, a substance use disorder, and other medical conditions was admitted to the facility's intensive care unit (ICU) after a suicide attempt. Almost two weeks into the ICU stay, the patient attempted suicide twice more. After these attempts, clinicians reinstated an order for one-to-one observation. For a time, facility staff failed to follow the facility policy that a one-to-one observation staff member have no other responsibilities. In this case, the registered nurse was performing one-to-one duties in addition to other nursing responsibilities for the patient. The OIG made eight recommendations to the VISN and facility directors related to various aspects of the suicide prevention program. The recommendation to the facility regarding one-to-one observation staff assignments in the ICU has been closed following revisions to the policy and facility staff education.[19]

In another incident, the OIG assessed the clinical care of an inpatient who died by suicide at the Sheridan VA Medical Center in Wyoming.[20] The patient was admitted to the facility's inpatient unit, placed on one-to-one observation status for suicidal ideation, started on protocols for treatment of

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[18] VA OIG, *Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana*, July 10, 2024.

[19] The OIG made one recommendation to the VISN director related to suicide prevention staff posting and identification of recruitment opportunities and six other recommendations to the facility director related to compliance with suicide prevention and other facility policies.

[20] VA OIG, *Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming*, July 25, 2024.

alcohol withdrawal symptoms, and had a psychiatry consult initiated. Four days later, the patient was found in the bathroom having died by hanging using a necklace. The OIG found that staff did not follow policy requirements to remove the patient's belongings or reduce environmental risks. This significant failure allowed the veteran to keep items, including the necklace that was used to complete suicide. Additionally, a nurse failed to conduct a warm handoff, as required, to a licensed independent practitioner for the completion of a Comprehensive Suicide Risk Evaluation after a positive suicide risk screening result. The psychiatrist completed a telemental health evaluation of the patient but did not complete the required Comprehensive Suicide Risk Evaluation. On the third day of admission, the psychiatrist did not reassess the patient before changing the patient's one-to-one observation status to every 15-minute checks and did not sign the evaluation note within the required 24-hour time frame, leaving the assessment unavailable to other providers.[21] Critically, the physician on duty on the third day said that had the note been viewable, they would have had a conversation with the psychiatrist to express concern and to convey the opinion that 15-minute checks were not adequate for this veteran. This lapse led to a recommendation, which is still open as not fully implemented, to ensure that suicidal patients are reassessed prior to changing one-to-one observation status orders. The other open recommendation relates to completing evaluations for inpatients who screen positive for suicide risk.

The OIG has closed the remaining two recommendations to the facility director related to completing and authenticating inpatient notes, as well as removing patient belongings and environmental risks. The OIG will follow up on the remaining planned actions until they are completed.

The OIG's Mental Health Inspection Program Identified Issues with VHA's Acute Inpatient Health Care

The OIG established the Mental Health Inspection Program in 2024 to regularly evaluate VHA's continuum of mental healthcare services. The inspection program evaluates acute inpatient health care across six domains: (1) leadership and organizational culture, (2) high-reliability principles, (3) recovery-oriented principles, (4) clinical care coordination, (5) suicide prevention, and (6) safety. Reviews initiated in FY 2024 focused on acute inpatient mental health care at select facilities.

A mental health inspection conducted at the VA Central Western Massachusetts Healthcare System in Leeds found noncompliance with suicide risk screening and evaluation policy.[22] Electronic health record reviews indicated most veterans were involved with interdisciplinary treatment team planning and had documented safety plans. However, some records did not include evidence of timely suicide risk screening. Staff did not consistently complete the Columbia-Suicide Severity Rating Scale within

[21] An unsigned note is not available to other providers. In this case, the psychiatrist told the OIG that the note was not signed within 24 hours due to the need for chart review, dictation, and edits.

[22] VA OIG, *Mental Health Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, March 5, 2025. The other Mental Health Inspection Program publication issued to date is the *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, September 26, 2024.

24 hours before discharge as required, and the safety plans reviewed did not always address ways to make the veteran's environment safer regarding the availability of potential lethal means. Additionally, the OIG found staff completed the "S.A.V.E." and lethal means safety training but not all staff completed the Skills Training for Evaluation and Management of Suicide requirement.[23] As a result, the OIG recommended

- the chief of staff ensures staff complete the Columbia-Suicide Severity Rating Scale within 24 hours before discharge and monitors compliance;
- the chief of staff ensures staff address ways to make veterans' environments safer from potential lethal means in safety plans and monitors compliance; and
- the facility director ensures staff comply with Skills Training for Evaluation and Management of Suicide requirements and monitors compliance.

The facility director concurred with these and the report's additional 13 recommendations and provided acceptable action plans. The OIG will begin the follow-up process in three months, given the report's March 2025 publication.

VHA MUST ADDRESS DEFICIENCIES IN COMPREHENSIVE DISCHARGE PROCESSES

Just as important as the actual inpatient care, VHA providers must ensure that newly discharged veterans are appropriately supported, given their increased risk for suicide. Accordingly, the OIG conducted a review of VHA's inpatient mental health unit suicide risk identification processes, suicide prevention safety plans, MHTC role requirements, and discharge coordination procedures in December 2024.[24] The team examined VHA policies, electronic health records, and conducted interviews of clinicians and patients.

Since 2008, VHA has required that every patient receiving mental health services be assigned a principal mental health provider, now referred to as the MHTC, to support care coordination.[25] Staff must also complete a suicide risk screening within 24 hours before a patient's discharge using the Columbia-Suicide Severity Rating Scale, and work with the patient to establish a suicide prevention safety plan which identifies sources of support and effective coping strategies. The OIG found staff failed to document required suicide risk screening for 27 percent of patients and did not complete safety plans for

[23] VHA identifies the "S.A.V.E." acronym as: signs of suicide, asking about suicide, validating feelings, and encouraging help and expediting treatment.

[24] VA OIG, *Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination*, December 18, 2024.

[25] VHA Handbook 1160.01(1); Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

12 percent of discharged patients. Failure to complete suicide prevention activities may result in an underestimation of patients' risk and a diminished use of life saving resources.

Over 30 percent of facilities lacked an MHTC policy, and separately, mental health unit staff failed to assign an MHTC for nearly 40 percent of patients. Failure to provide written guidance that outlines MHTC procedures may contribute to staff's lack of awareness of responsibilities and result in patients not being assigned an MHTC to offer resources and support during transitions in care. Over half of surveyed patients with an assigned MHTC could not identify that individual and more than 25 percent of MHTCs were uninvolved in discharge care coordination or the transition to outpatient care.

While most patients, regardless of MHTC assignment, attended at least one outpatient mental health appointment within 90 days of discharge, over half of surveyed patients identified self-motivation and 20 percent identified encouragement from a family member or friend as contributing to appointment attendance. The OIG concluded that the MHTC model did not effectively facilitate care coordination and MHTC assignment was not associated with a patient's likelihood of engaging in post-discharge treatment.

The OIG proposed that VHA leaders provide guidance regarding expectations for post-discharge mental health appointment scheduling to promote patient treatment engagement. The issued report had eight recommendations related to suicide risk identification and safety planning. They focused on MHTC written guidance, assignment, and effectiveness, as well as post-discharge mental health appointment scheduling and treatment engagement. All recommendations remain open.

VHA MUST COMPLY WITH REQUIRED POSTVENTION ACTIVITIES AFTER SUICIDES

VHA requires staff to conduct specific reviews and analyses to understand and apply lessons learned after a veteran attempts or completes suicide that can improve the quality and safety of care delivered to future patients. The following sections detail instances of noncompliance with numerous policies regarding root cause analyses, peer reviews, and institutional disclosures to patients' families or representatives. The OIG has also found opportunities for VA to ensure survivors are treated with sensitivity and provided support after the death of a veteran by suicide.

VHA Leaders Must Ensure Facilities Conduct Quality Improvement Programs

Since 2012, VHA has required that staff gather information following all reported patient deaths by suicide to identify contributory factors and to understand the circumstances that had affected the patient[26] A September 2024 OIG healthcare inspection focused on the suicide of a veteran six days after a mental health appointment at the VA Tuscaloosa Healthcare System in Alabama. The resulting report

[26] VHA *Suicide Prevention Program Guide*, November 2020; VHA Deputy Under Secretary for Health for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012.

highlighted several deficiencies with the administrative actions taken by facility leaders and staff after they learned the veteran had died by suicide. [27]

Root Cause Analyses

An interdisciplinary team uses a focused review to conduct the root cause analysis, which is meant to identify system issues that contribute to healthcare-related adverse events. Flowing from the analysis are proposed corrective actions to prevent future incidents.[28] According to VHA, after a root cause analysis is conducted, "the organization must then implement an action plan to fortify its systems against vulnerabilities with the potential to impact patients."[29] The root cause analysis' actions and outcomes must be monitored for completion and sustainment, ideally through a reporting system, such as a patient safety committee meeting.[30] The facility director initiated a root cause analysis eight days after facility staff received notification of the patient's death. The OIG found that facility staff did not inform facility leaders, as they should have, about closing an incomplete root cause analysis action item after it was determined to be "not feasible" to complete due to staffing shortages. This lack of communication diminished facility leaders' awareness of staffing barriers to address system vulnerabilities and improve the quality of care. The OIG has closed its recommendation that the facility director evaluate the root cause analysis process based on information presented by the facility.

Peer Review Policies

Peer reviews for quality management are "intended to promote confidential and non-punitive assessments" of clinical care to determine whether there are process improvement opportunities.[31] VHA Peer Review Committees are responsible for holding "formal discussions" regarding a peer review and ensure formal meeting minutes reflect the discussions.[32] In the Tuscaloosa Healthcare System review, the OIG found that the Peer Review Committee failed to address two systems-level issues identified during the process. The lack of committee documentation regarding discussions and tracking actions to resolution may have contributed to gaps in communication and follow-up, and consequently a failure to mitigate identified patient safety risks. The OIG recommended the facility director evaluate the Peer

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[27] VA OIG, Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama, September 26, 2024. The OIG also substantiated problems with appointment scheduling, supervision of a posttraumatic stress disorder clinic social worker, and medication management.

[28] VHA Handbook 1050.01, National Patient Safety Improvement, March 4, 2011, was rescinded and replaced by VHA Directive 1050.01, VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024. The policies contain similar language related to action items.

[29] VHA National Center for Patient Safety, Guide to Performing a Root Cause Analysis, February 5, 2021, updated in March 2024. The guides contain similar language related to root cause analysis.

[30] VHA National Center for Patient Safety, Guide to Performing a Root Cause Analysis, February 5, 2021.

[31] VHA Directive 1190, Peer Review for Quality Management, November 30, 2023.

[32] VHA Directive 1190.

Review Committee's processes on addressing and identifying system weaknesses in accordance with VHA requirements. The recommendation is now closed in response to information the facility provided.

Institutional Disclosures

An institutional disclosure is a formal process to inform a patient or the patient's personal representative when an adverse event occurred that resulted in the patient's injury or death, including specific information about rights and recourse.[33] A disclosure must be completed regardless of when the adverse event is discovered.[34] The facility's chief of staff in Tuscaloosa did not recall any consideration of an institutional disclosure for the patient.[35] Other leaders told the OIG that an institutional disclosure was not completed because the patient's death did not occur at the facility. Although a patient's death by suicide while receiving care at a facility requires the completion of an institutional disclosure, it is not limited to this circumstance.[36] In this case, a disclosure should have been considered regardless of the location of the patient's death. The OIG concluded that facility leaders may have had an erroneous understanding of institutional disclosure requirements and recommended the director determine if one was warranted. The recommendation was closed after the facility made the disclosure.

This is not the first time the OIG has been concerned that VHA facility leaders have misunderstood institutional disclosure requirements. Given the inconsistent application of the institutional disclosure policy that the OIG observed in various healthcare inspections during FYs 2022 and 2023, the OIG alerted the undersecretary for health in March 2024 to clarify institutional disclosure expectations.[37]

VHA Staff Can Take Actions to Better Interact with Grieving Family Members

Grief reactions to suicide commonly include strong emotions such as guilt, blame, and anger.[38] VHA instructs suicide postvention staff to encourage self-care and coping, provide resources, and offer follow-up support to manage grief over time for families and other loved ones.[39] Additionally, the facility's suicide prevention coordinator is expected to contact the next of kin to inform them about the

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[33] VHA Directive 1004.08, Disclosure of Adverse Events to Patients, October 31, 2018. VHA defines an adverse event as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers."

[34] VHA Directive 1004.08.

[35] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*.

[36] VHA Directive 1004.08; The Joint Commission, Sentinel Event Policy and Procedures, https://www.jointcommission.org/resources/sentinel-event/sentinel-event-policy-and-procedures/, accessed May 1, 2024.

[37] VA OIG, Institutional Disclosure Policy Requirements Should Be Clarified, March 13, 2024.

[38] National Action Alliance for Suicide Prevention, Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines, April 2015.

[39] VA, "Recommendations for Postvention – Meeting with Family/Loved Ones," Uniting for Suicide Postvention, accessed April 17, 2024. This site is not publicly accessible.

Behavioral Health Autopsy Family Interview Process and offer the opportunity to participate.[40] The suicide prevention coordinator is required to document the family member's interest in participating in an interview on a Family Interview Tool-Contact form.[41] In one healthcare inspection, the OIG found that the suicide prevention coordinator failed to complete the required contact form after being notified of the patient's death.[42] This failure prevented family members from being contacted for an interview during which information would have been provided on accessing grief support resources. The OIG has closed the recommendation that the VA Tuscaloosa Healthcare System's director ensure compliance with the Behavioral Health Autopsy Family Interview Process standards, including completion of the contact form.[43]

VHA MUST STRUCTURE ITS LEADERSHIP TO ENSURE CONSISTENT OVERSIGHT

In June 2024, the OIG testified that the VISN structure does not ensure accountability and lacks clearly defined leadership roles and standardized responsibilities, which could lead to deficient engagement with facility leaders and inconsistent oversight.[44] Early this week, the OIG highlighted these concerns in a national review of the governance structure and role of the VISN chief mental health officer (CHMO). The OIG concluded that without standardized role definitions and oversight authority, the CMHO's ability to effectively address weaknesses in facility mental health and suicide prevention program performance is limited.[45] The absence of consistent information regarding organizational governance structure and staffing may result in inequities in resources and insufficient oversight of VISN and facility mental health staff services. This may undermine the original purpose of the VISNs, which was to centralize oversight, align resources among facilities, and enhance patients' access to care.

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[40] VHA Deputy Under Secretary for Healthy for Operations and Management, "Behavioral Autopsy Program Implementation," memorandum to Network Directors, December 11, 2012. The Behavioral Health Autopsy Family Interview Process is a systematic review of relevant behavioral health information about the patient for a period prior to death, including demographic characteristics, risk and protective factors, use of mental health and crisis services, diagnoses and symptoms, and clinicians' notes. VHA, *Suicide Prevention Program Guide,* November 1, 2020. A review and related form must be completed within 30 days of the facility staff's awareness of a patient's death by suicide.

[41] VHA, *Suicide Prevention Program Guide*.

[42] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*.

[43] There were 13 total recommendations in the Tuscaloosa report. The others related to reviewing the patient's care; boxed warning education; suicide risk screening; appointment scheduling; lethal means safety counseling; PTSD clinic processes; traumatic brain injury evaluation; root cause analyses, peer review, and institutional disclosure processes.

[44] VA OIG, Statement of Julie Kroviak, MD, Principal Deputy Assistant Inspector General, Office of Healthcare Inspections, June 26, 2024.

[45] VA OIG, *Inadequate Governance Structure, and Identification of Chief Medical Health Officers' Responsibility.*

The OIG reviewed VHA written policies related to the oversight of mental health services, VISN organizational charts, and CMHO performance plans and functional statements (position descriptions).[46] The OIG conducted a survey and received responses from 18 CMHOs, their direct supervisors, and 108 of 143 (76 percent) facility mental health leads from across the nation about CMHO responsibilities, communication processes, supervisory structures, and authority. In addition, the OIG reviewed VHA's required "standardized VISN core organizational chart" and supplemental information and found a lack of standardization.

CHMOs reported understanding their oversight responsibilities of outpatient mental health services, mental health residential rehabilitation treatment programs, and primary care mental health integration services. They also confirmed monitoring facility action plans related to compliance and performance deficiencies, but they described a lack of authority as a major barrier to effective oversight, change implementation, and enforcement of noncompliance.

The OIG made five recommendations in March 2025 to the under secretary for health regarding the VISN CMHO. They addressed staffing requirements for mandatory and discretionary positions; standardized VISN core organizational charts to clarity the CMHO position and reporting structure; a functional statement (position description) to reflect responsibilities; a performance plan that aligns with a functional statement; and authority to enhance the governance and the effectiveness of mental health services.

CONCLUSION

Each day, VA staff actively engage in providing high-quality wraparound mental health services to veterans across the country. These services include screening for mental health needs and suicide risk factors, connecting veterans with identified risk factors to higher-level services, managing veterans' acute mental health crises in a variety of therapeutic settings, and supporting families who have lost a loved one to suicide. But there is much more work to be done. Leaders must ensure adherence to VHA policies and consistently implement practices designed to support veterans facing mental health challenges. In a large, decentralized healthcare system, these leaders must have clearly defined standardized roles, responsibilities, and the authority to drive necessary improvements and hold staff accountable.

Every veteran has a unique story of service and sacrifice, from which many carry invisible wounds that make it difficult to reintegrate and fully participate in civilian life. There will never be one solution to a problem as complicated and devastating as veteran suicide, but efforts must continue to better understand and treat those at highest risk. The OIG remains committed, therefore, to conducting

[46] Position descriptions include the major duties, responsibilities, and supervisory relationships of a position. A functional statement is the official description of the primary duties, responsibilities, and supervisory controls assigned by management to a position. For purposes of this testimony, the OIG considers these written descriptions interchangeable. VA Directive 5003, Position Classification and Position Management, August 22, 2022.

impactful, independent oversight that will provide VA with information to improve a wide range of outreach and response efforts, suicide risk identification, acute crisis management, coordinated care and integrated discharge planning, and research that serve veterans, their families, caregivers, and communities.

Madam Chair, this concludes my statement. I would be happy to answer any questions you or other members may have.