US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Inspection of the VA Jackson Healthcare System in Mississippi

Mental Health Inspection | **25-03937-260** | **September 2, 2026**

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

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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. The OIG conducted this inspection from January 12 through 30, 2026, to assess the mental health care delivered in the acute inpatient mental health unit (inpatient unit) at the G.V. (Sonny) Montgomery VA Medical Center (facility). The facility is part of the VA Jackson Healthcare System in Mississippi. The OIG completed the on-site portion of the inspection from January 28 through 30, 2026. At the conclusion of the on-site visit, the OIG team provided the Healthcare System Director with preliminary findings and observations from the inspection. On June 15, 2026, facility staff provided updated veteran representation, staffing, and environmental safety training information.

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 quality of care provided on the inpatient units. Ten recommendations were issued to facility leaders.

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 information on the OIG's data collection methods, see appendix A.[1]

Domain	OIG Summary
Leadership and Organizational Culture	The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care. The OIG found the Mental Health Executive Council did not have the veteran representation required by Veterans Health Administration (VHA) Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*.[2] According to a June 2026 update to the OIG, a veteran representative attended the March 2026 council meeting. Facility leaders described challenges with staff turnover and recruitment, particularly for inpatient unit psychiatrists, partly related to a geographical barrier.

[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. The local recovery coordinator was assigned multiple ancillary duties and was not provided the protected time required under VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, to fulfill all responsibilities of the position.[3] The inpatient unit did not have recovery-focused design elements outlined in *the VA Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, and veterans did not have accessible indoor alternatives to outdoor space, limiting their engagement in therapeutic activities and reducing essential therapeutic support.[4]
Clinical Care Coordination 	To assess the quality of clinical care coordination, the OIG reviewed access to services, facility procedures for involuntary treatment, medication management, and discharge planning. Staff did not complete documentation for medication risk-benefit discussions as required by VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*.[5] Further, most reviewed discharge instructions used language that could confuse veterans and caregivers, and some did not include the reason for prescribed medications.[6]
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. While inpatient staff completed or reviewed suicide prevention safety plans prior to discharge, they did not consistently document that they provided a copy of the plan to veterans or caregivers, as required by VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[7] The OIG could not determine if reviewed safety plans addressed ways to make the veteran's environment safer from potentially lethal means.

[3] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

[4] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.

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

[6] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," May 24, 2023; VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

[7] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06," September 29, 2023, updated on December 19, 2024. This policy was replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

Domain	OIG Summary
Safety 	The OIG evaluated aspects of safety, compliance with ongoing assessment of suicide hazards, and completion of mandatory staff training. The Interdisciplinary Safety Inspection Team did not report inspection attendance to the Environment of Care Committee; however, prior to the OIG review, the safety inspection team reviewed previous OIG reports to identify recurring issues and developed a plan to report attendance. During a physical inspection of the environment, the OIG observed some hazards that did not meet safety standards identified in VHA's Mental Health Environment of Care Checklist.[8] Many inpatient and inspection staff did not complete training as required by VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.[9] In a June 2026 update to the OIG, facility staff provided updated training records that demonstrated most staff completed the training.

VA Comments and OIG Response

Facility and Veterans Integrated Service Network leaders concurred with recommendations 1–10 and facility leaders provided corrective action plans (see appendixes B and C). Leaders described plans for sustained veteran representation on the Mental Health Executive Council, coverage of local recovery coordinator responsibilities, and improvement of the inpatient unit physical environment. Leaders also committed to improved documentation processes for medication informed consent and suicide prevention, as well as discharge instructions with easy-to-understand language. Plans for safety oversight included improved attendance tracking and training completion and documentation. The OIG will follow up on the planned actions until they are completed.

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[8] "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. This website provides an explanation of the Mental Health Environment of Care Checklist but does not link directly to the checklist.

[9] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, rescinded and replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. The policies contain similar language regarding safety inspection team requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

Contents

Abbreviations

OIG	Office of Inspector General
SOP	standard operating procedure
STEMS	Skills Training for Evaluation and Management of Suicide
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.[10] The OIG established the Mental Health Inspection Program to regularly evaluate VHA's continuum of mental healthcare services. On January 12, 2026, the OIG announced an inspection to evaluate acute inpatient mental health care provided at the G.V. (Sonny) Montgomery VA Medical Center (facility), part of the VA Jackson Healthcare System in Mississippi.[11] The OIG conducted inspection activities from January 12 through 30, 2026, and completed the on-site portion from January 28 through 30, 2026. Following the on-site visit, the OIG team provided facility leaders with preliminary findings and observations from the inspection. On June 15, 2026, facility staff provided updated veteran representation, staffing, and environmental safety training information.

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).[12] 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.[13] All healthcare systems must provide diagnosis, evaluation, 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.[14]

[10] "Mission, Vision, and Values," VA OIG, accessed December 15, 2025, https://www.vaoig.gov/about/mission-vision-values; "About VHA," VA, accessed December 15, 2025, www.va.gov/health/aboutvha.asp. The OIG considers "VHA" and "VA" interchangeable when referring to a medical facility.

[11] 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.

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

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

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

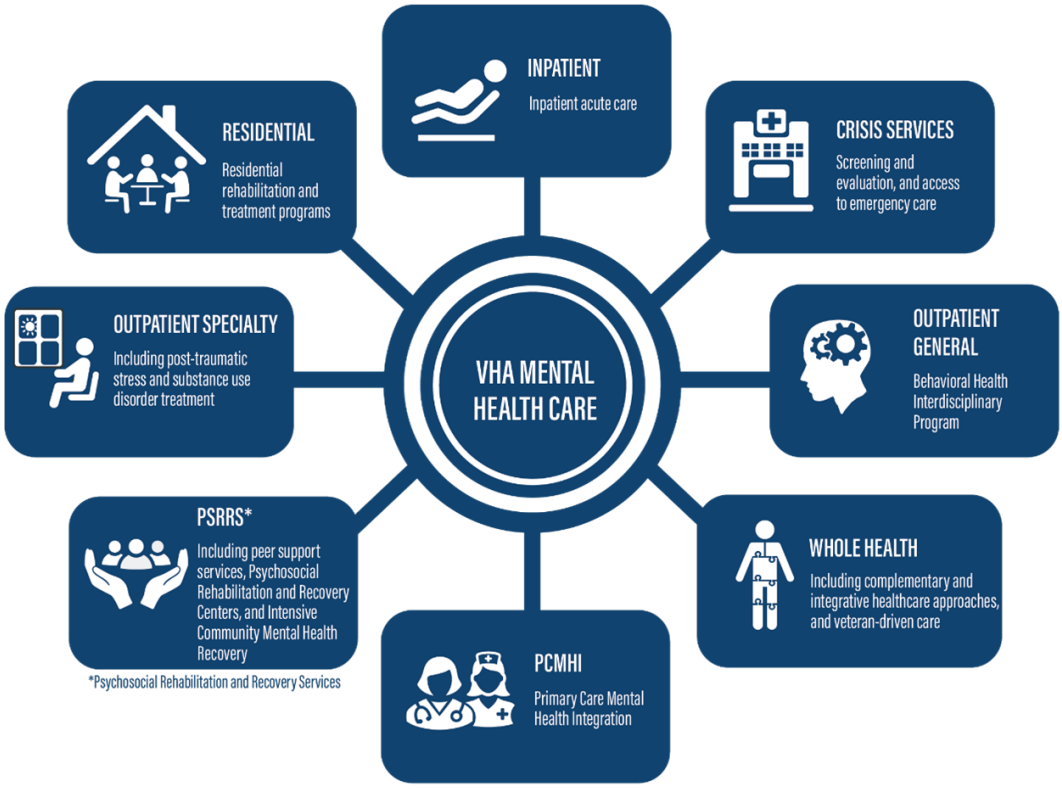

Figure 1. *VHA continuum of mental health care.*
Source: OIG analysis of VHA Directive 1160.01; VHA Directive 1163, Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.*

In fiscal year 2025, VHA healthcare systems delivered inpatient mental health care for 63,240 veteran stays.[15]

VHA Directive 1160.06(1) 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.[16]

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.

[15] 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).

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

About VA Jackson Healthcare System

VA Jackson Healthcare System, part of Veterans Integrated Service Network (VISN) 16, provides acute inpatient mental health care at the facility and operates seven community-based outpatient clinics in Columbus, Greenville, Hattiesburg, Kosciusko, McComb, Meridian, and Natchez, Mississippi.[17]

From October 1, 2024, through September 30, 2025, VA Jackson Healthcare System provided outpatient health care to 37,550 veterans. Of those, 12,154 received outpatient mental health care. Inpatient mental health unit (inpatient unit) staff cared for 350 veterans and maintained an average daily census of 11.[18] Staff submitted 28 consults for inpatient mental health care in the community during this period. According to facility data, the inpatient unit had 14 operating mental health beds at the time of the inspection (discussed further in Inpatient Unit Operations).

[17] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

[18] "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."[19] 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.[20]

The OIG assessed leadership structures and aspects of inpatient unit operations as they related to the delivery of quality care.

Leadership Structure

At the time of the OIG's inspection, the VA Jackson Healthcare System executive leadership team included the Healthcare System Director, Assistant Director, Chief of Staff, Deputy Chief of Staff, Associate Director, Associate Director for Patient Care Services, and Deputy Associate Director for Patient Care Services. The Chief of Staff, Associate Director for Patient Care Services, and their deputies oversaw patient care and supervised service directors, including the Associate Chief of Service, Mental Health (Associate Chief of Service); chief of social work; and acting chief nurse of mental health. The Associate Chief of Service served as the facility's mental health lead, a position required under VHA Directive 1160.01, and oversaw all mental health programs, including the inpatient unit.[21]

According to the Associate Chief of Service, not having direct supervisory authority over nursing and some social work staff in mental health programs posed challenges such as not being informed of disciplinary actions. Mental health leaders also cited staff turnover as a challenge but highlighted collaboration and frequent communication through regular meetings as strengths of the facility's organizational structure.

The acting VISN Chief Mental Health Officer reported that the VISN provided consultation and support for inpatient unit operations, for example, through regular meetings with mental health and discipline leads.

According to VHA Directive 1160.01, healthcare systems are required to establish a mental health executive council to ensure quality mental health care is delivered and includes treatment

[19] Edgar H. Schein, *Organizational Culture and Leadership, 4th ed*, (San Francisco, CA: Jossey-Bass, 2010), https://ia800809.us.archive.org/14/items/EdgarHScheinOrganizationalCultureAndLeadership/Edgar_H_Schein_Organizational_culture_and_leadership.pdf.

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

[21] VHA Directive 1160.01.

that is responsive to veteran preferences.[22] The facility had a Mental Health Executive Council chaired by the Associate Chief of Service that included representation from inpatient unit staff, as well as local recovery and suicide prevention coordinators.[23] However, the council did not meet the requirement for veteran representation during the 12-month review period.[24] The Associate Chief of Service reported discovering the requirement for veteran representation following a re-review of VHA Directive 1160.01 and subsequently identified a veteran representative.[25] According to a June 2026 update to the OIG, a veteran representative attended the March 2026 council meeting. The OIG will continue to monitor to ensure sustained veteran involvement. Without ongoing veteran input, the facility's Mental Health Executive Council could miss opportunities to further improve the quality of inpatient unit care.

Inpatient Unit Operations

VHA Directive 1160.06(1) requires facilities to have an inpatient mental health program manager (program manager) to coordinate and promote consistent, sustained, high-quality therapeutic programming on the inpatient unit.[26] The inpatient mental health program manager is responsible for oversight of all inpatient unit clinical services.[27]

At the time of the inspection, the chief of psychiatry and the acting chief nurse of mental health shared the required VHA program manager role as the facility's co-acting inpatient mental health program managers (program managers).[28] The acting program managers oversaw inpatient unit operations and compliance with applicable requirements. In a June 2026 update, the OIG learned that facility leaders hired a permanent program manager, who started in March 2026. Inpatient unit staff, including nurses, psychiatrists, and social workers, were generally supervised by their respective discipline leaders.

Facility leaders described challenges with staff turnover and recruitment, particularly for inpatient unit psychiatrists, partly related to the facility's location. Additionally, leaders reported that hiring inpatient unit staff was especially difficult because these positions were in-person and required work outside of daytime business hours. Mental health leaders reported relying on staff overtime for weekend coverage. According to October 2025 data, facility leaders reduced operating beds from 18 to 14 because of limited staff. The Chief of Staff stated position vacancies had no impact on inpatient mental health unit access. The unit maintained access to

[22] VHA Directive 1160.01.

[23] VHA Directive 1160.01. The facility refers to its council as the Mental Health Behavioral Science Council.

[24] VHA Directive 1160.01. The OIG reviewed meeting minutes from fiscal year 2025.

[25] VHA Directive 1160.01.

[26] VHA Directive 1160.06, amended to VHA Directive 1160.06(1).

[27] VHA Directive 1160.06, amended to VHA Directive 1160.06(1).

[28] VHA Directive 1160.06, amended to VHA Directive 1160.06(1).

care through available beds during the 12-month inspection period, with an average daily census of 11.

Facility leaders reported using several staff recruitment and retention tools, such as relocation reimbursement, an education debt reduction program, various residency and training programs, and competitive salary restructuring.

Facility leaders indicated that staff had ample opportunities to voice inpatient unit needs and concerns through leadership rounds on the unit, various meetings, and huddles (brief discipline-specific meetings on patient care).[29] The Associate Chief of Service also reported recent implementation of a quarterly inpatient unit staff survey, with a plan to address feedback through a workgroup.

VHA Directive 1160.01 requires facilities to have mechanisms for collecting feedback from veterans who obtain mental health services.[30] Mental health leaders identified processes to solicit input from veterans who used inpatient unit services through surveys, group programming, and informal interactions with staff. Additionally, mental health leaders reported incorporating veteran input into process improvement efforts, for example, by offering a better selection of snacks and clothing for veterans on the inpatient unit.

Recommendation

1. The Healthcare System Director ensures the Mental Health Executive Council includes ongoing veteran representation, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA [Veterans Health Administration] Medical Points of Service*.

For a detailed action plan, see appendix C.

[29] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[30] VHA Directive 1160.01.

Recovery-Oriented Principles

A recovery-oriented mental health treatment approach is based on an individual's "strengths, talents, coping abilities, resources, and inherent values."[31] 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.[32]

The OIG examined aspects of leadership, programming, and the physical care environment to evaluate the facility's integration of recovery-oriented principles on the inpatient unit.

Leadership

Local recovery coordinators play an important role in VA healthcare systems. They are considered collaborative mental health leaders who ensure recovery-oriented principles are integrated into care delivery. Their role is primarily nonclinical in nature, which allows them to dedicate most of their time to activities such as training, consultation, and education.[33]

To support veterans' recovery, VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, requires healthcare systems to have a full-time local recovery coordinator and a plan across the mental health care continuum for continued transformation and implementation of recovery-oriented services.[34] Additionally, VHA Directive 1160.06(1) requires the local recovery coordinator, in collaboration with the inpatient mental health program manager, to establish a standard operating procedure (SOP) that includes processes for "the education, staff training, and implementation of recovery-oriented care" on the inpatient unit.[35]

At the time of the inspection, the local recovery coordinator reported performing multiple ancillary duties (such as management of other programs) that effectively reduced the time dedicated to the position by approximately 80 percent.[36] Without a dedicated full-time local recovery coordinator, recovery-oriented principles may not have been implemented on the inpatient unit or elsewhere in the facility (see the Physical Environment section below).

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[31] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery, 10 Guiding Principles of Recovery*, 2012.

[32] US Department of Health and Human Services, Publication No. SMA-09-4371, *Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions*, 2011.

[33] VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 14, 2025.

[34] VHA Directive 1163.

[35] VHA Directive 1160.06(1).

[36] VHA Directive 1163; "Local Recovery Coordinators," VA Central Office Mental Health, accessed November 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/LOCAL RECOVERY COORDINATOR. (This site is not publicly accessible.)

Mental health leaders established the required SOP for staff training, education, and implementation of recovery-oriented services on the inpatient unit.[37] Additionally, facility leaders fulfilled the requirement for a local strategic plan that guides ongoing transformation toward recovery-oriented services across the mental health continuum.[38]

Recovery-Oriented Treatment

VHA's "Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements under VHA Directive 1160.06" requires inpatient unit staff to orient veterans to the unit and recovery-oriented care.[39] Additionally, VHA requires the interdisciplinary treatment team to develop, implement, and monitor progress on each veteran's treatment plan.[40]

Inpatient unit leaders reported that veterans learned about recovery-oriented care at admission and throughout their hospitalization.[41] Leaders stated the interdisciplinary team met with veterans twice weekly to establish individualized treatment goals and coordinate ongoing care. In addition, the facility's quality team conducted monthly chart reviews across all departments, including evaluations of inpatient mental health treatment plans.

The OIG team observed consistent nurse engagement with veterans on the inpatient unit and verified staff delivered at least four hours of recovery-oriented interdisciplinary programming each day, in accordance with VHA Directive 1160.06(1).[42]

[37] VHA Directive 1160.06, amended to VHA Directive 1160.06(1).

[38] VHA Directive 1163.

[39] 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.

[40] VHA Directive 1160.06(1).

[41] VHA SOP 1160.06.3.

[42] VHA Directive 1160.06(1).

Physical Environment

Figure 2. *Hallway and group room.*
Source: Photos of the facility's inpatient unit taken by OIG staff, January 28, 2026.

VHA recognizes the inpatient unit's physical environment as an element of recovery-oriented mental health care. The *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities* provides standards for healthcare systems to create hopeful and healing environments while maintaining safety.[43] Examples of hopeful and healing elements include natural lighting, artwork, and "warm/grounding neutral earth tone paint colors with accent tones."[44]

The OIG found furnishings and the overall physical space were generally in good repair. While the communal area had a mural depicting an outdoor scene, the space did not feature other recovery-focused elements. Similarly, veterans' bedrooms, hallways, and a group room were also without artwork and other recovery-oriented elements (see figure 2 for relevant images).[45] Further, the nurses' station was fully enclosed with ceiling-high glass barriers, which can hinder veterans' sense of access to inpatient unit staff. During the OIG exit briefing, leaders acknowledged the environment was not recovery-oriented and noted that a full-scale renovation will be initiated in fiscal year 2027 and will include recovery-focused improvements.

The OIG observed other spaces were inaccessible to veterans except during scheduled group sessions or meals. Veterans were limited to one common area, hallways, and bedrooms that contained only beds, which may have prevented them from engaging in constructive self-directed activities. An inpatient leader attributed restricted communal space access to limited visibility from the nurses' station. Additionally, a nurse manager stated that insufficient staffing prevented monitoring of these communal spaces.

The OIG found that staff did not incorporate access to a dedicated, safe, and secure outdoor space into inpatient unit programming. The unit also did not use design alternatives, such as

[43] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*, January 2021.
[44] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*
[45] VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities.*

large artwork or murals, in accessible spaces to simulate outdoor access not readily accessible.[46] Mental health leaders stated the unit's location prevented direct outdoor access except in limited circumstances for veterans with extended stays.

The limited availability of recovery-focused design elements, outdoor access, or appropriate alternatives may undermine veterans' emotional safety, limit opportunities for positive engagement, and reduce the therapeutic support essential for healing.

Recommendations

2. The Associate Chief of Service, Mental Health ensures the local recovery coordinator serves in a full-time capacity, in accordance with Veterans Health Administration Directive 1163, *Psychosocial Rehabilitation and Recovery Services*.
3. The Healthcare System Director ensures the physical environment on the inpatient mental health unit reflects recovery-oriented principles according to Veterans Affairs' *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

For detailed action plans, see appendix C.

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

Clinical Care Coordination

"Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective" treatment.[47] For veterans with "complex health and social needs, care coordination is crucial for improving their access to [services], clinical outcomes, [and] care experiences."[48] VHA's inpatient mental health services use a recovery-oriented approach with a goal of expediting the transition to a lower level of care.[49]

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 hospitalization and treatment, 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.[50] Facility leaders established a standard operating procedure and policy for inpatient unit admission and transfer processes, per VHA's "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."[51] In accordance with the facility's policy, the inpatient unit excluded admission for geropsychiatric veterans who required assistance with basic activities of daily living, and these veterans were referred for care in the community.[52] Staff submitted 28 consults for community inpatient mental health care from

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

[48] 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*, no. 3 (August 15, 2023), https://www.doi.org/10.3389/frhs.2023.1211577.

[49] VHA Directive 1160.06(1).

[50] VHA Directive 1160.01.

[51] VHA Office of Mental Health SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023, updated December 19, 2024; these versions were rescinded and replaced by VHA Office of Mental Health SOP 1160.06.2(1), "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," on February 17, 2026. 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; Facility SOP MH [Mental Health]-11M-067, "Guidelines for the Admission and Treatment of Patients to the Acute Inpatient Behavioral Health Recovery Unit (BHRU)," May 3, 2024; Facility MCP [Medical Center Policy] 586-11-90, *Transfer of Veterans*, July 2, 2025.

[52] Facility MCP 586-11-90.

October 1, 2024, through September 30, 2025. Of these, 26 were due to the inpatient unit's geropsychiatric exclusion. The OIG concluded this did not reflect a broader problem with access to care at the facility for the majority of veterans in need of inpatient mental health care.

Involuntary Hospitalization and Treatment

Facility policy, "Commitment Under Mississippi State Law," outlined written processes for involuntary hospitalization, as required in VHA Directive 1160.06(1).[56] Additionally, facility staff stated they used an online tracking tool to monitor compliance with state laws for involuntary hospitalization. Mental health staff also reported conferring with the Office of General Counsel when needed to ensure the facility's policy aligned with state laws.

The facility met requirements under VA's memorandum "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts." Facility leaders assigned a point of contact to consult with the facility staff and leaders who oversaw processes related to involuntary commitment.[57]

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."[53]

Standards and procedures for civil commitment are provided by state law and vary by state.[54] VHA requires that leaders consult with the Office of General Counsel, as necessary, to ensure that processes are consistent with applicable laws.[55]

VHA policy "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care," requires a registered nurse to record a review of documents required for admission, including voluntary or involuntary legal commitment status, prior to veterans' arrival on the inpatient unit.[58] Ninety percent of reviewed electronic health records

[53] "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 September 10, 2025, https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care_041919_508.pdf.

[54] "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.

[55] VHA Directive 1160.01.

[56] VHA Directive 1160.06(1); Facility MCP 116B-03, *Commitment Under Mississippi State Law*, February 12, 2021.

[57] Acting Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Establishing Veterans Health Administration Facility Involuntary Mental Health Commitment Point of Contacts," memorandum to Veterans Integrated Services Network Directors (10N1-23), July 30, 2025.

[58] VHA Office of Nursing Services VHA-ONS-NUR-22-01, "VA Approved Enterprise Standard (VAAES) Nursing Admission Screen, Assessment, and Standards of Care" (Standard Operating Procedure), September 20, 2022, revised September 10, 2024. Both versions were in effect during the electronic health record review period. Unless otherwise noted, all versions contain similar language related to documentation of voluntary or involuntary legal status.

included evidence that nursing staff documented veterans' legal commitment status in the appropriate note template, which met the threshold for compliance (see appendix A). Accurate information on veterans' legal commitment status can ensure that staff do not violate veterans' civil rights.

Medication Treatment

VHA Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures*, requires documentation of an informed consent discussion between prescribers and veterans for newly prescribed central nervous system medications used to treat a wide range of neurologic and psychiatric conditions.[59] The OIG found only 7 percent of electronic health records reviewed included documentation of informed consent discussions between prescribers and veterans about the risks and benefits of medication treatment. A mental health leader reported that staff engaged in discussions regarding informed consent; however, these discussions were not consistently documented in veterans' electronic health records. Facility staff reported reviewing published OIG Mental Health Inspection Program reports that identified similar concerns, and as a result, revised the note template prior to the on-site visit to prompt required documentation. The OIG anticipates improved documentation of informed consent discussions as a result of these changes.

Discharge Planning

Facility leaders established written guidance on care coordination processes for veterans transitioning out of inpatient care, as required by VHA Directive 1160.01.[60]

All reviewed electronic health records included the required discharge instructions and had documentation that the veteran was offered a copy of the discharge instructions, as required in VHA's *Health Record Documentation Program Guide Version 1.2*.[61]

All reviewed discharge instructions reflected documentation of scheduled outpatient mental health follow-up appointments prior to the veteran's discharge.[62] VHA's "Clinic Profile Management Business Rules" specify follow-up outpatient locations and services should be in

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

[60] VHA Directive 1160.01; Facility SOP MH-11M-071, "3MH Treatment and Discharge SOP," January 24, 2025.

[61] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023, was updated and replaced with VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3*, on February 13, 2025. Unless otherwise specified, the program guides contain similar language related to documentation requirements.

[62] VHA Office of Mental Health SOP 1160.06.2, rescinded and replaced with VHA Office of Mental Health SOP 1160.06.2(1).

easy-to-understand language and free from abbreviations and acronyms.[63] The OIG found very few records had discharge instructions with easy-to-understand language for follow-up appointment locations and services (see figures 3 and 4).[64] Mental health leaders reported discussing a change in the electronic health record system that would ensure clinic abbreviations would be spelled out in easy-to-understand language in the discharge instructions given to veterans. Discharge instructions with abbreviated location information can create barriers for veterans to attend follow-up appointments and receive timely mental health care.

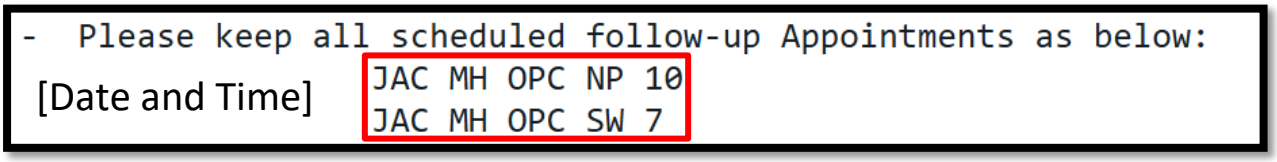

Figure 3. *Example from discharge instructions with abbreviated appointment location information.*
Source: OIG review of veterans' electronic health records.

Figure 4. *Discharge-related screening and documentation.*
Source: OIG review of inpatient unit electronic health records.
Note: Based on analysis of 50 records. Suicide risk screening discussed in Suicide Prevention (below).
**Corresponds to subset of records with a completed medication list (n = 49).*

[63] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules," updated May 24, 2023.
[64] VHA Office of Integrated Veteran Care, "Clinic Profile Management Business Rules."

All reviewed records included documentation that a medication list was provided at discharge. However, some records did not include the reasons for prescribed medications.[65] Inpatient unit staff reported being unaware of the requirement to document the rationale for medications prescribed outside the VA. Accurate and easy-to-understand discharge instructions could prevent medication errors at home following hospitalization.

Additionally, all discharge instructions were free from medical abbreviations that could be difficult for non-medically trained individuals to understand (see figure 4, above).[66] Facility pharmacy staff reported use of a software tool to aid in review of medications and generate a discharge packet and electronic health record note. The staff also described processes that include verification from pharmacists that discharge medication information is accurate and free from unapproved abbreviations before providing it to the veteran at discharge.

Recommendations

4. The Chief of Staff ensures compliance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requirements related to 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.
5. The Chief of Staff ensures veterans' discharge instructions include the follow-up mental health appointment location information in easy-to-understand language, in accordance with Veterans Health Administration's "Clinic Profile Management Business Rules," and develops a plan to monitor for sustained compliance.
6. The Chief of Staff ensures discharge instructions include the purpose for each listed medication, consistent with Veterans Health Administration Directive 1345, *Medication Reconciliation*, and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

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

[66] VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.2*, September 29, 2023; VHA Health Information Management Office, *Health Record Documentation Program Guide Version 1.3*, February 13, 2025.

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.[67]

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."[68] Per VA national strategy, providers play a critical role in identifying veterans at risk of suicide and helping manage at-risk behaviors.[69]

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

Suicide Risk Screening and Evaluation

The "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy, Minimum Requirements by Setting," 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.[70] Inpatient unit clinical staff consistently completed suicide risk screenings within the required time frame in most of the reviewed electronic health records (see figure 4, above).[71]

VHA memorandum "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update" requires facility directors or designees to implement standard operating procedures (SOPs) for suicide risk screening and evaluation and directs executive leaders to identify a champion to ensure staff stay informed of national updates.[72] Facility leaders

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

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

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

[70] VA, "Department of Veterans Affairs (VA) Suicide Risk Identification Strategy Minimum Requirements by Setting," (fact sheet), updated May 10, 2023, February 25, 2025, and October 30, 2025. All three versions contain similar language regarding inpatient mental health requirements; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11), "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (RISK ID Strategy)," memorandum to Veterans Integrated Services Network (VISN Director, et al.), November 23, 2022, was rescinded and replaced by "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum on January 7, 2025.

[71] VA, "VA Suicide Risk Identification Strategy Minimum Requirements by Setting"; While VHA requires staff to complete Columbia-Suicide Severity Rating Scales within 24 hours before discharge, the OIG also considered risk screenings compliant if completed on the day of discharge. The OIG used 90 percent as the expected level of compliance for electronic health record reviews.

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

established a local SOP and also identified a facility champion, per the memorandum requirements.[73]

Safety Planning

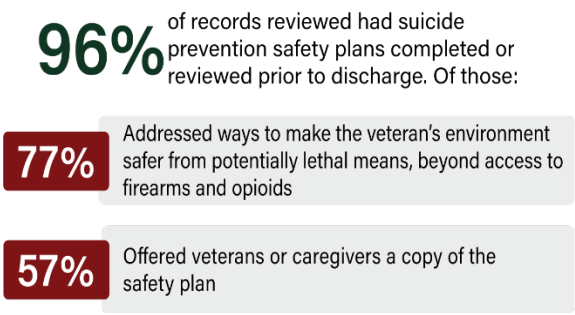

Figure 5. *Facility staff's compliance with VHA safety planning guidance.*
Source: OIG review of veterans' electronic health records.

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."[74]

The OIG found that inpatient staff consistently completed or reviewed suicide prevention safety plans prior to discharge, which is a requirement in VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA Directive 1160.06."[75] However, many reviewed safety plans did not have documentation that staff provided a copy of the plan to veterans or caregivers.[76] Mental health leaders stated that sometimes at discharge, staff may have forgotten to document that the safety plan was given to veterans even if it was provided. Leaders also reported that following review of OIG published reports, staff made modifications in the discharge note template to improve documentation and provided examples of the updated template to the OIG. Veterans could be more likely to use coping skills after discharge from the inpatient unit with a copy of the safety plan.

Some suicide prevention safety plans reviewed did not indicate staff addressed ways to make the environment safer from other potentially lethal means, beyond access to firearms and opioids, as outlined in the *VA Safety Planning Intervention Manual* (see figure 5, above).[77] Mental health leaders conveyed awareness that staff often missed this question, and noted that after the OIG's

[73] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: Suicide Risk Screening and Evaluation Requirements and Implementation Update," memorandum; Facility MCP 586-11M-01, *Assessment and Management of Veterans with Suicidal Behaviors*, September 15, 2025.

[74] Barbara Stanley and Gregory K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice* 19, no. 2 (May 2012): 256–264, https://doi.org/10.1016/j.cbpra.2011.01.001.

[75] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2, September 29, 2023, updated on December 19, 2024, rescinded and replaced with SOP 1160.06.2(1) on February 17, 2026. Unless otherwise specified, the three policies contain similar language regarding safety planning processes.

[76] VHA Office of Mental Health and Suicide Prevention SOP 1160.06.2(1).

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

electronic health record review, facility staff updated the safety plan template to make the response mandatory. Facility staff provided examples of safety plans, specifically responses to ways to make the environment safer, that are now more detailed and individualized to the veteran.

In a recent publication, the OIG made the following recommendation related to suicide safety plan completion:

The Under Secretary for Health identifies barriers to, and ensures documentation of, discussions specific to making the environment safer from identified lethal means in veterans' safety plans.[78]

In response to the OIG's recommendation, VHA leaders updated the suicide prevention safety plan template to require documentation of lethal means safety discussions. Therefore, the OIG does not make any further recommendations on suicide safety plan documentation in this report.

The identification of all potential lethal means in the veteran's environment, beyond firearms and opioids, can reduce the risk of self-harm.

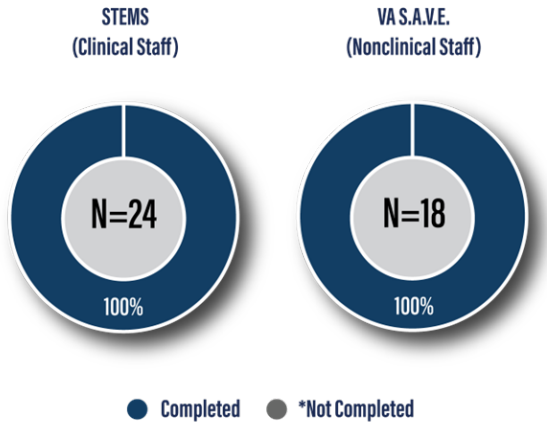

Figure 6. *Inpatient unit staff completion of mandatory suicide prevention trainings.*
Source: OIG document review of clinical and nonclinical staff training records.
Note: The OIG evaluated completion of STEMS and VA S.A.V.E. trainings from January 12, 2025, through January 11, 2026.

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 and supporting next steps) help clinical and nonclinical staff, respectively, identify the warning signs of suicide risk and appropriate interventions.[79]

The OIG determined all inpatient unit staff met the 95 percent completion target for STEMS and VA S.A.V.E. training established in the "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ [Frequently Asked Questions]" (see figure 6).[80]

[78] VA OIG, *Mental Health Inspection of the VA NY Harbor Healthcare System in New York*, Report No. 25-00729-23, December 18, 2025.

[79] VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; VA, "VA S.A.V.E. Training: Four Ways You Can Help a Veteran in Crisis" (fact sheet), June 2025.

[80] "Office of Suicide Prevention Suicide Prevention Mandatory Training Dashboard FAQ," VHA Office of Suicide Prevention, accessed April 15, 2026, https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators/SitePages/Education-and-Training.aspx. (This site is not publicly accessible.)

Recommendation

7. The Chief of Staff ensures staff provide a copy of the suicide prevention safety plan to veterans upon discharge from the inpatient unit, in accordance with Veterans Health Administration Office of Mental Health and Suicide Prevention Standard Operating Procedure 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06," and develops a plan to monitor for sustained compliance.

For a detailed action plan, see appendix C.

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."[81] An inpatient environment should be carefully designed, and staff should be trained to recognize hazards and minimize the potential for self-harm.[82]

To assess the inpatient mental health environment, the OIG evaluated ongoing assessments of suicide hazards and completion of staff training.

Mental Health Environment of Care

VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, outlines expectations for environment of care inspections.[83] The Interdisciplinary Safety Inspection Team (safety inspection team), consisting of both mental health and other facility staff, is responsible for conducting environment of care inspections using the Mental Health Environment of Care Checklist.[84] The National Center for Patient Safety continually updates this checklist "based on reports from the field of hazards or adverse events encountered at the local level."[85] Inspection team members are required to use this comprehensive checklist of more than 140 detailed environmental elements to "identify and abate suicide hazards on mental health units and other areas treating patients at high acute risk for suicide."[86]

As outlined in VHA Directive 1167, the safety inspection team should include an inspection lead, inpatient mental health unit program director, inpatient unit nurse manager, suicide prevention coordinator, patient safety manager, representative from engineering or facilities

[81] VHA Directive 1160.06, amended to VHA Directive 1160.06(1).

[82] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017, replaced with VHA Directive 1167, *Mental Health Environment of Care Checklist for Units Treating Suicidal Patients*, November 4, 2024. Unless otherwise specified, the policies contain similar language related to the inpatient unit interdisciplinary safety inspection team and Mental Health Environment of Care Checklist inspections and training requirements. The older directive was in place for part of the mental health environment of care checklist and training documentation reviews.

[83] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[84] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[85] "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. This website provides an explanation of the Mental Health Environment of Care Checklist but does not link directly to the checklist.

[86] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024; "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, October 24, 2025, updated April 29, 2026, https://dvagov.sharepoint.com/sites/vhancps/SitePages/Mental-Health.aspx. (This site is not publicly accessible.) The October 2025 version was in place during the inspection time frame.

management, and "one additional clinical staff from any discipline or work area."[87] The safety inspection team is required to report to the facility environment of care committee, with team membership, attendance, and findings documented as part of the inspection rounds summary.[88]

The facility maintained a safety inspection team with designated co-leads, conducted inspections at the required frequency, tracked hazards to resolution, and reported findings to the Environment of Care committee. However, the inspection attendance was not reported to the committee, as required.[89] Prior to the OIG review, a co-lead reported that the Healthcare System Director asked the safety inspection team to review previous OIG reports to identify any recurring issues. As a result, the team developed a plan to report attendance starting with the next scheduled environment of care inspection in July 2026. Reporting attendance can help ensure strong senior leadership oversight and supports the timely identification and resolution of potential environmental hazards.

The OIG observed adherence to most of the high-risk safety elements reviewed during a physical inspection of the unit. However, the OIG identified an unsafe trash can in a patient care area that was immediately removed by staff.[90] Additionally, the OIG observed items, such as installed card readers and a water fountain, protruding from hallway walls that did not meet safety standards. Facility staff removed most of the identified risks and, at the request of the OIG, developed an action plan to address and mitigate the remaining safety risks.[91]

Training

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.[92] Additionally,

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

[88] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024. The new directive revised the reporting requirements for the safety inspection team.

[89] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024. The new directive updated the requirement for the Mental Health Environment of Care Checklist inspection team attendance and findings to be reported to the Comprehensive Environment of Care Committee. VHA requires a designated team lead; however, the facility had three co-leads.

[90] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, October 24, 2025. The OIG reviewed the inpatient unit for randomized safety elements such as trash cans free of plastic bags, anchor-free window coverings, and ligature-free bathroom doors.

[91] "Mental Health Environment of Care Checklist," VHA National Center for Patient Safety, October 24, 2025.

[92] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024. The policies contain similar language related to training requirements.

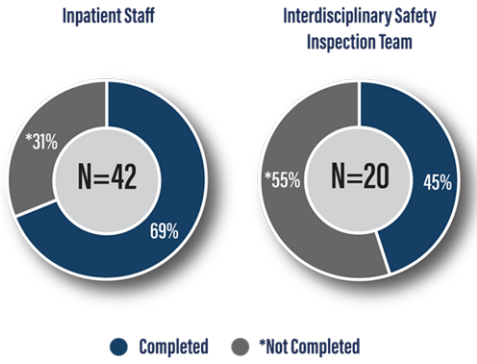

Figure 7. *Mental Health Environment of Care Checklist training completion.*
Source: OIG document review of staff training for inpatient unit and Interdisciplinary Safety Inspection Team staff.
Note: The OIG evaluated completion of Mental Health Environment of Care Checklist training from January 12, 2025, through January 11, 2026. Interdisciplinary Safety Inspection Team staff who were also inpatient unit staff are included in the denominator for both document reviews.

VA medical facility leadership must attest that required staff have completed the training, according to VHA Standard Operating Procedure 1167.2.[93]

Facility leaders attested that staff completed required annual Mental Health Environment of Care Checklist training as required.[94] However, the OIG found that many inpatient unit and safety inspection team staff did not actually complete the training (see figure 7).[95] A co-lead and nurse manager reported that the Mental Health Environment of Care Checklist training was mistakenly designated as "optional" and not assigned as an annual requirement. During the OIG on-site visit, the nurse manager reported the training was reassigned as an annual requirement. As a result of communication from the OIG, the Healthcare System Director instructed staff to complete the training by February 2, 2026. In a June 2026 update to the OIG, facility staff provided records that demonstrated most staff completed the training. Oversight of annual training on environmental hazards could reduce safety risks for veterans and staff on the inpatient unit.

Recommendations

8. The Healthcare System Director instructs the Interdisciplinary Safety Inspection Team to record and report attendance of inspections to the Environment of Care Committee, according to Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, and develops a plan to monitor for sustained compliance.
9. The Healthcare System Director develops and implements a plan to monitor Mental Health Environment of Care Checklist training completion for sustained compliance, consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.

[93] VHA Office of Mental Health SOP 1167.2, "Standard Operating Procedure for Submission of MHEOCC Attestations Under VHA Directive 1167," November 5, 2024.
[94] VHA Office of Mental Health SOP 1167.2, November 5, 2024; VHA Directive 1167, November 4, 2024.
[95] VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

10. The Healthcare System Director ensures that Mental Health Environment of Care Checklist training completion attestation is accurately documented, in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA [Veterans Health Administration] Directive 1167," and develops a plan to monitor for sustained compliance.

For detailed action plans, see appendix C.

Conclusion

To support quality of care improvements, the OIG reviewed the facility's acute inpatient mental health care across five domains. Facility leaders described challenges with staff turnover and recruitment, particularly for inpatient unit psychiatrists, but highlighted collaboration and frequent communication as strengths of the facility's organizational structure. Facility data indicated operating mental health beds were reduced due to limited staff. The Chief of Staff stated there were no adverse veteran care consequences due to staffing.

The OIG found several aspects of recovery-oriented care on the inpatient unit, such as veteran orientation to recovery-oriented care throughout hospitalization, consistent nurse engagement with veterans, and delivery of at least four hours of recovery-oriented interdisciplinary programming on each day. Although the facility employed a full-time local recovery coordinator, the assignment of multiple ancillary duties significantly reduced the time dedicated to the position.

Leaders acknowledged the inpatient unit environment was not recovery-oriented and noted that a full-scale renovation in fiscal year 2027 will include recovery-focused improvements. The OIG found that inpatient unit programming did not include access to a dedicated, safe, and secure outdoor space or alternatives that simulate outdoor space.

Facility staff met requirements related to involuntary hospitalization and used a tracking tool to monitor compliance with state laws, consulted with the Office of General Counsel when needed to ensure facility policy aligns with state laws, and assigned a subject matter expert as a point of contact.

Few reviewed electronic health records had documentation of informed consent discussions between prescribers and veterans about the risks and benefits of medication treatment or discharge instructions with easy-to-understand language for follow-up appointments. While all discharge instructions were free from medical abbreviations that could be difficult for non-medically trained individuals to understand, some did not include the reasons for prescribed medications.

Inpatient unit staff consistently completed suicide risk screenings and completed or reviewed suicide prevention safety plans within the required time frames. However, many reviewed safety plans did not have documentation that staff provided a copy to veterans or caregivers. In some safety plans, staff did not indicate that ways to make the environment safer from potentially lethal means beyond access to firearms and opioids were addressed.

Staff completed required suicide prevention training. Although many staff had not completed annual Mental Health Environment of Care Checklist training at the time of the OIG inspection, most eventually completed the training. Most environment of care requirements were met, but the OIG observed safety hazards. Facility staff removed most of the identified risks and, at the request of the OIG, developed an action plan to address and mitigate the remaining safety risks.

The OIG issued 10 recommendations to facility leaders. In response to the OIG's recommendations, leaders committed to ensuring sustained veteran representation on a facility council, coverage of Local Recovery Coordinator responsibilities, and improvement of the inpatient unit physical environment. Leaders reported plans for better documentation processes for medication informed consent and suicide prevention, as well as discharge instructions with easy-to-understand language. Plans for safety oversight included improved attendance tracking and training completion.

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: Methodology

The Mental Health Inspection Program inspections focused on the quality of care provided by VHA's inpatient mental health services.[96] The OIG randomly selected the VHA healthcare systems included in fiscal year 2026 reviews from all systems with inpatient mental health beds.[97] The OIG conducted a virtual and on-site review at the facility. The OIG team identified one area of concern beyond the scope of this review that required referral to the OIG hotline.

The OIG reviewed VHA and facility policies, standard operating procedures, and guidance documents in effect at the time of the inspection. Additionally, the OIG reviewed 12 months of healthcare system Mental Health Executive Committee meeting minutes. The OIG reviewed data specific to the facility, prior OIG reports related to the inpatient units, 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 training records for annual completion of Skills Training for Evaluation and Management of Suicide (STEMS), VA S.A.V.E (Signs of suicide, Asking about suicide, Validating feelings, and Encouraging help and supporting next steps), and Mental Health Environment of Care Checklist trainings.[98] 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 and Mental Health Environment of Care Checklist training

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards.[99] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. Office of Healthcare Inspection teams do not use AI as the

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

[97] 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 2026, the OIG excluded facilities with inpatient mental health beds that the OIG inspected in fiscal years 2024 and 2025. Allocation Resource Center, "Monthly Program Cost Report (MPCR) Handbook," October 2014, updated March 2017.

[98] VHA Directive 1071(1); VHA Directive 1167, May 12, 2017, rescinded and replaced with VHA Directive 1167, November 4, 2024.

[99] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M- 25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[100]

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 B and appendix C.

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.[101] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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, 2024, through September 30, 2025.[102] The OIG reviewed for documentation of a risk and benefit discussion specific to veterans who were newly prescribed central nervous system medications (used for treatment of "a wide range of neurologic and psychiatric conditions") during the inpatient stay.[103] 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.[104] The OIG team visually assessed the inpatient unit environment for warm and inviting design elements such as

[100] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

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

[102] The OIG identified the electronic 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.

[103] VHA Directive 1004.01(3); John A. Gray, "Introduction to the Pharmacology of CNS [Central Nervous System] Drugs," chap. 21 in *Katzung's Basic & Clinical Pharmacology*, 16th ed., Todd W. Vanderah: (McGraw Hill (2024), https://accesspharmacy.mhmedical.com/content.aspx?sectionid=281750155&bookid=3382&Resultclick=2.

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

natural lighting, artwork, and calming paint colors. The OIG also observed the unit for cleanliness and veteran access to secure outdoor space.[105] Further, the OIG's physical inspection of areas in the inpatient unit focused on selected safety elements specific to this facility.

The OIG reviewed the Mental Health Environment of Care Checklist data documented in the Patient Safety Assessment Tool, the software tool VHA uses to document these types of inspections, and assessed corrective actions taken for deficiencies unresolved for more than six months.[106]

[105] VHA Directive 1160.06; VHA Directive 1160.06(1); VA, *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*; VHA Directive 1850.01(1), *Health Care Environmental Sanitation Program*, March 29, 2023.

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

Appendix B: Health Service Area Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 31, 20263

From: Executive Director, Department of Veterans Affairs (VA) Health Service Area 4.1

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Jackson Health Care System in Mississippi

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

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.
2. Should you need further information, contact the Health Service Area 4.1 Regional Quality Officer.

(*Original signed by:*)

Stephanie A. Repasky, Psy.D.

[OIG comment: The OIG received the above memorandum from VHA on August 3, 2026.]

Appendix C: Healthcare System Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 31, 2026

From: Interim Director, Department of Veterans Affairs (VA) VA Jackson Healthcare System (586)

Subj: VA Office of Inspector General (OIG) Report, Mental Health Inspection of the VA Jackson Health Care System in Mississippi

To: Executive Director, VA Health Service Area 4.1

1. We appreciate the opportunity to review and comment on the OIG report Mental Health Inspection of the VA Jackson Healthcare System in Mississippi. Jackson Healthcare System concurs 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, Safety, & Improvement.

(*Original signed by*:)

Rolanda Webb, MBA

[OIG comment: The OIG received the above memorandum from VHA on August 3, 2026.]

Healthcare System Director Response

Recommendation 1

The Healthcare System Director ensures the Mental Health Executive Council includes ongoing veteran representation, in accordance with Veterans Health Administration Directive 1160.01, *Uniform Mental Health Services in VHA [Veterans Health Administration] Medical Points of Service*.

__X_ Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The Mental Health Executive Council charter was updated in February 2026 to include a Veteran in the membership. The Associate Chief of Service (ACOS) of Mental Health will ensure the Mental Health Executive Council includes Veteran representation at the quarterly meeting effective March 2026. The ACOS of Mental Health will report on Veteran attendance at Mental Health Executive Council. Compliance will be monitored quarterly, with a goal of 90% Veteran attendance for 2 consecutive quarters.

Recommendation 2

The Associate Chief of Service, Mental Health ensures the local recovery coordinator serves in a full-time capacity, in accordance with Veterans Health Administration requirements Directive 1163, *Psychosocial Rehabilitation and Recovery Services*.

__X_ Concur

_____Nonconcur

Target date for completion: November 2026

Director's Comments

On April 29, 2026, a VHA Policy Waiver (Waived Policy Number 1163) was submitted to VHA Office of Integrity and Compliance where the facility requested to waive the staffing requirement for a full-time equivalent employee (FTEE) requirement of Local Recovery Coordinator (LRC) is considered hard to fill. The waiver was denied on May 21, 2026, for the reason "The waiver request does not include an Action Plan for how the facility plans to cover the LRC role for the duration of the waiver." Mental Health Service is in the process of submitting a new waiver that includes a short-term Action Plan for how the LRC role will be covered throughout the duration of the proposed waiver period. In the Interim, the LRC duties and responsibilities will continue to be covered by the Local Recovery Services and Serious Mental Illness Program Manager-

Psychologist. Mental Health Service is confident they will be able to meet the FTEE requirement of 1.0 FTEE in full by converting an existing staff vacancy to a new LRC Social Worker by October 31, 2026.

Recommendation 3

The Healthcare System Director ensures the physical environment on the inpatient mental health unit reflects recovery-oriented principles according to Veterans Affairs' *Design Guide for Inpatient Mental Health & Residential Rehabilitation Treatment Program Facilities*.

__X_ Concur

_____Nonconcur

Target date for completion: April 2027

Director's Comments

The Inpatient Mental Health Unit will be repainted with aesthetically pleasing colors and add artwork and murals supporting the Mental Health Recovery Program with input from the LRC and Veteran Council. This work will begin in October 2026 with estimated completion April 2027.

Interior Design has submitted a furniture order to facilitate the reopening of currently locked dayrooms for free Veteran use. The initial furniture order is expected to be delivered in October 2026. After onsite safety inspection has been completed by the Interdisciplinary Safety Inspection Team, remaining furniture will be purchased and installed, with all installations completed by March 2027. These improvements will enable unrestricted access for Veterans to the large dayroom, which is presently locked due to safety concerns identified during Mental Health Environment of Care Checklist (MHEOCC) rounds.

A full renovation of the Inpatient Mental Health Unit is planned for fiscal year 2027; project activities in that year are limited to design work, with construction scheduled to begin in 2028 and conclude in 2029.

Recommendation 4

The Chief of Staff ensures compliance with Veterans Health Administration Directive 1004.01(3), *Informed Consent for Clinical Treatments and Procedures* requirements related to 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: September 2026

Director's Comments

The acute psychiatry inpatient progress notes were revised to include documentation of risks and benefits of newly prescribed medications being discussed with the Veteran and that the Veteran verbalized understanding. Compliance will be measured through monthly monitoring of 10 Veteran charts for the presence of documented discussion between the prescriber and Veteran on the risk and benefits of newly prescribed medications in the electronic health record, with a goal of 90% or greater compliance for 6 consecutive months. Data will be reported in Mental Health Executive Council quarterly.

Recommendation 5

The Chief of Staff ensures veterans' discharge instructions include the follow-up mental health appointment location information in easy-to-understand language, in accordance with Veterans Health Administration's "Clinic Profile Management Business Rules," and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: March 2027

Director's Comments

The Associate Nurse Executive (ANE) for Mental Health will ensure that Veterans' discharge instructions include the follow-up mental health appointment location and clinic name information in an easy-to-understand language. As part of the discharge instructions, a templated standardized appointment discharge letter will be reviewed with the Veteran that will include the date, clinic name, clinic location, and appointment time for all follow-up mental health appointments. The letter will be clear, concise and in easy-to-understand language. This communication will be reflected in the Veteran's electronic health record, with the Veteran receiving a hard copy of the letter at discharge. Workflows will be revised to align with the new process. Compliance will be measured through monthly monitoring of 10 Veteran charts for the presence of documentation in the electronic health record of easy-to-understand mental health appointments at the time of discharge, with a goal of 90% or greater compliance for 6 consecutive months. Data will be reported in Mental Health Executive Council quarterly.

Recommendation 6

The Chief of Staff ensures discharge instructions include the purpose for each listed medication, consistent with Veterans Health Administration Directive 1345, *Medication Reconciliation*, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: October 2026

Director's Comments

The Chief of Psychiatry and Inpatient Mental Health Pharmacist reviewed discharge medication instructions given to the Veteran to ensure all medications had a purpose. Compliance will be measured through monthly monitoring of 10 Veteran charts for the presence of documentation that all discharge medications had a purpose listed in discharge instructions, with a goal of 90% or greater compliance for 6 consecutive months. Data will be reported in Mental Health Executive Council quarterly.

Recommendation 7

The Chief of Staff ensures staff provide a copy of the suicide prevention safety plan to veterans upon discharge from the inpatient unit, in accordance with Veterans Health Administration Office of Mental Health and Suicide Prevention Standard Operating Procedure 1160.06.2, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units under VHA [Veterans Health Administration] Directive 1160.06," and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: September 2026

Director's Comments

The ANE for Mental Health revised the Nursing Discharge note template to capture if the Suicide Safety Plan was given to Veterans at the time of discharge. Compliance will be measured through monthly monitoring of 10 Veteran charts for the presence of documentation that Suicide Safety Plan was given to Veteran at discharge, with a goal of 90% or greater compliance for 6 consecutive months. Data will be reported in Mental Health Executive Council quarterly.

Recommendation 8

The Healthcare System Director instructs the Interdisciplinary Safety Inspection Team to record and report attendance of inspections to the Environment of Care Committee, as required by Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: December 2026

Director's Comments

An attendance sheet was developed by the Chair of the Interdisciplinary Safety Inspection Team (ISIT). The attendance sheet was utilized for the June MHEOCC rounds. Attendance sheets will be maintained by the ISIT Chair and attendance reported to the Hospital Environment of Care (EOC) Committee after each MHEOCC rounds. Compliance will be monitored for 2 consecutive MHEOCC inspections.

Recommendation 9

The Healthcare System Director develops and implements a plan to monitor Mental Health Environment of Care Checklist training completion for sustained compliance, consistent with Veterans Health Administration Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*.

__X_ Concur

_____Nonconcur

Target date for completion: August 2026

Director's Comments

MHEOCC training was reviewed and all Inpatient Mental Health Staff and ISIT team members that were non-compliant were sent a reminder to complete training. A spreadsheet was developed by the ISIT Chair that tracks date of completion for MHEOCC training for Inpatient Mental Health Staff and ISIT Team Members. The spreadsheet is reviewed monthly, and reminders are sent out to staff that need to complete the training in the upcoming month, with completions certificates sent to the ISIT chair to update spreadsheet. Compliance rates are reported monthly in the hospital EOC Committee and should be 90% or greater for both Inpatient Mental Health staff and ISIT Team members. Leadership will monitor compliance until 90% or greater goal is met for 6 consecutive months.

Recommendation 10

The Healthcare System Director ensures that Mental Health Environment of Care Checklist training completion attestation is accurately documented, in accordance with Veterans Health Administration Office of Mental Health Standard Operating Procedure 1167.2, "Standard Operating Procedure for Submission of MHEOCC [Mental Health Environment of Care Checklist] Attestations Under VHA [Veterans Health Administration] Directive 1167," and develops a plan to monitor for sustained compliance.

__X_ Concur

_____Nonconcur

Target date for completion: January 2027

Director's Comments

The ISIT Chair will track and report on the monthly MHEOCC training compliance and completion rates to the EOC Committee. In addition, training compliance will be verified for all required staff prior to each biannual MHEOCC rounds and training attestation. Results will be routed through the governance structure with final oversight and attestation by the Medical Center Director. Compliance will be 90% or greater completion rate for 6 consecutive months.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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